Performance

Report

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| Name: | St Francis Hostel |
| Commission ID: | 7152 |
| Address: | 678 North Beach Road, GWELUP, Western Australia, 6018 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 9 October 2023 |
| Performance report date: | 14 November 2023 |
| Service included in this assessment: | Provider: 683 Mt La Verna Retirement Village Inc  Service: 4680 St Francis Hostel |

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 R Beaman, 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 (performance assessment) – site 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 10 November 2023; and
* the performance report dated 02 August 2023 for the Assessment Contact undertaken on 15 June 2023.

# Assessment summary

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| 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 8 requirement (3)(e)

* Ensure the clinical governance framework is effective in relation to minimising the use of restraint, specifically mechanical and chemical restraint.

# 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. | Not Compliant |

Findings

Requirement (3)(e) was found non-compliant following an Assessment Contact undertaken on 15 June 2023 as an effective clinical governance framework, specifically in relation to minimising the use of restraint was not demonstrated. The service implemented several improvements to address the deficits identified, including providing education to staff on restrictive practices, training to staff around engaging in activities for consumers living with dementia, implementing a new electronic record system, and engaging substitute decision makers to discuss the risks of the use of psychotropic medications.

At the Assessment Contact visit in October 2023, the assessment team recommended requirement (3)(e) not met as they were not satisfied the initiatives taken had improved the clinical governance framework and found it was not effective in relation to minimising the use of restraint, specifically mechanical and chemical restraint. The assessment team’s report included the following information and evidence gathered through interview, observation, and documentation relevant to my finding:

* Risks associated with mechanical restraint, including use of dignity suits for two consumers had not been identified. There was no informed consent in relation to the use of the dignity suits and discussion of risks relating to use of the restraint was not undertaken.
* Management sought consent following feedback from the assessment team. One representative confirmed the risks in relation to the use of the dignity suit when they were first applied.
* Care plan documentation did not reflect the requirement for regular release of the restraint, and staff were not aware of the need to do this for both consumers.
* The psychotropic register is not effectively used to identify consumers subject to a chemical restraint, and four consumers on the register did not have accurate or all of the required information in place for the restrictive practices.

The provider acknowledged the deficits identified in this requirement in the assessment team’s report and provided additional actions and initiatives they implemented at the time of the Assessment Contact and since the visit to improve their performance. Those actions include:

* Informing representatives and staff of the risks associated with the use of restrictive practices.
* Ensuring behaviour support plans and informed consent is in place for the named consumers with mechanical restraints in place.
* Updating the psychotropic register to include accurate and up to date information, and behaviour support plans in place for all consumers receiving psychotropic medications.
* Strategies to trial prior to administration of medication documented and communicated to staff.

I acknowledge the provider’s response and the actions and initiatives they have implemented to rectify the deficits identified in relation to minimising the use of restraint. However, I find the clinical governance framework was not effective in relation to minimising restraint, specifically chemical and mechanical. In coming to my finding, I have considered and placed weight on the information in the assessment team’s report that shows for six consumers, restrictive practices were in place, including mechanical and chemical, however, they were not considered restrictive practices and as such did not have the required processes in place, including informed consent, or an accurate and up to date behaviour support plan with individualised strategies to trial to show the restrictive practice is last resort. Furthermore, I have considered for the two consumers sampled that have a mechanical restraint regularly in place, there had been no process or information to guide staff on release requirements and frequency, to ensure the restraint was in place for the least amount of time.

I acknowledge the plan for continuous improvement the provider has included in their response which outlines actions taken and one still to take to ensure compliance with this requirement. Whilst the provider has implemented most of the actions to improve their performance in this requirement, and at the time of the Assessment Contact implemented immediate actions to address the deficits in the use of mechanical restraint for two consumers, I find these actions will need time to be fully embedded to enable efficacy of the clinical governance framework.

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)