Performance

Report

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| Name: | Waterview Aged Care Facility |
| Commission ID: | 2391 |
| Address: | 16 Cumberland Street, TERALBA, New South Wales, 2284 |
| Activity type: | Site Audit |
| Activity date: | 17 June 2024 to 19 June 2024 |
| Performance report date: | 1 August 2024 |
| Service included in this assessment: | Provider: 853 Hunter Valley Care Pty Ltd  Service: 799 Waterview Aged Care Facility |

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 Waterview Aged Care Facility (**the service**) has been prepared by Katherine Richards, 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; 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; and
* the Approved Provider’s response received on 17 July 2024.

# 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 | **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 | **Not Compliant** |

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

# Areas for improvement

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

* **Requirement 8(3)(e)** – The service must ensure where clinical care is provided, an effective clinical governance framework was in place in relation to antimicrobial stewardship, minimising the use of restraint and open disclosure.

# 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. | Compliant |

Findings

This Quality Standard is assessed as Compliant as 6 of the 6 Requirements have been found Compliant.

Consumers and representatives confirmed consumers were treated with dignity and respect, with their identity, culture and diversity valued. Staff spoke of consumers in a respectful manner, and described how the consumer’s life history and culture influenced the delivery of their care. Care planning documentation reflected consumers’ diversity and background.

Consumers and representatives advised consumers’ backgrounds were valued, and staff provided care which was consistent with their cultural preferences. Policies were in place which ensured consumers’ cultural and ethnic backgrounds and beliefs were respected and supported.

Consumers and representatives stated consumers were supported to make decisions about their care and maintain their personal relationships. Care planning documentation evidenced consumers’ choices regarding how their care was to be delivered, who was involved in their care, and their relationships of importance. Staff were familiar with consumers’ personal choices, and advised they encouraged consumers to be as independent as possible and make their own decisions.

Staff demonstrated an understanding of the risks associated with consumers’ choices, and the strategies in place to promote their safety. Consumers and representatives confirmed consumers were supported to engage in their chosen activities which contained an element of risk. Care planning documentation demonstrated risks were identified by the use of assessments, and the strategies to mitigate risks had been discussed with consumers and their representatives.

Consumers and representatives reported they kept informed through printed information and verbal reminders. Staff described how they adapted their communication style to ensure information was effectively communicated to consumers living with cognitive or sensory impairments. The activities schedule and menu was observed to be displayed throughout the service.

Consumers and representatives advised consumers’ privacy was respected, and staff closed their doors prior to delivering care. Staff demonstrated a practical understanding of methods to ensure consumers’ privacy was maintained by knocking on their doors and awaiting their response prior to entry. Nurses’ stations were observed to be locked, and the electronic care management system was kept password protected when not in use.

# 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 assessed as Compliant as 5 of the 5 Requirements have been found Compliant.

Care planning documentation mostly evidenced the risks to consumers’ health and well-being were assessed to inform the delivery of safe and effective care and services, however, inaccuracies in care planning documentation for one consumer had not been identified and corrected by staff. This information was raised with management who created a continuous improvement initiative to review all care and service plans for accuracy. Furthermore, there was a lack of assessments to determine ability to operate security measures on the front door, which remained locked after business hours, and associated impact on whether this may result in potential for unauthorised environmental restraint. In response to this feedback, management created a continuous improvement initiative to display the keypad code, and to complete assessments to determine whether consumers were subject to environmental restrictive practices, see Requirement 8(3)(e) for further information. Staff described the initial and ongoing assessment and care planning process, and confirmed key assessments were completed during the consumer’s entry into the service to inform they delivery of consumers’ care and services.

Staff outlined how they assessed and captured consumers’ information relating to their current needs, goals and preferences, and described how they approached end of life planning conversations with consumers. Policies and procedures regarding advance care planning guided staff practice to undertake the assessment of consumers’ end of life needs, goals and preferences.

Care planning documentation evidenced an ongoing partnership between consumers, representatives, medical officers and allied health professionals in the assessment, planning and review of consumers’ care and service plans. Consumers and representatives confirmed they were involved in the assessment and planning of consumers’ care. Staff advised assessment and planning was completed in collaboration with consumers, representatives and external providers of care to ensure the consumer’s care needs were met.

Consumers and representatives reported assessment outcomes were regularly communicated to them, and a copy of the consumer’s care and service plan was accessible. Staff described their roles and responsibilities to ensure consumers, representatives and shared providers of care were informed of assessment outcomes through face-to-face conversation, telephone calls and emails. Summary care and service plans were noted to be accessible to consumers and representatives.

Care planning documentation evidenced care and service plans were reviewed for effectiveness on a regular basis and in response to changes in the consumer’s circumstances. Staff outlined the processes to review care and service plans every 3 months, through monthly Consumer of the Day reviews and when incidents occurred. Consumers confirmed their care and service plans were reviewed following falls, and their risk management strategies were updated.

# 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 assessed as Compliant as 7 of the 7 Requirements have been found Compliant.

Consumers and representatives confirmed consumers received safe and effective care which met their needs and optimised their health well-being. Care planning documentation demonstrated tailored care strategies for consumers, for example, where restrictive practices were consented for use, personalised behaviour support plans provided guidance of alternate management strategies to ensure restraint was used as a last resort. Staff demonstrated an understanding of consumers’ personal and clinical care needs, and the strategies in place to ensure the delivery of best practice care.

Staff described the high impact and high prevalence risks associated with the care of consumers and outlined the risk mitigation strategies in place to promote their safety. Consumers and representatives confirmed the risks to their well-being were effectively managed, and appropriate risk mitigation strategies were in place. Care planning documentation evidenced the risks to the consumer’s well-being were considered and effectively managed.

Staff outlined how they provided support to consumers during end of life care, including by ensuring their comfort was maximised and providing pain management. Care planning documentation for a late consumer evidenced they received care in alignment with their goals, and their comfort was maintained. A palliative care pathway was in place which outlined how the consumer’s end of life goals were to be respected, their comfort maintained and their quality of life maximised during the delivery of care.

Care planning documentation evidenced deterioration or changes in the consumer’s condition were recognised and escalated in a timely manner. Staff described the signs and symptoms they would look for which may indicate deterioration in the consumer’s condition, and advised the actions they would take to escalate their concerns. Consumers and representatives advised staff were responsive in identifying deterioration in the consumer’s condition, and would inform them of any changes.

Consumers and representatives confirmed the consumer’s preferences and needs were effectively communicated between themselves, staff and external providers of care. Staff advised information regarding the consumer’s condition was communicated during handovers and huddles, and documented in the electronic care management system. Care planning documentation evidenced the effective sharing of the consumer’s information to facilitate the delivery of their care and services.

Consumers and representatives advised referrals were timely and appropriate, and consumers had access to a range of external organisations and health professionals. Staff described their roles and responsibilities in relation to the referral process, and outlined how referrals were created to various providers of care. Care planning documentation evidenced referrals to allied health professionals were made in response to changes to the consumer’s condition.

Staff demonstrated an understanding of how they ensured the appropriate use of antibiotics, including by awaiting pathology results prior to the commencement. Consumers and representatives advised infection-related risks were effectively minimised, and staff wore personal protective equipment and practiced hand hygiene. An outbreak management plan, policies and procedures were in place to guide staff in response to various infectious outbreaks.

# 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 assessed as Compliant as 7 of the 7 Requirements have been found Compliant.

Consumers and representatives mostly advised consumers received supports which met their needs, goals and preferences, and maximised their quality of life. One representative said they would like to see more outdoor activities available, and lifestyle staff said this was considered when permitted by weather. Staff were familiar with the needs and preferences of consumers, and described how they supported consumers to engage in activities which optimised their well-being.

Consumers and representatives confirmed consumers were supported when they were feeling low, and could access regular religious services. Staff described how they identified consumers who were feeling low by observing their body language and levels of engagement, and would provide the consumer with emotional support through conversations or encouraging them to engage in their preferred activities. Staff were knowledgeable of the supports provided to consumers to maintain their spiritual well-being, and this information aligned with care planning documentation.

Consumers and representatives reported consumers were supported to participate in activities within the internal and external community, maintain contact with people of importance to them, and engage in their preferred activities. The lifestyle activities calendar evidenced a range of activities were offered to consumers catering to their various interests. Staff described how they supported consumers to maintain their social and personal relationships by encouraging visits, and facilitating phone and video calls.

Consumers and representatives confirmed consumers’ information was effectively communicated between staff and with external organisations where responsibility for care was shared. Staff demonstrated an understanding of consumers’ condition, needs and preferences, and advised information was communicated through care planning documentation and handovers. Care planning documentation provided detailed information to support safe and effective daily living care and services.

Although representatives reported the service had not referred consumers for volunteer visits in a timely manner, staff provided examples of referrals to external services and supports for consumers, including pastoral care and community service to broaden the lifestyle services delivered to consumers. Management provided evidence regarding their attempts to arrange and create volunteer referrals, however there were a lack of volunteers impacting timeliness of response.

Consumers and representatives mostly provided positive feedback regarding the quality, variety and quantity of their provided meals, however a consumer and representatives expressed dissatisfaction with the lack of availability of cultural foods and the quality of some meals. Management advised they would raise the feedback of the availability of cultural meals with the chef, and acknowledged the feedback regarding the quality of meals. The meal service was observed it be timely and calm, with consumers receiving meal assistance when required. Staff advised the menu was developed in consultation with a dietician and consumer input.

Consumers confirmed their mobility and daily living equipment was kept clean and well maintained. Staff outlined how they checked equipment prior to use to identify issues and ensure its safety. A range of mobility, lifestyle and leisure equipment was observed to be clean, well maintained and suitable for consumer use.

# 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 assessed as Compliant as 3 of the 3 Requirements have been found Compliant.

Consumers and representatives found the service environment to be welcoming and easy to understand. The service environment was observed to be welcoming and well-lit, with handrails and directional signage fitted throughout to assist consumers to navigate. Staff described how consumers’ sense of belonging and interaction was optimised by providing them with an orientation and ensuring walkways were free from clutter and hazards.

Consumers and representatives confirmed the service environment was clean, well maintained and comfortable, and consumers could move freely through indoor and outdoor areas. Maintenance staff advised they regularly conducted walkarounds to identify potential hazards, and to ensure the service environment was safe and suitable for all consumers. Maintenance documentation evidenced reactive requests for repair were completed in a timely manner.

Consumers reported their equipment, furniture and fittings were safe, clean and well maintained. Staff outlined their roles and responsibilities to ensure mobility equipment was cleaned on a regular basis and after use. Maintenance staff advised they regularly ensured the suitability of equipment, however they could not consistently evidence documentation which outlined their completed tasks. In response, management stated they were in the process of creating a system to track the completion of preventative maintenance.

# 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 assessed as Compliant as 4 of the 4 Requirements have been found Compliant.

Consumers and representatives confirmed they were comfortable and supported to provide their feedback and make complaints. Management advised consumers and representatives were supported to provide their complaints through care consultations, the completion of feedback forms and surveys and during consumer meetings. Feedback forms and locked submission boxes were observed within reception.

Consumers and representatives were aware they had access to advocacy and language services to raise and resolve their complaints. Staff mostly demonstrated an understanding of the advocacy and interpretation services available to consumers, management advised they would provide staff with further information regarding advocacy supports to ensure a consistent understanding. Information regarding advocacy supports, including the Commission, were observed throughout the service.

Consumers and representatives confirmed their complaints were responded to appropriately, and staff practiced open disclosure. Staff described their responsibilities to report and investigate complaints and incidents, and outlined the importance of applying open disclosure principles. The complaints register evidenced feedback and complaints were managed in alignment with procedures, and appropriate action was taken to resolve complaints.

Consumers and representatives reported their feedback and complaints were utilised to improve the quality of their care and services. Management confirmed all feedback was electronically recorded and analysed for trends to ensure improvement opportunities were identified. Complaints documentation evidenced complaints were recorded and included the improvement initiatives arising from the resolution of the complaint.

# 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 assessed as Compliant as 5 of the 5 Requirements have been found Compliant.

Consumers and representatives mostly advised there were enough staff to meet the care needs of consumers in a timely manner, however a consumer stated it would be beneficial for additional staff to be rostered on but did not outline any concerns regarding care delivery impacts. Staff confirmed there were sufficient staffing levels to meet consumers’ needs, and reported they could seek assistance from staff in other wings if required. Management advised the staffing roster was developed in consideration with staff availability, consumer care needs and regulatory care minute requirements.

Consumers and representatives confirmed staff were kind, caring, respectful and gentle when providing care. Staff demonstrated an understanding of consumers’ identity and preferences, and spoke of consumers in a respectful manner. Staff were observed to interact with consumers in a caring and gentle manner, and engaged consumers in conversation and activities.

Consumers and representatives reported staff were skilled and competent to perform their roles. Staff described the responsibilities associated with their roles, and the required qualifications and competencies which aligned with position descriptions. Personnel records evidenced staff had the required checks and registrations for their respective roles.

Consumers and representatives mostly advised staff were well trained and had the knowledge to deliver care to consumers, however a representative expressed staff were not well trained to deliver to promptly administer medications, this feedback was raised with management who advised they would investigate the issue. Staff confirmed they were supported with various online and in-person training sessions, however some gaps were demonstrated in their understanding of restrictive practices, see Requirement 8(3)(e) for further information. Training records evidenced all staff had completed or were schedule to complete their mandatory training modules.

Staff demonstrated an understanding of the performance appraisal process, and confirmed they were provided with opportunities to improve their knowledge and performance. Management advised the were not up to date with the completion of their performance appraisals and stated the appraisal process is being revised, and all appraisals expected to be completed by October 2024. Management outlined the performance of staff was monitored through informal observations and reviews, and they would engage with staff if underperformance was identified.

# 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. | Not Compliant |

Findings

This Quality Standard is assessed as Non-Compliant as 1 of the 5 Requirements have been found Non-Compliant.

The service was previously found non-compliant in relation to Requirement 8(3)(e) following an Assessment Contact conducted on 22 to 23 January 2024, which indicated the clinical governance framework was ineffective to minimise the use of restraints. Evidence in the Site Audit Report dated 17 to 19 June 2024 demonstrated improvement initiatives to address the identified issues which included the commencement of a clinical governance coordinator who was accountable for the auditing of clinical data and audits, and ensuring compliance with Quality Standards. Whilst improvement actions have been implemented to ensure a clinical governance framework was in place, the Assessment Team has recommended Requirement 8(3)(e) as not met, as an effective clinical governance framework in the identification, monitoring and minimisation of restrictive practices could not be demonstrated.

The Assessment Team considered clinical governance framework and practices had not supported effective assessment and planning processes to determine potential for environmental restraint. This was particularly in relation to considering whether consumers could independently access the external service areas through security measures on the front door. The consumer admission pack reflected consumers were provided with an Environmental Security Form which noted the front door is locked after-hours and the consumer can choose whether they would prefer to be provided with the keypad code or receive staff assistance to enter and exit the service. However, these supports were not assessed for appropriateness to the consumer’s capability, nor tailored strategies developed to support the consumer’s needs. Management acknowledged they had not considered the locked front door may subject consumers to an environmental restrictive practice, and staff did not consistently demonstrate an understanding of the application environmental restraints. Management conducted assessments to determine whether consumers could be subject to environmental restraints and identified 57 consumers were potentially impacted. Furthermore, the psychotropic register had not effectively identified psychotropic medication as a chemical restraint for 2 consumers despite having consent and behaviour support plans in place. Management reported a potential lack of understanding of the topic, and confirmed they were in the process of reviewing the psychotropic register with an expected completion date of 30 August 2024.

The Approved Provider refuted these findings were reflective of an ineffective clinical governance system. They contended the current process was effective, with the environmental security form completed reflecting options to provide fob key, door code, or seek staff assistance when the front door was locked overnight. The form was updated in January 2024 following the previous Assessment Contact, and improvement actions to ensure all consumers had been reviewed against this were on track to be completed by August 2024. The new form clearly identifies individual choice, available alternatives, and associated risks. However, in response to feedback during the Site Audit, the door code is now displayed and discussion of options of using the code or fob cards was held at a recent consumer meeting.

The Approved Provider acknowledged the education deficit amongst staff in relation to restrictive practices, and advised they will ensure all staff are educated, and will enhance the delivery of restrictive practice training through additional face-to-face education and toolbox talks. In response to the 2 consumers that were not documented within the psychotropic register, the Approved Provider stated this was a clerical error, supported by presence of necessary consent and behaviour support plans in place during the Site Audit. Other misunderstandings were also addressed.

I have considered the information provided by the Assessment Team and the Approved Provider, inclusive of their immediate actions to display the key code and conducting assessments. I acknowledge the front door was locked after-hours to enhance consumer safety. However, I find the Approved Provider’s response does not demonstrate a complete understanding of environmental restraint, and the clinical governance framework has not delivered effective policies, processes and training to staff to undertake effective assessment for consumers to determine whether imposed security measures restrict freedom of access and movement. Furthermore, whilst the Approved Provider states documents are available to support their understanding and assessment processes, these were not submitted within their response to inform my decision. I also consider staff did not demonstrate a consistent understanding regarding the application of restrictive practices to ensure the appropriate identification of restraints.

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

Consumers and representatives confirmed they were engaged in the development, delivery and evaluation of care and services. Management reported consumers and representatives were actively engaged through consumer meetings, feedback processes, surveys, informal conversations and during care consultations, and described their actions to form a Consumer Advisory Body. Consumer meeting minutes evidenced consumers were encouraged to provide their feedback and suggestions on various aspects of their care and services.

The service was previously found non-compliant in relation to Requirement 8(3)(b) following an Assessment Contact conducted on 22 to 23 January 2024, which indicated the governing body did not demonstrate appropriate systems were in place to enable the provision of safe, inclusive and quality care and services. Evidence in the Site Audit Report dated 17 to 19 June 2024 supports the service has implemented improvements to address the identified issues, and is now complaint with this Requirement. Improvement actions include the establishment of a governing body and the provision of education outlining their roles and responsibilities and the creation of a direct email address for the governing body to ensure the effective dissemination of information. Management advised reporting mechanisms were in place to inform the governing body of performance, audit results clinical data and feedback and complaints. Management stated the governing body maintained effective oversight through their involvement in regular meetings and reporting. Management provided examples of improvements driven by the governing body to enhance the quality of care and services.

The service was found non-compliant in Standard 8 in relation to Requirement 8(3)(c) following an Assessment Contact conducted on 22 to 23 January 2024, which indicated there were ineffective organisation wide governance systems in relation to information management, continuous improvement, workforce governance and regulatory compliance. Evidence in the Site Audit Report dated 17 to 19 June 2024 supports the service has implemented improvements to address the identified issues, and is now complaint with this Requirement. Improvement actions include the commencement of a clinical governance manager to oversee and guide clinical coordinators, the forthcoming implementation of a new electronic care management system to enhance the management of documentation and an internal auditing system to evaluate performance in comparison with other services. A review of the new auditing system evidenced additional continuous improvement opportunities were identified in relation to the consumer dining experience and service environment. Staff advised they could access the information required to perform their roles through the electronic care management system, online portal, and documents available in nurses’ stations. Management outlined the governing body’s oversight of the budget approval process and provided examples of recent purchases to improve the service environment. Management advised the governing body maintained oversight of feedback and complaints through regular reporting, and stated the governing body led improvement initiatives. Management stated they received correspondence from their head office in response to regulatory and legislative changes, which management then communicated to staff.

The service was previously found non-compliant in relation to Requirement 8(3)(d) following an Assessment Contact conducted on 22 to 23 January 2024, which indicated high impact risks were not effectively managed. Evidence in the Site Audit Report dated 17 to 19 June 2024 supports the service has implemented improvements to address the identified issues, and is now complaint with this Requirement. Improvement actions include the implementation of a clinical risk register to monitor high impact risks, the delivery of further education to staff and the benchmarking of high impact risks against other services. Staff demonstrated an understanding of consumers’ high impact risks, and the strategies to ensure the effective management of their risks. Management described the post-incident analysis process, whereby any instances or suspected instances of abuse and neglect are captured and appropriately escalated. Staff were aware of their responsibilities in relation to reportable incidents under the Serious Incident Response Scheme escalation pathway. Management advised consumers were encouraged to live their best life by supporting them to take risks and participate in the activities they enjoyed.

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)