**Performance**

**Report**

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| Name: | Progressive Home Care |
| Commission ID: | 500254 |
| Address: | C5, 1537-1539 Albany Highway, BECKENHAM, Western Australia, 6107 |
| Activity type: | Quality Audit |
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| Performance report date: | 7 February 2024 |

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

# Service included in this assessment

Home Care Packages (**HCP**) included:  
Provider: 9335 Progressive Home Care Pty Ltd  
Service: 27260 Progressive Home Care

**This performance report**

This performance report for Progressive Home Care (**the service**) has been prepared by Mary Murray, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the Assessment Team’s report for the Quality Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the Assessment Team’s report, received 24 January 2024, accepts the Assessment Team’s evidence and outlines the engagement of an external consultant to support the service to develop a remediation action plan and assist the service to return to full compliance.

# Assessment summary for Home Care Packages (HCP)

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| --- | --- |
| Standard 1 Consumer dignity and choice | Not Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Not Applicable** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

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

# Areas for improvement

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

**Standard 1**

Requirement 1(3)(d)

Provide information to consumers about the risks associated with the use of restraints.

Requirement 1(3)(f)

Review information systems to ensure that the system supports staff to keep health information secure and confidential.

**Standard 2**

Requirement 2(3)(a)

Ensure validated risk assessments are introduced to the assessment and care planning process and the outcome of these assessment inform risk management strategies and care planning.

Requirement 2(3)(c)

Establish processes which support care coordination staff to have a holistic understanding of the other organisations or individuals involved in the consumer’s care and what aspects of care is being delivered by each party, including where responsibilities for each party, start, end or overlap with others.

Requirement 2(3)(d)

Ensure care plans at the point of care reflect the current care needs of consumers and give sufficient information to new and regular staff on how care and services are to be delivered safely.

Requirement 2(3)(e)

Ensure any incident or change in circumstance for a consumer, is considered by care coordination / clinical staff and re-assessments are undertaken, when clinically indicated, to understand any changed needs and update care plans accordingly.

**Standard 3**

Requirement 3(3)(d)

Establish systems to ensure that when a consumer is clinically deteriorating that this is recognised by staff, reported as a matter of urgency and managed by an appropriately qualified staff member.

Requirement 3(3)(e)

Establish processes to ensure other organisations or individuals involved in the consumer’s care have the information they need to delivery safe and quality care in their area of responsibility and establish pathways for others to provide feedback into the service so that all organisations make clinical decisions based on the best information available.

**Standard 7**

Requirement 7(3)(c)

Ensure staff work within the scope of their role at all times and hold the relevant qualification for all care and services they provide.

Requirement 7(3)(d)

Ensure management and staff are supported with training to understand the quality standards and their responsibilities in ensuring the quality standards are met at all times.

**Standard 8**

Requirement 8(3)(b)

Ensure the governing body has the relevant clinical data to ensure safe and quality care is being delivered by the service and any subcontractors.

Requirement 8(3)(c)

Review organisational governance systems to ensure they are effective.

Requirement 8(3)(d)

Review risk management systems and ensure the service establishes an incident management system to support the management of risk to consumers.

Requirement 8(3)(e)

Develop a clinical governance framework and ensure staff apply the framework in their management of clinical matters.

# Standard 1

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| --- | --- | --- |
| Consumer dignity and choice | | HCP |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Not Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Not Compliant |

Findings

Requirement 1(3)(d)

The Assessment Team reported consideration of risk and supporting consumers in balancing risks with lifestyle choices is not evident. The Assessment Team provided evidence, summarised below, relevant to my finding.

Representatives and staff interviews identified the use of bed rails and wheelchair lap belts by consumers, without evidence of a prior conversation or exchange of information on the risks and/or benefits of having these devices in place.

Management confirmed a dignity of risk discussion had not been held with the consumer or their representative around the use of bed rails as it was considered the consumer’s choice to use the bed rails.

Management said the bed rails fold down and they are in place as a safety measure.

Dignity of risk is defined in the service’s assessment and planning policy and in the consumer dignity and choice policy, however, the framework is not applied by staff in their day to day practices.

The provider’s response to the Assessment Team’s report accepts the Assessment Team’s evidence and outlines the engagement of an external consultant to support the service to develop a remediation action plan and assist the service to return to full compliance.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the approved provider’s response. I acknowledge the approved provider has committed to develop a remediation action plan and stated their commitment to return to full compliance.

I am satisfied based on the information summarised above that the approved provider has not supported consumers to understand that their choice to use a restraint may be harmful to them. Management has not provided alternative suggestions to the use of a restraint and has not had discussions on strategies to minimise risk while supporting consumers in their life choices and individual appetite for balancing risk with their wellbeing.

I find the provider, in relation to the service, non-compliant with this Requirement.

Requirement 1(3)(f)

The Assessment Team reported the personal information of consumers is not held securely. The Assessment Team provided evidence, summarised below, relevant to my finding.

The service uses a telephone messaging system to share updated consumer information with support workers. This practice does not ensure confidentiality of consumer information.

Clinical staff maintain a loose sheet paper based system and a notebook where personal consumer notes are recorded. This information is not always placed on the consumer’s file and there is a risk of the documentation being lost or misplaced.

Management said the service is investigating the use of a digital care planning system, to make all progress notes, forms and care plans digital. Management said this would improve the confidentiality and privacy of consumers’ information.

The provider’s response to the Assessment Team’s report accepts the Assessment Team’s evidence and does not provide any additional evidence to demonstrate that information systems are effective in maintaining confidentiality.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the approved provider’s response which does not provide any further evidence to consider.

I acknowledge the approved provider is investigating the use of a care management platform to support information to be held securely.

I am satisfied based on the information, summarised above, that the approved provider’s current information management systems do not support the secure collection and retention of consumers’ sensitive health information.

I find the provider, in relation to the service, non-compliant with this Requirement.

Requirements 1(3)(a), 1(3)(b), 1(3)(c) and 1(3)(e)

The Assessment Team reported the service demonstrated each consumer is treated with dignity and respect with their identity, culture and diversity valued. Representatives indicated staff treat consumers with respect and they are treated with dignity when care and services are delivered. Staff spoke respectfully about consumers and could speak about each consumer’s preferences. The service has policies and processes that promote a person-centred, respectful approach to care and services.

The service demonstrated it provides care and services which are culturally safe. The service records cultural backgrounds and religious preferences and practices in care plans.

Representatives gave examples of services being tailored to ensure consumers receive cultural safe care and said, in various ways, that staff respect each consumer’s culture and values.

Representatives said consumers are involved in making decisions and can freely communicate their decisions. Management gave examples of how consumers are supported to make and/or continue connections with others and care documentation evidenced strategies in place to support social connections.

Policies and procedures were noted to guide staff in how consumers can be supported to exercise choice and independence.

Staff discuss budgets with consumers and provide a monthly statement which details information about care and services provided the previous month. This allows consumers to know what current fund balances are and to plan how the funding is going to be budgeted / utilised.

In coming to my finding, I have considered the Assessment Team’s assessment and evidence in the Assessment Team’s report.

I am satisfied based on the information summarised above, that the approved provider’s systems and processes support consumer dignity and choice, the service has an inclusive approach and consumers have information to inform their choices and decisions.

Based on the evidence that I have considered, as summarised above, I find that the approved provider complies with Requirements 1(3)(a), 1(3)(b), 1(3)(c) and 1(3)(e).

# Standard 2

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| --- | --- | --- |
| Ongoing assessment and planning with consumers | | HCP |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Not Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Not Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Not Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Not Compliant |

Findings

Requirement 2(3)(a)

The Assessment Team reported while consumer risks may be identified during the assessment process, strategies to manage these risks were not always evident. The Assessment Team provided evidence, summarised below, relevant to my finding.

Management said they had no consumers with clinical risks to their health and wellbeing and consumers on a level 4 home care package were most likely at risk of falling. A review of care plans showed consumers with clinical risks including diabetes management, dementia related behaviours and use of a percutaneous endoscopic gastrostomy (PEG) tube who had not had clinical risk assessments undertaken.

Other than the Rowland Universal Dementia Assessment Scale, validated assessment tools for other clinical risks, such as skin integrity or pain are not in use.

Management said they will review the care plans and add more specific information to guide staff in identifying and managing risks to consumers.

The provider’s response to the Assessment Team’s report accepts the Assessment Team’s evidence and did not provide any further evidence to demonstrate effective assessment is occurring.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the approved provider’s response.

I have also considered relevant evidence in Requirements 3(3)(a) and 3(3)(b) as it relates to clinical risk.

I am satisfied, based on the information above, that the approved provider is not using validated clinical assessment tools to understand the care and services each consumer requires and that the outcome these tools are not being used to inform care planning.

I find the provider, in relation to the service, non-compliant with this Requirement.

Requirement 2(3)(b)

The Assessment Team reported consumers’ goals needs and preferences including advance care planning are not captured during care planning. The Assessment Team provided the evidence, summarised below, relevant to my finding.

Representatives interviewed said, together with the consumer, they have input into the services needed and how the services are to be provided to the consumers. Representatives are satisfied care plans are developed around the consumer’s goals, needs and preferences.

Clinical staff said the initial assessment captures the consumer’s needs, goals and preferences.

Two representative described conversations with the service about consumers’ end of life wishes occurring however on one occasion the consumer’s preference was not recorded in their care plan.

In coming to my finding, I have considered the Assessment Team’s assessment and evidence in the Assessment Team’s report which does not demonstrate a systemic failure in assessment of a consumer’s needs goals and preferences or advance care wishes.

Based on the evidence that I have considered, as summarised above, I find that the approved provider complies with this Requirement.

Requirement 2(3)(c)

The Assessment Team reported the service does not have a system for understanding which other health professionals or services are involved in supporting the consumer’s health and wellbeing and how the service might contribute to any shared goals. The Assessment Team provided evidence, summarised below, relevant to my finding.

Representatives said and the service demonstrated that a partnership approach with consumers is used when planning care and services.

The service did not demonstrate it partners with others involved in the consumer’s care such as general practitioners, allied health practitioners and hospital discharge services.

The service was unaware that a consumer with significant weight loss was under the care of a speech pathologist and can no longer swallow medications whole. Strategies to support the consumer to achieve the aims of the allied health care practitioner are therefore not recorded in the consumer’s care plan.

The service has not engaged with a diabetic consumer’s general practitioner or others involved in the consumer’s diabetes support when it is evident to staff that the consumer is no longer able to manage their medication needs.

Support workers said when consumer’s needs change, they speak to the family to discuss the consumer’s new care needs.

The provider’s response to the Assessment Team’s report accepts the Assessment Team’s evidence. It does not provide any evidence that the service is developing an integrated plan for the consumer’s care.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the approved provider’s response.

I have also considered relevant evidence in Requirements 3(3)(a).

I am satisfied, based on the information summarised above, that the approved provider is not actively seeking to understand from the representative or consumer which other health care providers are involved in supporting the consumer’s health and well-being at any point in time.

I find the provider, in relation to the service, non-compliant with this Requirement.

Requirement 2(3)(d)

The Assessment Team reported the care plan held in the consumer’s home is often out of date and does not reflect the consumer’s current care needs or relevant information to guide staff. The Assessment Team provided the evidence, summarised below, relevant to my finding.

Support workers said the care plan in the consumer’s home is not consistently updated to reflect the consumer’s changed needs.

Staff rely on telephone text messages to understand any changing needs of the consumer.

Staff take direction from family members on what to do to support the consumer’s care needs as these needs change over time.

Management acknowledged care plans in consumers’ homes are not always up to date and specifically not updated after a consumer is discharged from hospital and their care needs have changed.

The provider’s response to the Assessment Team’s report accepts the Assessment Team’s evidence. It does not provide any evidence that care plans are consistently up to date or that they can be relied on as an communication tool for staff about the consumer’s care and services.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the approved provider’s response.

I am satisfied, based on the information summarised above, that care plans are an unreliable source of care planning information.

I find the provider, in relation to the service, non-compliant with this Requirement.

Requirement 2(3)(e)

The Assessment Team reported re-assessments of care and services are not undertaken when there is a change in the consumer’s health or wellbeing. The Assessment Team provided evidence, summarised below, relevant to my finding.

Two representatives described consumers’ deteriorating health. Both consumers were hospitalised as a result of the decline in their health status and had changed care needs as a result, however, clinical re-assessments were not undertaken. Management stated for one consumer the general practitioner was managing the decline and for the second consumer, the family were caring for the consumer and an assessment would occur when services re-commenced.

Management was asked when reassessment occur. Management said every 3 to 6 months, annually or if trigged earlier by an incident such as hospitalisation, a fall, diet change, or deterioration in a consumer’s condition. A review of consumer care plans did not evidence care plans were updated after an incident occurred.

Support workers discussed consumers’ changing care needs however, said they make an independent decision on the significance of any change and may or may not report any change or incident to management.

Care workers are only required to submit progress notes every three months which does not support the prompt identification of a need for re-assessment.

Management were unable to provide progress notes from staff relating to the consumers who had been identified as having deteriorating health. In some instances management were not aware of the consumer’s deterioration until the Assessment Team brought it to their attention.

Management said they are looking into an electronic care management system so progress notes would be available digitally for all staff. In the meantime, management said they would speak to support workers to make sure they are returning the progress notes to the office.

The provider’s response to the Assessment Team’s report accepts the Assessment Team’s evidence. It does not provide any evidence that re-assessments when clinically indicated are occurring or evidence that the outcome of the re-assessments are being communicated to staff.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the approved provider’s response.

I have also considered relevant evidence in Requirements 3(3)(a) and 3(3)(b) as it relates to re-assessments.

I am satisfied, based on the information above, that the approved provider is not consistently undertaking re-assessments to ensure, when consumers have changed needs, that services remain effective. The ability for the service to be alert to care changes is limited as staff make their own decisions on what is important to report to the clinical staff and do not submit progress notes on a daily / shift basis which is ordinarily the case and supports clinical oversight to occur.

I find the provider, in relation to the service, non-compliant with this Requirement.

# Standard 3

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| Personal care and clinical care | | HCP |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Not Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Not Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

Requirement 3(3)(a)

The Assessment Team reported the service is not delivering best practice care. The Assessment Team provided evidence, summarised below, relevant to my finding.

Management said one consumer is receiving clinical care for wound management and this is being delivered by an external wound consultant.

Representatives interviewed reported satisfaction with the care consumers receive.

The Assessment Team received feedback from a representative that a staff member is applying dressings and ointment for a consumer who has poor skin integrity and supporting them with their diabetic management by administering insulin. Management were not aware that a support worker has been applying dressings or administering insulin.

Four consumers have a restraint in place, being a lap belt for a wheelchair and / or bedrails.

Care plans do not provide sufficient detail to guide care, deficits include a lack of validated assessments, poor identification of risk and a lack of tailored information.

Policies to guide staff are limited to skin care and wound care, continence care and dementia support.

In coming to my finding, I have considered the Assessment Team’s assessment and evidence in the Assessment Team’s report which does not demonstrate a systemic failure in the delivery of safe and effective care.

I have considered that a staff member has worked outside of the scope of their role in my finding of in Requirement 7(c) and I do not intend to consider that evidence again in this Requirement.

I have considered the use of restraint in my finding in Requirement 8(3)(e) and I do not intend to consider that evidence again in that Requirement.

I have considered the deficits in assessment and care plans in my findings in Requirements 2(3)(a) and 2(3)(e) and I do not intend to consider that evidence again in this Requirement.

I have considered the Assessment Team’s evidence in Requirement 2(3)(c), where representatives interviewed said they have an opportunity to discuss consumers’ needs and preferences including how services are to be delivered to them, at a time and a day suitable to their care needs.

Based on the evidence that I have considered, summarised above, I find the provider, in relation to the service, compliant with this Requirement. The Assessment Team has not described any negative impact to a consumer which has occurred as a result of poor clinical care, and I am satisfied that the care being provided is tailored.

Requirement 3(3)(b)

The Assessment Team reported the service is not effectively managing high impact or high prevalence risks. The Assessment Team provided evidence, summarised below, relevant to my finding.

Consumers identified as being at potential risk of harm do not have effective strategies in place to reduce the risk to the consumer.

The service does not use an incident management system.

Support workers said if they witness an incident they will let the family know and take their direction.

Management said they know some support workers are not reporting incidents as they report the incident to the family. Management said they were not concerned about this because the family will let them know when an incident occurs. Management said they will speak to support workers and remind them to report any incidents to management in future.

Management was asked if any consumers had been hospitalised in the last 6 months. Management responded they do not record in progress notes if a consumer has been hospitalised as some consumers are in and out of hospital multiple times and it is difficult to keep track. Management said they were recording hospitalisation in My Aged Care and they will start to record in the service’s systems when a consumer is hospitalised.

Registered nurses interviewed were asked how they effectively manage high-impact or high-prevalence risks associated with the care of each consumer. Registered nurses said that they are not involved in clinical care, do not have the tools to do their job and there is a lack of communication about the clinical needs of consumers between the service and clinical staff.

One consumer was identified by the Assessment Team as having deteriorating health, post an acute health episode and ongoing weight loss. Management said that the consumer is seeing a dietician, although this is in conflict with other interviews which understood the allied health professional to be a speech pathologist. Staff were not aware of any weight management strategies in place.

One consumer with a wound managed by a wound consultant was noted, however, staff could not say whether the wound was resolving or not, stating that the consumer was under the care of their general practitioner.

In coming to my finding, I have considered the Assessment Team’s assessment and evidence in the Assessment Team’s report which does not demonstrate a systemic failure in management of high impact or high prevalence risks.

I have considered care planning strategies in my findings in Requirements 2(3)(a) and I do not intend to consider that evidence again in this Requirement.

I have considered the absence of an incident system and lack of governance around reporting incidents, including hospitalisations in my finding in Requirement 8(3)(d) and I do not intend to consider that evidence again in this Requirement.

I have considered that Registered Nurses said they do not have the tools to do their job in my finding in Requirement 7(3)(d) and I do not intend to consider that evidence again in this Requirement.

I consider that the evidence does demonstrate a lack of coordinated care and I have considered this aspect of the evidence in my finding in Requirement 3(3)(e).

I have considered whether the Assessment Team has demonstrated harm to consumers as a result of the mismanagement of risk by the service and I find their evidence does not include a demonstration of harm.

Based on the evidence that I have considered, summarised above, the Assessment Team has not demonstrated that risks have been mismanaged, as the evidence is that allied health support and specialist clinical supports were in place for consumers.

I find the provider, in relation to the service, compliant with this Requirement.

Requirement 3(3)(c)

The Assessment Team reported the service is not recognising and addressing consumer’s needs, goals and preference nearing the end of their life. The Assessment Team provided evidence, summarised below, relevant to my finding.

Representatives outlined their discussions with the service about the end of life wishes of consumers and that end of life plans had been made.

Management said the needs, goals and preferences of consumers nearing the end of their life generally are not discussed by the family for religious reasons.

Management said consumers who enter the palliative care phase of their illness are referred to an organisation that is able to meet their specific care needs, and provided an example of this occurring for a consumer in the past.

Documentation review noted discussions regarding the consumers’ end of life wishes and advance care planning were not being consistently recorded in care plans.

Management advised care plans do not contain a section to record consumer’s wishes or discussion about advanced care planning or end of life. Management said care plans will be updated to include this information.

The service is not following processes outlined in their policy. There is lack of communication and detailed documentation detailing consumers’ end of life wishes and that adequate end of life care may not always be in place for consumers.

In coming to my finding, I have considered the Assessment Team’s assessment and evidence in the Assessment Team’s report which does not demonstrate that consumers do not receive appropriate palliative care.

I am satisfied that the service has demonstrated it has linkages with specialist palliative care providers and have used these linkages to facilitate palliative care in the past.

I am not persuaded by the Assessment Team’s evidence about a lack of communication.

I have considered evidence of poor documentation at this service in Standard 2 and do not intend to consider it again in this Requirement.

Based on the evidence that I have considered, as summarised above, I find the provider, in relation to the service, compliant with this Requirement as the evidence is that consumers have made their end of life wishes known and receive appropriate palliative care by a specialist service.

Requirement 3(3)(d)

The Assessment Team reported the service is not responding to deterioration in consumers’ health. The Assessment Team provided evidence, summarised below, relevant to my finding.

A consumer had reoccurring hospital admissions as reported by the consumer’s representative to the service, however clinical staff said they were not aware of the consumer’s ongoing deterioration.

Evidence in Requirement 8(3)(d) of the Assessment Team’s report notes the deterioration was demonstrated by ongoing falls and weight loss. The consumer has since passed away.

The Assessment Team discussed with management that some staff were not reporting changes or deterioration in a consumer’s health. Management responded they will speak to staff to ensure they record and report any changes to a consumer’s health.

The provider’s response to the Assessment Team’s report accepts the Assessment Team’s evidence. It does not provide any additional evidence to demonstrate that deterioration in consumers’ health is recognised by staff, escalated to the service and effectively managed by suitably qualified staff.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the approved provider’s response.

I am satisfied based on the information summarised above, that clinical deterioration is not being clinically managed.

I find the provider, in relation to the service, non-compliant with this Requirement.

Requirement 3(3)(e)

The Assessment Team reported the service is not effectively communicating information with others involved in the consumer’s care. The Assessment Team provided evidence, summarised below, relevant to my finding.

Information regarding care and services provided by external consultants such as a physiotherapist or podiatrist are communicated to management following a referral. However, information about the consumer’s condition is not always communicated with others where responsibility of care is shared such as general practitioners, hospitals, and speech pathologist.

Management advised they have not been receiving discharge summaries from the hospital or communications from general practitioners involved in the care of consumers.

The Assessment Team identified deficits in information flow between relevant parties for consumers with wounds and diabetes.

The provider’s response to the Assessment Team’s report accepts the Assessment Team’s evidence. It does not provide evidence that clinical information is effectively shared.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the approved provider’s response.

I have also considered evidence in Requirement 3(3)(b) which includes feedback from clinical staff that there is a lack of communication about the clinical needs of consumers between the service and clinical staff.

I am satisfied based on the information summarised above, that the service is not effectively sending or receiving clinical information in a way supports optimal care of consumers.

I find the provider, in relation to the service, non-compliant with this Requirement.

Requirement 3(3)(f)

The Assessment Team reported the service is not providing timely and appropriate referrals. The Assessment Team provided evidence, summarised below, relevant to my finding.

The service demonstrated there is timely and appropriate referral to internal and external providers that can meet the needs of the consumer where it cannot be provided by the service provider, such as allied health services.

Representatives interviewed confirmed there are timely and appropriate referrals to allied health services and discussed referrals to occupational therapists, podiatrists and physiotherapists that had occurred.

One consumer was not referred to their service’s clinical staff or any external providers during a period of clinical deterioration. Management said the hospital and the consumer’s general practitioner were managing the consumer’s clinical care needs.

Documentation review indicates information is provided to staff but not all information related to the clinical care needs or clinical risks are documented, including diabetic management plans.

In coming to my finding, I have considered the Assessment Team’s assessment and evidence in the Assessment Team’s report, which does not demonstrate a systemic failure in timely referrals.

I have considered the deficits in documentation at this service in my findings in Standard 2 and do not intend to consider them again in this Requirement.

I have considered the evidence that an internal referral to the service’s clinical team did not occur for one consumer in my finding for Requirement 3(3)(e) and do not intend to consider it again in this Requirement.

Based on the evidence that I have considered, as summarised above, I find the provider, in relation to the service, compliant with this Requirement as the evidence is that referrals occur and they are timely.

Requirement 3(3)(g)

The Assessment Team reported the service is not minimising infection related risks. The Assessment Team provided evidence, summarised below, relevant to my finding.

Support workers and management advised that personal protective equipment is available to all staff, training has been completed on infection prevention control measures and COVID-19 prevention.

Management, staff and representatives reported if a consumer has COVID-19, support workers can choose not to wear a gown.

In one instance where consumers lived in the same household and one consumer contracted COVID-19, donning and doffing of PPE procedures were not followed between consumers as staff found it too difficult.

Management said they do not prescribe antibiotics. Management said they provide consumers with an antibiotic fact sheet so consumers can make informed choices.

In coming to my finding, I have considered the Assessment Team’s assessment and evidence in the Assessment Team’s report, which does not demonstrate a systemic failure in minimising infection related risks and is based on a single example.

It is unclear to me in the example provided whether the consumer with COVID-19 living in the same household with a second consumer was isolating or living in their usual household / communal environment. As such I cannot judge whether the lack of donning and doffing of PPE is a significant issue or not. I also do not have sufficient information to ascertain if the staff member in delivering care would be in contact with the consumer’s blood or body fluids, where the use of a gown is recommended.

Consumers at risk of infection including consumers with a wounds (discussed in Standard 4) and a consumer with a PEG feed (discussed Standard 7) were interviewed by the Assessment Team and were satisfied with their services and did not raise any concerns around infection control measures.

I am satisfied that the service is providing information to consumers about reducing the risk of increasing resistance to antibiotics and that information is relevant in the home care context where prescription of antibiotics is not occurring directly by the service.

Based on the evidence summarised above, I am not persuaded by the Assessment Team’s evidence that infection control practices are inadequate.

I find the provider, in relation to the service, compliant with this Requirement.

# Standard 4

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| Services and supports for daily living | | HCP |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Not applicable |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

The Assessment Team found that consumers get service and supports to support their wellbeing and enable them to do the things they want to do. The Assessment Team found the organisation is optimising each consumer’s independence, health, wellbeing and quality of life.

The Assessment Team provided evidence, summarised below, relevant to my finding.

Support workers were knowledgeable about consumers’ needs, goals and preferences as described by consumers, which aligned with information documented in care plans. Support workers provided practical examples of how they support consumers to maintain their independence and quality of life.

Representatives said the service supports consumers when they are feeling low and have strategies in place to help meet the consumer’s specific spiritual and psychological needs.

Access to the community is facilitated, examples include, coffee clubs, religious events and visiting family and friends.

Staff know consumers well and discussed how they support consumers do things that are meaningful and interesting to them.

Staff generally said they have the relevant information to do their role and spoke about formal and informal avenues for communicating about the consumer’s day to day social support and activity needs.

Representatives said there is timely follow up from referrals and are satisfied with services and supports delivered by referral services, including mental health support services.

The service demonstrated where equipment is provided it is safe, suitable, clean, and well maintained. Equipment provided to consumers is fit for purpose and adjusted to their specific needs.

Representatives interviewed said they are satisfied with the equipment the service provides to consumers and described how equipment it selected for suitability and on the recommendations of allied health professionals.

I am satisfied based on the evidence summarised above, that services and supports for consumers’ day to day lives are in place and effective.

I find the provider, in relation to the service, compliant with all Requirements of Standard 4.

# Standard 5

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| Organisation’s service environment | | HCP |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Not applicable |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Not applicable |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Not applicable |

Findings

This Quality Standard is not applicable as the service provides care in the home.

# Standard 6

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| Feedback and complaints | | HCP |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Requirement 6(3)(c)

The Assessment Team reported the service is not taking action in response to complaints. The Assessment Team provided evidence, summarised below, relevant to my finding.

Representatives interviewed said they have no complaints about the care and services being provided.

The consumer handbook presents information about complaints and feedback, and defines open disclosure as involving an honest discussion and sharing of information between the consumer and relevant staff, including senior management.

When interviewing management about the lack of complaints in the feedback register, management said they have not received any complaints. However, they offered examples of receiving phone calls from representatives saying they would like a different support worker. Management said this type of feedback is not recorded on the feedback and complaints register because it is about consumer preferences and management did not consider it to be feedback or a complaint.

Management was unable to provide written evidence and documentation on how they receive and act upon feedback and what actions are taken to address this feedback. No evidence of use of open disclosure was presented to the Assessment Team.

In coming to my finding, I have considered the Assessment Team’s assessment and evidence in the Assessment Team’s report, which does not demonstrate a systemic failure in appropriate action being taken in response to complaints.

I have considered the governance aspects of complaints, such as the maintenance of a complaints register, in my findings in Standards 8 and do not intend to consider them again in this Requirement.

I have placed weight on the direct feedback from consumers/representatives. I have considered that the service has 24 consumers and the Assessment Team interviewed 7 of these consumers or their representatives, without an example of the service being unresponsive to their requests / feedback.

I am satisfied based on the evidence that I have considered, as summarised above, that the service has dealt with issues where the consumer has been dissatisfied, however categorised, to the satisfaction of the consumer.

I find the provider, in relation to the service, compliant with this Requirement.

Requirement 6(3)(d)

The Assessment Team reported the service is not using feedback and complaints to improve the quality of care and services. The Assessment Team provided evidence, summarised below, relevant to my finding.

Management does not record feedback or complaints in a way that allows them to be reviewed and inform continuous improvement activities.

Management said they would start to record all feedback and complaints on a feedback register so patterns and trends which might emerge can be identified.

The provider’s response to the Assessment Team’s report accepts the Assessment Team’s evidence.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the approved provider’s response.

I have also considered the evidence in Standard 8(3)(a) of the Assessment Team’s report. The evidence outlines management discussed a suggestion provided by a consumer about developing group activities for consumers. Management said they are developing and researching how to implement regular group activities for consumers. Management said they have spoken with many of the families of consumers already. Management said they expect to commence the first activity in December 2023, once they find a suitable community hall or location to conduct the activity. This issue is listed on the plan for continuous improvement.

Based on the evidence that I have considered, as summarised above, I find the provider, in relation to the service, compliant with this Requirement. I accept management’s statement that a complaints / feedback register will be initiated. I am satisfied that the service has demonstrated it listens to consumers and I consider the development of an activity group a quality improvement to the service.

Requirements 6(3)(a) and 6(3)(b)

The Assessment Team reported the service is encouraging consumers, representatives and others to provide feedback and make complaints and facilitates access to advocates and interpreters.

The Assessment Team provided evidence, summarised below, relevant to my finding.

Representatives said they know how to raise issues and make complaints and stated they do not have any complaints about the service. The service has policies and procedures in place to guide staff practices on feedback and complaints mechanisms. Feedback forms are provided to consumers in their consumer files and information about how to raise complaints and feedback is included in the consumer handbook. Although there are no complaints recorded in the complaints/feedback register, there are 4 entries of positive feedback included.

Management said advocacy information and contact details for the Commission are included in the consumer handbook. Management has also provided brochures for an advocacy service to all consumers.

Staff know how to direct consumers and others to advocacy services and how to access interpreters to support consumers when required.

In coming to my finding, I have considered the Assessment Team’s assessment and evidence in the Assessment Team’s report.

I am satisfied, based on the information summarised above, that consumers can make complaints and get advocates and/or interpreters to support them to make a complaint.

I find that the approved provider complies with Requirements 6(3)(a) and 6(3)(b).

# Standard 7

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| Human resources | | HCP |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Not Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirement 7(3)(a)

The Assessment Team reported the workforce is not planned in a way that delivers safe and effective care. The Assessment Team provided evidence, summarised below, relevant to my finding.

The Assessment Team requested a copy of the service’s roster and data on unfilled shifts, however, management did not provide this information to the Assessment Team.

Representatives stated the consumers receive quality care and services and staff stated they have time to complete their rostered activities.

Management discussed how they backfill shifts if a support worker is unavailable, including communicating with the consumer about the change.

In coming to my finding, I have considered the Assessment Team’s assessment and evidence in the Assessment Team’s report which does not evidence a systemic failure in workforce planning. While the Assessment Team did not sight the service’s roster, representatives and staff agree the workforce is sufficient and there is a process to manage unplanned leave.

I find the provider, in relation to the service, compliant with this Requirement.

Requirement 7(3)(b)

The Assessment Team reported that the service demonstrated workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. Representatives interviewed confirmed staff are kind and caring. Support workers and management spoke about consumers in a kind and respectful way during the Quality Audit.

Based on the evidence summarised above, I find the provider, in relation to the service, compliant with this Requirement.

Requirement 7(3)(c)

The Assessment Team reported the workforce does not have the qualifications and knowledge to perform the roles they are undertaking. The Assessment Team provided evidence, summarised below, relevant to my finding.

Representatives described support workers undertaking clinical duties including administering medications and injections and dressing wounds.

Management was unable to demonstrate that support workers hold the relevant qualification or that support workers are working under the direction and supervision of a registered nurse.

The provider’s response to the Assessment Team’s report accepts the Assessment Team’s evidence. It does not include evidence that staff undertaking clinical duties hold a relevant qualification.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the approved provider’s response.

I have also considered relevant evidence in Requirements 3(3)(a) on support workers working outside of the scope of their role.

I have also considered evidence in Requirement 3(3)(b) from registered nurses who said that they are not involved in clinical care, which evidences a lack of direction and supervision of support workers in clinical matters.

Based on the acceptance of the Assessment Team’s evidence by the approved provider and a lack of further evidence to consider, I find the approved provider non-compliant with this Requirement.

Requirement 7(3)(d)

The Assessment Team reported the workforce does not receive adequate training to undertake their roles. The Assessment Team provided evidence, summarised below, relevant to my finding.

Although support workers stated they receive enough training to perform their roles, the service could not provide evidence of training about the Quality Standards.

The workforce described completing training in infection prevention and control, first aid, cardiopulmonary resuscitation and manual handing.

Management stated all staff complete an orientation training program which covers cultural safety, wellness and reablement, consumer directed care, maintenance of consumers’ social connections, duty of care, advance care planning and end of life. The Assessment Team’s reviewed the training content in the orientation program and found it limited.

Staff have not been provided with training on the serious incident response scheme (SIRS), the aged care code of conduct or restrictive practices. Management said they are going to ensure staff complete incident and SIRS training in the new calendar year.

Management said they do not have a training register or matrix.

The provider’s response to the Assessment Team’s report accepts the Assessment Team’s evidence. It does not include evidence that staff have completed relevant training, such as the code of conduct which was introduced on 1 December 2022.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the approved provider’s response which does not provide any further evidence to consider.

I have also considered evidence in Requirement 3(3)(b) from registered nurses who said that they do not have the tools to do their job, which I find evident from the failures of the approved provider to comply with Standard 2 and Standard 3.

Based on the acceptance of the Assessment Team’s evidence by the approved provider and a lack of further evidence to consider, I find the approved provider non-compliant with this Requirement.

Requirement 7(3)(e)

The Assessment Team reported the service does not monitor the performance of its workforce. The Assessment Team provided evidence, summarised below, relevant to my finding.

The service demonstrated it completes performance appraisal processes for staff on an annual basis.

Staff interviewed confirmed they have taken part in performance assessment processes annually.

Management explained the performance assessment process and the Assessment Team sighted evidence of performance appraisals on staff personnel files.

The service has contracts with subcontractors which detail performance expectations and processes for review.

Management stated they complete annual performance appraisals with staff but do not keep a centralised database or records to evidence this is occurring.

Management discussed how staff can request additional support and training through the performance process. For example, a staff member requested hoist training through a performance appraisal process and management arranged for this training to occur.

In coming to my finding, I have considered the Assessment Team’s assessment and evidence in the Assessment Team’s report which does not demonstrate a systemic failure in monitoring the performance of its workforce.

Based on the evidence that I have considered, as summarised above, I find that the approved provider complies with this Requirement, while a register is not in place, information is held on personnel files and staff said performance reviews are occurring.

# Standard 8

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| Organisational governance | | HCP |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Not Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Not Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Not Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Not Compliant |

Findings

Requirement 8(3)(a)

The Assessment Team reported the service is not engaging consumers in its service development. The Assessment Team provided evidence, summarised below, relevant to my finding.

The service does not seek input into care and services from consumers and does not have a consumer advisory board.

Management said they engage consumers in service improvements through providing feedback and gave an example of actively exploring how to expand it service offering to include regular group activities as requested by consumers.

The continuous improvement plan evidences an action to implement a consumer advisory body and speak to consumers to see who wants to be on the advisory body, however, this has not progressed to the point that the advisory board is established.

The Assessment Team was not provided with examples of consumer surveys conducted by the service. However, on the service’s website, there are positive quotes from consumer surveys conducted in 2019 and 2020.

In coming to my finding, I have considered the Assessment Team’s assessment and evidence in the Assessment Team’s report which does not demonstrate a systemic failure in engaging with consumers.

Based on the evidence that I have considered, as summarised above, I find that the approved provider complies with this Requirement, as I am satisfied the approved provider has systems to engage consumers.

Requirement 8(3)(b)

The Assessment Team reported the service is not promoting a culture of safe care. The Assessment Team provided evidence, summarised below, relevant to my finding.

The governing body consists of two directors, neither of whom have a clinical background.

While the governing body meets regularly with clinical staff, clinical staff hours total approximately one day per week.

No formal clinical reporting occurs and no governance meeting minutes were provided to the Assessment Team to demonstrate how the governing body has line of sight to the quality of care being delivered by staff.

The provider’s response to the Assessment Team’s report accepts the Assessment Team’s evidence. It does not include evidence of how the governing body is alert to the quality and safety of care or how it takes corrective actions if care is found to be unsafe or of a poor quality.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the approved provider’s response which does not provide any further evidence on its governance systems to consider.

Based on the acceptance of the Assessment Team’s evidence by the approved provider and a lack of further evidence to consider, I find the approved provider non-compliant with this Requirement.

Requirement 8(3)(c)

The Assessment Team reported the service did not demonstrate evidence of systems relating to all the sub requirements of this Requirement. The Assessment Team provided evidence, summarised below, relevant to my finding.

Staff cannot access all the relevant information to support them to deliver safe care.

The Assessment Team asked for evidence about how budgets and funding are managed and were not provided any evidence to support that management have oversight of consumers who overspend or underspend their package.

The service does not have a proactive way of planning for future workforce needs.

Staff have not been briefed on relevant regulatory compliance issues, for example the code of conduct, and therefore are not aware of their obligations.

The way complaints and feedback are categorised by the service, limits how effective they might be in driving improvements.

Policies and procedures are in place but not consistently followed by staff.

The provider’s response to the Assessment Team’s report accepts the Assessment Team’s evidence. It did not include evidence that the service’s governance systems are effective in informing members of the governing body on how the service is performing.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the approved provider’s response.

Based on the acceptance of the Assessment Team’s evidence by the approved provider and a lack of further evidence to consider, I find the approved provider non-compliant with this Requirement.

Requirement 8(3)(d)

The Assessment Team reported the service did not demonstrate evidence of systems relating to all the sub requirements of this Requirement. The Assessment Team provided evidence, summarised below, relevant to my finding.

Management could not advise the Assessment Team of current high-impact or high-prevalence risks to consumers within the service, although these risks became evident through the audit process. High impact and/or high prevalence risks for current consumers include wound management, complex clinical care needs, consumers living with a cognitive impairment, the use of injectables and the use of restraint.

The service does not have a system for identifying issues such as abuse or neglect and staff do not have a culture of escalating information to management.

Assessment and care planning is inadequate and as a result consumers’ actual care needs are poorly understood by the service. Consumers may be missing out on care or services that could improve their lives.

The service does not have an incident management system, support workers do not consistently report incidents to the service and care plan reviews do not consider the impact of an incident on the future clinical or social needs of the consumer.

The provider’s response to the Assessment Team’s report accepts the Assessment Team’s evidence. It did not include evidence that the service is actively managing risk.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the approved provider’s response.

I have also considered evidence in Requirement 3(3)(b).

Based on the acceptance of the Assessment Team’s evidence by the approved provider and a lack of further evidence to consider, I find the approved provider non-compliant with this Requirement.

Requirement 8(3)(e)

The Assessment Team reported the service does not have a clinical governance framework in place. The Assessment Team provided evidence, summarised below, relevant to my finding.

Clinical staff could not describe how they apply antimicrobial stewardship in their approach to clinical care.

Management did not demonstrate how they ensure that restraints are used as a last resort in the support of consumers. Discussions about the use of restraint and the exploration of less restrictive options were not evident. Staff applying restraint, including lap belts and bed rails are not trained in restraint management.

Management explained what open disclosure with reference to the service’s policy but did not demonstrate that relevant staff have been trained in open disclosure or how this approach is used in day to day practice.

The provider’s response to the Assessment Team’s report accepts the Assessment Team’s evidence. It did not include evidence that a clinical governance framework has been developed.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the approved provider’s response.

I have also considered relevant evidence in Requirements 3(3)(a).

Based on the acceptance of the Assessment Team’s evidence by the approved provider and a lack of further evidence to consider, I find the approved provider non-compliant with this Requirement.

1. The preparation of the performance report is in accordance with section 57 of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)