Performance

Report

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| Name: | Milford House Nursing Home |
| Commission ID: | 2035 |
| Address: | 2-4 Milford Street, RANDWICK, New South Wales, 2031 |
| Activity type: | Site Audit |
| Activity date: | 10 January 2024 to 12 January 2024 |
| Performance report date: | 16 February 2024 |
| Service included in this assessment: | Provider: 372 Thompson Health Care Pty Ltd  Service: 621 Milford House 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 Milford House Nursing Home (**the service**) has been prepared by Katherine Richards, 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 consumers, representatives, staff, management, and others; and
* the provider’s response to the assessment team’s report received 13 February 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 | **Not 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

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

* Requirement 3(3)(a) – the approved provider ensures each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice, is tailored to their needs and optimises the health and well-being of each consumer, particularly for those consumers with changed behaviours subject to chemical restraint.

# 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

This Quality Standard is assessed as Compliant as 6 of the 6 Requirements are assessed as Compliant.

Consumers and representatives said staff were respectful and valued consumers as individuals. Staff could describe consumers’ backgrounds in line with feedback and care planning documentation. Policies and procedures ensured consumers were treated with dignity and respect.

Consumers explained how the service recognised cultural needs and supported consumers to participate in cultural celebrations. Staff explained how they met the cultural needs of consumers and encouraged all to participate in cultural celebrations. Care planning documentation included consumers’ cultural needs and backgrounds and detailed how care and services were personalised to ensure provision of culturally safe care.

Consumers explained how they were supported to make decisions about their care and services and maintain relationships of importance. Staff explained they supported consumers to make informed decisions and respected their choices. The Dignity and choice policy outlined each consumer is supported to exercise choice and independence in determining their own care.

Consumers and representatives said consumers are supported to take informed risks. Staff explained they respect consumer choices, undertake assessments to understand the risk, and discuss mitigating strategies. Care planning documentation identifies risks associated with consumer preferences, consultation with the consumer and/or representative, and personalised strategies to minimise harm.

Consumers and representatives said the service provides sufficient information in an appropriate manner. Staff explained different methods by which information is communicated and demonstrated awareness of consumers’ communication needs. Information displayed in communal areas included menus and details of scheduled activities.

Overall, consumers and representatives reported their privacy was respected, although one was concerned about other consumers entering their room without permission. Staff outlined how they respected privacy of consumers. One staff member reported observing other staff ask consumers for personal information in communal areas, and management confirmed this did not align with expectations, with responsive memoranda and education coordinated. Protocols were implemented to maintain confidentiality, such as use of password secured logins to access personal information.

# 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

This Quality Standard is assessed as Compliant as 5 of the 5 Requirements are assessed as Compliant.

The service was found non-compliant in Standard 2 in relation to Requirement 2(3)(a) following an Assessment Contact in August 2023. Evidence in the Site Audit report dated 10 to 12 January 2024 supports that the Service has implemented improvements to address the non-compliance. However, the Assessment Team recommended Requirement 2(3)(a) Not Met, finding most consumers subject to use of chemical restraint did not have person centred behaviour assessments and behaviour support plans to inform safe practice. The Assessment Team stated interventions were generic in all but one of the sampled consumer files, with deficiencies in development and documentation of strategies to be trialled prior to use of chemical restraint. Management acknowledged the feedback during the Site Audit, commencing immediate training for clinical staff, and developed continuous improvement activities to review all behaviour assessments and behaviour support plans.

The provider’s response states they have systems and processes aligning with the intent of the Requirement and includes copies of procedures, including the Assessment and care plan mapping tool, and documentation on the application and use of restrictive practice. The response identifies and addresses inaccuracies in the Assessment Team report in relation to care planning documentation and medication names. Also included is analysis of information relating to named consumers and acknowledgement of areas for improvement in documentation to ensure information is clearly assessed, documented, and communicated. A continuous improvement plan has also been provided, however, does not reflect any activities specific to the Site Audit report for this Standard.

I acknowledge the provider’s response and improvement actions being undertaken. The provider states, and submitted medical reports demonstrate, one named consumer was prescribed psychotropic medication in preparation for end-of-life care rather than chemical restraint. I note on the medication chart one of the medications has been documented for management of behaviour and psychological symptoms of dementia, which differs to the provider’s explanation. Transfer documents from the hospital state the medication is for ‘agitation’ without clarifying if this was dementia or terminal agitation. The provider acknowledges better assessment and planning could have been undertaken, particularly in relation to identify and develop strategies for changed behaviours related to dementia which were still present during the consumer’s palliative care. However, the consumer has a behaviour support plan with consent for chemical restraint on an ‘as required’ basis and I consider this sufficient to inform staff management of the consumer’s changed behaviours.

The provider’s response includes copies of behaviour support plans for other named consumers. I have reviewed these and consider they demonstrate tailored behaviour support plans with all components to meet legislative requirements, including personalised strategies recommended following review by dementia specialists. Although the behaviour support plans do not clearly outline when chemical restraint should be administered, guidance for administration is referenced within the consent for use of chemical restraint information, referring the reader to review the medication chart.

Whilst I consider there to be some areas for improvement in documentation, acknowledged by the provider within their response, I find the evidence before me demonstrates assessment and planning processes were used to identify risk and develop personalised behaviour support plans for consumers subject to chemical restraint.

For the reasons outlined above, I find the service Compliant with Requirement 2(3)(a).

I am satisfied the other Requirements in Standard 2 Ongoing assessment and planning with consumers are Compliant.

The Service was found non-compliant in Standard 2 in relation to Requirement 2(3)(b) following an Assessment Contact in August 2023. Evidence in the Site Audit report dated 10 to 12 January 2024 supports that the Service has implemented improvements to address the non-compliance and is now compliant with this Requirement. Consumers and representatives said assessment and planning reflected consumer needs and they were offered opportunity to discuss end-of-life wishes. Staff said care planning documentation included details of consumers’ needs, goals, and preferences. Care planning documentation highlighted key information including consumer end-of-life wishes on the summary page.

Staff explained regular care plan reviews included consumers, representatives, Medical officers and other Allied health professionals and specialists. Consumers and representatives confirmed they actively participated in assessment and planning processes. Care planning documentation evidenced consultation and input from consumers, representatives, and other providers, in line with policies and procedures.

Consumers and representatives said they received communication about changes in consumer care and services, although some were unaware that they could access the documented care plan. Management advised care plans were routinely offered following review and could be requested, with immediate follow up undertaken for those expressing concern. Clinical staff and Allied health providers detailed how they shared outcomes of assessment and planning with consumers, representatives, and other providers of care and services.

Care planning documentation demonstrated routine reviews were undertaken every 3 months, and evaluation of strategies had been undertaken following change or incident. Clinical staff could explain the routine 3-monthly review processes with annual case conferences, and monthly monitoring through the Consumer of the day schedule. Consumers and representatives confirmed involvement in regular review of care and services plans.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(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

This Quality Standard is assessed as Non-compliant, as one of the 7 Requirements have been assessed as Non-compliant.

The service was found non-compliant in Standard 3 in relation to Requirement 3(3)(a) following an Assessment Contact in August 2023. Evidence in the Site Audit report dated 10 to 12 January 2024 supports that the Service has implemented improvements to address the non-compliance. However, the Assessment Team recommended Requirement 3(3)(a) Not Met in relation to use of chemical restraint for consumers without demonstrating tailored alternate strategies were trialled and exhausted. Furthermore, deficits were identified in documentation for individual consumers when monitoring pain and neurological status after a fall and within wound charting.

The provider’s response states they have systems and processes aligning with the intent of the Requirement, referencing policies, training, monitoring, and continuous improvement mechanisms to ensure adherence with legal and best practice obligations. The response identifies and addresses inaccuracies in the Assessment Team report in relation to documentation and medication names. In relation to monitoring following falls, the provider’s investigation identified documentation was undertaken but dispersed through various records, with education of staff subsequently undertaken. The provider has acknowledged improvements related to staff knowledge and documentation processes, with improvement actions including education and enhancing existing policies and processes to offer clearer guidance on documentation.

Also included are analysis of information relating to named consumers, and explanation of how this was used to deprescribe chemical restraint medications for one consumer. The provider states one of the named consumers identified as being administered chemical restraint without trial of non-pharmacological strategies was prescribed medication for terminal agitation. However, the medication chart submitted states the regular use of a prescribed psychotropic medications is for atypical dementia and behavioural and psychological symptoms of dementia. Whilst the consumer was not identified as using ‘as required’ psychotropic medication in response to changed behaviours, I find there to be no evidence of non-pharmacological strategies being trialled prior to the Medical officer’s decision to introduce a new psychotropic medication due to the consumer ‘calling out all the time’ within provided documentation. In coming to my decision on compliance, I have considered that whilst the consumer was on a palliative trajectory at the time, end-of-life care was commenced over a month after this change of medication.

For the other named consumer, evidence did not demonstrate tailored non-pharmacological strategies were trialled on each occasion prior to use of chemical restraint. When strategies were documented, they were limited to provision of reassurance and redirection despite detailed strategies being available to staff within the behaviour support plan. Documentation also demonstrated inconsistencies in documenting the evaluation of effectiveness of medications when chemical restraint had been used.

I acknowledge the provider’s response and improvement actions being undertaken. Evidence from the provider demonstrates consumers were monitored following falls and training has been provided to staff on documentation of this and ensuring every wound photograph includes a disposable ruler to reflect the current size.

However, for the two named consumers, I find the Service did not meet legislative requirements to demonstrate chemical restraint was used as a last resort. For both named consumers, the psychotropic medications were prescribed and used in response to consumers’ changed behaviours, meeting definition of chemical restraint under the *Quality of Care Principles 2014*. Whilst consent has been obtained for use, and behaviour support plans developed, as identified in Standard 2 Requirement (3)(a), I find the service did not demonstrate tailored strategies were trialled prior to use, and the chemical restraint was not used as a last resort. I also find the failure to document an evaluation of medication effectiveness does not align with best practice.

For the reasons outlined above, I find the service Non-compliant with Requirement 3(3)(a).

I am satisfied the other Requirements in Standard 3 Personal care and clinical care are Compliant.

The Service was found non-compliant in Standard 3 in relation to Requirement 3(3)(b) following an Assessment Contact in August 2023. Evidence in the Site Audit report dated 10 to 12 January 2024 supports that the Service has implemented improvements to address the non-compliance and is now compliant with this Requirement. Consumers and representatives described how risks were effectively managed. Staff were familiar with risks for consumers and could explain implemented strategies outlined in care planning documentation.

Staff described provision of end-of-life care with a focus on optimising comfort, managing pain, and providing emotional support. Progress notes evidenced active involvement of palliative care specialists and provision of supportive medical management. Policies and procedures informed best practice end-of-life care.

Care planning documentation identified timely identification of consumers’ deterioration or change of health, with appropriate response, such as monitoring or escalation. Staff explained how they recognised, responded to, and managed health changes of consumers. Guidance on management of acute deterioration was available through policies and procedures.

Consumers and representatives said staff were aware of their condition, needs, and preferences without need to repeat information. Staff explained how they communicated consumer information through verbal handovers, written handover sheets, and within progress notes. Care planning documentation demonstrated changes to condition or care delivery were documented, as well as communication of this information with representatives and other providers.

Staff said referrals to other providers were made by senior clinical staff or management. Consumers said referrals were timely and appropriate to consumer needs, which was reflected in care planning documentation.

Staff described infection prevention and control measures, including application of outbreak management plans, and measures taken to ensure appropriate antibiotic use. Infection control procedures, including COVID-19 screening, were observed to be strictly adhered to. Consumers and representatives said they observe staff using precautions, such as personal protective equipment, and manage infections and outbreaks effectively.

# 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

This Quality Standard is assessed as Compliant as 7 of the 7 Requirements are assessed as Compliant.

Consumers reported provision of services and supports to optimise their independence and quality of life. Staff explained assessment processes to capture needs, goals, and preferences to tailor services, and identify need for additional services and supports.

Consumers said staff provide emotional support when they are feeling low. Staff explained activities are designed to maintain consumers’ spiritual well-being, and they spend extra time with consumers with increased emotional needs. Care planning documentation captured consumers’ spiritual needs, and available activities included one-on-one therapy.

Consumers said they felt supported to participate in the community as well as do things of interest and spend time with people of importance. Staff explained how consumers were supported to participate in community activities and the activities program was developed around consumer interests. Consumers were observed interacting with visitors.

Staff described methods for sharing information about consumers. Written information on consumer’s dietary needs was readily accessible to kitchen staff.

Staff explained referral processes for available services, such as the community visitor scheme and emotional well-being services. Referral information was not always reflected in care planning documentation, with management stating they would coordinate staff education on documentation of referrals and responsive visits.

Consumers and representatives said they were satisfied with the variety, quality, and quantity of food, with dietary needs accommodated and alternate meals available. Kitchen staff explained the menu is drafted at organisational level but tailored to the consumer cohort through obtaining feedback during a trial period. The menu demonstrated available choices for each meal, and sandwich options if preferred.

Staff explained processes to ensure equipment is maintained, clean, and safe for use. Equipment was observed to be suitable, clean, and in good condition.

# 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

This Quality Standard is assessed as Compliant as 3 of the 3 Requirements are assessed as Compliant.

Consumers and representatives said the service is easy to navigate and is personalised to feel like home. Staff explained design principles to optimise independence, such as wide hallways, clear signage, and ensuring the environment is clutter-free. Indoor and outdoor communal areas facilitated interactions between consumers and visitors.

Staff described cleaning and maintenance processes, including enhanced cleaning for infection control. Consumers said rooms were cleaned and they were confident to report maintenance concerns. Management explained processes to enable free movement of consumers included leaving internal doors open during the day, and consumers were observed moving independently throughout the service environment.

Furniture and equipment were observed to be clean and in good condition, with service requirements met. Management described the preventative maintenance schedule included regular checks of equipment, and audits and checks are undertaken for cleaning and maintenance processes.

# 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

This Quality Standard is assessed as Compliant as 4 of the 4 Requirements are assessed as Compliant.

Consumers and representatives were aware of feedback processes and said they were comfortable to make complaints. Staff described processes to encourage and support representatives to submit feedback or complaints, including through meetings or directly with staff. Feedback and complaint forms were readily available and displayed throughout the service, with a locked suggestion box for anonymous submission if required.

Consumers said they were unaware of external advocacy services although had not found a need to consider accessing them. Management described regular visits from advocacy services to hold discussions with consumers. Staff were aware of how to contact interpreter services, but advised there was no current requirement. Information on external complaint organisations were displayed on pamphlets and posters.

Consumers and representatives said the service appropriately responds to and resolves complaints. Management and staff demonstrated an understanding of open disclosure, detailing actions they would take in response to a complaint. Most complaints were recorded within the feedback register, outlining issues and responsive actions. One record for a complaint lodged on the first day of the Site Audit did not comprehensively identify all issues or actions, however, these were observed to be reflected in the consumer’s progress notes and a subsequent incident report.

Management explained how feedback and complaints were reviewed to identify trends and lead to improvements, providing examples of actions taken in response to past issues. The Continuous improvement plan captured information from a variety of sources, including feedback, with timely actions undertaken.

# 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

This Quality Standard is assessed as Compliant as 5 of the 5 Requirements are assessed as Compliant.

Most consumers and representatives described sufficiency of staff to meet consumer needs in a timely manner. Two representatives said continence care was not always timely, however, had not raised concerns with management, with one describing the issue arose on only one occasion. Some staff said there were not always enough staff, particularly when consumers needed assistance of multiple staff. Management explained how staffing numbers ensure enough staff to meet consumer needs, using monitoring processes to ensure safety, increasing staff numbers where required. Furthermore, management said they consider staffing sufficiency before accepting new consumers. Sampled rosters showed shifts were filled, and management described processes for coverage of unplanned leave.

Consumers and representatives said staff are kind, caring, gentle and respectful. Policies and procedures and staff guidelines inform staff behaviour, outlining the commitment to treating consumers with dignity and respect whilst valuing identity, culture, and diversity.

Management outlined how they ensure staff are competent and capable to perform the duties within their position descriptions, including considering qualifications and knowledge during hiring processes. Staff described onboarding processes and competency assessments required for their roles. Records demonstrated monitoring of compliance of legislated requirements for aged care employment, including police checks and registrations, and vaccinations in line with state directives.

Staff described training they received, including mandatory training modules, and said they felt supported to provide quality care and services. Where staff gave feedback of additional training requirements to improve care, management advised targeted education could be provided. Areas for improvement to inform education were identified through monitoring processes. Training records demonstrated staff received training to deliver outcomes required by the Quality Standards, including infection prevention, incident reporting, and restrictive practice training.

Management described how staff performance was monitored through formal processes, such as an annual performance appraisal, and informal processes, such as observations and feedback. Staff demonstrated familiarity with the performance appraisal processes and outcomes. Records demonstrated all current staff were up to date with scheduled reviews.

# 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

This Quality Standard is assessed as Compliant as 5 of the 5 Requirements are assessed as Compliant.

The service was found non-compliant in Standard 8 in relation to Requirement 8(3)(e) following an Assessment Contact in August 2023. Evidence in the Site Audit report dated 10 to 12 January 2024 supports that the Service has implemented improvements to address the non-compliance. However, the Assessment Team recommended Requirement 8(3)(e) Not Met, with deficiencies in production and review of behaviour support plans for consumers subjected to chemical restraint attributed to deficits in the clinical governance framework. This resulted in an inability to demonstrate restrictive practices were used as a last resort. Discrepancies in identifying chemical restraint for all impacted consumers were reflected within the psychotropic register report.

Whilst the provider’s response neither refutes nor accepts the Assessment Team’s finding, it reflects the presence of systems and processes aligning with the intent of the Requirement, referencing policies, training, monitoring, and continuous improvement mechanisms to ensure adherence with legal and best practice obligations. The response describes the monitoring and oversight model for antimicrobial stewardship, restrictive practices, and use of open disclosure, along with guiding policies and procedures. In relation to the discrepancies in identifying psychotropic medications prescribed as chemical restraint, the provider has acknowledged their investigation identified a documentation error, and staff training will be provided.

Copies of processes relating to assessment and planning and identifying and using chemical restraint have been submitted within the provider’s response. Although the submitted Continuous improvement plan information does not identify activities specific to Standard 8, other evidence within the provider’s response demonstrates investigations, staff education, discussion within staff meeting minutes have been undertaken to identify potential for improvement.

I acknowledge the provider’s response and improvement actions being undertaken. In coming to my decision of compliance, I have placed weight on the monitoring processes described by the Assessment Team, with evidence of ongoing assessment of restrictive practice use and deprescribing practices. Whilst I have made a finding of non-compliance in Standard 3 Requirement 3(3)(a) relating to the service failing to demonstrate chemical restraint was used as a last resort for each consumer, I do not find the evidence before me demonstrates deficiencies within clinical governance processes or oversight. The provided documentation relating to restrictive practices reflects the legislation and Commission guidance material, and although it does not detail the information required to be documented within behaviour support plans, consumer information within the provider’s submission demonstrates all essential components are included. The submitted psychotropic register demonstrates consideration of whether medication is used as chemical restraint, detailing reason for prescribing, and behaviour support plans have been created for consumers with chemical restraint and/or changed behaviours. Ongoing training and education is provided to ensure staff understand policies, procedures, and expectations.

For the reasons outlined above, I find the service Compliant with Requirement 8(3)(e).

I am satisfied the other Requirements in Standard 8 Organisational governance are Compliant.

Consumers and representatives expressed satisfaction with the level of engagement in the delivery and evaluation of care and services, with opportunities for input through consumer meetings and feedback mechanisms. Management described involvement of consumers through meetings, surveys, and audits as well as the care evaluation and case conferences. Meeting minutes demonstrated input was sought on services and supports, complaints, and management of a recent outbreak.

Management described the organisational and governance structure and how they are informed through reporting processes to ensure the delivery of safe and quality care. Board meeting minutes demonstrated monitoring processes and discussion of incidents, indicators, and complaints. A Board member described how the governing body had coordinated an independent auditor to identify strengths and areas for improvement, with management saying focus audits were also conducted to identify gaps and monitor outcomes of improvements.

Organisational governance systems included policies, procedures, and oversight. Management and staff demonstrated understanding of obligations, policies, and processes. Financial governance is managed through a budget, which is monitored and reviewed regularly, with processes to seek approval for additional expenses to meet consumer needs. Management explained the oversight from the governing body on feedback and complaints to ensure practicing of open disclosure and effective resolution.

Management and clinical staff demonstrated understanding of risks associated with the care of consumers and how these were monitored for effective management, with reporting submitted to the organisation’s Quality team to inform the Board. Policies and procedures are available to guide staff in identifying and responding to abuse and neglect, with education provided within mandatory training topics. Incidents reported within the incident management system were investigated with oversight by the governing body with monitoring to ensure mandatory reporting was identified and undertaken. Whilst the Assessment Team identified 2 incidents which they believed should have been reported through the Serious Incident Response Scheme, however, management explained how the investigation included consideration of whether this was required. Risk assessment processes and available services and supports enabled consumers to live their best lives.

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)