Performance

Report

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| Name of service: | The Italian Village |
| Service address: | 6 Mumford Avenue ST AGNES SA 5097 |
| Commission ID: | 6018 |
| Approved provider: | Italian Benevolent Foundation SA Inc |
| Activity type: | Site Audit |
| Activity date: | 26 September 2022 to 28 September 2022 |
| Performance report date: | 17 November 2022 |

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 The Italian Village (**the service**) has been prepared by T Wilson, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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 Site Audit; the Site 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 21 October 2022.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Non-compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **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 Consumer Dignity and Choice Requirment Requirement 1(3)(f) - Each consumer’s privacy is respected and personal information is kept confidential. Ensure that staff understand and adhere to maintianing a consumers privacy and dignity, including the use of unauthorised photographs.

# Standard 1

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| Consumer dignity and choice | |  |
| 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. | 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. | Non-compliant |

Findings

I have found this this Quality Standard is Non-compliant as Requirement 1(3)(f) has been found Non-compliant.

Whilst the Assessment Team found Requirement 1(3)(f) to be compliant I disagree for the reasons below.

Standard 8 Requirement 8(3)(d) describes an incident where one staff member is alleged to have taken photographs of consumers, or of consumers’ rooms, furniture or personal affects, without consent and distributed those images to other staff within the service. Whilst the incident was under investigation at the time of the site audit, the staff member, despite orientation which highlights the requirement of privacy and directs the correct use of consumers’ personal information, took the photographs and distributed them through email to other staff within the service who also did not consider consumers’ privacy and report the matter.

I do not consider that each consumer privacy has been respected as whilst it was not evident what the photographs actually contained, it did contain images of consumers without their consent being obtained.

Accordingly, it is for these reasons I find Requirement 1(3)(f), Each consumer’s privacy is respected and personal information is kept confidential is Non-compliant.

Consumers and representatives confirmed consumers are treated with dignity and respect and provided examples of how staff do that. Staff could describe how they treat consumers to maintain their dignity by following individualised information for each consumer. Staff are provided with information on how to understand consumers, respect their identity and treat them as individuals.

Consumers and their representatives confirmed that staff understand their cultural needs and considered what was important to them for their care. Information is obtained on entry about consumers’ care needs and cultural background information and included in the care plan to ensure staff understand their individual needs. Staff confirmed they use this information when providing care to ensure it is appropriate to the consumer.

Consumers and representatives confirmed they are involved in decision making and can make their choices which is respected by the service. Staff understood consumer rights and the importance of respecting the choices of those in their care. Care documentation included involvement of consumer representatives and the choices consumers have made to ensure staff understand their wishes.

Consumers are able to make informed choices about the risks they wish to take. The service is supported by policies and procedures to guide staff to do that. All risks are documented and discussed with consumers with mitigating strategies put in place to reduce any risk. Two consumers who choose to leave the site unattended did not have risk choice forms in place. However, the service had determined the consumers were able to do this thorough capability assessments and had mitigating strategies in place. Another consumer who choose to sleep in a chair also did not have a risk assessment in place, but again the service had assessed the risks and had mitigating strategies in place. Risk choice forms were commenced for all consumers during the Site Audit.

Consumers confirmed they are provided with information that is timely and accurate and allows them to make decisions. Information was observed to be displayed around the service, including some information in both Italian and English.

I am satisfied that the remaining five Requirements are Compliant.

# Standard 2

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

Findings

This Quality Standard is compliant as five of five Requirements have been found to be Compliant.

The Assessment Team recommended that Requirement 2(3)(a) is Non-compliant as whilst there are diabetes management plans in place, blood glucose levels are not always documented as per the medical officers directions, and for one consumer staff were unable to demonstrate knowledge regarding consumers on fluid restrictions or where it is required to be documented.

A consumer who is an insulin dependent diabetic sometimes does not allow staff to check insulin levels post administration with the Assessment Team citing a specific small period where this had not occurred. With the other consumer staff could did not demonstrate knowledge regarding a consumers fluid restriction and kitchen staff did not document any consumers fluids when provided morning or afternoon tea.

The service provided a response which addressed both consumers. A blood glucose chart was provided which showed that blood glucose levels were recorded including where the consumer had refused and when they were away on a hospital admission. The charts showed that the refusals were documented but I was not provided with any progress notes to show what had occurred around the refusals. The service provided fluid balance charts for the consumer which showed that all fluid restrictions had been followed. Audits were undertaken to ensure correct processed were being followed in relation to fluid restriction which was found to be compliant. They also pointed out that both consumer have not suffered any harm in relation to the issues raised.

I have considered both the Assessment Team’s report and the response and evidence submitted by the service and I disagree with the Assessment Team.

Additional information provided in the report shows that all sampled consumers had been assessed on entry to the service and had care plans developed, including individualised strategies to manage and reduce identified risks. Consumers and representatives confirmed that the care planning is effective and informs the delivery of safe and effective care and services.

In considering the evidence provided it did not indicate that non-recording of blood glucose levels was systemic nor were fluid restrictions not being managed. Only two consumers had issues raised, and the report did not indicate there were any more with the same issues. I was able to satisfy myself through the evidence provided by the service that the consumers are not at risk and the risks have documented plans to guide staff in the provision of care. Whilst progress notes were not provided to show what occurred around the refusal of the blood glucose levels, there was no evidence of any harm to the consumer.

It is for these reasons I find 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 is Compliant.

Consumers and representatives confirmed assessment and planning identifies and addresses consumers’ current needs, goals and preferences and staff are familiar with their care and routines. Care planning information contains individualised strategies including advanced and end of life care planning. Staff confirmed that discussions are undertaken on entry in relation to end of life planning.

Through documentation it was confirmed consumers and/or representatives are part of the assessment and care planning review processes on entry and at 6-month reviews and relevant persons have been informed of incidents and changes to the health status of consumers. Staff were able to demonstrate how referrals are made and how others including physiotherapists and dieticians and others involved to provide care to consumers.

Representatives confirmed their involvement in care plan discussions and reviews undertaken with the written care plans. A summary care plan placed in consumers’ rooms allowing consumers and representatives to view the care plans at any time.

It was confirmed that care plans are reviewed following incidents or when circumstances change such as a fall. Staff demonstrated they are familiar with the process to prompt review and a checklist has been implemented to identify when changes may impact a consumer.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | 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. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| 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

This Quality Standard is compliant as seven of seven Requirements have been found to be Compliant.

The Assessment Team recommended that Requirement 3(3)(a) is Non-compliant as restrictive practice is not in line with the service’s policies and procedure and in line with legislative requirements.

The Assessment Team asserted that nine consumers who are ambulant are subject to restrictive practice due to their beds being placed at a low height. The Assessment Team observed numerous beds at a low height. Staff interviewed stated consumers’ beds are placed at the lowest height whilst in bed. Staff confirmed Consumer A and B are a high falls risk and the bed is in a low position for falls management. When discussed with management they were not aware of this practice and gave an undertaking to review the nine consumers mentioned. They also stated that not all staff have been trained in the bed tag initiative which is bed tags to designate the height the bed should be placed for consumers to transfer safely.

The Assessment Team also asserted that Consumers C and D are provided with psychotropic medications and are subject to restrictive practice as they do not have a medical diagnosis to support the use of the medications. Documentation for consumers receiving phsychotropic medications for anxiety did not demonstrate consumers having an anxiety disorder but had a symptom of anxiety for other underlying medical diagnosis. When discussed with management they gave an undertaking to review the psychotropic medication registers to ensure consumers that have restrictive practice in place have the appropriate authorities.

The service did not agree with the assessment team that consumers were subject to restrictive practice without the appropriate authorities in place and provided the following evidence to substantiate their claim.

Consumer A and B mobility care plans were provided which did state for both consumers that the bed was to be at the physiotherapist recommended height for transfers. On both care plans it did not state that the beds were to be placed at the lowest height when the consumers are in bed. The service also asserted that the beds for all nine consumers are not floor line beds, they are normal aged care beds which cannot be lowered to the floor. They also asserted that the Assessment Team did not observe any of the nine consumers in bed nor did they speak to any of the night staff to confirm the beds are placed at the lowest height when they are in bed.

They also provided evidence to show a current project underway at the service where the bed height as recommended for each consumer by the physiotherapist is tagged on each bed to ensure it is at the correct height. The training records for all staff were provided and an audit was undertaken with staff which showed all staff barring two new staff were aware of the project.

In relation to Consumer C, the service provided the hospital discharge summary showing the consumer is palliative and the medication is being used to treat the symptoms of the disease the consumer has. They highlighted it is not being used as a restrictive practice but to keep the consumer as comfortable as possible.

The diagnosis list for Consumer D was provided which was dated prior to the Site Audit which showed that the consumer has a diagnosis of anxiety disorder. They also have a behavioural support plan which shows that restrictive practice is used and provides the best practice strategies to use prior to using the psychotropic medications and it also states there is a three monthly review with the general practitioner and the substitute decision maker.

I have considered the Assessment Team’s report and the Service’s response and associated evidence and I disagree with the recommendation on Non-complaint.

In relation to the restrictive practice of the low beds with the information provided I cannot ascertain whether consumers are subject to restrictive practice or not. The observations provided are of empty beds being at a lower height, not with consumers in them. I do have the information from staff that they place the beds at a low height but it has not been explained how low the beds are or which consumers beds are lowered. The service has stated they are not floor line beds but nothing tells me the height at which they are placed. I also do not have any information from consumers or representatives explaining the impact of the height the beds are placed at. The bed tag project was mentioned but that was specifically for the height of the bed for consumers to safely transfer which does not have anything to do with restrictive practice. I have not been provided with enough information to convince me it is restrictive practice that is being used.

In relation to the chemical restrictive practice I am satisfied that Consumer C is a palliative consumer who is being provided with the medication to ease the symptoms of their condition and they are not subject to restrictive practice. Consumer D has a behaviour support plan which states they are subject to restrictive practice that is reviewed three monthly. In relation the assertion by the Assessment Team that the consumer does not have a diagnosis of anxiety disorder, the service provided evidence dated prior to the Site Audit to show that they do.

It is for these reasons I find Requirement 3(3)(a) Compliant.

Clinical and care staff were knowledgeable about sampled consumers’ high impact and high prevalence risks and could detail how they identify, assess and manage such risks. There is a high impact high prevalence risk register where consumers risks are recorded and a meeting is held to discuss the risk for each consumer with risk mitigation strategies put in place to reduce the risks.

Care files reviewed showed advance care directives, palliative care plans and charting was commenced when consumers were identified as entering end of life care. Staff confirmed they had received training in end-of-life care and pain management. Consumer representatives confirmed they are satisfied with palliative and comfort care given to consumers.

Consumers and representatives confirmed that prompt action was taken when deterioration has occurred. Staff could describe the escalation process for review by medical officers or other specialist services. Care files confirmed deterioration has been responded to in a timely manner.

Consumers and representatives said staff were familiar with their preferences and needs, and representatives said they received updates following reviews, changes or incidents. Staff could describe how they receive information about consumers through handovers, meetings, the care system and emails. Care files contained entries from medical officers, Allied Health, and summaries of specialist reports along with information being provided to external providers where appropriate.

Consumers and representatives said other organisations are involved in care and this occurs promptly. Staff could describe the referral processes, and there is policies and procedures to guide them with the referral process.

The service was found Non-compliant in Requirement 3(3)(g) following an COVID-19 outbreak management meeting, with a risk escalation issued on 22 December 2021. On this visit they were able to demonstrate they are now Compliant with this requirement. Staff have undertaken additional training in infection control and outbreak management and they could describe how the guidelines and resources for outbreak management. Infections are monitored to ensure the over prescription of antibiotics does not occur. Audits are conducted to ensure the practice is maintained.

# Standard 4

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| Services and supports for daily living | |  |
| 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. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

This Quality Standard is compliant as seven of seven Requirements have been found to be Compliant.

Consumers confirmed they feel supported to do things they enjoy and are assisted to maintain their independence. Staff described consumer interests and preferences which aligned with their care plans and showed staff how to support them. One-to-one visits and well-being checks are conducted by the lifestyle team or other organisations for consumers identified as having reduced mobility, prefer not to attend group activities or are at risk of isolation and/or depression.

Consumers said they are engaged in meaningful activities and are supported to attend cultural or religious activities and events. Care and lifestyle staff could describe how they provide support to consumers to enhance their wellbeing. Consumers have their emotional, spiritual and psychological well-being identified and documented in lifestyle assessments and care plans including religious/cultural affiliations and support strategies to assist to maintain mental health.

Consumers said they are supported to pursue their interests and take part in the community and social activities of their choosing. Staff interviewed were knowledgeable about consumers’ social relationships, preferences and interests and could describe how they support consumers to do things of interest to them. Consumers were observed participating in group activities, interacting with visitors and consumers engaging with each other in communal spaces.

Care documents confirmed information about consumers preferences and goals is reflected in their care planning information which is effectively communicated within the service through use of the electronic clinical management system, meetings and handovers. Staff said information is accessed in the care plan on the electronic clinical management system and on service issued phones. Progress notes demonstrated that consumers’ needs and preferences are communicated internally and externally when required.

Clinical documentation shows that referrals to other organisations, individuals and providers of other care and services are initiated in a timely manner. Staff could describe how they work with external organisations and use volunteers to help supplement the lifestyle program, which was also reflected in care planning documentation.

Consumers confirmed they enjoyed the meals and are supported to provide feedback for meal options. Staff were knowledgeable about consumer’s needs and preferences and described how they seek feedback regarding menu changes. Documentation showed consumer’s dietary needs and preferences, including allergies, likes and dislikes, were included in care plans and available to hospitality staff through the electronic clinical management system and dietary books provided to the kitchens and serveries.

Consumers said they are satisfied with the equipment available which meets their needs and they feel safe when using it. Staff interviewed confirmed the service has enough equipment available to them to perform their role. Staff were aware of how to report any maintenance issues in relation to equipment. The service has maintenance records and registers demonstrating the service has a system in place for preventative and reactive maintenance requests.

# Standard 5

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| Organisation’s service environment | |  |
| 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. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

This Quality Standard is compliant as three of three Requirements have been found to be Compliant.

The service was previously found Non-compliant in Requirement 5(3)(b) due to consumers not having free movement to both the indoors and the outdoors. This has now been remedied with the improvements implemented including ensuring doors are left unlocked and providing fobs for those who are able to access doors to outdoor areas themselves. It was observed consumers were able to move freely around the service.

The service environment was observed to be welcoming with easy access to communal spaces including atriums and balconies. Supports such as handrails, elevators and ramps were observed throughout the service to assist with consumers mobility and access in their environment. Consumers rooms were observed to be decorated with personal items and possessions.

Consumers confirmed they found the service clean and comfortable with no safety concerns raised and they could go indoors and out as they please. Staff could describe processes undertaken to ensure the service remains well maintained and clean.

Consumers were observed using equipment during activities, using mobility aids to assist with transport and walking. Equipment and furniture for leisure and living which were observed to be safe, clean, maintained and fit for consumers' purpose. There is a proactive and reactive maintenance schedule for maintenance requirements which was up to date. Call bell systems are spot check audited to ensure they are functioning and accessible for consumers.

# Standard 6

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| Feedback and complaints | |  |
| 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

This Quality Standard is Compliant as four of four Requirements have been found to be Compliant.

Consumers and representatives said they were aware of feedback and complaint mechanisms available. They found management very approachable and helpful and were confident in using the system. Staff could describe how they support consumers who wish to make a suggestion, provide a compliment or make a complaint and were aware of the complaints system. Consumers are provided with documentation to advise them of how to provide complaints and feedback.

Consumers and representatives confirmed they have access to interpreters, advocacy and external complaint handling services. Pamphlets and advocacy information were observed in both English and Italian in the service. Advocacy services attended a resident and representative meeting in July 2022.

Consumers and representatives confirmed appropriate action is taken to address feedback and complaints and felt the service has a transparent approach when things go wrong. The service has feedback, complaints and open disclosure policies and procedures in place which guides staff in how to identify, manage, escalate, document, and resolve complaints. Educations is provided to staff on open disclosure processes. There is a continuous improvement log and evidence of this log being used to improve quality of care for consumers out of issues that have been raised.

# Standard 7

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

Findings

This Quality Standard is compliant as five of five Requirements have been found to be Compliant.

The service was found to be Non-compliant in Requirement 7(3)(a) and Requirement 7(3)(c) following an COVID-19 outbreak management meeting, with a risk escalation issued on 22 December 2021. The service was found to be experiencing significant staffing shortages during the outbreak and staff were not competent in following infection control measures to manage the spread of infection. The service implemented improvement measures including the number of infection prevention control team leaders to manage outbreaks, staff training and surge workforce lists to assist with vacancies. The Assessment Team recommended they changes were effective in returning the service to compliance.

Consumers confirmed the service has adequate numbers of staff to meet their needs, however, some consumers said they have experienced greater than usual wait times for call bells to be answered and there are not always enough staff. The majority of staff reported the workforce numbers are adequate for them to perform their roles against the needs and expectations of the consumers. There are systems in place to plan workforce requirements against the care needs of consumers in placement numbers and individual consumer acuity.

Consumers interviewed confirmed staff show kindness and care and respect their identity, culture, and diversity with the service catering for a large community of Italian heritage. Staff interviewed could detail the service’s expectations for staff interactions with consumers, in being caring and respectful in consumer interactions and being mindful of individuals culture and identity.

Consumers confirmed staff have the appropriate skills and knowledge to fulfil their role and meet their care needs. Staff confirmed they are confident they are competent in completing their duties due to the training they undertake, including training that allows them to expand their knowledge and skills. There are onboarding and induction processes for new staff and is tailored for staff in different roles. Individual staff qualifications and mandatory training status is monitored for currency and work will cease to be allocated work to anyone who has lapsed in these areas.

There is a framework to manage performance which includes performance appraisals and assessment against the benchmarks of the role. Staff could convey the process for their performance evaluation and the level of expectation placed upon them by the service. There is a system to record performance management actions.

# Standard 8

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

Findings

This Quality Standard is Compliant as five of five Requirements have been found to be Compliant.

Requirement 8(3)(c) was recommended as Non-compliant as the service was not meeting regulatory compliance requirements regarding informed consent and the use of restrictive practices in accordance with the Quality of Care Principles (2014). Although the service has identified some consumers were subject to restrictive practices, the service did not consider all consumers who are placed on floor level beds that can mobilise may be subject to restrictive practice, and consumers subject to chemical restraint through the use of antipsychotic medication required the appropriate authorisation forms. The service implemented a bed tag system to ensure consumers’ beds are placed at the correct position, however, interviews with staff found they were not aware of this system and its purpose.

The service strongly refuted that it is not always effective at identifying the regulatory compliance requirements in regarding informed consent and the use of restrictive practises. The consumers visited and named by the Assessment Team in relation to mechanical restraint, namely floor line beds, are not allocated floor line beds and do not have the functionality to be considered a mechanical restraint. The two consumers identified in Standard 3 Requirement (3)(a) that the Assessment Team asserted were chemically restrained without authorisation did not have unauthorised restraint as Consumer C is palliative and Consumer D does have a diagnosis of anxiety disorder.

The service states they also have strong clinical governance systems to identify, monitor and review the use of restrictive practices along with risk management tools such as audits to ensure all restrictive practises are identified and the appropriate actions are taken with each one. There are also policies and procedures for staff to follow and mandatory training modules and resources for staff on restrictive practice. An audit and training information was provided for the bed tag project.

I have considered the information from both the Assessment Team, the service and the information in Standard 3 Requirement 3(3)(a) and I find the service is Compliant with Requirement 8(3)(c).

Overall, I do not have any compelling evidence to show me that the service is not meeting their legislative requirements in relation to restrictive practice as outlined in the Quality of Care Principles (2014). The service was able to show that with chemical restrictive practice the two consumers named were not, for the reasons provided by the Assessment Team, subject to unauthorised restrictive practice. In relation to the mechanical restrictive practice the bed tag project was raised on several occasions, but I was not given any information on how this relates to restrictive practice except that the bed is placed at a certain height to safely transfer consumers and beds were observed at a lower height with no consumers in them. Without this evidence I have to trust the service along with the evidence they provided that restrictive practice is undertaken in line with legislative requirements.

Requirement 8(3)(d) was recommended as Non-compliant as risk assessments and related authorisations are not always undertaken for consumers where a risk activity has been identified such as two consumers leaving the service independently or where staff had implemented a restrictive practice to prevent the consumer from getting out of bed independently. Following an incident where a staff member, unauthorised, shared photographs of consumers with other staff, the Assessment Team asserted the service had not considered other risks for consumers regarding the potential impact on their emotional and psychological wellbeing and reporting under serious incident response scheme (SIRS) requirements in a timely manner.

The service provided a response which refuted all issues raised by the Assessment Team.

The service asserted the risk management strategy in relation to the staff member sharing unauthorised photographs was to suspend the staff member whilst an investigation was undertaken. As a result of the investigation, it was determined that the incident did not fit the criteria to be a reportable incident under the serious incident response scheme.

In relation to the two consumers who leave the service on their own, both have a leisure and lifestyle assessment that confirms they are cognitively sound and contains risk mitigating strategies such as both carrying service cards with them for contact details, they advise staff when they leave, where they are going and what time they are expecting to return to the service. The service asserts, based on what the Assessment Team stated that a risk assessment was not undertaken, is not correct. Both consumers have been risk assessed and that is why they had the mitigating strategies in place and one consumer had only recently recommenced outings again and a risk assessment was undertaken during the Site Audit. They are also reviewing their procedures, flowcharts and forms to support customer independence and self determination to make their own choices, including taking risks.

I have considered the information from both the Assessment Team, the service and the Aged Care Quality Safety Commissions Serious Incident Response Schemes (SIRS) guide for residential providers and I find the service is Compliant with Requirement 8(3)(d).

In relation to the incident with the staff member sharing unauthorised photographs, at the time of the site audit the staff member was suspended and an investigation was being completed. I reviewed the SIRS guide for providers and this circumstance was not included to guide whether it should or should not be reported as an incident. The information provided by the Assessment Team was that the photographs did not have consumers’ faces in them and the one that did was a palliative consumer. The purpose of the photographs were not explained and I am unsure why the photograph of the palliative person was sent to the Board. The service states they have since completed and investigation, but the investigation documents were not provided. They have stated the staff member will return to the service with education and the full support of senior and people and culture management. Whilst I do consider this is breaching consumer privacy as outlined in Standard 1 Requirement 1(3)(f) I do not have enough information to convince me this should have been reported under the SIRS.

The two consumers leaving the service unaccompanied have had mitigating strategies put in place to ensure their safety as evidenced in the leisure and lifestyle assessments. What they show is both consumers are cognitively sound and tell the service where they are going and when they are expected to return along with taking a service card with them each time they go out. I consider by implementing these strategies they have assessed the risks of the consumers leaving the service even if it was not a risk assessment form.

I have considered the information in relation to risk assessments for restraint under Requirement 8(3)(e) as this requirement is specific to minimisation of restraint and the risk associated with their use.

Consumers confirmed they are engaged and supported in the development, delivery and evaluation of care and services through various feedback mechanisms such as bi-monthly resident meetings, food focus groups and surveys. Improvements are communicated through meetings. The organisation has a consumer engagement officer, who speaks Italian and is a qualified psychologist, and their responsibility is to liaise and engage with consumers and their families. The service monitors and reviews how it is engaging consumers and representatives, through site, executive and Board level meetings, to determine its effectiveness.

The organisation has a range of reporting mechanisms to ensure the Board is aware and accountable for the delivery of services. The service provides the Board with a comprehensive report that includes information related to risk, clinical/SIRS incidents, complaints, continuous improvement and human resources to ensure they are aware and can make any appropriate changes. The governing body supports improvements at the service by providing funding for upgrades that benefit the health and wellbeing of consumers such as environmental refurbishments and improving staff practices by introducing more efficient electronic software systems.

The clinical governance framework provides guidance on the service’s governance structure, executive roles and responsibilities, financial requirements, risk management and consumer engagement. Education is provided to clinical staff surrounding antimicrobial stewardship and it was discussed at a resident meeting in August 2022 where pamphlets were distributed to representatives and the service participates in a national annual antimicrobial stewardship survey. Open disclosure is embedded in the services values and training, through investigation of incidents and engagement with the consumer and/or representative.

The application of restraint is documented and the service attempts to minimise the use of restraint. The Assessment Team asserted that not all forms of restrictive practice are identified and documented as per the information Requirement 8(3)(c) and Standard 3 Requirement 3(3)(a). I have considered those Requirements along with the information in Requirement 8(3)(d) and I consider that the service is minimising restraint.

1. The preparation of the performance report is in accordance with section 40Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)