Performance

Report

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| Name of service: | Naracoorte Health Service |
| Service address: | 101 Jenkins Terrace NARACOORTE SA 5271 |
| Commission ID: | 6926 |
| Approved provider: | Limestone Coast Local Health Network Incorporated |
| Activity type: | Assessment Contact - Site |
| Activity date: | 10 January 2023 to 12 January 2023 |
| Performance report date: | 07 March 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 Naracoorte Health Service (**the service**) has been prepared by K. Rochow, 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 a sample of management, staff, consumers, representatives and others;
* the provider’s response to the Assessment Team’s report received 10 February 2023; and
* the Performance Report dated 04 August 2022 for a Site Audit conducted on 17 May 2022 to 19 May 2022.

# 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 | **Not applicable as not all requirements have been assessed** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **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.

**Standard 3 Requirement (3)(b)**

* Where chemical restraint is used, ensure the requisite informed consent is obtained and that it used as a last resort to support the effective management of high-impact or high-prevalence risks associated with the use of chemical restraint.

**Standard 8 Requirement (3)(d)**

* Ensure staff and management are using the organisation’s incident management system effectively to ensure all opportunities to consider, review and investigate incidents are undertaken, including considerations of reporting incidents to the Serious Incident Response Scheme and to review efficacy of risk mitigation strategies.

# Standard 1

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| Consumer dignity and choice | |  |
| 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)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Following a Site Audit conducted from 17 May 2022 to 19 May 2022, the service was found to be non-compliant with Requirements (3)(d) and (3)(f) in this Standard where it was found the service was unable to demonstrate:

* it supported consumers to take risks to enable them to live the best life they can, specifically in relation to consumers’ choices relating to dietary preferences contrary to specialist directives at times they chose and participation in activities with an element of risk; and
* each consumer’s privacy was respected, and their personal information kept confidential. Specifically, that consumers’ personal and confidential information was observed to be accessible.

**Requirement (3)(d)**

The Assessment Team’s report provided information and evidence of actions taken to remedy Requirement (3)(d) in this Standard, including (but not limited to):

* Reassessments for consumers identified as requiring supports for dignity of risks have been completed and were inclusive of consultation about risks, consequences and mitigation strategies to support engagement in chosen activities as safely as possible.

At the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found consumers are supported to take risks which enable them to live their best lives, including the implementation of strategies to mitigate risks. The Assessment Team provided the following information and evidence relevant to my finding:

* Consumers were able to describe how the service supports them to engage in activities which have an element of risk, and confirmed that the service had discussed risks and consequences with them and were consulted about the development of risk mitigation strategies.
* Staff were able to describe how they support consumers to take risks, in accordance with consumers’ care plans.
* Risk assessments for sampled consumers demonstrated consumers’ risks were identified, evaluated and included an acknowledgement by the consumer/representative of their understanding of risks and how the service will support them. However, the Assessment Team observed one consumer to have a personal oil heating unit in their room which had not been identified and assessed for potential risks associated with its use. The service immediately commenced risk assessment processes when alerted to this and the Assessment Team confirmed the consumer had not been harmed during the use of this heater.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(d) in this Standard. I encourage the service to use their overall assessment and monitoring processes to identify activities or use of equipment by consumers which may present risks, to ensure the requisite risk assessment process can be used to identify risk mitigation strategies and supports for consumers in all facets of their life.

**Requirement (3)(f)**

The Assessment Team’s report provided information and evidence of actions taken to remedy Requirement (3)(f) in this Standard, including (but not limited to):

* Computer stations and consumer files were previously located in the main corridor but have now been moved to a mobile ‘workstation on wheels’.
* Consumers’ personal information was removed from their doors and the information is now in the seven-day handover sheet.

At the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found consumers’ privacy and confidentiality of information was maintained. The Assessment Team provided the following information and evidence relevant to my finding:

* The Assessment Team observed the ‘workstation on wheels’ to be kept locked when not in use and to have no private or confidential information on display. Staff were also observed to knock on consumers’ doors before entering and to close doors before providing personal care.
* Consumers and representatives indicated personal care is provided in a private and respectful manner.
* The service uses privacy consent forms to seek permission from consumers/representatives to collect and hold private and personal information, inclusive of information sharing with external professionals and organisations.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(f) in this Standard.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

Following a Site Audit conducted from 17 May 2022 to 19 May 2022, the service was found to be non-compliant with Requirements (3)(a), (3)(d) and (3)(e) in this Standard where it was found the service was unable to demonstrate:

* assessment and planning considered risks to consumers’ health and well-being to inform safe and effective care and services, specifically in relation to the use of chemical and physical restraint;
* the outcomes of assessment and planning, including recommendations from allied health professionals, were effectively communicated to the consumer and/or representative and documented in a care and service plan that was readily available to the consumer and where care and services were provided; and
* care and services were regularly reviewed for effectiveness, when circumstances changed or when incidents impacted on the needs, goals or preferences of the consumer.

**Requirement (3)(a)**

The Assessment Team’s report provided information and evidence of actions taken to remedy Requirement (3)(a) in this Standard, including (but not limited to):

* A review was undertaken for all consumers subject to restrictive practices, inclusive of behaviour support plans, dignity of risk and consents.
* Behaviour support plans were strengthened to ensure alternative strategies were identified and documented.
* Training was conducted in relation to assessment, care planning and review processes, and partnering with consumers/representatives in care and lifestyle goals.

At the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found the service was able to demonstrate assessment and planning, including consideration of risks to consumers’ health and well-being which informs the delivery of safe and effective care and services. The Assessment Team provided the following information and evidence relevant to my finding:

* Consumers and representatives interviewed confirmed they are involved in review of care plans and two representatives confirmed assessments were completed when their family member first entered the service.
* Staff follow an admission checklist for assessments when a consumer first moves into the service, which was confirmed through a sample of care planning documentation, with care plans reflective of consumers’ needs, goals and preferences.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(a) in this Standard.

**Requirement (3)(d)**

The Assessment Team’s report provided information and evidence of actions taken to remedy Requirement (3)(d) in this Standard, including (but not limited to):

* Staff duty lists were reviewed to provide guidance to staff in relation to responsibilities and tasks associated with assessments and communication.
* Consultation with allied health services has resulted in an agreement with both dietetics and speech pathology services reviewing consumers on a fortnightly basis and training for these health specialists in relation the service’s electronic care system was provided to ensure timely and effective communication of recommendations.

At the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found the service was able to demonstrate assessment and planning identifies and addresses consumers’ current needs, goals and preferences, and are documented in a care plan. The Assessment Team provided the following information and evidence relevant to my finding:

* Sampled consumers’ care plans were inclusive of consumers’ goals, needs and preferences.
* Consumers and representatives are satisfied with the care provided and have viewed care plans.
* Staff described how they are informed about changes to consumers’ care plans.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(d) in this Standard.

**Requirement (3)(e)**

The Assessment Team’s report provided information and evidence of actions taken to remedy Requirement (3)(e) in this Standard, including (but not limited to):

* Training was conducted in relation to assessment, care planning and review processes, and partnering with consumers/representatives in care and lifestyle goals.
* A ‘What’s my responsibility’ table has been developed to prompt staff to undertake required assessments and care planning, in addition to the review of duty statements.

At the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found the service was able to demonstrate consumers’ care and services are regularly reviewed, and changes made to reflect consumers’ needs and inform staff when changes are made. The Assessment Team provided the following information and evidence relevant to my finding:

* Clinical staff were able to describe reassessment processes, including making referrals if required.
* Two consumers’ assessments and care plans demonstrated staff undertook reassessments, referrals and updates to care plans when consumers’ conditions changed or following incidents.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(e) in this Standard.

# Standard 3

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

Findings

Following a Site Audit conducted from 17 May 2022 to 19 May 2022, the service was found to be non-compliant with Requirements (3)(a), (3)(b), (3)(d) and (3)(e) in this Standard where it was found the service was unable to demonstrate:

* the delivery of safe and effective clinical care, specifically in relation to the safe administration of medication, post-falls management, wound care management and trialling of alternatives prior to the use of restrictive practices;
* effective management of high-impact or high-prevalence risks associated with physically and verbally aggressive responsive behaviours;
* changes to consumers’ emotional, psychological or clinical condition were recognised and responded to in a timely manner; and
* information relevant to the provision of care of consumers was documented or communicated to those staff who deliver care.

The Assessment Team have recommended Requirements (3)(a), (3)(d) and (3)(e) as met and Requirement (3)(b) as not met. The provider submitted a response to the Assessment Team’s report, specifically addressing Requirement (3)(b). Based on the Assessment Team’s report and the provider’s response, I find Requirements (3)(a), (3)(d) and (3)(e) to be compliant and Requirement (3)(b) to be non-compliant. I have provided reasons for each Requirement below.

**Requirement (3)(a)**

The Assessment Team’s report provided information and evidence of actions taken to remedy Requirement (3)(a) in this Standard, including (but not limited to):

* Wound care training was organised through an external provider in response to significant deficits identified in wound care monitoring by the service in August 2022.
* A new post-falls flowchart was developed and implemented, and all observations are now required to be documented in the service’s electronic care system.

At the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found the service was able to demonstrate each consumer receives effective clinical care which is best practice, tailored to their needs, and optimises their health and well-being. The Assessment Team provided the following information and evidence relevant to my finding:

* Consumers and representatives interviewed confirmed safe and effective personal and clinical care is provided.
* Documentation for a consumer who had a fall demonstrated observations were completed in accordance with the organisation’s falls protocol and relevant notifications and referrals were made.
* Following admission to hospital for two consumers, the service demonstrated the consumers were reviewed by relevant health specialists and strategies and interventions effectively implemented to manage weight loss and pressure injuries which occurred during the hospital admission.
* Wound charts for a consumer’s wound demonstrated the wound was healing and being monitored daily and was dressed in accordance with the prescribed regime.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(a) in this Standard.

**Requirement (3)(b)**

The Assessment Team’s report provided information and evidence of actions taken to remedy Requirement (3)(b) in this Standard, including (but not limited to):

* Implemented weekly clinical risk meetings where consumers’ responsive behaviours and behaviour support plans are discussed.
* Six-monthly training schedule for staff includes dementia and responsive behaviours, understanding the treatment of dementia behaviours in aged care and understanding and differentiating dementia, delirium and depression.
* An electronic risk management system was implemented to monitor consumers identified with high-risk care needs.
* A memorandum was sent to staff in relation to the update to the responsive behaviour protocol.
* Flowcharts were developed to guide staff in monitoring, escalating and documenting post incidents.

However, at the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found that while improvement initiatives for this Requirement had been implemented, the service was unable to effective management of high-impact or high-prevalence risks associated with the care of each consumer. Specifically, their findings relate to staff not using non-pharmacological strategies prior to administration of medications to manage responsive behaviours or pain. The Assessment Team provided the following information and evidence relevant to my finding:

* A review of documentation, including progress notes, assessments and monitoring charts demonstrates a consumer (Consumer A) was administered medication to manage responsive behaviours and pain, without the service being able to demonstrate the trialling of non-pharmacological strategies prior to the administration of these medications or the confirmation of requisite consent for the use of psychotropic medications. Specifically:
  + Staff administered a psychotropic medication to Consumer A on four occasions without having obtained the requisite consent from the consumer’s nominated representative.
    - Management stated they had verbally consulted with Consumer A’s representative who said that management were able to act on behalf of the consumer for medical related decisions, including the use of chemical restraint.
* During the Assessment Contact, management contacted Consumer A’s representative via email to clarify that management can make medical decisions on behalf of Consumer A. However, documentation provided to the Assessment Team did not clarify this position.

The Assessment Team spoke with Consumer A’s representative who confirmed consent for chemical restraint cannot be made by management. Further to feedback to management about the conversation had between the Assessment Team and the representative, management indicated the medication was provided for pain relief, so was not considered a chemical restraint.

* + - The Assessment Team showed management progress notes which demonstrated medication was administered not for the purpose of pain relief on two of the four occasions and there was one occasion where there was no entry for the indication of use.
    - During the Assessment Contact, management confirmed a Serious Incident Response Scheme report was submitted for transparency and further review in relation to the administration of these psychotropic medications.
  + Consumer A’s behaviour support plan directs that psychotropic medication should only be administered for ‘severe exacerbation of behaviours’ and the medical officer directed it should only be administered if there is no response to pain relieving (opioid) medication. However, on the four occasions it was not administered in accordance with these directives:
    - on two occasions where management identified the medication was administered without the required consent;
    - one occasion where there is no progress to support the reason for the administration of the medication; and
    - on an occasion where the medication was administered prior to exhausting pain medication options in accordance with the medical officer’s directive.
  + A pain assessment completed over an approximate three-week period included notations of 17 instances of moderate pain, and one instance of severe pain. However, during this period, Consumer A was administered pain relieving medication on six occasions and psychotropic medication on four occasions.
  + Progress notes show on two occasions, Consumer A was administered pain relieving medication, however, did not include other strategies trialled before administering the pain medication. Additionally, on one occasion, the effectiveness of the pain-relieving medication was not noted.
  + During an approximate three-week period, there were seven incidents of Consumer A physical hitting staff while attending to their care needs noted in behaviour charting. However, these incidents were not captured on incidents forms.
  + Interviews with care staff confirmed Consumer A can be physically and verbally aggressive towards staff when personal care is initiated, and these instances are documented in progress notes.

The provider submitted a response to the Assessment Team’s report which included specific responses to the Requirements recommended as not met and additional information. The provider submitted the following information and evidence relevant to my finding:

* A memorandum was sent to staff in relation to the requirement for staff to report incidents where harm has occurred.
* The protocol for organisation’s incident management system is being progressed at a regional level to strengthen the use as it does capture high incident/high prevalence issues.
* Weekly clinical risk meetings are held, previously under the guidance of the nurse advisor, but this has been continuing after this time. Monitoring of all consumers is considered a part of this weekly meeting.
* A pain management protocol is in draft and will include management and use of non-pharmacological strategies. This is a high priority issue and will be captured through the audit system.

Based on the Assessment Team’s report and the provider’s response I find the service has not effectively managed the high-impact of high-prevalence risks associated with the care of Consumer A. I find that the service was unable to demonstrate the effective management of high-impact or high-prevalence risks associated with the use of psychotropic medications to support effective management of Consumer A’s responsive behaviours.

In coming to my finding, I have considered that the service was unable to demonstrate that they had obtained the legislatively required consent from Consumer A’s representative prior to the use of a psychotropic medication and/or chemical restraint. While management indicated they had consent from the representative to act on behalf of them for medical related decisions for Consumer A, including consent to the use of chemical restraint, I have relied upon the Assessment Team’s conversation with the representative who confirmed consent for chemical restraint cannot be made by management. I consider that informed consent from the consumer and/or nominated representative for medications used for chemical restraint is integral to ensuring risks associated with its used are identified and effectively managed; chemical restraint was used for Consumer A on four occasions without this consent. Additionally, while management asserted that the psychotropic medication was used to manage Consumer A’s pain, progress notes and omission of documented reasons for administration of the psychotropic medication indicates it was not used as a last resort, after all non-pharmacological strategies had been trialled.

I have also considered that Consumer A’s behaviour support plan directs that psychotropic medication should only be administered for ‘severe exacerbation of behaviours’. Based on progress notes relating to the four occasions where psychotropic medication was administered, there was no indication other alternatives were trialled before it was administered.

Additionally, I have considered the consumer’s pain charting in the period in which the consumer was subject to chemical restraint, which indicates several instances of moderate pain and one instance of severe pain. However, during this period, Consumer A was administered pain relieving medication on six occasions and psychotropic medication on four occasions which indicates staff had not always considered pain as a trigger for the responsive behaviour. Additionally, the medical officer directed that psychotropic medications should only be administered if Consumer A does not respond to pain relieving medication. Progress notes do not demonstrate staff exhausted or evaluated pain relieving medication options or non-pharmacological pain-relieving strategies prior to the use of the psychotropic medications. I consider that effective management of high-impact or high-prevalence risks associated with the use of chemical restraint includes trialling all other alternative strategies and using the psychotropic medications as a last resort to manage responsive behaviours.

I have considered the Assessment Team’s evidence relating to seven incidents of Consumer A physical hitting staff while attending to their care needs which was noted in behaviour charting but not on an incident form in Standard 8 Requirement (3)(d), relating to the service’s incident management system.

For the reasons detailed above I find the service to be non-compliant with Requirement (3)(b) in this Standard.

**Requirement (3)(d)**

The Assessment Team’s report provided information and evidence of actions taken to remedy Requirement (3)(d) in this Standard, including (but not limited to):

* An ‘Observation – change in condition’ form was implemented to guide staff to undertake clinical observations when a change in a consumer is observed.
* Staff now undertake a delirium screening assessment when a consumer shows an increase in confusion.
* Nursing management review progress notes every 24 hours to identify any changes/deterioration for consumers.

At the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found the service was able to demonstrate that staff recognise and respond to consumers’ decline in mental health, cognition, or physical function in a timely manner. The Assessment Team provided the following information and evidence relevant to my finding:

* A consumer said when they were unwell, staff informed the registered nurse who reviewed them and contacted the medical officer.
* Consumers’ care files demonstrated changes to consumers’ conditions, function or capacity is recognised and responded to with appropriate assessments and changes to care. Additionally, consumers are referred to medical officers, speech pathologists, dietitians, physiotherapists and geriatricians, and any recommendations from these specialists have been implemented.
* Staff described processes they use when they observe a change to consumers’ condition or if they are unwell.
* Clinical staff were able to describe examples of when a consumer has deteriorated and the actions taken in response, including referrals to medical officers and other health professionals.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(d) in this Standard.

**Requirement (3)(e)**

The Assessment Team’s report provided information and evidence of actions taken to remedy Requirement (3)(e) in this Standard, including (but not limited to):

* Staff were provided with additional training in relation to the messaging function of the electronic care system, including the appointment of a specific educator to provide education across a six-month period. Staff also participated in a refresher course for this system.
* A memorandum was sent to staff in relation to the messaging function of the electronic care system.
* Nursing management review progress notes every 24 hours to identify actions to be taken, with a clinical progress review sheet provided to the registered nurse on duty for actions to be resolved within 24 hours.
* A seven-day handover sheet was implemented to support staff to monitor changes for consumers over a week-period

At the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found the service was able to demonstrate consumers’ needs, preferences and changes to care are documented and communicated within the organisation, and with relevant others. The Assessment Team provided the following information and evidence relevant to my finding:

* Consumers and representatives feel consumers’ needs and preferences are effectively communicated.
* Nursing management provided examples of how they use the messaging function in the electronic care system to inform staff of changes to consumers’ needs or requirements/tasks for individual staff.
* Staff confirmed they are informed about changes to consumers’ care through the seven-day handover sheet, messages in the electronic care system and confirmed they have access to up-to-date information and care plans to support them to provide care and services.
* Clinical staff described processes used for sharing information, including recommendations and reviews by other health specialists.
* Medical officers and allied health professionals have access to the service’s electronic care system.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(e) in this Standard.

# Standard 4

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| Services and supports for daily living | |  |
| 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)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |

Findings

Following a Site Audit conducted from 17 May 2022 to 19 May 2022, the service was found to be non-compliant with Requirements (3)(b), (3)(c) and (3)(e) in this Standard where it was found the service was unable to demonstrate:

* services and supports for daily living promoted each consumer’s emotional, spiritual and psychological well-being;
* services and supports for daily living supported each consumer to do the things of interest to them; and
* referrals to individuals, organisations and other providers of care were actioned in timely or appropriate manner.

The Assessment Team have recommended Requirements (3)(b) and (3)(c) as met and Requirement (3)(e) as not met. The provider submitted a response to the Assessment Team’s report, specifically addressing Requirement (3)(e). Based on the Assessment Team’s report and the provider’s response, I find Requirements (3)(b), (3)(c) and (3)(e) to be compliant. I have provided reasons for each Requirement below.

**Requirement (3)(b)**

The Assessment Team’s report provided information and evidence of actions taken to remedy Requirement (3)(b) in this Standard, including (but not limited to):

* Staff participated in training relating to behaviour management which included dementia and responsive behaviours, understanding the treatment of dementia behaviours in aged care and understanding and differentiating dementia, delirium and depression.
* Care staff now have expanded access to the electronic care system to allow them to access and edit consumers’ ‘engagement and interactions’ daily monitoring forms.
* A consumer who has had previous episodes of depression is actively monitored by the lifestyle team, with ongoing progress notes made in relation to activity attendance, perceived moods and one-to-one interactions.

At the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found the service was able to demonstrate services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. The Assessment Team provided the following information and evidence relevant to my finding:

* Consumers and representatives indicated consumers’ emotional, spiritual and psychological well-being is supported.
* A consumer’s care file demonstrated staff identified a change in mood and staff put actions in place to respond, monitor and report on the consumer’s condition.
* The Assessment Team observed lifestyle activities, including one-to-one time with consumers with impaired mobility or cognition.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(b) in this Standard.

**Requirement (3)(c)**

The Assessment Team’s report provided information and evidence of actions taken to remedy Requirement (3)(c) in this Standard, including (but not limited to):

* Lifestyle staffing hours and numbers for lifestyle staff have increased, with two staff now delivering the lifestyle program. The lifestyle coordinator described how staff duties are divided between the two staff with one delivering group activities and the other providing one-to-one engagement/activities.
* The range of activities has increased, and attendance sheets and surveys confirm consumers are enjoying the new activities.
* The main dining room has been redesigned to encourage communal dining.

At the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found the service was able to demonstrate consumers are supported to participate in their community, have personal and social relationships and do things of interest to them. The Assessment Team provided the following information and evidence relevant to my finding:

* Consumers confirmed they are supported to participate in the community, have personal and social relationships and do things of interest to them.
* The Assessment Team observed group activities to be well attended and participants appeared engaged.
* Lifestyle staff stated they develop the group activity program in accordance with consumers’ preferences which are identified through assessment processes. Additionally, staff were also able to recall consumers’ likes, dislikes and important relationships.
* The Assessment Team observed consumers using the redesigned communal dining area for meals.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(c) in this Standard.

**Requirement (3)(e)**

The Assessment Team’s report provided information and evidence of actions taken to remedy the Requirement (3)(e) in this Standard, including (but not limited to):

* The plan for continuous improvement refers to external services but all are clinical in nature.
* The lifestyle coordinator and the aged care lead could describe suitable external sources they are seeking, however, have not yet implemented any of these services.
* On three occasions, community members brought in animals for pet therapy and photos indicate consumers enjoyed the activity.

However, at the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found that while improvement initiatives for this Requirement had been commenced, at the time of the Assessment Contact, the improvements had not been implemented. The Assessment Team provided the following information and evidence relevant to my finding:

* Lifestyle staff stated contact with outside organisations has been conducted over the phone but were unable to demonstrate formal arrangements have been established. However, there was a volunteer observed to be helping with the activities program and spending time with consumers.
* A list of community organisations obtained by the service from the community’s’ local council was produced to demonstrate who the service was trying to engage to provide services.
* Activity calendars developed and distributed by the lifestyle program demonstrated that overall, activities being delivered are done so internally.

The provider submitted a response to the Assessment Team’s report and disputes the Assessment Team’s recommendation. The provider submitted the following evidence and information relevant to my finding:

* There was no evidence of consumers requesting external support during the Assessment Contact. If requests had been made, the service would have actioned them.
* There have been several causative factors which have delayed the implementation of external services, including limited access to the service to those with mandatory COVID-19 vaccination requirements until December 2022, and a COVID-19 outbreak which occurred in October 2022.
* Even though there have been no consumer requests, the service has undertaken progress to engage external providers to support linkages to the community, including the recommencement of library and church services at the end of January 2023, the local nursery was contacted and a consumer is planned to be supported to attend a local ‘men’s shed’ in the community from February 2023. Additionally, various plans to engage further supports through advertising have been planned.
* The service has a transport bus which can be booked and used by families and individuals, with many using the bus during the Christmas season.

Based on the Assessment Team’s report and the provider’s response I find the service has demonstrated timely and appropriate referrals to individuals, other organisations and providers of other care and services.

In coming to my finding, I have considered that while the Assessment Team assert that the service was unable to demonstrate that formal arrangements/referrals had been made, lifestyle staff state they have been in contact with outside services for consumers. Additionally, the service was able to demonstrate that they have identified organisations and individuals who may provide services for consumers, and since the Assessment Contact specified dates have been confirmed to commence supports from the community. While there is no information or evidence about consumers who require specific referral to services, in coming to my finding, I have also relied upon evidence in the Assessment Team’s report which includes that community members have provided pet therapy and a volunteer was observed to be assisting consumers during the Assessment Contact, and evidence from Requirement (3)(c) in this Standard where consumers have confirmed they are supported to participate in the community, and do things of interest to them. Thus, demonstrating there are community connections and referrals to individuals to support consumers.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(e) in this Standard.

# Standard 5

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| Organisation’s service environment | |  |
| 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 |

Findings

Following a Site Audit conducted from 17 May 2022 to 19 May 2022, the service was found to be non-compliant with Requirement (3)(b) in this Standard where it was found the service was unable to demonstrate:

* the service environment to be safe, clean and well maintained.

The Assessment Team’s report provided information and evidence of actions taken to remedy Requirement (3)(b) in this Standard, including (but not limited to):

* Several actions to improve the service environment have been implemented, including new flooring in the main dining room, decommissioning of a shower until planned works have been completed and covering of wiring in the main common area.
* New cleaning trolleys are being used which allow for chemicals to be stored securely and rooms designated for cleaning and storing contaminated equipment were observed to be closed with keypad lock units installed.
* Internal audits are being conducted to confirm compliance with this Standard and consumer satisfaction with the service environment.

At the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found the service was able to demonstrate the service environment to be well maintained, with wide corridors free from obstruction and provided a positive and comfortable environment, which allowed consumers to move freely both indoors and outdoors. The Assessment Team provided the following information and evidence relevant to my finding:

* The Assessment Team observed the environment to be clean and cleaning staff regularly cleaning communal areas.
* The service is monitoring cleaning staff and associated practices, with recent deficits identified and remedial actions, such as a draft training program, inclusive of competency-based learning. Management indicated updates to procedures and processes have been developed with consultation with staff to occur prior to finalisation.
* A proactive maintenance schedule is used to support ongoing maintenance of the service environment and repairs and maintenance tasks can be logged via an electronic request system.
* Kitchenettes and dining areas were observed to have sharp utensils stored safely. However, kettles were observed to be accessible, with management responding on the day of the Assessment Contact to initiate a strategy to support safe storage and use of kettles.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(b) in this Standard.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Following a Site Audit conducted from 17 May 2022 to 19 May 2022, the service was found to be non-compliant with Requirement (3)(d) in this Standard where it was found the service was unable to demonstrate:

* feedback and complaints raised through consumer meetings, satisfaction surveys and audits, had been used to improve the delivery of care and services, specifically in relation to the lifestyle program, staffing levels, call bell response times and the quality of the meals.

The Assessment Team’s report provided information and evidence of actions taken to remedy Requirement (3)(d) in this Standard, including (but not limited to):

* Resident and representative meetings have been reinstated with feedback now captured on the feedback log for review and action.
* Staff have participated in education sessions in relation to using feedback to make improvements.

At the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found the service was able to demonstrate feedback is identified, monitored, analysed, trended and reviewed for areas of improvement. The Assessment Team provided the following information and evidence relevant to my finding:

* Consumers and representatives interviewed indicated they have observed improvement to care and services, including meals, the environment, call response times and the lifestyle program. Additionally, they are satisfied management endeavour to improve care and services following feedback.
* The service’s plan for continuous improvement, newsletters, surveys and resident and representative meeting minutes demonstrated consumers and representatives are consulted with and provide feedback, which is logged on the feedback register with planned actions for improvement, including additions to the plan for continuous improvement, where applicable.
* Organisational reports demonstrate complaints and feedback data is used to identify trends and opportunities for improvement.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(d) in this Standard.

# Standard 7

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

Findings

Following a Site Audit conducted from 17 May 2022 to 19 May 2022, the service was found to be non-compliant with Requirements (3)(a), (3)(c), (3)(d) and (3)(e) in this Standard where it was found the service was unable to demonstrate:

* adequate staff numbers, in particular lifestyle staff, to ensure the delivery of quality care and services in accordance with consumers’ needs, goals and preferences;
* members of the workforce were competent and knowledgeable to perform their roles effectively;
* the workforce was trained, equipped and supported to deliver the outcomes required by the Quality Standards; and
* the workforce had their performance regularly assessed, monitored or reviewed.

**Requirement (3)(a)**

The Assessment Team’s report provided information and evidence of actions taken to remedy Requirement (3)(a) in this Standard, including (but not limited to):

* An analysis of the roster was undertaken for all care and service areas, with adjustments made and further reviews are ongoing.
* Recruitment of additional staff, including new management, clinical and care staff, and support staff.

At the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found the service was able to demonstrate the workforce is planned to enable, and the number and mix of the workforce enables, the delivery and management of safe and quality care and services. The Assessment Team provided the following information and evidence relevant to my finding:

* Overall, consumers and representatives interviewed confirmed they have observed improvements in the timeliness of the provision of care.
* All staff interviewed indicated there are generally enough rostered staff to ensure they complete their duties in a timely manner and management support the filling of unplanned leave/unfilled shifts, including using agency staff.
* A rostering clerk has been employed to assist in managing the roster and filling unplanned leave to support the nursing management to focus on clinical oversight. Rosters are reviewed regularly by management and the leadership team to monitor staff numbers and skills mix.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(a) in this Standard.

**Requirement (3)(c)**

The Assessment Team’s report provided information and evidence of actions taken to remedy Requirement (3)(c) in this Standard, including (but not limited to):

* Face-to-face training for staff in relation to various areas of care, including behaviour, pain, wounds, mediation, falls management, assessment and care planning, restrictive practices, Serious Incident Response Scheme (SIRS) and nutrition and hydration was provided.
* Monitoring of staff competency now includes the ‘7-day handover’, daily progress notes and incident review.

At the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found the service was able to demonstrate the organisation has processes to ensure the workforce has the appropriate qualifications and registrations, with ongoing processes by management to monitor staff practices. The Assessment Team provided the following information and evidence relevant to my finding:

* Consumers and representatives indicated they are confident staff have the knowledge and competency to perform their roles effectively.
* Staff said they feel supported by management with training and mentoring opportunities to guide them.
* Progress notes and care planning documentation demonstrated staff are generally providing care in accordance with the organisation’s policies and procedures, and with best practice.
* Management demonstrated areas for improvement of staff practices were identified through monitoring processes.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(c) in this Standard.

**Requirement (3)(d)**

The Assessment Team’s report provided information and evidence of actions taken to remedy Requirement (3)(d) in this Standard, including (but not limited to):

* A training plan has been developed which includes training sessions in relation to a range of care, clinical and legislative topics and which have been delivered to staff in a face-to-face forum, with a view to continue with this training regime.
* Staff huddles have been implemented to provide education and support opportunities.

At the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found the service was able to demonstrate the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. The Assessment Team provided the following information and evidence relevant to my finding:

* Consumers and representatives indicated they are confident staff have knowledge and competency to perform their roles effectively.
* Clinical and care staff said they are provided with adequate training opportunities to perform their roles confidently and confirmed they have participated in additional face-to-face training sessions and have training through meetings.
* Staff indicated they feel supported in their roles and management/supervisors are available to provide additional training and support.
* Training records demonstrate face-to-face training has been provided in addition to the online mandatory training. While management confirmed there has been a delay with all staff completing their practical manual handling training, they confirmed they are working on a remedial strategy and staff who have not completed the practical training are working with experienced staff.
* Management was able to describe the service’s onboarding processes, including orientation, buddy shifts and mandatory training to support new staff.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(d) in this Standard. However, I encourage management to implement their planned remedial actions for staff practical manual handling training to ensure staff are competent and are equipped to perform their roles safely and effectively.

**Requirement (3)(e)**

The Assessment Team’s report provided information and evidence of actions taken to remedy Requirement (3)(e) in this Standard, including (but not limited to):

* Progress notes are reviewed every 24 hours by nursing management to monitor staff practices, with reflective tools used where deficits have been identified.
* Six-monthly staff performance reviews are completed.
* A review of nursing management administrative tasks has been undertaken, with support roles implemented to allow nursing management to oversee the provision of care. Additionally, offices for nursing management have been re-located to increase their access to staff and clinical oversight.

At the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found the service was able to demonstrate regular assessment, monitoring and review of the performance of each member of the workforce. The Assessment Team provided the following information and evidence relevant to my finding:

* Consumers indicated staff perform their roles well and provide them with the care and services they require.
* Staff confirmed the participate in six-monthly performance appraisals and a performance appraisal report demonstrate the service is meeting their target completion, with overdue appraisals mostly relating to extended leave.
* Management was able to describe the service’s framework for monitoring staff performance and actions taken to manage any identified deficits.
* Staff confirmed the implementation of the reflective practices tool when deficiencies are identified.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(e) in this Standard.

# Standard 8

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| Organisational governance | |  |
| 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. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

Following a Site Audit conducted from 17 May 2022 to 19 May 2022, the service was found to be non-compliant with Requirements (3)(c), (3)(d) and (3)(e) in this Standard where it was found the service was unable to demonstrate:

* effective organisation wide governance relating to information management, continuous improvement, workforce governance and regulatory compliance;
* effective risk management systems and practices, including managing high-impact of high-prevalence risks associated with the care of consumers, recognising and responding to abuse, and managing and preventing incidents, including the use of an incident management system; and
* effective clinical governance framework in relation to minimising the use of restraint.

The Assessment Team have recommended Requirements (3)(c) and (3)(e) as met and Requirement (3)(d) as not met. The provider submitted a response to the Assessment Team’s report, specifically addressing Requirement (3)(d). Based on the Assessment Team’s report and the provider’s response, I find Requirements (3)(c) and (3)(e) to be compliant and Requirement (3)(d) to be non-compliant. I have provided reasons for each Requirement below.

**Requirement (3)(c)**

The Assessment Team’s report provided information and evidence of actions taken to remedy Requirement (3)(c) in this Standard, including (but not limited to):

* The service has transitioned paper charting over to the electronic clinical management systems, with staff participating in training relevant to understand this change in process.
* Communication processes have been reviewed with clinical meetings, seven-day handover and internal audits conducted to convey information and identify areas for continuous improvement.
* A review of legislative requirements was completed to understand if the service was complying with all relevant legislative obligations. In response, the service has implemented behaviour support plans for relevant consumers.
* A face-to-face training schedule was developed to ensure staff competency in clinical care and services. Additionally, there was recruitment of roles to support more effective clinical oversight.

At the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found the service was able to demonstrate a generally effective governance systems with monitoring systems, assigned delegations and accountabilities, and policies and procedures. The Assessment Team provided the following information and evidence relevant to my finding:

* Staff interviewed said they can readily access the information they need to support them to perform their roles effectively, including consumer care information, policies, procedures and online training.
* The plan for continuous improvement demonstrates the service has monitoring processes to identify opportunities for improvement and uses a range of mechanism to identify improvements. The plan for continuous improvement is monitored by the leadership team and outstanding improvement initiatives are reported to the Board.
* Consumers and representatives indicated they are encouraged to participate in continuous improvement through feedback, surveys and meetings.
* Policies and procedures were up-to-date and were in accordance with relevant legislative requirements, including restrictive practices and the SIRS.
* The organisation has memberships with peak bodies to monitor regulatory changes.
* Examples of budget expenditure was provided, and management described the annual financial planning processes and financial delegation system.
* The service has processes to ensure staff are selected, trained and supported to meet the organisation’s values and job specifications.
* Comments and complaints are managed at the service level and reported at relevant leadership and Board meetings.

In coming to my finding, I have also considered effective processes and outcomes in relation to assessment and care planning, management of complaints and changes to human resources, with evidence I have considered in the relevant Standards.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(c) in this Standard.

**Requirement (3)(d)**

The Assessment Team’s report provided information and evidence of actions taken to remedy the Requirement (3)(d) in this Standard, including (but not limited to):

* An electronic risk management system has been implemented to profile, identify and manage consumers’ personal and clinical risks.
* Weekly clinical risk meetings have been established to discuss and mitigate consumers’ risks, in conjunction with the risk management system.
* Staff and management participated in SIRS training and toolbox sessions in relation to incident management systems.
* Progress note reviews are undertaken by the nursing management and the use of a ‘seven-day handover’ tool supports communication of consumers’ risks.
* The organisation’s SIRS procedure was reviewed by a consultant.

However, at the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found that while improvement initiatives for this Requirement had been implemented, the service was unable to demonstrate effective systems to manage, monitor and analyse incidents to manage high-impact or high-prevalence risks. Specifically, at the Site Audit conducted from 17 May 2022 to 19 May 2022, the service was not consistently recording behavioural incidents within the incident management system, in accordance with the service’s policies and procedures. The Assessment Team found this practice of not recording all behavioural incidents is ongoing and physical and verbal behaviours towards staff, where injury did not occur, are not being recorded within the incident management system. The Assessment Team provided the following information and evidence relevant to my finding:

* Staff interviewed indicated there are two consumers who are physically aggressive towards staff, especially when staff are delivering care. While behaviour charts/progress notes have captured nine instances for Consumer A in an approximate four-week period of physical and verbal aggression towards staff, and seven instances for Consumer B in an 11-day period of physical and verbal aggression towards staff, these have not been recorded within the incident management system.
* Both Consumer A and B’s responsive behaviours in the form of physical and verbal aggression towards staff have not been identified within the incident management system, which is monitored by the organisation to ensure appropriate support to the service where required.
* The weekly clinical risk meeting which was held following instances of Consumer A and Consumer B being aggressive towards staff, did not include identification of these responsive behaviours. Additionally, consumers discussed on the meeting template did not have information inclusive of evaluation of risk, currents strategies and efficacy of the strategies. Management and staff indicated consumers’ risks and changes are communicated verbally and the risk meeting did not include review of the effectiveness of strategies.
* The organisation’s procedure indicates staff are to complete an incident report for incidents associated with responsive behaviours. However, management said this is incorrect and staff are to only record an incident associated with a responsive behaviour when injury, psychological or emotional harm has occurred.
* Governance meeting minutes did not include a breakdown of clinical data for each service but rather reported the data at an organisational level. However, a new role has been implemented to monitor and report on any areas of concern at a service level.
* An incident was not considered for a SIRS report because management indicated the representative had given verbal consent for the service to make clinical decisions on behalf of Consumer A.

The provider submitted a response to the Assessment Team’s report which included specific responses to the Requirements recommended as not met and additional information. The provider submitted the following information and evidence relevant to my finding:

* A memorandum was sent to staff reminding them of the need to report all incidents.
* The organisation is undertaking a review of incident reporting and considering whether to remove the requirement for staff to report all incidents, particularly those which result in no harm. They consider that issues are reported via behavioural charts and collated and analysed at clinical risk meetings. Additionally, the Assessment Team did not include information about increased incidents of physically and verbally aggressive behaviours towards staff by Consumers A and B, leading to review by medical officers and external service providers.
* SIRS education has been conducted on site and a further review of staff understanding of SIRS has commenced with a questionnaire recirculated to staff.
* Consumer A’s representative was contacted to determine consent expectations and the outcome of this discussion was placed in the consumer’s file in the electronic care system.

Based on the Assessment Team’s report and the provider’s response I find the service has not demonstrated effective risk management systems and practices associated with managing high-impact or high-prevalence risks associated with the care of consumers and the use of an effective incident management system.

In coming to my finding, I have considered the service are not using effective risk management systems and practices in relation to the recording and investigation of responsive behavioural incidents, particularly that staff confirmed that they are not always acting in accordance with the service’s incident management procedure through completing an incident form for responsive behavioural incidents where there was no harm. The provider asserts that risks are monitored and managed through review of behavioural charts and progress notes and that Consumer A and Consumer B were reviewed by relevant medical officers and external health specialists through these processes. However, I consider that for Consumer B, the referral and review was conducted prior to an 11-day period in which the consumer had seven instances of physical and verbal abuse towards staff. I find that if the service had considered these incidents through their governance risk management processes, such as the clinical risk meeting, it would have provided several opportunities for consideration of the effectiveness of the current responsive behavioural strategies, inclusive of specialist recommendations. Additionally, for Consumer A, while a referral and review were conducted during the four-week period in which there nine instances of physical or verbal aggression towards staff, I consider the service missed an opportunity to effectively monitor and consider efficacy of strategies.

In coming to my finding, I have also considered evidence from Requirement (3)(b) in Standard 3 Personal care and clinical care in relation to Consumer A being administered psychotropic medication without the requisite consent and without it being used as a last resort. Staff had reported an incident on the initial two occasions where the psychotropic medication was administered without informed consent. However, further investigation and clarification of consent was not obtained following these incidents, and psychotropic medications continued to be administered. While management asserts the psychotropic medication was administered for pain management, progress notes do not demonstrate it was used as a last resort or that all other pain-relieving strategies had been exhausted. Accordingly, I consider the service had not taken the opportunity to review the incident report effectively to ensure any medications used as chemical restraint were administered in accordance with legislative requirements for Consumer A. Therefore, find there was not an effective use of the service’s incident management system.

For the reasons detailed above I find the service to be non-compliant with Requirement (3)(d) in this Standard.

**Requirement (3)(e)**

The Assessment Team’s report provided information and evidence of actions taken to remedy the Requirement (3)(e) in this Standard, including (but not limited to):

* Face-to-face restrictive practice training was provided to staff.
* A review of legislation and documentation was undertaken to ensure appropriate application of regulatory requirements. A review of behaviour support plans was undertaken to ensure all legislative requirements were met.
* Management review progress notes and incidents daily to ensure clinical oversight, including care provided which is not best practice and staff knowledge/competency is appropriate.

At the Assessment Contact undertaken on 10 to 12 January 2023, the Assessment Team found the service was able to demonstrate that the service has a clinical governance framework with up-to-date policies and procedures to guide staff practice. The Assessment Team provided the following information and evidence relevant to my finding:

* Behaviour support plans have been implemented and include personalised information and strategies to minimise the use of restraint, in accordance with legislative requirements.
* Clinical staff interviewed were familiar with antimicrobial stewardship principles, have received training and could demonstrate practices in accordance with reducing the risk of increasing resistance to antibiotics. The service uses auditing processes to monitor antibiotic usage and have identified areas for improvement in which an action plan has been developed.
* Management said they conduct progress note reviews, review all incidents and conduct audits. However, these processes were not effective for one consumer who did not have the requisite consent obtained prior to the administration of chemical restraint and the service was also unable to demonstrate that chemical restraint was used as a last resort.
* Overall, clinical and care staff were able to demonstrate understanding of the principles of open disclosure and restrictive practices.

For the reasons detailed above, I find the service to be compliant with Requirement (3)(e) in this Standard. While the Assessment Team presented evidence which indicates one consumer (Consumer A) was chemically restrained and was provided psychotropic medication without it being the last resort, I have considered that overall, the service has an effective clinical governance framework which governs and monitors clinical care provision, with staff demonstrating awareness and knowledge of relevant practices and processes. I have considered the deficits relating to the Consumer A are specifically related to effective risk management practices associated with managing high-impact and high-prevalence risks associated with the care of consumers. That is, there was a systemic failure to effectively respond, investigate or review the use of chemical restraint for Consumer A to ensure the requisite consent and trialling of alternative strategies was completed before the use of the chemical restraint. Please see Requirement (3)(d) in this Standard and Requirement (3)(b) in Standard 3 Personal care and clinical care for further reasoning and information.

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