Performance

Report

**1800 951 822**

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| Name of service: | St Francis Hostel |
| Service address: | 678 North Beach Road GWELUP WA 6018 |
| Commission ID: | 7152 |
| Approved provider: | Mt La Verna Retirement Village Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 15 June 2023 |
| Performance report date: | 2 August 2023 |

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

**This performance report**

This performance report for St Francis Hostel (**the service**) has been prepared by M Glenn, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers and representatives;
* the provider’s response to the Assessment Team’s report received 25 July 2023; and
* the Performance Report dated 25 January 2023 for an Assessment Contact - Site undertaken on 30 November 2022.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 8** Organisational governance | **Non-compliant** |

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

# Areas for improvement

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

**Standard 8 requirement (3)(e)**

* Review clinical governance framework in relation to minimising the use of chemical restraint.
* Review processes to ensure staff are competent in the safe use and administration of chemical restraint.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |

Findings

Requirement (3)(a) was found non-compliant following an Assessment Contact undertaken on 30 November 2022 where it was found the service did not consistently provide care that was best practice or tailored to consumers’ needs in relation to identifying pressure injuries in a timely manner, and deficiencies in the management of restrictive practices. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Audit of the psychotropic register to ensure congruency of information for all consumers.
* Education on pressure injury management and individual training for registered nurses on restrictive practices.
* Updated policies and procedures regarding restraints.
* Transition to an electronic care management system which covers all restraints and alerts that generate frequency of review.
* Daily skin integrity checks conducted by registered nurses following staff concerns.

At the Assessment Contact undertaken on 15 June 2023, staff stated they consider the needs and preferences of consumers to ensure they are providing personal and clinical care that is best practice and meets their needs. Staff and consumers indicated skin integrity issues are being managed effectively and pressure injuries are prevented by staff repositioning consumers who can no longer reposition themselves. Consumers and representatives are satisfied with the clinical and personal care consumers receive.

The Assessment Team found consumers prescribed psychotropic medication that meets the definition of chemical restrictive practice were not effectively identified. I have considered this information is more aligned with the service’s and organisation’s clinical governance processes, specifically minimising use of restraint. As such, I have considered this information in my finding for requirement (3)(e) in Standard 8 Organisational governance.

For the reasons detailed above, I find requirement (3)(a) in Standard 3 Personal care and clinical care compliant.

# Standard 8

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

Findings

The Quality Standard is assessed as non-compliant as one of the five specific requirements has been assessed as non-compliant. The Assessment Team recommended requirement (3)(e) in Standard 8 Organisational governance not met.

**Requirement (3)(e)**

The organisation demonstrated effective practices and processes relating to antimicrobial stewardship and open disclosure. However, the Assessment Team were not satisfied the organisation demonstrated aspects of a clinical governance framework for minimising the use of restraint. The Assessment Team’s report provided the following evidence relevant to my finding:

* Management and staff did not demonstrate an understanding that consumers prescribed psychotropic medication for the purpose of modifying behaviours were subject to chemical restraint.
* As consumers were not identified as being subject to chemical restraint, legislative requirements were not adhered to, including using medication as a last resort to prevent harm, trialling and documenting alternate strategies prior to use of the medication, undertaking a valid informed consent, conducting ongoing monitoring and evaluation, and implementing appropriate behaviour support plans.
* Information relating to minimising chemical restraint in the monitoring tool and on the psychotropic medication register was not completely accurate.

In the provider’s response, they acknowledged the service did not demonstrate an understanding of chemical restraint and the legislative requirements. The provider recognises improvements required and provided a continuous improvement plan to address the deficits identified in the Assessment Team’s report. Improvements include, but are not limited to:

* Updated the psychotropic medication register to identify restrictive practice.
* Communication sent to families to promote awareness of restrictive practice.
* Clinical governance training for the care manager.
* Ensuring registered nurses are aware of all legislative requirements surrounding restrictive practice.

I acknowledge the provider’s response. However, I find the organisation’s clinical governance framework did not support the minimisation of restrictive practices, specifically chemical restraint. I have considered management and staff’s lack of awareness of chemical restrictive practices has not ensured consumers prescribed medication for the sole purpose of modifying behaviours have not been identified or the use of the chemical restraint managed in accordance with legislative requirements. As such, opportunities to minimise use of restrictive practices have not been identified or actioned.

I acknowledge the provider has submitted a continuous improvement plan outlining actions to remedy the deficits identified with planned completion dates. However, I consider that the planned completion date for the improvement actions planned and/or implemented, is noted as the end August 2023, therefore, time will be required to establish efficacy, staff competency and improved consumer outcomes.

For the reasons detailed above, I find requirement (3)(e) in Standard 8 Organisational governance non-compliant.

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