Transcript

Aged Care Quality and Safety Commission

Accountabilities of Governing Bodies in Aged Care

**Presented by:**

**moderator:**

Pam Christie

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**Panellists:**

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[*Opening visual of slide with text saying ‘Australian Government with Crest (logo)’, ‘Aged Care Quality and Safety Commission’, ‘Engage’, ‘Empower’, ‘Safeguard’, ‘Accountabilities of Governing Bodies in Aged Care’, ‘Janet Anderson PSM, Aged Care Quality and Safety Commissioner’, ‘Dr Melanie Wroth’, ‘Chief Clinical Advisor’, ‘Ann Wunsch, executive Director, Quality Assessment and Monitoring Operations’, ‘1800 951 822’, ‘agedcarequality.gov.au’*]

[The visuals during this webinar are of each speaker seated at a long table and presenting in turn to camera, with reference to the content of a PowerPoint presentation being played on screen]

**Pam Christie:**

Good morning everyone and welcome to our webinar today on Accountabilities of Governing Bodies in Aged Care hosted by the Aged Care Quality and Safety Commission.

I’d like to begin by acknowledging the traditional owners of the lands we’re meeting on today and pay my respect to Elders past and present and to acknowledge Aboriginal people today.

My name is Pam Christie and I’m your facilitator for today’s panel discussion. I’d like to start by introducing our panel. On my left here we have in the middle Janet Anderson, our Commissioner. We also have here Melanie Wroth, our Chief Clinical Advisor, and Ann Wunsch, who is our Executive Director for Quality Assessment and Monitoring with the Commission.

We’re going to start today’s webinar with a panel discussion. Each of our panellists will answer some questions about accountabilities of governing bodies in aged care particularly focusing on Standard 8 of the new Aged Care Quality Standards. We’re going to be running some opinion polls throughout the session so we look forward to your participation in sharing your thoughts and ideas about some of the questions we raise. That will be anonymous by the way. We won’t know what your views are. But we would also encourage you to put some questions forward to the panel. We’ll have plenty of time at the end of the session to answer your questions but don’t wait until then. Put your questions forward as we proceed today.

So let’s get started. I’d like to hand to Janet to make some opening remarks.

**Janet Anderson:**

Thanks Pam. Hello everyone. Thank you for joining us today and for your interest in this important topic. Today we’re discussing Standard 8 of the Aged Care Quality Standards which as you know commenced in July this year, organisational governance. We at the Commission are keen to ensure that aged care services generally and boards and executives of aged care services in particular understand what is expected of you in relation to Standard 8.

But before I go into that I want to take a moment to talk about the interim report of the Royal Commission into Aged Care Quality and Safety. Now that report said many things and it drew into sharp relief board accountability for the operations of aged care services. I’m sure that everyone along with the Commission are reflecting on the findings of that report which effectively hold a mirror up to us as funders, as regulators, as providers of aged care, and it’s not a flattering picture.

All of us need to engage with this sobering and challenging analysis of Australia’s aged care system, come to grips with where the system and services are failing and falling short of community expectations and commit to making the necessary changes. Older Australians deserve at least that.

Let’s now move onto a consideration of Standard 8, organisational governance. In dealing with this topic we’re going to assume that you’re already aware of the centrality of consumer experience to the totality of the Quality Standards. Now for many aged care services the implementation of the new Standards has required significant and for some transformational change in your care model, in your engagement with consumers, to ensure that your consumers’ needs, goals, values, preferences guide and shape the care and services you provide. And that’s the case whether you run a residential service or a home service.

So today’s webinar recognises that as members of boards and executive teams you have significant leadership responsibilities. You play a vital role in setting the culture within your organisation and also in leading change. My colleague Ann Wunsch will be detailing your accountabilities under each of the requirements in Standard 8 and explaining how we assess compliance. Dr Melanie Wroth, Chief Clinical Advisor, will talk to us about clinical governance which is specifically included in Standard 8 and will highlight an issue also singled out by the Royal Commission in its interim report minimising the use of restraint.

We’re also interested to hear your views as Pam has said about the requirements in Standard 8 and we’re going to access your views through your participation in the online polls so please use that device to let us know how you’re tracking through the presentation and what you’re thinking.

Finally we’re looking forward to answering your questions when we’ve concluded the formal part of the presentation so please start thinking about those and sending them through to us as we go. Thanks Pam.

**Pam Christie:**

Thank you Janet. Now an important part of this morning. We asked all our participants to make sure they’ve downloaded our new app on the Standards, and we’re going to take this opportunity this morning for Janet to formally launch our new app.

**Janet Anderson:**

This sounds like ‘And now we break for a word from our sponsor’. Standards to Go. We’re very excited about this. I hope all of you have taken the opportunity of downloading the app. It’s found very straightforwardly through a search for Quality Standards. As the slide indicates it appears on the wheel when you look at it and you can press any one of those wedges or the circle in the middle, the Standard comes up, you can read through it, and then there is also in the options menu opportunities to contact us by email, to access online resources. And we are looking always to increase the offer through this app. Please make good use of it. It’s something of which we’re very proud and we’d be very pleased to see a very significant spike in the number of people who’ve downloaded it. So thanks very much.

**Pam Christie:**

Thank you Janet. We’re now going to move to Standard 8 and again Janet I’ll ask you to introduce the Standard which of course you can see on the screen the consumer outcome and the organisational statement that is common for each of the eight Standards. But Janet can you tell us what good organisational governance actually looks like? What are we talking about here?

**Janet Anderson:**

I’m going to start at a tangent to that question by asking each of you what’s your organisation’s primary goal?

Now as you reflect on that question I hope running through your head is some variation of improving life through care. Not supporting wellbeing or promoting safety and quality but improving life through care. It feels like a radical thought doesn’t it in these turbulent times. That’s what we expect you to be reaching for and for your services to be aspiring to deliver day in and day out. If you’re an executive your job is to arrange or manage your organisation, your human resources, finances, physical infrastructure, information and communication technology, all the fundamentals that go to achieving that goal. If you’re a board member your job is to provide organisational leadership, to set the strategic direction for the organisation, to model and promulgate your expectations around culture, and to oversee the work of the managers to ensure that the organisation is achieving its goals.

So at the highest level this requires a contemporary and up to date understanding of and a focused engagement with both risk and opportunities for continuous improvement. Now of course it’s also about ensuring organisational capability. So I don’t mean to diminish the essential quality and nature of things like human resources, finances, physical infrastructure, ICT. They are the enablers, the essential enablers. But if we stay at that high level then the questions I have for you in relation to risks and improvements are how will you know how the organisation is doing on managing risk and harnessing opportunities for improvement? This is a pivotal question. What information do you need as a board member and what information do you need as a manager to answer that question?

Now I strongly recommend you start by asking your consumers. Have a look at the consumer outcome statement that’s on the slide here, and indeed if you like you can access it through your app, and ask yourself are your consumers confident that your organisation is well run. Do you know what they think? Are your consumers partners with you in improving the delivery of your care and services? Now the governing body of an aged care service is accountable for the safety and quality of the care and services across your organisation and at all times including at 4:00am on a Tuesday morning or at midnight on a Saturday night and managers are responsible for delivering safe quality care and best practice consumer experiences and outcomes.

Now that statement illustrates how Standard 8 actually supports all the other Standards as well. Effective governance doesn’t rely on a single, uniform approach and different organisations have different corporate structures. Of course they do. And that’s absolutely fine as long as the board or other governing body of that organisation demonstrates that they one, put the consumer first at the centre of everything they do, two, promotes a culture of quality and safety, including effective governance systems, and three, drives and monitors improvements.

So in closing this particular section I’m going to ask you some questions and I want you to contemplate. Do you know what your consumers think of your service and are they indicating that they are confident that your service is well run? Does your service have a strong culture of safety and quality? If you’re a board member do you know? And is your service driving improvements? If you’re a board member are you asking questions about this?

Ann and Melanie will explore these questions in greater detail as they work through the specific requirements under Standard 8.

**Pam Christie:**

Thanks Janet. Yes we’re going to move through each of the five requirements of Standard 8 now, explaining what they mean and also Ann’s going to help us understand better how quality assessors will assess compliance with each of those requirements. But I think it is significant to note that under the new Standards that governance is a whole Standard in itself. So it’s really quite a big focus and we’ll be working through particularly the new features of this Standard.

So to start with requirement 3(a) I’d like to introduce Ann Wunsch. And Ann can you just briefly describe what this Standard means for governing bodies in aged care?

**Ann Wunsch:**

So Standard 8 really starts with a discussion around consumer engagement. And the issue here is how consumer engagement is embedded in the culture of all aged care services. This is engagement in a broad sense but also specifically in consumers developing, delivering and evaluating their care and services. And we call this approach codesign. So you need to be able to understand the extent to which you have a codesign model in your organisation where consumers are designing their care with you and you are delivering the care that meets their particular needs and expressed preferences to live the best life that they can.

Now Standard 1 is about consumer dignity and choice but in 8 3(a) it’s about the decision making process and the design and the evaluation of the experience of that care that enhances consumers’ dignity and choice. So 8 in a sense gives expression to Standard 1 for each person.

Now some of the questions that governing bodies need to consider in this particular requirement is that they need to be able to evidence how a diverse range of consumers that are supported in their services are involved in developing and designing and evaluating their care and services.

How do you ensure that you get consumer feedback? Are there multiple ways in which this is done in your organisation? Are there multiple modes of seeking feedback? Do the options available for seeking and obtaining feedback encourage and support consumers from diverse backgrounds to contribute and discuss their particular needs and views?

What systems do you have? What systems have you developed to ensure that you can seek and act on feedback from consumers? And we’ll talk about information systems a little bit further on in the presentation but when you consider the frame of the Aged Care Quality Standards you’ll see that you need responsive information systems across the board from gathering information in relation to individual consumers but also information systems that provide effective, relevant information to the governing body or to the board about outcomes for consumers.

Now do you use the feedback from consumers to evaluate and improve your services?

What relationships does your organisation have with consumer advocates and consumer representative groups? Now if you look at Standard 4, 4 3(a) talks about services and supports for daily living assist consumers to participate in their community within and outside the organisation’s service environment. Noting that you need to understand the communities from which your consumers come from how do you as an organisation have relationships with the various communities that your consumers come from? How do you understand those communities? And so when we come and ask you about the communities that your consumers come from how can you evidence those relationships with those communities? Do you involve advocates, groups and others in the development, delivery and evaluation of care and services? Do you seek to get feedback from these organisations? Do you ask community organisations to provide their perspective on the effectiveness of care and services in your service? Is that a useful lens for you to test some of the quality that you provide by asking those organisations to express their views?

**Pam Christie:**

So Ann you’ve asked quite a few questions there. We’re going to go to our first poll now and ask our participants to rate themselves or rate their organisation against this requirement. Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. Is your organisation exceeding, meeting or developing this requirement? So we’d ask you to start your assessment and we’re going to move on with an explanation about how we actually assess this requirement and then I’ll come back in a couple of minutes to share the results of the group.

So Ann can you just very briefly outline what assessors are looking for when they’re determining whether this requirement is met on an assessment visit?

**Ann Wunsch:**

So we interview consumers and representatives and ask them questions around their involvement in making decisions about care and evaluating care and services. So we are seeking to understand what involvement they have had and they are having now, noting that these Standards came into effect on 1 July. So since 1 July how have they been engaged in making decisions and evaluating their care and services?

We’re also seeking to understand to what extent the organisation is engaging with consumers and their representatives in fixing issues or deficiencies in services. So through whatever process the organisation uses, whether that be a survey, when you provide the survey results to consumers and representatives and you clearly outline where the deficiencies or issues were how are you engaging with consumers and representatives to contribute to the solutions to those issues? Are they active participants? Are they providing you a focus group to explore options to solve problems and issues? And when you find a situation where you have failed to meet one of the requirements or multiple requirements how are you using consumers and representatives to assist you in identifying the means to meet those requirements? Once again how are you involving their input in what needs to be done to meet the Aged Care Quality Standards?

**Pam Christie:**

Thanks Ann. We might pause there for a minute just to look at our poll results. We’ve had 135 people responding to our poll.

3.7% of respondents have said that they’re exceeding that requirement. We do know there’s best practice out there and that’s fantastic but we’d like that number to grow. 51.8% are meeting, 44.5% have acknowledged that they’re still developing their capability in that requirement.

Now I might just add we won’t be assessing each of the requirements in this way but I’ll just draw everyone’s attention to the fact that we do have a self-assessment tool as part of our resources. If you go to your app and you look on the top right hand corner of the hamburger menu and look under our guidance and resources you can search for ‘Self-assessment’. Make sure you put a hyphen. Self-assessment. And you’ll go to our self-assessment tool. And you might want within your organisation to look at using that tool to assess your level of compliance against all the Standards. It is a requirement when organisations are applying for reaccreditation but we’d encourage you to do it at any time to reflect.

So we’ll move now to our second requirement under Standard 8 3(b) and I’ll pass back to Ann again to just explain what this requirement means for governing bodies.

**Ann Wunsch:**

And I sound like I’m doing an ad for the app but please note that when you go into the app you can use the menu to find the glossary, and the glossary will provide you with the basis to understand a number of the terms that we’re using and the themes that come through the Standards, some of which you may be unfamiliar with. So please start from the glossary and just scroll through that. And it will just help you understand some of the issues that we’ll be discussing in Standard 8.

Now Standard 8 is interesting because it actually has a requirement that is explicitly referencing a governing body’s accountability. So it’s a requirement that the governing body promotes and delivers a culture of safe, inclusive, quality care and services. And if you look at Standard 8 and the five requirements it actually provides an agenda for a governing body. You should look at your board agenda now and see to what extent does it line up with the requirements under Standard 8?

Now as a governing body you should be modelling and promoting a culture of safe, inclusive, quality care and services across your organisation. How are you doing that? When we come and assess you how will we know that that is the model that you are promoting? What are the signs and signals that consumers and representatives and our assessors can understand in relation to that?

How do you demonstrate that you’re committed to and lead a culture of safety and quality improvement? Now our assessment process involves us talking with consumers and talking with representatives but it also involves us talking with staff and management. And we’ll be seeking to understand what they understand about the governing body that they’re working within and what it is communicating to them.

So your priorities and your strategic objectives, how are they communicated to staff and to others? What information do you ask for to ensure you understand your organisation’s performance?

How do you know that your organisation is meeting the expectations of your consumers, your workforce, the community and others and particularly those with diverse needs? Now I hope that you’re familiar with the diversity framework and action plans that are on the Department of Health’s website but the shared action plan in particular is useful because it’s got a number of actions that are directly pitched at governing bodies. So I’ve just got it here on my iPad. It’s set out in terms of foundational actions moving forward, leading the way. For instance one of the actions it lists is does the membership of your governing body reflect the diversity of your service’s client base? Is that a relevant consideration for you as a governing body to look at the diversity of your membership?

**Pam Christie:**

So Ann we might move to our next poll which helps you to answer some of the questions and issues Ann raised. The question is when did you last consider the views of consumers when assessing the performance of your organisation? And the options for responses for this question are last month, within the last six months or within the last 12 months or not at all. So we look forward to your responses to that. And just while we’re waiting for those responses Ann how do we assess this requirement? In fact we’ve got some questions coming through from our audience already and one of the questions was what are assessors actually looking for when they’re assessing this requirement?

Culture’s sometimes a hard thing to evidence.

**Ann Wunsch:**

So assessors will be asking staff and management to describe how the governing body promotes a culture of safe and inclusive quality care and services. They’ll be asking consumers for examples of how the organisation is seeking their feedback to improve service culture. And this is not just the process of seeking feedback but how service culture has been improved as a result of that feedback and if they can provide examples. For each of the questions we ask we’re asking for the service to provide an example of a particular circumstance not just a statement or a document that sets out the organisation’s commitment. Although that is important that there are documents that staff can refer to so they have a reference point for the particular work they do. But we want actual examples of how management of the organisation demonstrates behaviours and values consistent with those behaviours and values promoted by the governing body.

Do you have a statement on your website? Do you have statements that are visible within your organisation when we ask staff can they explain how their role contributes to the overall promotion of safety and quality in the organisation?

**Pam Christie:**

So we’ve got our results coming through. Do you want to hear them?

**Janet Anderson:**

Yes please.

**Pam Christie:**

So within the last month 46.7%, which is the highest score which is excellent. Within the last six months is 42.2% of respondents. Within the last 12 months 8%, and not at all 2.9%. So I think the message is very well understood.

So we’ll move now to our third requirement, requirement 3(c) under Standard 8. This is quite a long and complex requirement so Ann can I ask you to just briefly again explain what does this actually mean for governing bodies and leaders of aged care services?

**Ann Wunsch:**

So this requirement lists the key areas that an organisation needs to establish effective organisation wide governance systems.

Importantly information management systems. And when we go back to Standard 1, Standard 1 clearly sets out the service’s responsibility in capturing and understanding the unique existential needs of each individual, their preferences and the design of the service with them to meet those needs and preferences. Standard 8 requires an information management system. Clearly an information management system needs to be fit for purpose in order to be able to capture and communicate effectively within the service those individual needs, preferences in relation to the way services are designed and delivered.

Now that information system needs to take into account the privacy and the confidentiality requirements for each person and communicate information to the relevant people in the service for the purposes of delivering that care in a way that the person wants that information communicated. That’s really critical. Now we know that when we seek your application for reaccreditation you provide us with some information about particular groups in your organisation that you are delivering services to. They may be special needs groups. You may also have indicated on My Aged Care that you deliver care and services and have particular specialty areas. Your information systems need to reflect how you are doing that. So when we seek to understand your particular service response to a special needs group or to particular individuals we will want to see that tailored care according to that individual’s needs reflected in the information that you capture, that you gather and that you use to inform the care, deliver the care and evaluate the care.

That’s information management.

**Pam Christie:**

And just very briefly cover the other ones thanks Ann.

**Ann Wunsch:**

I will. Okay. Continuous improvement. Once again we talked about the engagement with consumers in order to inform continuous improvement. We need to be able to see where your improvements have been informed by identified needs and identified risks and that that is the basis by which you are planning and delivering care.

Financial governance. And our interest in financial governance is how you use processes to ensure the delivery of safe and quality care including your capital and revenue costs. How are they apportioned to deliver safe and effective care based on consumer information and consumer engagement? So consumers are informing the way you assign expenditure.

Workforce governance is really critical because it’s about the extent to which you have arrangements that meet the unique needs of consumers across the seven day a week, 24 hour period that you’re delivering care. You know that there are particular times in a 24 hour clock where there are pressures, where there are risks, and how does the governance of that workforce ensure that the right staff are working in the right places to deliver care according to the risks as you have understood them in your service?

Regulatory compliance is about your knowledge and application of relevant legislation to delivering effective, safe and quality care. It’s about regulatory requirements, legislation, standards and guidelines.

And feedback and complaints. While we have a whole Standard in relation to this issue it’s about the systems that you have in place under Standard 8 to ensure that you can demonstrate improved results based on the input that you have from feedback and complaints. How are you using that data? What effect and improvement can you demonstrate from the use of that data? So most of these issues in this particular requirement go to the systems that underpin the service delivery that you offer.

Now noting that these are different from the expected outcomes of the previous Standards of the Home Care Common Standards and of the Accreditation Standards you need to consider the extent to which your systems are fit for purpose for the Aged Care Quality Standards because we will be looking to understand each of these items in relation to this requirement.

**Pam Christie:**

Thanks Ann. Well let’s move to our poll. And we’re actually going to ask you from that list of governance requirements under Standard 3(c) which of these requirements do you feel least confident about? So what’s the one that’s worrying you the most or the one that you feel least confident about being able to meet?

And Ann while we’re just waiting for this poll to be answered I might ask you a question that’s come in from one of our participants in relation to financial governance. And it’s Jack who asks:

*Q: Do assessors need to see all our financial records? If not what is expected for a governing body to demonstrate financial governance?*

Would you be able to answer that now given it’s really relevant to the question about how our assessors actually assess compliance?

**Ann Wunsch:**

So assessors don’t need to see all your financial records but they do need to understand the interaction between the consumer needs and how finances are apportioned in the organisation. So when the acuity of consumers changes, when particular needs emerge and there needs to be an expenditure in relation to that issue, how does your system demonstrate agility or flexibility to respond to those changing needs by apportioning expenditure relevant to those needs. So we really want you to be able to talk us through the processes and show us where expenditure has been allocated in response to changing needs.

Now that might be in relation to the staffing profile that you have. It might be in relation to capital expenditure of some kind. It might be in relation to security systems that you might be putting in place. But we want you to be able to provide the narrative that takes us from the identified issue, the need, the way the financial expenditure has been budgeted for these purposes, the expenditure, the evaluation of that. It’s taking us through how your financial governance system is responsive to consumers’ needs.

**Pam Christie:**

Thanks Ann. Let’s have a look at our results of our poll. The area that people are least confident about is workforce governance at 27.9% followed by information management at 23.3%. Third is financial governance at 20.8% of respondents, then we go to regulatory compliance 10.8%, feedback and complaints 9.2% and continuous improvement 7.7%. So certainly workforce is a very big issue in aged care.

But we might move on to our fourth requirement under Standard 8, effective risk management systems and practices. So again can you kick off our discussion Ann by just explaining a bit more about this requirement?

**Ann Wunsch:**

So this requirement has three elements to it and the first two are around the risk management system so I’ll deal with them together. The system needs to be able to identify and assess risks to health, safety and wellbeing of consumers. Where risks are identified organisations are expected to find ways to reduce or remove these risks in an appropriate timeframe. And I want to use the illustration here of identifying where there have been unlawful sexual contact or mandatory reports. While it’s critical that the service has identified and responded to these matters through a reporting lens what we’re really looking for here is how are you using your risk management system to find ways to reduce or remove these risks in an appropriate timeframe? So this is about surveillance, detection of risk and seeking to reduce or remove risk.

So if there have been particular incidents in relation to unlawful sexual contact what is your surveillance in relation to that risk for consumers? What does your governing body understand in relation to that issue? What risk management system have you in place that provides you with confidence that you can identify and detect for the purposes of reducing and removing this risk?

Now risks need to be understood across the week in terms of the risks associated say with a nightshift against the risks associated with a day shift or a morning shift. What do your incidents tell you about where the greatest risk is and what surveillance and systems have you in place to mitigate, reduce or remove these risks? So this goes beyond responding to a matter and reporting a matter. It goes to seeking to identify and put risk mitigation strategies as part of an effective risk management system.

Now the third element of this, it’s interesting because it’s about the dignity of risk here, and that is that the requirement requires services to support consumers to live the best life they can. Now within your risk management system you need to be able to understand how you can support individuals to take risks in an informed way to live the best life they can. So that is an active engagement with consumers where they understand the risks associated with their preferences and you understand the risks associated with you supporting those preferences in the service setting that you work in. And where that is possible you’re supporting them to live the best life they can, and where their preference may be one that takes a form that you find an unacceptable level of risk how are you actively engaging with them to provide a compromise that gives them the opportunity to enjoy whatever experience they’re seeking to enjoy to live the best life they can.

**Pam Christie:**

So Ann we’re not going to have a poll for this requirement but we just thought we’d take a bit of a break and maybe brainstorm some examples of what that might look like. Because dignity of risk is an issue that’s often raised and is challenging for providers to manage those risks as well as support consumers to live the best life they can. Would any of the panel like to have a go?

**Janet Anderson:**

Before we get to examples there are a couple of points to draw out there which Ann also flagged. The first is – and service providers often ask me this question about a tension that they perceive between duty of care and dignity of risk. And I certainly understand in a care context how those could be seen to be pulling in different directions. But it seems to me that jointly planning care and services, provider and consumer working together, is the best way of getting it right every single time. Because it’s about making informed choices by an individual for an individual and supporting the delivery of those choices as far as that is possible.

And the second observation I’d make before we go to actual examples is it can never be a set and leave arrangement. Individuals’ preferences change over time but also their capabilities and dispositions, and indeed their appetite for risk also changes over time. So it’s something that needs to be part of an ongoing conversation between the care providers and the consumer. So what would you like to do today? How can we enable that for you to do that in a way which is going to ensure that you are safe as far as possible? And if that’s not something which is immediately available to us, as Ann said what is the compromise solution we can come to which is going to give you that enjoyment, that pleasure, that level of fulfilment that you are seeking as a consumer and that also keeps you as safe as possible?

Do you want to offer a particular example either of you? Because I know that there are many that we could.

**Dr Melanie Wroth:**

I can offer perhaps a clinical example. Let’s give an example of a resident who has been assessed by a speech pathologist as having a risk of aspiration and the recommendation that the safest form of food for that resident would be pureed food and thickened fluids. And one way of approaching that is to say well that’s what the speech pathologist has recommended so that’s what we will provide for this person. And understanding the risk of that would involve that you are potentially taking away that person’s main source of enjoyment and that you are therefore putting that person at risk of not eating enough and losing weight and all of the clinical consequences of malnutrition.

The other way you could approach it is to go to the consumer or to their representative and say this is a risk and if you aspirate it may be unpleasant and you may get pneumonia, but we could elect to take that risk and you could just continue to eat normal food and see how you go. Why don’t you tell us which you’d like to do. So that’s sort of two ways of approaching the management of the potential risk of aspiration.

**Pam Christie:**

Thanks. That’s great.

**Ann Wunsch:**

I was talking with a service recently about their approach to assisting a consumer reduce or graduate their alcohol consumption after they had sustained a fall. It was a significant fall. So the service had adopted an approach which involved a dialogue about the risk in relation to that fall, the reduced mobility as a result of the fall, but a compromise around how they would assist the person who continued to want to consume alcohol but in a safer way where the quantity that was being consumed could be better understood and managed. So there was better surveillance around that from the service.

**Pam Christie:**

Great. Okay. So we’re moving on now to Standard 3(e) which is the last of our requirements under Standard 8. And thanks Ann for all your input. I’m going to now ask Dr Melanie Wroth to help us to better understand clinical governance. And our first question to you Melanie is what is clinical governance? How can we understand it?

**Dr Melanie Wroth:**

Thanks Pam. So clinical governance is an integrated set of leadership behaviours, policies, procedures, responsibilities, relationships, planning, monitoring and improvement mechanisms. It’s implemented with the purpose of supporting safe, quality, clinical care and good clinical outcomes for each consumer. And so this is a clear responsibility of aged care services to ensure that safe, effective, high quality, clinical care is occurring within their facility or their service for their particular consumers. And the purpose of clinical governance is to support the workforce and visiting practitioners to provide this safe and quality clinical care. For this reason clinical governance should be integrated into the corporate governance arrangements of an aged care service and this includes for a service providing home-based services. Clinical governance should be part of the way an aged care service does business, not an added extra on top of the care and services that are provided to aged care consumers.

Clinical governance frameworks encompass policies, procedures and processes. These should explain the roles, responsibilities and relationships for quality and safety across the organisation. The framework should outline the planning, monitoring, reporting and review of clinical care and it should support consistent and appropriate leadership to care about and to drive clinical outcomes for consumers as individuals.

**Pam Christie:**

So why is it so important in aged care that we have a clinical governance framework in place?

**Dr Melanie Wroth:**

So aged care particularly has consumers that are often frail and sometimes extremely frail and with significant clinical needs. Elderly consumers often have multiple chronic illnesses. Many have dementia and some are getting towards the end of their lives and in need of a high level of care and may have palliative needs to address any suffering.

Poor clinical care can lead to harm, to suffering and to premature death. So having effectively clinical governance arrangements in place helps aged care providers to understand the current clinical risks for the particular consumers in their care and this will help them to prevent harm to those consumers and to improve the processes of clinical care. And clearly this needs to be an active and responsive system that recognises and adapts to the new or changing clinical risks and needs. Where new consumers enter the service or when they return to the service for example from hospital the system needs to recognise and respond to any changes that have occurred. The governing body needs to be satisfied with evidence that this is the situation in their service.

An example is a clinical risk for a consumer who may be placed on insulin. So this might be a current consumer or a consumer that’s new to the service. The staff caring for this consumer need to understand that insulin may cause a hypoglycaemic episode particularly for example if someone has stopped eating. If the insulin is given at the wrong time this may cause problems. The staff caring for that particular person need to be able to recognise this, to understand that it needs urgent treatment and to be able to test the blood sugar and administer appropriate food or drink. They need to understand that they may need to seek advice urgently and that they must know who they should go to for this advice.

So a particular risk clearly would be if you have new staff to the service including agency or temporary staff. If this consumer is relying on an agency staff overnight to assist with their clinical care then the system within the service needs to be able to ensure that that person providing the care understands the risks to this consumer. The governing body needs to know what the processes are to ensure that this is occurring and to make sure that they have enough interest, concern and information to be satisfied.

Another example might be recognising when a consumer has a clinical deterioration or becomes unwell. Staff obviously need to be familiar enough with the normal state of this consumer in order to be able to know that something has changed. If someone is normally alert and cheerful and mobile and they become drowsy, incontinent and confused one day then this is a clinical deterioration and needs appropriate review and treatment and maybe even transfer to hospital. If the person caring for this consumer does not know that this consumer is not normally like this then the opportunity to manage and respond appropriately will have been missed and the consumer may come to great harm.

It must be clear to the carer who they are to alert, whether it’s the family or the GP or someone in the organisation, and this would be applicable also in the home care setting. So in the home care setting the carers that see the person may be their only chance to have a clinical deterioration or a clinical issue picked up and escalated. And the carers need to know exactly who they should go to if there are concerns and to know that it’s an expectation that they will raise concerns.

In the case of wound, ulcer or pressure injury management a good clinical framework, a good clinical governance framework will identify which consumers are at risk. They will recognise when a wound is worsening or getting infected. They will identify who carers should escalate a problem to and when medical expert wound care advice should be sought. If pressure injuries are occurring the clinical governance framework should identify these pressure injuries early and an assessment of why this might be occurring should be happening and an assessment of what action needs to be taken within the service, and the governing body should be aware of the increase and of the actions taken.

**Pam Christie:**

So we’re going to pause there Melanie for a poll and ask our participants should clinical governance be integrated into the corporate governance arrangements of an aged care service? I think you might have given us a bit of a hint on the answer to that question.

**Dr Melanie Wroth:**

Check whether you were listening.

**Pam Christie:**

That’s a yes/no. And we’ll just wait for your responses. But also I have noted a few questions coming in and we will just remind everyone we will take them at the end so please keep putting your questions forward. But perhaps while we’re waiting for the poll results Melanie we could just move to the next slide and talk briefly – again I think this is a pretty quick answer – but who has a role in clinical governance?

**Dr Melanie Wroth:**

The quick answer is everyone has a role in clinical governance. So clearly the consumer needs to be consulted as outlined in Ann’s talk but in relation to clinical care the consumer also needs to be consulted with. Now obviously everyone else in the organisation has a role and these roles vary. The governing body is accountable for ensuring that the aged care service provides the safe clinical care by defining which role everybody has. They need to set a clear vision and strategic direction with strong organisational culture driving it. They need to lead an organisational culture that is open and transparent. They need to ensure that robust clinical governance arrangements are implemented to support and empower the workforce and visiting practitioners. They need to understand the key current clinical risks for their service and they need to monitor and evaluate all aspects of clinical care through regular and rigorous reviews of clinical quality and safety performance data.

**Pam Christie:**

Great. Well our poll results are coming in so I will just have a quick look at them. 93.1% said yes, clinical governance should be integrated into corporate governance. 6.7% said no. So do you want to just tell us why it is so important to integrate clinical governance into corporate governance arrangements?

**Dr Melanie Wroth:**

So clinical governance arrangements if they are not incorporated into corporate governance arrangements would have the risk that the governing body has absolutely no knowledge of or gives the message that they have no concern about the clinical arrangements and the clinical outcomes within their facility. And clearly this is not going to satisfy the Standards and it’s not going to result in effective oversight of good clinical care.

**Pam Christie:**

Thank you very much. And our last question to you in this area is just to briefly outline the main components of clinical governance. And I might just at this point put a plug for our clinical governance resources that are on our website because particularly this slide goes to a lot of the resources and material that are available for providers.

**Dr Melanie Wroth:**

So the variety of settings and models in aged care means that there’s no single best practice approach to clinical governance. Each service governing body is responsible for developing a framework that addresses the clinical care in their particular service. But there are core elements that all types of services need to consider. The first is leadership and culture and this goes back to the question that we’ve just had as to why clinical governance arrangements need to be part of the corporate governance. The governing body must drive a culture that values supports and promotes consistent clinical quality and safety. They must make it clear that they are concerned about clinical care and outcomes and that it is a priority for them. They must encourage all staff to raise issues that may be relevant to clinical care and they must encourage them to bring errors or poor outcomes to the attention of the governing bodies so that the system can look at causes and rectify any problems. The governing body can then ensure that the clinical governance framework has responded successfully and that outcomes have improved. A culture of blame and cover up will ensure that problems continue and a culture of disinterest will ensure that the governing body doesn’t know what’s happening.

Consumer partnerships are also a core element because the needs, goals and preferences of consumers should guide their clinical care. The framework needs to clearly identify the role of the consumer or their representative if they can’t speak fully for themselves in planning care of their own circumstances. Particular care needs to be taken for consumers who are unable to speak for themselves and have no identified person to speak for them, and the clinical governance framework needs to take into account what is being done to promote the interests of these individuals.

Governing body members could for example go down to the consumers themselves, go actually into the workplace from time to time and try to understand what actually is happening.

They must ensure that they understand that the consumers are engaged in their own care driving and that they are clearly able to express to a particular person how are they going to tell the organisation and how is this process actually working for the consumer.

**Pam Christie:**

Thanks Melanie. And so when our assessors go out to visit a service, whether it’s a residential or home service, what are they looking for. What is sort of good clinical governance? How is it evidenced in a service?

**Dr Melanie Wroth:**

So strong clinical governance may be evidenced by evidence of the fact that leaders are actively pursuing clinical quality and safety, that they’re monitoring and driving performance, that the leaders are asking questions, that they’re receptive to concerns or problems and that they demonstrate this is a priority that they will respond to. Managers and team leaders should be able to clearly state that they know what their responsibilities are for quality and safety and that care staff know what their own responsibilities are and who to discuss clinical issues and concerns with. Consumers or representatives will say that they are encouraged and supported to express their wishes and make decisions about their clinical care and that these are documented. They will say that the organisation takes their wishes and concerns seriously. They will say that they are giving informed consent when clinical issues are discussed with them and that they understand what their role in giving informed consent is.

Consumers will tell us that they are codesigning processes and that they’re contributing to planning and decision making particularly where it affects them. The organisation will be able to develop that there are systems and processes in place to manage, guide and improve clinical care. And if there are guidelines and policies in place that all relevant staff know where to find them and that they are actually using them.

It may be evidenced by showing that quality and safety of care is monitoring from a range of data sources including the experiences of consumers, clinical practice and clinical outcomes. A service governing body can demonstrate that they are actively reviewing and acting on information about clinical quality and safety. The governing body will be able to demonstrate that they’re actively involved in planning, implementing and monitoring improvements in clinical care and a service will be able to demonstrate that open disclosure is practiced when things go wrong.

An example of this is around the area of nutrition. The governing body might ask questions about the food and nutrition. The governing body knows what consumers think of the food and whether it meets their individual needs and wishes. Perhaps they go and sample it from time to time themselves. The governing body knows what systems exist for menu planning and where the ingredients are sourced from. The governing body knows what quality oversight there is in relation to food handling in the service. It knows where consumers eat and what the dining environment is like. It knows whether staff are sitting with consumers to enable the social side of eating to be encouraged and that carers feeding residents interact with them kindly while they’re doing it.

The governing body could know whether or not there’s a system to check who is eating and who is not. If someone is not then is there a mechanism or a person with responsibility to know this and find out why? Is there a record of weight and a policy of how to respond early if somebody is losing weight? The governing body needs to understand that food and nutrition is a clinical issue because it may relate to mouth and dental care, to swallowing and to mood, that the clinical impacts of poor nutrition are frailty, falls, osteoporosis, poor wound healing, poor immunity and potentially pain and poor quality of life. So the governing body in this respect can make it known that it expects staff to be actively involved in optimising the food and the dining experience and nutrition and that they want to know if any problems are identified. Knowing that the menus look good clearly is not enough.

**Pam Christie:**

Thanks Melanie. And maybe I’ll ask Ann a question. One of the questions that’s come through from Libby is:

*Q: How does clinical governance apply in different kinds of aged care services?*

So maybe go to home care. What does clinical governance look like in a home care service?

**Ann Wunsch:**

So I was thinking of an example of say a meal delivery service where that is the only service touchpoint with a consumer. We have certainly understood services that have sound clinical governance frameworks where the person delivering the meal is able to identify that the person’s clinical condition has deteriorated because of their familiarity with that person and has escalated that issue within the service. So that’s really an illustration of how it applies across a broad range of aged care services. And where meal delivery services may not identify themselves as a clinical service, they actually play a very important role because they may be the only service touchpoint with an individual. They may be the only human contact that a consumer may have, and they have a very important role in both delivering an important service but also understanding a consumer’s presentation.

**Pam Christie:**

Thank you. So we’re going to move now to our final sort of issue under Standard 8 under the requirements, an area that’s very topical at the moment and certainly been highlighted through the Royal Commission. And it’s the question of minimising the use of restraints, both physical and chemical. And I’m going to ask Janet Anderson to make some opening comments if you like about this requirement before we then look into more detail about how we assess it and actually draw out a case study for our final poll. Thanks Janet.

**Janet Anderson:**

Thank you. The interim report of the Royal Commission which was released on Thursday as we’ve already identified brought to focus three issues which they considered required priority attention. And the second of the three was the concerning high levels of chemical restraint. Now we at the Commission have also been very exercised by that and indeed others before us and around us have also. They were particularly concerned about what appears to be high levels of the use of psychotropic medications in residential aged care. And again this has been identified by bodies such as the Australian Commission on the Safety and Quality in Healthcare. And there are a number of approaches which have been put in place over the last ten or so months.

From the 1st of July you would be aware there is a new quality of care principle minimising the use of restraint which Melanie will be talking to us about, and there are also a number of resources that the Commission has been producing and I hope you’ve accessed these. We have produced and Melanie has written some scenarios and she will be drawing on those in this webinar. We have issued a regulatory bulletin. We have undertaken or provided a tool for services to undertake a self-assessment of the use of psychotropic medication among your consumers. And many services have implemented that and found it to be very beneficial. Ann has received a lot of very interesting commentary around the use of that tool and a number of services who’ve self-identified that they were not specifically aware of some of the consumers who had been receiving that sort of medication for too long and for whom different choices were now being made obviously in close consultation with the treating prescriber.

So there’s a lot that’s already available. Melanie is leading a particular set of projects within the Commission. We have been very exercised by the amount of resource material which is already available and seemingly readily accessible about the appropriate use of medication generally and psychotropic medication specifically. So for there to be so much information already available and such variable use of that information puzzles us. We don’t know how to understand that and part of Melanie’s project is to unpack that and consider what strategies are available to our Commission to ensure that providers not only are aware of their responsibilities – and when I say providers I’m talking about health practitioners as well – aware of their responsibilities and performing appropriately against not just the Standards but also the Quality of Care Principles. Thanks Pam.

**Pam Christie:**

Thank you. So Melanie from your perspective can you talk a little bit more about this requirement, and also I think you were going to draw on a case study for us.

**Dr Melanie Wroth:**

Yeah. So first of all I just want to make it clear that the Commission is fully aware that some people in residential aged care services have very challenging behaviours that can be extremely difficult to manage during periods of time in the process of deteriorating with dementia. So I don’t want to give the impression that we don’t understand the challenges that are out there in the sector, but we are making it very clear that it’s an area of priority for the Commission to make sure that any restraint is used as a last resort only when absolutely necessary in combination with all other possible strategies that are non-pharmacological or non-restraint strategies to manage behaviour, and that the review is regular and responsive such that any chemical restraint that occurs is done with consent and within the law and for the minimum amount of time and at the minimum dose. So want to make it really clear that living in a restraint free environment is a basic human right.

So if you can just take a little bit of time to read the definition of restraint on the slide where it’s any practice, device or action that interferes with a consumer’s ability to make a decision or restricts a consumer’s free movement. This includes clearly both physical and chemical restraint. And chemical restraint will interfere with a consumer’s ability to make a decision because they are by definition forms of sedative drugs and that they may well render a consumer unable to move about the way they normally do or the way they normally want to.

Any use of restraint should take into account the risk of harm to that consumer or to others around them and how severe that risk is. So an example of a behaviour that may have restraint associated with it is wandering, where somebody’s wandering around. And in fact an assessment of that person may decide that actually wandering really doesn’t cause anybody any harm, that they’re just wandering around. And if their wandering can be made interesting then that may assist in some way. But restraint in that individual may actually be counterproductive in that in order to stop them wandering they may need to be so sedated that they become incontinent, that they fall if they try to get up, they may not have any meaningful interaction with their loved ones or with staff and they may not even be able to wake up properly and fully eat a meal.

So the risk of harm to that person without restraint may be very low and the risk of harm with restraint may be very high. And that’s the sort of situation that the person assessing someone as requiring restraint would need to take into account.

So what I want to do is just consider the case of Viv. Now Viv is one of the fictitious characters that are in our scenarios. The scenarios that we put up on our website look at a whole range of types of restraint used and have a small discussion about why they are or aren’t restraint in those particular circumstances. So Viv is a new consumer at a residential facility and she’s got moderate dementia and the facility knows that when she’s admitted to them. Her daughter says she’s never displayed any behaviours of concern, and a short while after she enters the facility her daughter asks to see her medication chart because she just wants to check that she’s on the right tablets and she notices that she’s been prescribed Risperidone PRN. PRN means to be given as required. So she asks the registered nurse what this is and why it’s been prescribed and she was told that all new consumers with a diagnosis of dementia are prescribed this in case they do display any behaviours of concern. Now Viv’s daughter’s quite concerned that she wasn’t consulted.

So just might go to Pam to poll you on what you think is going on here.

**Pam Christie:**

This is our last poll. So just in the case of Viv do you think this is a form of chemical restraint? It’s a yes/no, a simple answer.

And maybe while we’re waiting for those responses as well as the resources on our website, the scenarios, I know we’ve also got the self-assessment tool Ann that was developed to support services assess their own use of chemical restraints. Do you want to talk to that briefly while we just wait for the poll results?

**Janet Anderson:**

Talk specifically about the feedback you received and some of the commentary that it provoked.

**Ann Wunsch:**

Okay. So I was fortunate to be the signatory to this and therefore the contact person for services who wanted to engage around whether the circumstances in their service constituted restraint or not. And the particular case that Janet had discussed earlier was a service that had by using the self-assessment tool for the first time counted the numbers of people that were subject to prescribed psychotropic medication and their comment to me over the phone was ‘We were surprised. We didn’t realise we had this many. And then now we’ve looked at some of them we have people here that are close to the end of life. They don’t need this prescribed medication anymore’. So immediately we understand that two of them don’t need to be prescribed psychotropic medication.

Now those two people, that’s significant, because that is conscious, intentional review, assessment and de-prescribing for two individuals for a small service in country Australia. So the engagement with this self-assessment tool has really been very positive in our view. We know though and we’re still encountering some services that don’t seem to have used it. And it’s not mandatory but a service still needs to evidence under Standard 8 and under the clinical governance requirements what its approach is to minimising use of restraints. So if you’re not using our self-assessment tool we’ll seek from you a like type tool or evidence to assist us understand your overall governance around restraint.

I think that we also understood through the process of this self-assessment that there was some confusion in aged care services about what was restraint and particularly I think the issue that has emerged is that if a service deemed that something wasn’t restraint then that would satisfy the Commission that it wasn’t restraint. Whereas in order to understand whether it’s restraint or not you really need to complete the tool. As you work your way from left to right across the page and answer the questions or ask and answer those questions you will be able to evidence whether appropriate consents have been obtained, whether you’ve used non-pharmacological approaches, whether the person is accessing activities and interests that have meaning to them and the frequency in which those activities and interests are being engaged in.

So when people have rung me and said ‘Do I have to do this’ my answer is well no, because it’s not mandatory. Should you do this? Yes. I think you should. Or you should have some other way of being able to evidence your approach to restraint because we’ll seek to engage with you about this when we come and visit next.

**Pam Christie:**

Thank you very much. Well we do have the results now and 97.4% said yes and 2.6% said no to the case of Viv. So Melanie maybe just to close on this issue you could explain your answer to the question.

**Dr Melanie Wroth:**

Sure. So medications for the purposes of restraint that are prescribed in a PRN or an as needed setting have been identified really as an area of greater risk rather than lesser risk. So the fact that for Viv Risperidone had been prescribed just in case I’ll give you an example of why that might be a risk. So Viv has got no behaviours, no documented behaviours that would suggest that chemical restraint is in any way warranted in her current circumstances. So in that case there is obviously no strategies that have been identified or documented to support Viv for behaviours that she doesn’t have. And the fact that the Risperidone has been prescribed means that somebody could potentially come in the night, be alone in the care of Viv, not really understand that PRN means only when necessary, think it’s a regular medication for Viv and give it to her, or that person may find that Viv is getting very agitated and distressed and thinks that Risperidone is the appropriate drug for that and fail to recognise that in fact she’s getting agitated and distressed because she needs to go to the bathroom or she’s got pain or because she’s got a new infection that has made her delirious.

So there is a particular risk associated with this and the fact that the Risperidone was prescribed in case there was a problem clearly enables Viv to be given that medication at any time. And so it’s really important that the prescribing happens legally and the requirements still apply for PRN medication as they do for regular medication, that there needs to be a practitioner performing an assessment of the person and the behaviours of concern and the risk of harm to that person, and an assessment of what behavioural management strategies that are not restraint that can be implemented for that person and that would need to be individualised clearly because what might calm me down may not be the same as what might calm Pam down because we are such different people.

So all the requirements for PRN medication are the same and everybody in the facility needs to understand what restraint is and what the implications are. And I would again ask you to have a look at the scenarios just to understand the breadth of issues and the breadth of types of restraint that there may be that you could consider.

So I just want to reiterate that it’s not acceptable to have a prescription made just in case it’s needed. There needs to be a clear documented need and the circumstances in which that medication need to be clearly written as part of the medication. And the legislation, the state and territory laws in relation to prescribing psychotropic medication and particularly antipsychotic medication, that informed consent needs to be obtained. And in order to obtain informed consent – and by definition really when you’re using chemical restraint the person on whom you’re using the medication is probably not able to give informed consent by the very nature of the fact that they’ve got impaired behaviour monitoring.

And so it’s important to know that informed consent isn’t just asking someone to agree to the medication. The person giving consent must understand what the problem is, what the proposed management is, what the options are, what the pros and cons are of each of those options, and they need to understand that they’ve got a choice and that they can withhold consent. They can say no.

Also it’s important to know that consent isn’t permanent. Consenting to restraint now doesn’t necessarily mean you can still be restraining that person five years later because the needs may be very different. And so restraint with high risk associated obviously needs to be reassessed more frequently and the consent needs to be rediscussed in an appropriate timeframe that’s agreed on with the person giving consent and that’s appropriate to the changing needs and changing assessments of the person.

**Pam Christie:**

Thank you Melanie. And I might also pass back to Ann. I know at our opening site visits we’re continuing to have a big focus on use of restraints and asking the question of providers, particularly for residential services, what percentage of their residents are subject to physical or chemical restraint so that we have a better picture. And I guess for boards it would be important that they have the same oversight of that sort of information.

**Ann Wunsch:**

That’s absolutely right. And the risk screening questions are used across our compliance monitoring program but also in our reaccreditation audits. And I think the important point that Melanie’s raised is the risk management lens on the use of PRN. So we talked about under Standard 8 3(d) effective risk management systems. Your risk management system needs to identify the individuals in your service for which there is a PRN order in place. Because that is clearly a risk for those consumers. That’s part of your overall surveillance. So we note that in assessment performance reports assessors are documenting the percentages of consumers for which there is a PRN order but it hasn’t been dispensed. The order and the prescription is the risk if it is a strategy that is in place across the service. So you need to really focus on those sorts of risks as part of your overall risk management strategy.

**Pam Christie:**

Thank you. So we’re going to move now to our Q&A session and we have got some great questions that have come through from our participants. We’ll try and get through them all but if we don’t we will post responses on our website. So thank you for the questions. They very much help us understand the issues. The first question is from Gary and it’s going back to workforce governance. And remember workforce governance was the highest scored area of focus or concern for providers. So Gary’s question is:

*Q: How is adequate staff assessed in relation to workforce governance when there are no staff or consumer ratios?*

I’m looking at you Ann.

**Ann Wunsch:**

Sure. Okay. So there’s two ways of approaching this Gary and one is looking at the needs of consumers and the other is looking at the overall governance arrangements around workforce. But if we start with consumers. The example that we use when we’re talking about this issue is that if you were to poll the consumers in your service and you asked them the question ‘How many of you want a shower in the morning?’ And then you ask the next question ‘And how many of you want to be showered by a woman?’ Then ‘How many of you also want an evening shower?’ Now you start to build the picture around how you need to roster and allocate staffing based on preferences and needs. Now the answers to those questions, they’re just a starting point but they give you a way of being able to see what is the build of your staffing complement for mornings, for evenings. And then when we talked earlier about what are some of the risks associated with pressure points, for instance overnight. If your call bell data tells you that you’ve got significant call bell wait times overnight then how do you allocate or distribute staffing to manage that particular risk or need.

So by starting with the data, starting with the consumers that have expressed preferences for how they wish to live the best lives they can, looking at the particular risks associated with their care needs, their comorbidities, any deteriorating clinical conditions, and then how do you as a governing body determine the arrangements to put in place the right staffing to meet those needs. And if you use the requirements in Standard 8 – doing an ad again here – as the basis by which you understand your agenda for your board, you’re drawing through these issues. You’re drawing through consumer feedback, consumer need. You’re drawing through identified risks. You’re drawing through issues that come through your clinical governance framework. And that should inform you about the build of your workforce.

**Pam Christie:**

Thank you. I think the next one might be for Melanie because it goes back to a clinical situation. And it’s from Ellie. Thank you Ellie.

*Q: What would you do if the consumer actually aspirates when you’ve worked collaboratively with the consumer in their plan of care? Who’s legally responsible for the consumer’s care?*

**Dr Melanie Wroth:**

So obviously in discussing the risks of the aspiration when you’re talking to the consumer about that, that would be something that you’d be considering at the time. So you would be able to say to the consumer ‘Well if you choose to do this and you do have an aspiration we’ll help you manage that at the time. If you get pneumonia would you like us to transfer you to hospital? If it becomes a problem for you we can stop feeding you and change over to thickened fluids and we can help you monitor that’. But I would suggest that if the risks – in the same way as getting informed consent for medication, if the risks of all of those options, the benefits of all of those options have been explained to somebody with the capacity to understand it and a clear choice has been made, that that would mean that the risk has been taken on by the person giving consent to take that course of action.

**Pam Christie:**

Thank you. And another question from Jessica.

*Q: What does high impact, high prevalence risk actually mean under Standard 8?*

I think you spoke about that Ann in your explanation of the requirement.

**Ann Wunsch:**

So there are particular risks in residential aged care which are understood because of the frailty of consumers and they are risks around pressure areas. They are risks around falls. They are risks around weight loss, unexplained weight loss. But there are other risks associated with isolation and depression and lack of engagement, and for consumers with diverse needs there are risks around reliving earlier traumas that they had in their lives or risks around not being able to engage because their language of choice is not English or is not a language that staff can understand.

So it’s a combination of the risks that are known in relation to consumers in aged care, and your clinical indicators will tell you about these risks, but you also need to understand the specific risks associated with the circumstances of each individual. And those two things together will give you the high prevalence risks associated with care.

**Dr Melanie Wroth:**

High impact risks for consumers are risks that will have a serious consequence to that consumer. And in relation to clinical care high prevalence risks would be risks that are being experienced by a large number of consumers in your service. So if you have a large number of consumers with severe dementia or you have a large number of consumers who are at risk of falling or you have a large number of diabetics in your service, those would be high prevalence risks. And then the impact of those risks will depend on the harm that might come should those risks come into play.

**Pam Christie:**

Now we’ve got quite a few questions around clinical governance arrangements. The first one from Bob is:

*Q: Do governance bodies need clinically aware members, ie doctors or nurses on their boards?*

**Janet Anderson:**

I’ll start. It’s not a fundamental requirement and it may be that that information can find different ways of being present and being accessible to boards. On the other hand a clinician as a board member would probably be a value add. I mean you’d need to manage any potential conflict of interest but the voice they would bring to the table and the expertise that they could offer, particularly if they had some understanding of care for older people, would undoubtedly add value to some of the conversations. As I say it’s not obligatory but it is certainly an idea along with the other sorts of expertise that any board would seek to access or have on it.

**Pam Christie:**

Thank you Janet. And both David and Michael ask a similar question so I might try and bring it together. So David asks – the challenge for a clinical governance committee is that they’re not dealing with individual consumers or residents. They will be monitoring this at an organisational level. So David was sort of asking:

*Q: What are some good examples of organisational governance monitoring?*

But Michael asks a similar question because he asks:

*Q: The examples provided for clinical governance are valid however many are operational matters from the governing board’s perspective. Should there be KPIs? What sort of information and data regarding clinical governance should the governing body be monitoring?*

**Janet Anderson:**

I’ll take this up. You might want to follow. Really good question and it shows that you’re engaging in detail with the material so thank you.

You can go a number of directions here but what seems to me – and you’re right. As a board member it is not your role to get into the operational detail. But I come back to the question I asked earlier on. What do you know about the operation of the organisation? Now that needs to be synthesised and presented to the board as a regular report. It might be let’s call them adverse events. Now you don’t need to know about every single adverse event but how many of them have occurred, what are the circumstances in which they’ve occurred, what has been learned from that occurrence and what has taken place if anything was necessary to ensure that systemically and from the perspective of individual staff members’ performance it will not happen again. That is absolutely squarely the role of boards and board members, to know with assurance from the information that you receive from the service routinely, from the management of that service, these things have happened. This is what we’ve learned from them and this is what we’ve done to ensure they will not happen again. That then allows you if you want to interrogate individual circumstances to make the general point. But you don’t need to hear and understand individual circumstances except where they are illustrative as a case study of something which has been fixed systemically and through recruitment and training practices. Is there anything you want to add?

**Dr Melanie Wroth:**

No. I think that really covers it, that it’s just so important to ensure that you’re getting enough data to really satisfy yourself that the clinical issues within your service are being properly addressed. And if you’re not understanding the data or you’re not comfortable that you’ve got enough data or you’re seeing an escalation in something that you haven’t got the information that it’s being adequately addressed, I would suggest that those were the sort of things that you’d be looking at. And it may be different year to year and it may be different when you get a new cohort of residents or consumers.

**Ann Wunsch:**

I’d like to draw your attention to the open disclosure framework, because as a governing body you will want from time to time to understand the need to conduct an investigation or root cause analysis to better explore what has occurred in a single instance or a number of instances where there’s been poor care and a bad outcome for consumers. So that is probably the space where you will want to have line of sight to an individual set of circumstances particularly if it’s illustrative as Janet said of broader concerns in the organisation.

**Pam Christie:**

So one more related question was:

*Q: How will we assess the governing body understands about its service? Will we be interviewing the CEO or the board members during an assessment activity?*

**Ann Wunsch:**

So we’re interviewing senior management and we’re interviewing staff. We’re interviewing consumers and representatives. I mean if the board wants to make itself available to us then we would not decline the opportunity to engage with them. We’re not seeking out boards specifically during a reaccreditation audit but if staff and management are able to provide us with examples of the engagement that the governing body has in relation to its broader responsibilities under the requirements of Standard 8 and if we get consistent feedback when we talk to consumers, to representatives, to staff and to management, that serves as a significant proxy for understanding what the board’s position is. So we’re looking for evidence of the board’s commitment, how it promotes effective governance. So it’s documents, it’s the information provided to us by senior management, it’s staff, and it’s consumers and representatives. And as I said if boards want to engage with us on site we’re certainly interested in their participation. But when we look at the size and scale of aged care across Australia it comes in many different shapes and forms and while we won’t always have an opportunity to engage with governing bodies we certainly want to be able to see the DNA of that governing body throughout the evidence that is presented to us by the service in their self-assessment and on site when we interview and seek to observe and understand care.

**Pam Christie:**

Thank you. We’ve got time for a few more questions. Tracey is bringing us back to the issue of dignity of risk that we spoke about earlier.

*Q: Under the current staffing arrangements and funding the practicality of dignity of risk processes is limited. How can providers improve this aspect of care for consumers through codesign?*

**Janet Anderson:**

That’s a great question.

**Pam Christie:**

It is a great question.

**Janet Anderson:**

I’ll start. You can go.

Talk to the consumer. Work with the consumer. Codesign is a technical word. It puzzles some people. Unpack it. Understand it as having a conversation, ongoing dialogue with the consumer. What floats your boat? What sets your hair back? What gives joy in your life? And how can we as the service provider help you experience that pleasure, that enjoyment, that fulfilment, whatever it is, how modest. Now if it’s I really want to fly a glider as a 98 year old, there’s a further conversation you might want to have with them particularly if they’re legally blind and they have a few other impairments besides. But it’s the conversation. It is so fundamentally important that you have a relationship of trust between the care givers and the care receivers and you talk about what matters to that individual, you come to know them as a person and then you work with them to see what can be done to make their lives enjoyable and fulfilling in their current circumstances.

**Ann Wunsch:**

So as it turns out most people don’t want to actually go in a glider although I notice when we go to - - -

**Janet Anderson:**

I will.

**Ann Wunsch:**

Okay. All right. But I notice when we go to conferences and the dignity of risk piece comes up there’s always a slide of a hot air balloon. But actually people want to do all sorts of things and some of them are not particularly labour intensive or require significant arrangements around them. It might be ‘I want to sit outside and have lunch on the grass today and enjoy it as a picnic rather than sit in the dining room’. But without that conversation you can’t understand what it is that individuals would just seek. It’s the if only question. If only I could. And what does that look like?

So I think this does not lend itself to the old model of the single assessment when the person comes into aged care that somehow ends up informing the rest of their time there. This is about regular engagement and changes in preferences and needs and wants over time and also seeing the opportunities in your service to live the best life they can. So if you ask the person ‘What would living the best life you can look like here? What would change things for you and give you joy?’ you’ll find people have all sorts of ideas about things that are not particularly difficult to achieve but have a huge impact on their emotional wellbeing and on their happiness and will also have a big impact on you as a service. Because when people are really engaged and enjoying themselves codesigning care with them becomes a happy place for services as well as for the people who receive that care.

**Pam Christie:**

Thanks Ann. And I might also mention we’ll be shortly publishing some new guidance material for providers on codesign as part of our work on better understanding consumer engagement. So that will be out before the end of the year.

A few more questions. One right down your alley Melanie.

*Q: Can a power of attorney consent for environmental restraint, so physical restraint?*

**Dr Melanie Wroth:**

The terminology of a power of attorney - - -

**Pam Christie:**

Sorry. That was from Sandra. Thanks Sandra.

**Dr Melanie Wroth:**

Sandra thank you for that. I don’t know what state you’re in Sandra but the power of attorney laws and even the terminology differs within jurisdictions throughout Australia which is a difficulty when we try to answer a question for the whole of Australia. In New South Wales a power of attorney only deals with financial and estate property matters. So in New South Wales no. But I believe that the situation and the terminology may be different I think that in some jurisdictions an attorney covers both lifestyle choices such as where somebody should live and whether they should be not allowed to leave that place, and also financial matters. So I can’t answer that other than to say that would vary and your local Tribunal would be able to answer that question.

**Janet Anderson:**

And that’s an important landing point. Please wherever you are in Australia know the laws of your particular jurisdiction because as Melanie said they do differ. It creates complexity in our environment where we are quality assessing compliance monitoring nationally, but we do rely on services to know and indeed to assist consumers to understand the laws that apply in that particular jurisdiction.

**Pam Christie:**

Okay. A couple more related quick questions.

Pin coded doors.

*Q: There are lots of pin coded doors to external areas that residents would have difficulty in operating. We understand this is environmental restraint but families are very resistant to any changes to current practice.*

This is from Mary.

*Q: Would we be non-compliant?*

**Ann Wunsch:**

So this is a complex area. When you say families are resistant, we know that there’s a responsibility here for services to assist consumers and their representatives to understand the new Standards and to be involved in a self-assessment against the new Standards so they are also clear about what a service is required to do and how they can seek to have their best life delivered through the new Standards. So it’s that engagement around the Standards with consumers, with representatives, with advocacy groups and with the communities from which your consumers come from is a really important piece of this.

Now in that dialogue you will need to set out what complying with relevant legislation is in relation to minimising restraint and also what your service response is in relation to that and how you are going to comply with relevant legislation and the Standards. And that means talking about the issue of providing people with the free access to move around the facility, inside and outside, so they get to breathe the fresh air. It also means coming to grips with how your security system is going to support both people who should and could leave the facility freely because they are not placed at any risk in doing so, and also provide security to those people who need to be maintained in the facility because leaving the facility presents significant risks to them. Now all that is part of that dialogue. It’s a dialogue you need to have with consumers and representatives more broadly and it’s a dialogue you must have with each individual and their family of choice or representative so that they understand what the service is providing to support both their freedom and also the security needs around their safety.

**Pam Christie:**

I’m just going to squeeze in a couple of final questions because we’re nearly out of time. Back to you Melanie.

*Q: Isn’t the GP responsible for medication prescribed for psychotropic restraint and how to enable this training to staff?*

This question’s from Jay. Thank you Jay.

**Dr Melanie Wroth:**

Yes. Thank you Jay. You’re absolutely right. The GP in the majority of cases or the prescriber is sometimes not a GP. That person is responsible for ensuring that there is a need for that medication, that the medication is the most appropriate medication in the circumstances, that the dose is a safe dose and that that’s going to be appropriately reviewed. And that prescriber is also responsible for ensuring their local legislative requirements for obtaining informed consent, and that includes identifying who the appropriate person is to give that informed consent. That is the responsibility of the prescriber.

However prescribers to consumers in residential aged care are not prescribing in a void. They are prescribing in response to information that’s given to them. It may be by their own observation and assessment. It may be by family members. And it may very likely involve engaging with the care staff on what the behavioural issues are. And the care staff in the facility may also hold the information about who the substitute decision maker should be. So in terms of communication around the decision to prescribe for chemical restraint and to monitor for its effectiveness and for side effects that’s actually an interface between the GP and the service.

And further to that the service has a clear responsibility to make sure that care provided to their consumers is legally provided, and that includes ensuring that the correct consent is obtained. It doesn’t necessarily mean that the service has to obtain the consent themselves but they will clearly be involved in the discussions around the decision to prescribe and those discussions may include discussions with the prescriber and with the family and indeed with the consumer.

**Pam Christie:**

And a final one on restraint. Sam’s asking:

*Q: How does chemical restraint apply to home care?*

The requirement of course is under the Standards and under the principles for residential.

**Dr Melanie Wroth:**

Yes. So that’s exactly right. And it’s surprising how common restraint is in a home care setting. You may well be finding people who are completely unable to leave. They’re locked into their own houses. Or they are being prescribed sometimes quite large quantities of chemical restraint that may or may not be appropriate and may or may not be being appropriately reviewed. And I would suggest that the clinical governance frameworks of those services should at least be alert to when people are being restrained and particularly if it’s being done illegally and in the context of potential abuse or neglect. And if somebody is becoming over-sedated or making mistakes with their medications then that’s exactly the sort of situation that the carer in the home should be able to recognise and have somebody to discuss it with and somebody to escalate it to. That might be ringing the family, it might be calling an ambulance, it might be just escalating to somebody within the service that they’re concerned about this particular consumer.

**Pam Christie:**

Thank you. And a final question I might put to you Janet from Lyn. And it’s very topical today given the Royal Commission is meeting in Mudgee and looking at rural and regional issues.

*Q: Has the Commission considered the consequences of Standard 8 for rural and regional services where there’s a struggle to find people to serve on boards and governing bodies?*

**Janet Anderson:**

Absolutely. And thank you Lyn. And good on you for drawing our attention to the rural and remote services of which there are a number. If I might very briefly segue into a conversation I had with a gentleman after a presentation I gave a little while back. He came up and introduced himself and said that he was a member of a voluntary board and the board came together infrequently to oversee the operation of a small, rural residential care service. And he said ‘Look we don’t take it too seriously. The fact of the matter is it is a very, very well run service. The consumers love it. We have always been found fully compliant. Really there’s no difficulty whatsoever. And the board come together, we enjoy each other’s company, but you couldn’t really talk about us as exercising close scrutiny of the operations of the service because all that we know about it and all that we see of it, all that we hear about it is favourable’. He said ‘So what are your expectations of us as a board?’ And I said ‘You need to smarten up’.

Now I wasn’t quite that blunt. But what I said was ‘It’s just great that you and your colleagues come together and do the work you do, and I am really thrilled to hear that the service that you oversee is high performing. But it could change. If for example your manager moved on or was rendered unavailable through illness and somebody had to act within the service who didn’t know quite as much, or there was a very significant changeover of key staff down at the care worker level, it could change. It could change within a week or a fortnight. If you had a minor inundation and had to move some of the residents into different sort of accommodation. Any set of circumstances could have the effect of tipping that service into a more high risk profile and things could start to go wrong fairly quickly. Would you as a board know that, understand it and be ready to place certain expectations on the management of the service in order to avoid risks materialising into harm?’ And he stood there looking at me and he said ‘Yes. I understand what you’re saying. I absolutely get that. And I’ll go back and talk to my fellow board members and we’ll see what we can do’.

We’re not asking for corporate style boards but we are asking for boards who come together regularly to oversee the functioning of the service and to assure themselves as board members that that service is doing everything it can to achieve good experiences and outcomes for the consumers. It obviously goes to all the things that Ann talked about in relation to financial oversight, human resources, physical infrastructure and so on and so forth. But at the heart of all of that it’s actually about the care being experienced and the outcomes being achieved for those consumers. And we need boards who are leaning into that responsibility.

**Pam Christie:**

Thanks Janet. And thank you for all your questions. I’m sure the panel would agree they were really good. It’s time to close. And Janet do you have just a few comments to wrap up our discussion today?

**Janet Anderson:**

I do Pam. Thank you. The slide demonstrates what I think is probably a truism, that everyone has a role to play in ensuring that the care delivered to consumers is safe and of appropriate quality and it’s delivering really good experiences and outcomes for consumers. And you can see on that spiral how many players we’ve actually identified and there may be more that you would identify as well.

But today we’ve been talking about Standard 8 and organisational governance. And what we’ve tried to do is to draw out the specific accountabilities and responsibilities which devolve to boards and to executives, to managers of those services. The governing body particularly is crucial to developing a strong culture across the organisation however large or small it is and whether it’s in a very remote part of Australia or in a metropolitan area, which is squarely aimed at improving life through care.

So you as a board member – and I’m talking specifically to the board members here – you as a board member have a unique responsibility to exercise leadership to ensure that the consumer is put at the centre of your care model, to promote a culture of safety and quality including effective governance systems, and to drive and monitor improvements. Rising successfully to this challenge will enable your service to be known for excellence. And isn’t that something to which you all aspire.

**Pam Christie:**

Thanks very much. So that’s the close of our webinar today. In answer to Jan’s question, yes this webinar is being recorded so it will be available if anyone needs to watch it. It will be available. Carolyn also asked about how to load the app again. And just go to your app store and type in ‘Quality Standard’ and once you see the coloured wheel you’ll know that is the right app. But certainly you can contact us. We’ll be sending you out an evaluation. Please fill out the evaluation so that we can also improve our services to you.

Thanks very much for everyone who’s participated and thank you for our panel today. Thank you very much.

**Janet Anderson:**

Thank you Pam.

[*Closing visual of slide with text saying ‘Contact us’, ‘Engage’, ‘Empower’, ‘Safeguard’, ‘Phone 1800 951 822 (free call)’, ‘+61 2 9633 1711 (from outside Australia)’, ‘Email info@agedcarequality.gov.au’, ‘Write Aged Care Quality and Safety Commission’, ‘GPO Box 9819’, ‘IN YOUR CAPITAL CITY’, ‘Website www.agedcarequality.gov.au’, ‘Facebook @AgedCareQuality’, ‘Twitter @AgedCareQuality’, ‘Australian Government with Crest (logo)’, ‘Aged Care Quality and Safety Commission’*]

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