Performance

Report

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| Name of service: | Milford House Nursing Home |
| Service address: | 2-4 Milford Street RANDWICK NSW 2031 |
| Commission ID: | 2035 |
| Approved provider: | Thompson Health Care Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 30 August 2023 to 31 August 2023 |
| Performance report date: | 31 October 2023 |

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

**This performance report**

This performance report for Milford House Nursing Home (**the service**) has been prepared by J Durston, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received 25 September 2023

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-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 | **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 2(3)(a) – The approved provider ensures that assessment and care planning includes identification of the current risks to the consumer’s health safety and wellbeing, in the areas of changed behaviours, use of psychotropic medication, wound management and falls management.
* Requirement 2(3)(b) - The approved provider ensures that assessment and planning identifies and addresses consumers’ current needs, goals, and preferences in the areas of wound management, pain management, behavioural support and restrictive practices.
* Requirement 3(3)(a) – The approved provider ensures consumers receive effective personal and clinical care and services that meet their current needs, goals and preferences in the areas of wound and skin management, bowel management, behaviour support and restrictive practices such as chemical restraint.
* Requirement 3(3)(b) – The approved provider ensures effective identification and management of high impact high prevalence risks in relation to wound management.
* Requirement 3(3)(b) – The approved provider ensures incident reports are consistently completed and reviewed, including identification of incident causes, mitigation strategies and evaluation of their effectiveness.
* Requirement 8(3)(e) – The approved provider ensures clinical monitoring, auditing and reporting is complete, accessible across the organisation, identifies all high impact high prevalence risks to consumer health safety and wellbeing at the local and organisational level, provides guidance and direction on resolution of non-compliance with the Quality Standards and legislative requirements and identifies areas for continuous improvement.

# 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 |

Findings

The service was found non-compliant in Requirement 1(3)(a) following a site audit from 14 February to 17 February 2022. The service did not demonstrate consumers are treated with dignity and respect, in areas of personal and hygiene care, assistance with meals, personal safety and communication with negative impact on their health, safety and wellbeing.

During the Assessment Contact conducted from 30 August 2023 to 31 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The service’s privacy and dignity policy was updated and education was delivered to all staff on treating consumers with dignity and respect.

During the Assessment Contact the Assessment Team found the service did not demonstrate consistent respectful and dignified treatment of consumers. Some consumers and representatives said respectful, individual, and diverse care was given and staff and management were able to describe individual consumers’ diverse needs and preferences. However, the assessment team observed consumers’ care plans did not include this detail, and the service did not demonstrate consumers’ privacy and dignity was always respected. The Assessment Team observed a consumer’s catheter bag partially exposed in the dining area, and staff members were observed discussing residents’ care during lunch breaks, impacting consumers’ dignity and respect. The Assessment Team acknowledged the service promptly responded to their feedback during the Assessment Contact. A staff toolbox talk was delivered on confidentiality, privacy and consumer dignity. An email reminder was sent to staff to attend to consumers’ preferences as to use of stands and covers for those using catheter bags, and documentation was updated in line with service procedures.

In their response to the Assessment Team report, the approved provider outlined the organisation’s policies and procedures and improvement initiatives, supplied their updated continuous improvement plan with relevant improvement actions, and care documentation for named consumers to support their compliance with this requirement. The approved provider advised the service had conducted a consumer dignity and choice audit that addressed Standard 1 requirements. The audit identified deficiencies in accurate recording of consumer preferences. Staff training was delivered on consumer privacy and dignity and documentation of consumer preferences.

I have considered the approved provider’s response and the actions outlined in its plan for continuous improvement. I commend the approved provider’s prompt action to address issues in relation to this requirement identified by the Assessment Team during the Assessment Contact, and the consumer survey completed prior to the assessment to clarify areas for improvement in relation to consumer dignity and choice, and the actions outlined in the plan for continuous improvement. With these considerations I find the approved provider’s evidence to be more compelling in regard to compliance for this requirement and am satisfied the provider is well positioned to ensure consumers are treated with dignity and respect.

Accordingly, I find Requirement 1(3)(a) compliant.

# 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. | Non-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. | Non-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 service was found non-compliant in Requirements 2(3)(a), 2(3)(b) and 2(3)(e) following a site audit from 14 February to 17 February 2022.

Requirement 2(3)(a)

During the 2022 site audit the service did not demonstrate assessment and care planning informed safe and effective care in relation to changed behaviours, wound management, mobility and transfers and pain management.

During the Assessment Contact conducted from 30 August 2023 to 31 August 2023, the service provided evidence that it has implemented improvements to meet the requirement, including additional staff training, care plan reviews and message alerts to trigger care plan reviews on the electronic care management system.

During the Assessment Contact the Assessment Team found the service did not demonstrate assessment and planning consistently considered personal and clinical risks to individual consumers’ health and well-being to inform the delivery of safe and effective care in the areas of changed behaviours, use of psychotropic medication, wound management and falls management.

In their response to the Assessment Team report, the approved provider outlined the organisation’s policies and procedures and improvement initiatives, supplied their updated plan for continuous improvement with relevant improvement actions, and care documentation for named consumers to support their compliance with this requirement. The approved provider’s response included updated falls safety assessments for two named consumers. Their previous falls safety assessments noted the consumers’ high falls risk and the several falls they have had in 2023 but did not include the falls risk associated with potential side effects of their prescribed psychotropic medications. I acknowledge the approved provider has reviewed and updated the safety assessments for the named consumers in response to the Assessment Team’s feedback during the Assessment Contact. However, the documentation showed the assessments were both updated 12 days after the Assessment Contact occurred indicating an extended period where the consumers’ falls risk was still not highlighted to guide safe care and services.

The approved provider has made comprehensive amendments to its plan for continuous improvement to address the deficiencies related to this requirement. However, I consider the planned and actual actions taken to date require time to ensure effectiveness, timeliness and sustainability to minimise risk to consumers’ health, safety and wellbeing.

Accordingly, I find Requirement 2(3)(a) non-compliant.

Requirement 2(3)(b)

During the 2022 site audit the service did not demonstrate assessment and planning consistently identified and addressed current needs, goals and preferences of consumers, in the areas of personal care and changed behaviours.

During the Assessment Contact conducted from 30 August 2023 to 31 August 2023, the service provided evidence that it has implemented improvements to meet the requirement, including relevant staff training, updated care plans containing consumers’ needs and preferences and consultation with consumers and representatives regarding use of restrictive practices.

During the Assessment Contact the Assessment Team found the service did not demonstrate care planning documentation consistently reflected consumers’ needs, goals, and preferences. There was conflicting information in some wound charts regarding wound management. Allied health assessments were populated in consumers’ progress notes but not to their care plan in the electronic care management system. The assessment and care planning documentation for some consumers contained generic rather than individualised behaviour support and pain management strategies, and one named consumer’s care plan did not record they were subject to environmental restraint.

In their response to the Assessment Team report, the approved provider outlined the organisation’s policies and procedures and improvement initiatives, supplied their updated Olan for continuous improvement with relevant improvement actions, and care documentation for named consumers to support their compliance with this requirement. The approved provider noted that the service is dedicated to delivering high quality customer centred and collaborative care. The approved provider supplied a behaviour support plan for a named consumer that was updated 3 weeks after the Assessment Contact. Overall, it contained generic rather than individualised behaviour support strategies, including listening and reassurance, engagement in meaningful activities, and space to calm down. I acknowledge that the approved provider supplied evidence of a hard copy, signed restrictive practices consent form for the consumer identified as requiring one during the Assessment Contact. However, I note the form was signed two weeks after the Assessment Contact and the form states the restrictive practice cannot be put into effect until the resident of guardian/representative has signed the hard copy of the form.

The approved provider has made comprehensive amendments to its plan for continuous improvement to address the deficiencies related to this requirement. However, I consider the planned and actual actions taken to address this requirement require time to ensure effectiveness, timeliness and sustainability to minimise risk to consumers’ health, safety and wellbeing.

Accordingly, I find Requirement 2(3)(b) non-compliant.

Requirement 2(3)(e)

During the 2022 site audit the service did not demonstrate care and services for consumers presenting with ongoing and unresolved changed behaviours were appropriately reviewed to identify effective interventions, including when existing care interventions were evaluated as ineffective.

During the Assessment Contact conducted from 30 August 2023 to 31 August 2023, the service provided evidence that it has implemented improvements to meet the requirement, including staff training, inclusion of successful non-pharmacological strategies and interventions in behaviour support plans and a new bowel management program.

During the Assessment Contact the Assessment Team found the service did not demonstrate care plans were consistently reviewed for effectiveness following changes in care needs. Care documentation showed non-pharmacological interventions were not regularly used to identify effective interventions to manage changed behaviours prior to using chemical restraint. The effectiveness of psychotropic medications used as chemical restraint were not monitored and evaluated, nor were non-pharmacological strategies always evaluated prior to or in conjunction with the use of restrictive practices for behaviour support. The behaviour support plan for one consumer observed by the Assessment Team to display changed social behaviours on several occasions did not reflect any review of their behaviour support strategies. The risks associated with the potential side effects of psychotropic medications were not always assessed. The organisational policy and procedure for attending post fall neurological observations were not always followed.

In their response to the Assessment Team report, the approved provider outlined the organisation’s policies and procedures and improvement initiatives, supplied their updated plan for continuous improvement with relevant improvement actions, and care documentation for named consumers to support their compliance with this requirement. The approved provider disputed the Assessment Team’s findings, noting if there are changes in care requirements due to unforeseen alterations in medical conditions, recent incidents or extended hospital stays or falls the service reassesses the consumer’s care plan. The approved provider submitted evidence of a report that showed a specialist dementia assessment service had reviewed one named consumer with behavioural deterioration and recommended alternative behavioural support strategies, since the Assessment contact. The approved provider also supplied consumers’ falls safety assessments, reviewed during that time. The assessments noted potential side effects of prescribed psychotropic medications that could increase their risk of falls such as dizziness, and confusion and provided instructions to monitor those consumers at risk.

I have considered the approved provider’s response, the actions it has taken and in its plan for continuous improvement to return to compliance in this requirement. I note that the lack of timely review of care plans following changes in the care needs of several consumers was dealt with in Requirements 2(3)a) and 2(3)(b). I acknowledge the care plans submitted by the approved provider show that comprehensive care plan reviews are now taking place, including input from external agencies in response to changed circumstances and/or incidents that impact consumers’ care needs.

Accordingly, I find Requirement 2(3)(e) 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. | Non-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)(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 |

Findings

The service was found non-compliant in Requirements 3(3)(a), 3(3)(b) and 3(3)(d) following a site audit from 14 February to 17 February 2022.

Requirement 3(3)(a)

During the 2022 site audit the service did not demonstrate it consistently provides care and services that are best practice or tailored to consumers’ needs, in particular for consumers with changed behaviours or unmet needs including pain, infections, constipation, and chemical and mechanical restraint.

During the Assessment Contact conducted from 30 August 2023 to 31 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The care plans of consumers identified in the Site Audit report were reviewed and the service met with consumers and/or their representatives to discuss their care and services. Monitoring charts were commenced for consumers who have restrictive practices. Education was provided to staff in restrictive practices and behavioural triggers, skin integrity, pain identification and management, delirium, following care plans, reporting and documentation, and all registered nurses received training in Methicillin-resistant Staphylococcus aureus (MRSA) and skin integrity.

During the Assessment Contact the Assessment Team found the service demonstrated continued deficiencies in relation to the provision of safe and effective personal and clinical care for consumers. While consumers’ representatives were generally satisfied with the personal and clinical care provided, observations and review of consumers’ care documentation showed there were areas for improvement in personal and clinical care including wound and skin management, bowel management, behaviour support and restrictive practices such as chemical restraint.

Bowel management plans were not tailored to individual consumer needs, goals and preferences and the least invasive treatment options were not trialled before use of more invasive treatments for constipation. In response, management said they would review the service’s bowel regime and include prune juice or pear juice for consumers who are constipated and would discuss individualised bowel management care plans for consumers at the next clinical meeting.

The Assessment Team found not all consumers who were identified to be at high risk of and had current pressure injuries, and who were unable to move themselves, had a pressure alternating mattress on their bed as a preventive strategy. Also wound charts did not consistently contain clear photographs and measurements to effectively track wound progress or deterioration. There was inconsistent re-swabbing of wounds with confirmed MRSA, to ensure the infection had cleared.

Behaviour management was not consistent with person centred, individualised provision of care and services. Some consumers’ behaviour support plans did not include strategies/interventions to manage current changed behaviours, and/or the strategies were generic, such as ‘redirecting’ or engaging’ rather than individualised strategies. Consumers’ behaviour support plans documented staff were to monitor for physical needs such as pain, constipation, or infection, but care documentation showed this was not consistently done when consumers displayed changed behaviours.

The Assessment Team found chemical restraint practices were not in line with best practice. Chemical restraint was not used as a last resort after non-pharmacological behaviour support strategies had been tried and found ineffective. While consent was obtained from consumers’ representatives, the consent was not informed. There was not consistent documentation as to the reason the chemical restraint was used, interventions trialled prior to its use or the potential side effects of chemical restraint that could place consumers’ health and/or safety at risk.

In their response to the Assessment Team report, the approved provider outlined the organisation’s policies and procedures and improvement initiatives, supplied their updated plan for continuous improvement with relevant improvement actions, and care documentation for named consumers to support their compliance with this requirement. The approved provider supplied a consumer’s care plan that had been reviewed after the Assessment Contact and included a range of non-invasive strategies to prevent and manage constipation instead of the more invasive treatments that had previously been the main approach used. Other care documentation was provided that demonstrated the approved provider has made care plan changes to improve the safety and effectiveness of care provided to consumers in these areas.

I commend the actions taken by the approved provider and its comprehensive revised plan for continuous improvement in relation to this requirement. However, the evidence supplied in their response has largely demonstrated planned rather than actual compliance. The revised care plans provided demonstrate the approved provider’s understanding of the actions required, but there were few monitoring charts or other forms of evidence provided to demonstrate that the changes to care have been embedded and sustained in practice. I consider it will take time for these improvements to reflect compliance.

Accordingly, I find Requirement3(3)(a) non-compliant.

Requirement 3(3)(b)

During the 2022 site audit the service did not demonstrate it effectively managed high impact high prevalence risk such as pain, changed behaviour, constipation, delirium, infections, and restrictive practices.

During the Assessment Contact conducted from 30 August 2023 to 31 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. Wound charts were reviewed and updated. Wound audits and monthly wound reports were commenced and consumer restrictive practice monitoring charts were implemented. Education was delivered in key areas.

The Assessment Team found the service did not demonstrate effective management of high impact/high prevalence risk associated with the care of each consumer. The service did not follow the organisations’ processes for managing and monitoring high impact/ high prevalence risks. Service management and the organisation’s senior management team had differing information regarding the identification and management of risks associated with the care of consumers. The risk of pressure injuries was not consistently and effectively managed. There were significant inconsistencies in the number of pressure injuries reported by management to the Assessment Team and the wound report generated from the electronic care management system. The Assessment Team found incident reports showed incidents were not consistently reviewed and evaluated to identify causal factors, strategies to prevent recurrence and to ensure continuous improvement of care and services. This was evident for consumers who had multiple falls.

In their response to the Assessment Team report, the approved provider outlined the organisation’s policies and procedures and improvement initiatives, supplied their updated plan for continuous improvement with relevant improvement actions, and care documentation for named consumers to support their compliance with this requirement. The approved provider advised the service is dedicated to the effective management of consumers with high-risk conditions, and noted the organisation’s carefully crafted policies, procedures and guidelines for the management of high impact high prevalence risk. The approved provider did not provide evidence of incident documentation that showed causal analysis, identification and evaluation of mitigation strategies is now occurring following incidents. However, the care documentation provided in evidence by the approved provider included care planning documentation that contained limited information on triggers of specific falls incidents, and still contained mainly generic rather that individualised falls prevention strategies, particularly in cases where behaviour support was a significant factor.

I have considered the approved provider’s response, the actions it has taken and its revised plan for continuous improvement. However, I am not convinced from the evidence supplied, that the approved provider has sufficiently embedded the analysis, management and mitigation of high impact high prevalence risks associated with the care of each consumer into current practices and requires more time for this to occur.

Accordingly, I find Requirement 3(3)(b) non-compliant.

Requirement 3(3)(d)

During the 2022 site audit the service did not demonstrate it consistently identifies deterioration in consumers’ skin integrity, behaviours, bowel function, infections and nor does it respond to deterioration in a timely manner.

During the Assessment Contact conducted from 30 August 2023 to 31 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. Staff education was delivered on key areas such as restrictive practices, pain management and skin integrity and recognising the deteriorating resident.

During the Assessment Contact the Assessment Team found the service did not consistently demonstrate timely identification and response to deterioration in consumers’ condition, including reassessment, care plan review and referrals to appropriate specialists in areas such as wound deterioration and weight loss.

In their response to the Assessment Team report, the approved provider outlined the organisation’s policies and procedures and improvement initiatives, supplied their updated plan for continuous improvement with relevant improvement actions, and care documentation for named consumers to support their compliance with this requirement.

The approved provider advised the organisation has related policy, staff training and robust information systems to enable the workforce to identify and respond to resident deterioration in a timely manner, complemented by transparent care conferences, staff clinical handovers and huddles at the service. The approved provider supplied documented evidence confirming a wound specialist had reviewed wounds for several named consumers identified by the Assessment Team during the Assessment Contact as having significant wound deterioration that required specialist intervention. There was also documented evidence provided that showed pain monitoring and evaluation of pain management interventions was attended for a named consumer over a five-day period that confirmed the revised pain management strategy was effective. Documentary evidence was supplied that showed the service had arranged for a review of a named consumer’s deteriorating skin rash. However, I note the medical review occurred three weeks after the Assessment Contact.

I have considered the approved provider’s response, the actions it has taken and its plan for continuous improvement to return to compliance in this requirement. I note the documented lack of timely response in relation to one consumer’s deteriorating skin condition, which had been identified by the Assessment Team during the Assessment Contact. However, timely review of care plans was considered in Requirements 2(3)(a) and 2(3)(b). I acknowledge that overall, the approved provider has demonstrated it has recognised and taken action to effectively manage deterioration in consumers’ condition since the Assessment Contact.

Accordingly, I find Requirement 3(3)(d) is 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 |

Findings

The service was found non-compliant in Requirement 6(3)(c) following a site audit from 14 February to 17 February 2022. The service did not demonstrate it manages complaints relating to consumers safety and wellbeing and often these were not escalated to management for action.

During the Assessment Contact conducted from 30 August 2023 to 31 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. For those consumers named in the report, staff were identified and provided with education on dignity during personal care. There was also a review of the SIRS reporting process.

During the Assessment Contact the Assessment Team found the service demonstrated that appropriate action is taken in response to complaints and an open disclosure process is employed when things go wrong. Consumers and their representatives reported being satisfied that appropriate action is taken in response to their complaints. Representatives said they felt comfortable raising feedback and complaints with the service. Staff were able to explain how the service’s complaints and open disclosure procedures applied to their work. However, not all feedback was documented in the feedback register in line with the feedback policy and procedure. Management acknowledged this and said they would review the process to ensure all feedback is included in the register.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings. Having considered the evidence provided, I am satisfied the approved provider has demonstrated its commitment and a return to compliance in this requirement.

Accordingly, I find Requirement 6(3)(c) compliant.

# Standard 7

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

Findings

The service was found non-compliant in Requirement 7(3)(c) following a site audit from 14 February to 17 February 2022. The service did not demonstrate staff had the required knowledge in some areas to perform their roles and responsibilities, and there was not a system to assess the competence of new staff.

During the Assessment Contact conducted from 30 August 2023 to 31 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The service updated the manual handling competencies for all new staff including competency assessment. Staff attended the new competency-based training.

During the Assessment Contact the Assessment Team found the service demonstrated its workforce is competent and has the knowledge to provide care and service for consumers. Consumers and representatives advised they were satisfied with the care and services they are provided at the service and said staff know what they want and how they want things done for them. The Assessment Team reviewed documentation such as mandatory education and competency records and was satisfied the workforce is qualified and has the knowledge to meet their role responsibilities.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings. Having considered the evidence provided, I am satisfied the approved provider has demonstrated a return to compliance with this requirement.

Accordingly, I find Requirement 7(3)(c) compliant.

# Standard 8

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| Organisational governance | |  |
| 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. | Non-compliant |

Findings

The service was found non-compliant in Requirements 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e) following a site audit from 14 February to 17 February 2022.

Requirement 8(3)(b)

During the 2022 site audit the service did not demonstrate the governing body is accountable for the culture of safe, inclusive, and quality care and services.

During the Assessment Contact conducted from 30 August 2023 to 31 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The cultural diversity policy was updated to include information from the broader organisational diversity framework and management received education on the organisation’s diversity plan. Reporting processes to the governing body regarding the provision of safe, inclusive and quality care were reviewed and refined.

During the Assessment Contact the Assessment Team found the service demonstrated its governing body promotes a culture of safe, inclusive, and quality care and services. Management provided several examples of the Board’s action in this area. They advised that in the last 6 months the Board has been integral in undertaking environmental upgrades raised by consumers in 2023. In response to a consumer survey the Board directed that an environmental audit was undertaken that resulted in repairs of equipment to ensure consumer comfort and safety. The board also approved the replacement of alternating air mattress for the mitigation of pressure injurie in response to an independent audit of equipment.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings. Having considered the evidence provided, I am satisfied the approved provider has demonstrated a return to compliance with this requirement.

Accordingly, I find Requirement 8(3)(b) compliant.

Requirement 8(3)(c)

During the 2022 site audit the service did not demonstrate it has effective organisation-wide governance of regulatory compliance including understanding, application and monitoring of behaviour support plans, incident management, restrictive practices, and the Serious Incident Reporting Scheme (SIRS).

During the Assessment Contact conducted from 30 August 2023 to 31 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The process for reviewing the plan for continuous improvement, audit forms, procedures and systems were reviewed. Education was delivered to staff and management on regulatory compliance and capturing and managing complaints.

During the Assessment Contact the Assessment Team found senior executive staff said there are organisation specific roles to ensure any regulatory changes are included in their governance systems and communicated across the organisation to ensure compliance. Education records showed training has been delivered and policies updated to ensure compliance with regulatory changes. The director of nursing and quality lead have oversight on feedback and complaints at the service.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings. Having considered the evidence provided, I am satisfied the approved provider has demonstrated a return to compliance in this requirement.

Accordingly, I find Requirement 8(3)(c) compliant.

Requirement 8(3)(d)

During the 2022 site audit the service did not demonstrate effective management of high impact high prevalence risk associated with the care of consumers, effective identification and response to abuse and neglect of consumers, management and prevention of incidents including the use of incident management systems.

During the Assessment Contact conducted from 30 August 2023 to 31 August 2023, the service provided evidence that it has implemented the following improvements to meet the requirement. The risk management framework was reviewed to ensure it addresses high impact high prevalence risks for consumers, including the risk rating and control process.

During the Assessment Contact the Assessment Team found the service demonstrated it has a risk management system to report, risk, access and use the information for continual improvement of care and services. The organisation’s eight step risk management framework includes a comprehensive approach to identify and manage risks. The risk register, including SIRS incidents indicated the service has a clear understanding of its regulatory responsibilities and priorities to ensure the safety of consumers.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings. Having considered the evidence provided, I am satisfied the approved provider has demonstrated a return to compliance in this requirement.

Accordingly, I find Requirement 8(3)(d) compliant.

Requirement 8(3)(e)

During the 2022 site audit the service did not demonstrate it effectively manages the minimisation of the use of restrictive practices or broader clinical care for consumers.

During the Assessment Contact conducted from 30 August 2023 to 31 August 2023, the service provided evidence that it had reviewed the clinical governance framework to be more effective in minimising the use of restraint.

During the Assessment Contact the Assessment Team found the service did not demonstrate it had active oversight or was supported to maintain oversight on clinical risks to ensure consumers received continual safe and effective clinical care and services. There were deficits in clinical oversight by management and senior organisational staff responsible for monitoring the quality of clinical care and services to the required standards. The service was unable to provide clinical audit documentation requested by the Assessment Team and was unable to confirm if clinical audits were undertaken. The service did not demonstrate it effectively managed restrictive practices in line with legislative requirements. It was unclear whether there was clinical oversight and monitoring of the effectiveness of behaviour support provided to consumers with changed behaviours. Staff demonstrated an understanding of antimicrobial stewardship and open disclosure.

In their response to the Assessment Team report, the approved provider outlined the organisation’s policies and procedures and improvement initiatives and supplied their updated plan for continuous improvement with relevant improvement actions to support their compliance with this requirement. The approved provider supplied minutes for a clinical governance team meeting that mainly contained administrative content but did not include key information relevant to clinical governance such as clinical trends, risks, management strategies continuous improvements in clinical care or quality issues.

The Quarterly Director of Nursing Report submitted by the approved provider showed that the organisation does undertake high level clinical audits. The report contained organisational and service trends on clinical indicators and complaints, outlined key clinical indicators requiring improvement and broadly recommended ‘targeted interventions and strategies’ and ‘implementation of appropriate interventions’ were needed to address the clinical issues identified. However, the document contained limited clinical analysis and guidance on required improvements beyond the trend data. Also, the report demonstrated significant gaps in relation to clinical risk governance in certain areas. For example, the section on Serious Incident Reporting Scheme trends stated the data received was not accurate and as a result a decision was made not to analyse and track data trends until a reliable process was available to capture the data.

I have considered the approved provider’s response to the Assessment Team Report. However, I have placed more weight on the findings of the Assessment team in relation to the lack of clinical audit documentation and ineffective clinical oversight demonstrated in the areas of clinical care mentioned. I have also placed weight on the deficiencies in the documentation supplied by the approved provider in response to the Assessment Team Report, to evidence effective clinical governance. I acknowledge the actions outlined in the service’s revised plan for continuous improvement. However, I consider it will take time for these improvements to be implemented and embedded into sustainable practice.

Accordingly, I find Requirement 8(3)(e) non-compliant.

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