Performance

Report

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| Name of service: | The Royce Manor |
| Service address: | 123 Mulgoa Road PENRITH NSW 2750 |
| Commission ID: | 0938 |
| Approved provider: | The Royce Aged Care Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 8 August 2023 to 10 August 2023 |
| Performance report date: | 27 October 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 The Royce Manor (**the service**) has been prepared by J. Howard, 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 site audit conducted from 8 August 2023 to 10 August 2023; 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 Approved Provider’s response to the site audit report, received 8 September 2023.
* Other information and intelligence held by the Commission in relation to this service.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Non-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 | **Non-compliant** |
| **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.

* **Requirement 3(3)(a)** - The service ensures tailored continence care and manual handling are provided according to the needs of consumers and use of restrictive practices is applied as per best practice.
* **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.
* **Requirement 7(3)(d)** - The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.
* **Requirement 8(3)(e) -** Where clinical care is provided, a clinical governance framework, including but not limited to antimicrobial stewardship, minimising the use of restraint and open disclosure.

# Standard 1

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| Consumer dignity and choice | | Compliant |
| 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. | Compliant |

Findings

Consumers and representatives said consumers were treated with dignity and respect and felt valued. Staff were knowledgeable of consumers’ personal backgrounds and life histories and how these influenced care and services. The consumer handbook reflected consumers’ right to be treated with dignity and respect and staff were guided by a diversity and equity policy.

Consumers said their cultural backgrounds were valued and respected. Staff were familiar with consumers from culturally and linguistically diverse backgrounds and tailored care and services, accordingly, including using translation tools and facilitating cultural events. Care documentation reflected consumers’ culturally diverse needs and preferences.

Consumers and representatives said they were supported to make choices regarding consumers’ care and services. Consumers were supported to maintain relationships through regular visits from representatives and tailored services for married consumers. Care documentation reflected consumers’ individual choices regarding care and relationships they wished to maintain.

Consumers said they were supported to take risks to enable them to live their best lives. Staff confirmed assessing consumers wishing to take risks upon entry and, in consultation with allied health professionals, ensuring they understood benefits and potential harms. Staff were guided by a consumer risk taking policy to support consumer choice.

Consumers and representatives said they received timely information which they could understand, including for meals and activities. Staff described using communication methods tailored to consumer needs and further providing information through activity schedules, menus and on noticeboards.

Consumers said their privacy was respected and staff confirmed they knocked on doors and awaited permission to enter and sought consumer consent prior to providing care. Consumer information was secured in the service’s password protected electronic care management system or locked inside nurses’ stations.

# Standard 2

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| Ongoing assessment and planning with consumers | | Compliant |
| 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

Consumers and representatives confirmed they were involved in care assessment and planning. Staff described undertaking assessments upon entry, including consideration of risks to a consumer’s health and wellbeing. Care documentation evidenced appropriate risk assessments and mitigation strategies in accordance with service protocols.

Consumers and representatives confirmed care planning included consumers’ needs and preferences, including end of life wishes. Management said end of life wishes were discussed upon entry, and during routine reviews if required. Care documentation contained information on consumers’ needs, goals and preferences, including advance care plans.

Consumers and representatives confirmed their ongoing participation in assessment and planning of care and services. Staff described working in partnership with consumers and representatives and care documentation evidenced integrated and coordinated assessment, planning and review involving various allied health professionals.

Consumers and representatives confirmed staff regularly discussed consumers’ care and services and offered copies of care plans. Staff confirmed updating consumers and representatives regarding care outcomes and meeting minutes evidenced staff informing representatives of consumers’ clinical care.

Most care and services were reviewed for effectiveness in response to changes or incidents. Staff confirmed care plans were reviewed at 1 and 3 month intervals or in response to incidents; however, care plans were not promptly reviewed in relation to 2 incidents. At the time of the site audit, staff provided evidence that care reviews had since been undertaken in relation to these incidents resulting in updated care.

# Standard 3

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| Personal care and clinical care | | Non-compliant |
| 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. | Non-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. | Non-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

The site audit report recommended two Requirements in this Standard were Not Met - Requirements 3(3)(a) and 3(3)(d). In reaching my decision, I considered the site audit report’s findings; the evidence documented in the site audit report; and the material in the Approved Provider’s response:

*Requirement 3(3)(a):*

The site audit report contained evidence of deficiencies in the provision of safe and effective clinical care. At the commencement of the site audit, 13 consumers subject to chemical restrictive practices did not have documented medical diagnoses, or documented consent from representatives and allied health professionals. The site audit report noted consent had been provided when medications were initially prescribed, and non-pharmacological interventions had been trialled prior to medication use; however, appropriate documentation was not available at the commencement of the site audit. Further, management initially reported 5 consumers were subject to chemical restraint, but later amended this to a total of 19 consumers, inclusive of the aforementioned 13 consumers.

The site audit report further showed staff had not monitored the weight of 1 named consumer over an 8-week period, during which the consumer lost weight following administration of new medication. The consumer was noted as experiencing vomiting, abdominal pain and decreased appetite lasting 2 weeks before they were referred to a medical officer for review. The consumer remained symptomatic for a further 6 weeks until commencement of food and fluid charting and weight assessments which showed significant weight loss. At the time of the site audit, management acknowledged protocols to weigh consumers each month had not been followed and described plans to provide staff with additional training.

The site audit report showed neurological observations and pain assessments had not been conducted in accordance with service policy in relation to one named consumer following a fall. At the time of the site audit, management acknowledged these oversights, and that the consumer’s care documentation did not include a mobility and transfer assessment.

The provider’s response dated 8 May 2023 stated the service had since audited all consumer medication charts and any consumer prescribed psychotropic medication would be included on the chemical restraint register, including 19 consumers referenced in the site audit report who now have in place risk assessments and signed consents. The provider noted plans to review medication charts monthly, or following changes, and provide additional staff training. While the provider stated this information in their summary response, apart from auditing medication charts, these initiatives were not included on the service’s plan for continuous improvement.

The provider did not acknowledge deficiencies regarding weight monitoring for one named consumer or evidence actions in response to an 8-week period in which the consumer was not weighed or referred to a dietitian. Further, the provider refuted the need for neurological and pain assessment for one named consumer following a fall, stating the consumer did not sustain a head injury during the fall and had denied experiencing pain.

While the provider has advised undertaking some responsive actions, most deficiencies brought forward in the site audit report have not been addressed.

Therefore, I find the service is not compliant with Requirement 3(3)(a).

*Requirement 3(3)(d):*

The Site Audit report contained evidence of deficiencies regarding weight measurement protocols for one named consumer whose weight loss was initially undetected for 18 days following a return from hospital. After this time, the consumer was referred to a medical officer, advised to follow a calorie-dense diet and subsequently gained weight. At the time of the site audit, management acknowledged the deficiencies and advised improvements would be made to clinical oversight and staff trained to identify signs of deterioration.

The Approved Provider’s response dated 8 September 2023 disagreed with the deficiencies identified in the site audit report regarding weight management protocols for one named consumer. The provider stated the consumer was not weighed immediately following return from hospital as staff were following recommendations made by a dietitian on 17 May 2023. However, the site audit report noted this was the date the consumer was admitted to hospital and did not describe review by a dietician. Further, the Approved Provider’s response did not bring forward evidence to support review by a dietitian on 17 May 2023. However, the plan for continuous improvement included in the Approved Provider’s response contained details of plans to review consumers who experienced weight loss greater than 2 kilograms, conduct weekly monitoring and refer to medical officers and dietitians.

While the provider has advised it has commenced some actions in response to the findings in the site audit report, these actions are yet to be completed, embedded or evaluated to demonstrate their effectiveness in recognising and responding to consumer deterioration in a timely manner.

Therefore, I find the service is non-compliant with Requirement 3(3)(d).

*The other Requirements:*

I find the service is compliant with the remaining 5 requirements of Quality Standard 3.

Management and staff were knowledgeable of consumers susceptible to high-impact and high-prevalence risks and associated prevention strategies. Staff and allied health professionals met monthly to discuss prevalent risks and care documentation for most consumers reflected assessments undertaken to identify risks and responsive clinical and environmental mitigation strategies.

Staff were knowledgeable of palliative care processes to ensure comfort and minimise pain. Care documentation for a palliating consumer confirmed their comfort and dignity was maintained by staff and by an external palliative care team. Staff were further guided by an end of life policy detailing psychological, spiritual and social needs.

Consumers and representatives gave positive feedback concerning how staff communicated information about consumers’ condition, needs and preferences. Staff were knowledgeable of consumers’ individual needs and preferences and exchanged information through handover and meetings. Care documentation reflected continuous information sharing between those involved in consumer care and staff were observed exchanging consumer information and updating care plans.

Most consumers and representatives gave positive feedback regarding the service’s referral process to specialised individuals and services. Staff described referrals made to a range of allied health professionals, including speech pathologists, which informed delivery of care and services. Referrals to various specialists to supplement care were reflected in care documentation. Deficiencies regarding timely referral to specialist providers have been considered under Requirement 3(3)(d) where they are most relevant.

Staff were knowledgeable of, and had attended training for, infection control practices and antimicrobial stewardship. An Infection Prevention Control lead understood their responsibilities under the service’s outbreak management plan and observations confirmed viral screening of all visitors and staff demonstrating infection prevention practices.

# Standard 4

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| Services and supports for daily living | | Compliant |
| 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

Consumers said they were supported to engage in activities of interest which promoted their independence and quality of life. Management described undertaking lifestyle assessments with consumers upon entry to identify individual preferences and inform activity planning. An activity calendar reflected various events including garden walks, exercise classes and sensory activities held in the memory support unit.

Consumers said the service supported their emotional, spiritual and psychological well-being. Staff described supporting consumers through one-to-one support, and by facilitating visits by volunteers and religious representatives. Care documentation contained evidence of consumers’ emotional and spiritual needs and responsive support from staff.

Consumers said they were supported to undertake activities within the service and community, and staff described support available to enable consumers’ participation, including chaperoning consumers to sporting events and weekly bus outings. Care documentation identified consumers’ interests, personal and social relationships.

Consumers said the service effectively shared information with those involved in their care. Staff were made aware of consumers’ needs, likes, dislikes, and preferred activities through handovers and the electronic care management system. Care documentation evidenced information to support safe and effective care.

Staff described collaborating with other care and service providers, including hairdressers, volunteers and pastoral carers to supplement activities. Care documentation evidenced consumers receiving individualised psychological care from volunteers.

Consumers gave positive feedback regarding the variety, quality and quantity of meals. Staff confirmed menus were informed by consumer feedback and were aware of dietary restrictions and preferences. Observations confirmed consumers finished their meals and were assisted by staff, where required.

Consumers confirmed access to mobility and lifestyle equipment was observed to be safe, suitable clean and well-maintained. Staff said there was sufficient supply of equipment which was cleaned following each use. Records showed timely completion of preventative and responsive cleaning and maintenance.

# Standard 5

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| Organisation’s service environment | | Compliant |
| 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

Consumers said the service was welcoming, easy to navigate and provided a sense of belonging. The service environment included bedrooms and a memory support unit spread over multiple levels, kitchen and laundry, lounge and dining areas. Staff provided orientation sessions to consumers upon entry and encouraged consumers to personalise their rooms. Consumers were observed to have decorated their rooms with their own items and were freely mobilising throughout the environment.

Consumers provided positive feedback regarding the cleanliness and maintenance of the service and said they could move freely inside and outside. Staff confirmed daily cleaning of all areas and weekly deep cleaning and preventative and responsive maintenance processes. Records confirmed all cleaning and maintenance tasks were up to date.

Furniture, fittings, and equipment were observed to be safe, clean, and well-maintained. Cleaners were observed cleaning shared areas and consumer rooms and kitchen appliances, air conditioners and call bells had been checked and were in working order. Records confirmed some appliances had recently undergone annual maintenance checks.

# Standard 6

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| Feedback and complaints | | Compliant |
| 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

Consumers and representatives were aware of processes to provide feedback or make a complaint. Management confirmed it encouraged consumers to provide feedback or make complaints through feedback forms. Observations confirmed the availability of feedback forms and displayed brochures and posters provided lodgement information for feedback and complaints.

Most consumers and representatives said they were aware of advocacy services and were comfortable raising issues with staff in the first instance. Most staff were knowledgeable of advocacy services and how to access them on behalf of consumers. Staff who were unaware of such services said they would escalate any matters to senior staff. Meeting minutes confirmed staff were expected to be aware of advocacy services for the information of consumers. The consumer handbook included information about available advocacy services.

Consumers and representatives said their complaints were responded to and actions taken to resolve their concerns. Staff described processes for responding to feedback and complaints, including the use of open disclosure. Records demonstrated complaints were recorded and actioned in accordance with service procedures.

Consumers confirmed their feedback and complaints were used to improve care and services. Management described communication as a trending topic of complaints and reviewing communication mechanisms between the service and representatives, resulting in implementation of notices and updates to improve communication pathways. Records confirmed continuous discussion of feedback and complaints by the service’s governing body.

# Standard 7

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| Human resources | | Non-compliant |
| 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. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The site audit report recommended Requirement 7(3)(d) was not met. In making my decision, I considered the assessment team’s findings; the evidence documented in the site audit report; and the Approved Provider’s response.

*Requirement 7(3)(d):*

The site audit report found deficiencies in staff training to ensure staff were equipped to deliver quality care and services. A need for further training was raised by 7 representatives, with some describing new staff being unaware of consumers’ preferences, and some staff requiring dementia care training. Some staff were unaware of incident management escalation processes and types of restrictive practice. Records showed a small proportion of staff had completed mandatory training and this deficiency was not recorded in the service’s plan for continuous improvement. At the time of the site audit, management acknowledged delays in staff completing mandatory training had resulted from engagement of a significant number of new staff and viral outbreaks at the service.

In its response of 8 September 2023, the Approved Provider did not refute the findings of the site audit report and stated staff were consistently trained regarding high-impact and high-prevalence risks during daily shift handovers. The service’s plan for continuous improvement stated that all staff were to complete mandatory training by end of November 2023, and for mandatory corporate training to occur twice each month for staff who were yet to complete relevant topics.

While the provider has advised it has commenced actions in response to the site audit report’s findings, these are yet to be completed, embedded or evaluated to demonstrate staff are trained, equipped and supported to deliver outcomes required by the Quality Standards.

Therefore, I find the service is non-compliant with Requirement 7(3)(d).

*The other Requirements:*

I find the service is compliant with the remaining 4 Requirements of Quality Standard 7.

Most consumers and representatives provided positive feedback regarding staffing numbers and their care needs being met. While a small proportion of representatives said there were insufficient staff, they confirmed consumer needs were still being met. Staff confirmed there were sufficient staff and vacancies were filled with permanent employees or agency staff as a last resort. Records confirmed almost all shifts filled, continuous attendance by registered nurses and call bells answered within benchmarked timeframes.

Consumers and representatives said staff interactions were kind, caring and respectful. Staff were knowledgeable of consumers’ needs and identities and were observed interacting with consumers in a respectful manner. Staff were guided by a code of conduct outlining expected behaviours.

Consumers and representatives said staff performed their duties effectively; however, most said staff would benefit from further training. I considered staff training under Requirement 7(3)(d), where it is most relevant. Management described induction processes to ensure new recruits understood their duties and were initially paired with experienced staff for support. Records evidenced staff held valid registrations, had been security vetted and these credentials were monitored for currency.

Management confirmed staff completed annual performance appraisals and their performance was also discussed following incidents. New staff underwent probationary reviews at 6 months, post commencement. Records showed staff were progressing through annual performance appraisals which were monitored by management.

# Standard 8

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| Organisational governance | | Non-compliant |
| 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. | Non-compliant |

Findings

The site audit report recommended Requirements 8(3)(c) and 8(3)(e) were not met. In reaching my decision, I considered the assessment team’s findings; the evidence documented in the site audit report; and the Approved Provider’s response.

*Requirement 8(3)(c):*

The site audit report found deficiencies in effective governance systems relating to staff training, noting a small proportion of staff had participated in mandatory training and some staff demonstrated insufficient knowledge of incident management and restrictive practices. I have considered these deficiencies under Requirement 7(3)(d) where they are most relevant.

Further, the site audit report noted deficiencies in regulatory compliance, noting the administration of medication to consumers without appropriate medical diagnoses, or a chemical restrictive practice without consumer or representative consent. I have considered these deficiencies under Requirement 3(3)(a) where they are most relevant.

The Approved Provider’s response dated 8 September 2023 included a plan for continuous improvement which stated all registered nurses had completed restrictive practice training as of 30 August 2023. Further, the provider’s response set out a range of workforce governance policies, procedures, frameworks and training to meet the requirements of the Quality Standards.

Considering the information brought forward by the provider, including completion of staff training and details of an established workforce governance framework, I decided the service is compliant with Requirement 8(3)(c).

*Requirement 8(3)(e):*

The site audit report found deficiencies in the service’s clinical governance framework regarding monitoring and assessment of chemical restrictive practices. During the site audit, management confirmed 5 consumers were subject to chemical restraint, while later reporting a further 13 consumers. Meeting minutes evidenced policies and procedures had not been followed which required review of the service’s psychotropic medication register to monitor consumers and ensure alignment with care plans. At the time of the site audit, management were unable to evidence consent for the use of chemical restrictive practices had been in place prior to the site audit for all consumers found to have been administered psychotropic medications. I have further considered these deficiencies under Requirement 3(3)(a) where they are relevant.

The Approved Provider’s response dated 8 September 2023 included a plan for continuous improvement which stated all chemical restraints were to be reviewed by September 2023 as well as all consumers’ medication reviewed monthly for the next 6 months to ensure appropriate medication management. The plan further detailed intended commencement of weekly clinical meetings to discuss consumers susceptible to high-impact or high-prevalence risks.

While the Approved Provider’s response contains details on how it has commenced actions in response to the site audit report, these actions are yet to be completed, embedded or evaluated to demonstrate an effective clinical governance framework.

Therefore, I find the service non-compliant with Requirement 8(3)(e).

*The other Requirements:*

I find the service is compliant with the remaining Requirements of Quality Standard 8.

Consumers and representatives said they were involved in the development and delivery of care and services. Management confirmed consumers and representatives were involved through meetings, reviews, discussions and the feedback and complaint processes. Meeting minutes reflected regular involvement of consumers in the development and delivery of care and services.

Management confirmed the governing body promoted a safe and inclusive culture by participating in various clinical and operational meetings and reviewing reports from the service regarding serious incidents, internal audits, feedback and complaints. Meeting minutes reflected discussion of data reported by the service and responsive actions.

The service utilised a systematic approach to manage high-impact and high-prevalence risks, to identify, report, escalate and review risks and incidents to improve care delivery. Management described systems to identify the need for further staff training following incidents and to monitor risks identified as prevalent. However, the site audit report showed deficiencies in prompt identification, reporting and escalation of deterioration of 2 named consumers. I have considered these deficiencies under Requirement 3(3)(a) where they are most relevant.

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