Valencia Nursing Home

Performance Report

24 Valencia Road   
CARMEL WA 6076  
Phone number: 08 9293 5248

**Commission ID:** 7863

**Provider name:** Burswood Care Pty Ltd

**Assessment Contact - Site date:** 20 July 2022

**Date of Performance Report:** 18 August 2022

# Performance report prepared by

Janine Renna, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 7 Human resources** |  |
| Requirement 7(3)(a) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(e) | Non-compliant |

# Detailed assessment

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 Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

The following information has been taken into account in developing this 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/representatives and others; and
* the provider’s response to the Assessment Contact - Site report received on 8 August 2022.

# STANDARD 7 Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The Assessment Team assessed Requirement (3)(a) in Standard 7 Human resources as part of the Assessment Contact and have recommended the service meets the Requirement. As all other Requirements in this Standard were not assessed, an overall rating of the Standard has not been provided.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and based on this information, I find the service compliant with Requirement (3)(a) in Standard 7 Human resources. I have provided reasons for my finding under the specific Requirement below.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Compliant

*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.*

The Assessment Team was satisfied the service demonstrated 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. The Assessment Team provided the following evidence relevant to my finding:

* Three consumers said staffing numbers were sufficient to meet their needs.
* Staff said there are enough staff to meet consumers’ needs and preferences.
* Rostering is undertaken two weeks in advance to identify and address unfilled shifts. Agency staff are utilised when necessary. Rosters show only one unfilled shift in the two weeks preceding the Assessment Contact.
* Clinical staff and management reported one key management personnel position had recently been filled, however, the appointed individual is regularly unwell and does not attend work. There was no evidence this has had adverse impacts to consumer care delivery.
* Staffing numbers appeared to be adequate throughout the Assessment Contact and staff were observed assisting consumers as required.

The provider’s response did not address the Assessment Team’s findings in relation to this Requirement.

Based on the information summarised above, I find the service compliant with Requirement (3)(a) in Standard 7 Human resources.

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

The Assessment Team assessed Requirement (3)(e) in Standard 8 Organisational governance at the Assessment Contact and have recommended the service does not meet the Requirement.

I have considered the Assessment Team’s findings, the provider’s response and the evidence documented in the Assessment Team’s report and based on this information, I find the service non-compliant with Requirement (3)(d) in Standard 8 Organisational governance. I have provided reasons for my finding under the specific Requirement below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(e) Non-compliant

*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.*

The Assessment Team found the service demonstrated an effective clinical governance framework in relation to open disclosure and antimicrobial stewardship. However, the Assessment Team was not satisfied the organisation’s clinical governance framework was effective in relation to the use of restraint, as consumers subject to chemical restraint were not monitored, Behaviour support plans did not include information required by legislation and informed consent was not obtained prior to use of restraint. Additionally, governance processes did not identify ineffective management of one consumer’s behaviours. The Assessment Team provided the following evidence relevant to my finding:

* Of the eight sampled consumers who were subject to chemical or physical restraint, there was no evidence indicating informed consent had been obtained and processes were not undertaken to ensure the use of restraint was reviewed, used as a last resort and used for the least amount of time possible.
* Changes to dosage or cessation of chemical restraint were not reflected on the psychotropic register and consumers were not consistently monitored to identify impact of medication changes.
* Care planning documentation did not consistently include information to guide staff in relation to the use of physical restraint, how to monitor and ensure the consumer’s safety while the restraint was in use and strategies to be trialled before using restraint. For one consumer, there was no evidence behaviour charting or review had occurred in the eight months preceding the site audit to identify whether the restraint was still required. For another consumer, care planning documentation did not identify that a restraint was in use.
* While the organisation’s policy provided clear guidance for the use of restrictive practices and was in line with legislative requirements, it was in draft form at the time of the Assessment Contact.
* Governance processes did not identify that one consumer’s behaviours of wandering, intrusiveness and agitation have not been effectively managed. The consumer has been a victim of seven incidents relating to unreasonable use of physical force from male consumers whilst displaying wandering and intrusive behaviours. Four of the seven incidents involved the same perpetrator. The consumer’s care plan did not provide strategies to guide staff in ensuring the consumer’s safety, particularly when around the perpetrators. Where behaviours had occurred, documented strategies were not consistently implemented, and monitoring did not always occur to identify triggers or effectiveness of trialled interventions.

The provider acknowledges the Assessment Team’s findings in relation to this Requirement. The provider’s response includes evidence to demonstrate actions have been taken and/or planned to address deficiencies identified by the Assessment Team. These include, but are not limited to, undertaking medication audits, documenting consent for use of restraint, review of consumers subject to restraint, implementing new policies and procedures, and completion of psychotropic medication assessments. I acknowledge actions taken by the service to rectify issues identified by the Assessment Team.

In coming to my finding, I have considered the Assessment Team’s findings, information in the Assessment Team’s report and provider’s response, which demonstrates at the time of the Assessment Contact, the organisation’s clinical governance framework was not effective in relation to minimising the use of restraint and managing behaviours.

I have considered that the service did not meet its regulatory obligations under the *Quality of Care Principles 2014*, as informed consent had not been obtained and processes were not undertaken to ensure the use of restraint was reviewed, used as a last resort and used for the least amount of time possible. I have also considered that the organisation’s restrictive practice policy in place at the time of the Assessment Contact was in draft form.

I have also considered that the service cannot effectively monitor consumers subject to chemical restraint, as while a psychotropic medication register is maintained, it is not updated when reductions or cessation in medication has occurred.

In relation to another consumer who displays agitation and wandering and intrusive behaviours, the service failed to identify that their behaviours were not effectively managed. The consumer has been a victim of unreasonable use of physical force by other consumers whilst displaying wandering and intrusive behaviours. Despite these incidents, the consumer’s care plan does not guide staff in maintaining their safety, particularly when around the perpetrators, nor has monitoring or charting occurred to identify triggers or the effectiveness of trialled interventions.

Based on the information summarised above, I find the service non-compliant with Requirement (3)(e) in Standard 8 Organisational governance.

# 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 the organisation’s clinical governance framework in relation to the use of restraint and behaviour management.