Bethanie Waters

Performance Report

18 Olivenza Crescent   
PORT KENNEDY WA 6172  
Phone number: 08 9593 9300

**Commission ID:** 7276

**Provider name:** The Bethanie Group Incorporated

**Assessment Contact - Site date:** 14 September 2021 to 15 September 2021

**Date of Performance Report:** 9 November 2021

# 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 1 Consumer dignity and choice** |  |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** |  |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** |  |
| Requirement 3(3)(a) | Compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(d) | Compliant |
| **Standard 4 Services and supports for daily living** |  |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** |  |
| Requirement 5(3)(b) | Compliant |
| **Standard 7 Human resources** |  |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Compliant |
| **Standard 8 Organisational governance** |  |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | 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
* the provider did not respond to the Assessment Team’s report.

# STANDARD 1 Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

The Assessment Team assessed Requirements (3)(a) and (3)(b) in this Standard at this Assessment Contact. As all other Requirements in this Standard were not assessed, an overall rating of the Standard has not been completed.

The purpose of the Assessment Contact was to assess the service’s performance in relation to Requirements (3)(a) and (3)(b) in this Standard. These Requirements were found non‑compliant following a Site Audit conducted on 8 March 2021 to 10 March 2021, where it was found the service had not demonstrated each consumer receives culturally safe care and services, and is treated with dignity and respect, with their identity, culture and diversity valued.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended the service meets Requirements (3)(a) and (3)(b) in this Standard.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and I find the service compliant with Requirements (3)(a) and (3)(b). I have provided reasons for my finding under the specific Requirements below.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

The service was found non-compliant with Requirement (3)(a) following a Site Audit conducted on 8 March 2021 to 10 March 2021, as the service did not demonstrate each consumer is treated with dignity and respect at all times. Consumers expressed dissatisfaction with the personal care they received, stating it was not always delivered in a respectful or appropriate manner. The service has since implemented a number of improvements to address deficits identified by the Assessment Team.

At the Assessment Contact, the Assessment Team conducted interviews with consumers, representatives and staff, reviewed documentation and undertook observations, and was satisfied with the effectiveness of measures implemented in response to the previous non-compliance. The Assessment Team was also satisfied this evidence demonstrated each consumer is treated with dignity and respect, with their identity, culture and diversity valued. The Assessment Team provided the following evidence relevant to my finding:

* All consumers and representatives confirmed consumers get the care they need and are treated with respect. They reported staff were friendly and helpful when needed.
* Staff demonstrated knowledge of consumers’ likes, dislikes, food preferences and things of importance to them. Staff reported the service has policies and procedures to guide them in the delivery of consumers’ care.
* Care planning documentation for each sampled consumer was individualised and reflected their preferences for care, things or people of importance to them, activities they enjoy and aspects of their lives that are significant.
* Staff were observed to be respectful, friendly, attentive and appropriate in their engagement with consumers.

The provider did not respond to the Assessment Team’s report.

Based on the above evidence, I find the service compliant with Requirement (3)(a) in Standard 1 Consumer dignity and choice.

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

The service was found non-compliant with Requirement (3)(b) following a Site Audit conducted on 8 March 2021 to 10 March 2021, as the service did not demonstrate consumers’ cultural needs are considered to ensure care and services are delivered in a culturally safe manner. The service has since implemented a number of strategies to address deficits identified by the Assessment Team. For example:

* The service has trialled various strategies to assist staff in communicating with a non-English speaking consumer, including the use of interpreter and translation services, and communication cards.
  + The representative reported staff contact them regularly to ensure their relative is understood when other communication strategies are ineffective, to ensure care and services are delivered in a way that align with the consumer’s culture and traditions.

At the Assessment Contact, the Assessment Team conducted interviews with staff, reviewed documentation and undertook observations, and were satisfied the service demonstrated care and services are culturally safe. The Assessment Team provided the following evidence relevant to my finding:

* Staff provided examples of how they tailor care and services to meet consumers’ cultural needs. Staff were observed interacting with consumers in a kind, respectful and patient manner, in line with their specified cultural needs.
* Signage was observed on consumers’ doors to indicate whether they want staff to knock before entering and alert staff to introduce themselves for those who are vision impaired.
* Care planning documentation identifies consumers’ cultural needs, goals, values, interests and relationships of importance to them.

The provider did not respond to the Assessment Team’s report.

Based on the above evidence, I find the service compliant with Requirement (3)(b) in Standard 1 Consumer dignity and choice.

# STANDARD 2 Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Assessment Team assessed Requirements (3)(a) and (3)(e) in this Standard at this Assessment Contact. As all other Requirements in this Standard were not assessed, an overall rating of the Standard has not been completed.

The purpose of the Assessment Contact was to assess the service’s performance in relation to Requirements (3)(a) and (3)(e) in this Standard. These Requirements were found non‑compliant following a Site Audit conducted on 8 March 2021 to 10 March 2021, where it was found the service had not demonstrated that care and services are reviewed regularly for effectiveness, and assessment and planning processes considered risks to consumers’ health and well-being to inform the delivery of safe and effective care and services.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended the service meets Requirements (3)(a) and (3)(e) in this Standard.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and I find the service compliant with Requirements (3)(a) and (3)(e). I have provided reasons for my finding under the specific Requirements below.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

*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.*

The service was found non-compliant with Requirement (3)(a) following a Site Audit conducted on 8 March 2021 to 10 March 2021, as the service did not demonstrate risk assessment tools were always used to effectively assess consumers’ clinical needs, resulting in ineffective care. Where assessment of risks to consumers’ health and well-being was undertaken, they were not effective in delivering safe and quality care and services.

At the Assessment Contact, the Assessment Team conducted interviews with consumers, representatives and staff, and reviewed documentation, and was satisfied with the effectiveness of measures implemented in response to the previous non-compliance. The Assessment Team was also satisfied this evidence demonstrated assessment and planning, including consideration of risks to consumers’ health and well-being, informs the delivery of safe and effective care and services. The Assessment Team provided the following evidence relevant to my finding:

* All consumers and representatives confirmed they are involved in assessment and planning processes to the extent they wish to be involved and expressed satisfaction with strategies in place to manage risk to consumers’ health and well‑being.
* For two sampled consumers, interviews with consumers, representatives and staff, and documentation demonstrated comprehensive assessment and planning, including implementation of management and prevention strategies, to mitigate the risk to their health and well-being.
* Care planning documentation showed risks are assessed accurately and in a timely manner, with appropriate prevention strategies put in place.
* Staff confirmed they are aware of the service’s assessment and planning procedures and have undertaken training in the use of risk assessment tools.

The provider did not respond to the Assessment Team’s report.

Based on the above evidence, I find the service compliant with Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers.

### Requirement 2(3)(e) Compliant

*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.*

The service was found non-compliant with Requirement (3)(e) following a Site Audit conducted on 8 March 2021 to 10 March 2021, as the service did not demonstrate care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals and preferences of the consumer.

At the Assessment Contact, the Assessment Team conducted interviews with staff and reviewed documentation and was satisfied with the effectiveness of measures implemented in response to the previous non-compliance. The Assessment Team was also satisfied this evidence demonstrated care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals and preferences of the consumer. The Assessment Team provided the following information relevant to my finding:

* Interviews with staff and documentation demonstrated a care plan evaluation checklist has been implemented, with care plans reviewed for effectiveness every six months and upon return from hospital.
* Documentation showed care plans are updated in a timely manner following reassessments of consumers’ changed needs, goals or preferences.
* One staff provided two examples of care plans that were reviewed for effectiveness following an incident or change in consumers’ needs, goals or preferences.

The provider did not respond to the Assessment Team’s report.

Based on the above evidence, I find the service compliant with Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers.

# STANDARD 3 Personal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The Assessment Team assessed Requirements (3)(a), (3)(b) and (3)(d) in this Standard at this Assessment Contact. As all other Requirements in this Standard were not assessed, an overall rating of the Standard has not been completed.

The purpose of the Assessment Contact was to assess the service’s performance in relation to Requirements (3)(a), (3)(b) and (3)(d) in this Standard. These Requirements were found non‑compliant following a Site Audit conducted on 8 March 2021 to 10 March 2021, where it was found the service had not demonstrated that each consumer receives safe and effective care that is best practice, tailored to their needs and optimises their health and well-being, that high impact or high prevalence risks associated with the care of each consumer is effectively managed, and deterioration or change in consumers’ function, capacity or condition is recognised and responded to in a timely manner.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended the service meets Requirements (3)(a), (3)(b) and (3)(d) in this Standard.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and I find the service compliant with Requirements (3)(a), (3)(b) and (3)(d). I have provided reasons for my finding under the specific Requirements below.

### Assessment of Standard 3 Requirements

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

*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.*

The service was found non-compliant with Requirement (3)(a) following a Site Audit conducted on 8 March 2021 to 10 March 2021, as the service did not demonstrate each consumer received safe and effective clinical care that is best practice, specifically in regard to wound care, pressure injuries, pain management and use of restraint.

At the Assessment Contact, the Assessment Team conducted interviews with representatives and reviewed documentation and was satisfied with the effectiveness of measures implemented in response to the previous non-compliance. The Assessment Team was also satisfied this evidence demonstrated each consumer received safe and effective care that is best practice, tailored to their needs and optimises their health and well-being. The Assessment Team provided the following evidence relevant to my finding:

* Three representatives were satisfied with the care their family members receive and provided examples of best practice in relation to the use of restraint and continence care. Representatives were satisfied with the personal care provided by staff and considered care and services were consistent.
* Documentation showed from March to August 2021, the use of physical restraint has reduced by 85.71%.
* For three consumers, care planning documentation showed chemical restraint is being used in line with best practice principles and regulatory requirements, including trialling non‑pharmacological strategies prior to the administration of psychotropic medication, exploring opportunities to cease or reduce the dosage, and administering the medication as a last resort.

The provider did not respond to the Assessment Team’s report.

Based on the above evidence, I find the service compliant with Requirement (3)(a) in Standard 3 Personal care and clinical care.

### Requirement 3(3)(b) Compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

The service was found non-compliant with Requirement (3)(b) following a Site Audit conducted on 8 March 2021 to 10 March 2021, as the service did not demonstrate effective management of high impact or high prevalence risks associated with pressure injuries, behaviours and physical restraint. The service has since implemented a number of strategies to address deficits identified by the Assessment Team. For example:

* A review of all consumers’ individual risks and interventions to minimise the risk was conducted.
* A ‘high risk/high prevalence’ matrix has been created.
* Staff have been provided training on the use of the Braden Risk Assessment tool, regency chairs and pressure relieving devices, behaviour management.
* Wound care processes have been reviewed.
* Care plans have been updated to include individualised behavioural management strategies for consumers that exhibit challenging behaviours.

At the Assessment Contact, the Assessment Team conducted interviews with staff, reviewed documentation and undertook observations, and was satisfied the service demonstrated high impact or high prevalence risks associated with the care of each consumer is effectively managed. The Assessment Team provided the following evidence relevant to my finding:

* Documentation showed the number of consumers with pressure injuries has reduced from 23 to nine from March 2021 to September 2021.
* For consumers that have pressure injuries, documentation demonstrated pressure relieving strategies are in place and wounds are reviewed regularly in line with the service’s procedures.
* Management advised an incident was reported under the Serious Incident Response Scheme (SIRS) for one consumer who had a pressure injury that was not identified until stage four. A root cause analysis was subsequently undertaken, which identified opportunities for improvement, with additional staff training implemented.
* Staff demonstrated knowledge of consumers with a high risk of falls, challenging behaviours, pressure injuries and infections, and were able to describe how they are prevented and managed.
* The service gathers and analyses clinical incidents data to identify and manage risks associated with the care of each consumer. Consumers considered ‘at risk’ are identified and strategies are implemented to mitigate risk, including infections, falls, skin tears, pressure injuries and challenging behaviours.

The provider did not respond to the Assessment Team’s report.

Based on the above evidence, I find the service compliant with Requirement (3)(b) in Standard 3 Personal care and clinical care.

### Requirement 3(3)(d) Compliant

*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.*

The service was found non-compliant with Requirement (3)(d) following a Site Audit conducted on 8 March 2021 to 10 March 2021, as the service did not demonstrate processes and procedures on clinical deterioration were always followed, which had resulted in delays in appropriate care and treatment. The service has since implemented a number of strategies to address deficits identified by the Assessment Team, which include the introduction of staff huddles, and changes to handover processes and handover templates.

At the Assessment Contact, the Assessment Team conducted interviews with staff, reviewed documentation and undertook observations, and was satisfied the service demonstrated 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. The Assessment Team provided the following evidence relevant to my finding:

* One staff confirmed huddles are undertaken daily to discuss changes in consumers’ behaviour or health status to ensure timely identification and response to deterioration.
* Staff described the process of reporting changes in consumers’ condition, including factors indicating the consumer is different from their usual self.
* For sampled consumers, documentation showed when changes to consumers’ cognitive or physical function occurred, it was investigated by clinical staff and escalated to a relevant health professional. Where appropriate, the consumer was transferred to hospital for further investigation.
* One representative was satisfied the service acted appropriately and promptly to their family member’s change in condition. Care planning documentation supported the representative’s view.

The provider did not respond to the Assessment Team’s report.

Based on the above evidence, I find the service compliant with Requirement (3)(d) in Standard 3 Personal care and clinical care.

# STANDARD 4 Services and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

The Assessment Team assessed Requirements (3)(a), (3)(b) and (3)(g) in this Standard at this Assessment Contact. As all other Requirements in this Standard were not assessed, an overall rating of the Standard has not been completed.

The purpose of the Assessment Contact was to assess the service’s performance in relation to Requirements (3)(a), (3)(b) and (3)(g) in this Standard. These Requirements were found non‑compliant following a Site Audit conducted on 8 March 2021 to 10 March 2021, where it was found the service had not demonstrated each consumer gets safe and effective services and supports for daily living that promotes their emotional, spiritual and psychological well-being, meets their needs, goals and preferences, and optimises their independence, health and well-being. It was also found the service did not demonstrate equipment was safe, suitable, clean and well maintained.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended the service meets Requirements (3)(a), (3)(b) and (3)(g) in this Standard.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and I find the service compliant with Requirements (3)(a), (3)(b) and (3)(g). I have provided reasons for my finding under the specific Requirements below.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Compliant

*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.*

The service was found non-compliant with Requirement (3)(a) following a Site Audit conducted on 8 March 2021 to 10 March 2021, as the service did not demonstrate each consumer gets safe and effective services and supports for their daily living. Specifically, activities were not provided to consumers despite informing staff about things of interest to them, and consumers were observed to be isolated and without engagement or stimulation. The service has since implemented a number of strategies to address deficits identified by the Assessment Team. For example:

* Lifestyle plans have been reviewed to capture and support consumers’ needs, goals and preferences.
* The lifestyle program has been reviewed to ensure it reflects consumers’ interests and preferences, individual activity stations have been set up throughout the service environment.
* Lifestyle staffing has been increased.

At the Assessment Contact, the Assessment Team conducted interviews with consumers, representatives and staff, reviewed documentation and undertook observations, and was satisfied the service demonstrated each consumer gets safe and effective services and supports for daily living that meets their needs, goals and preferences and optimises their independence, health, well-being and quality of life. The Assessment Team provided the following evidence relevant to my finding:

* All consumers and representatives interviewed confirmed consumers are supported and encouraged to attend wellness programs and lifestyle activities and provided examples of how consumers’ needs and preferences are supported.
* Staff demonstrated knowledge of consumers’ individual needs and described how they provide support to maintain consumers’ independence and ensure their well-being and quality of life is optimised. Staff provided examples of how lifestyle activities are tailored to consumers’ preferences individual needs.
* Care plans for sampled consumers detailed things of importance to them, and how they can be supported to achieve their goals and maintain independence.
* Consumers were observed enjoying and engaging in a group activity.

The provider did not respond to the Assessment Team’s report.

Based on the above evidence, I find the service compliant with Requirement (3)(a) in Standard 4 Services and supports for daily living.

### Requirement 4(3)(b) Compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

The service was found non-compliant with Requirement (3)(b) following a Site Audit conducted on 8 March 2021 to 10 March 2021, as the service did not demonstrate each consumer’s emotional, spiritual and psychological well-being was supported. The service has since implemented a number of strategies to address deficits identified by the Assessment Team. For example:

* Care plans for consumers named in the report following the Site Audit conducted on 8 March 2021 to 10 March 2021 were reviewed and updated to include information about services and supports to promote their emotional, spiritual and psychological well-being.
* Staff have been recruited across different disciplines to provide additional emotional support to consumers.

At the Assessment Contact, the Assessment Team conducted interviews with consumers, representatives and staff, and documentation, and was satisfied the service demonstrated services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. The Assessment Team provided the following evidence relevant to my finding:

* All consumers and representatives considered consumers’ emotional, spiritual and psychological well-being is adequately supported. Consumers provided examples of how staff support them when they feel sad or emotional, and how their spiritual needs are being met.
* Sampled care plans were individualised and included strategies to enhance consumers’ emotional, spiritual and psychological well‑being.
* Staff confirmed they refer to care plans to understand consumers’ needs, preferences and interests, and strategies to support and connect with them. Staff provided examples of how they support consumers’ emotional, spiritual and psychological well-being, including those who do not speak English.

The provider did not respond to the Assessment Team’s report.

Based on the above evidence, I find the service compliant with Requirement (3)(b) in Standard 4 Services and supports for daily living.

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

The service was found non-compliant with Requirement (3)(g) following a Site Audit conducted on 8 March 2021 to 10 March 2021, as the service did not demonstrate that suitable equipment is provided to meet the needs of all consumers. The service has since implemented a number of strategies to address deficits identified by the Assessment Team, which include purchasing a range of equipment to support consumers’ needs.

At the Assessment Contact, the Assessment Team conducted interviews with staff and was satisfied the service demonstrated equipment is safe, suitable, clean and well maintained. The Assessment Team provided the following evidence relevant to my finding:

* Management reported equipment had been purchased to ensure all consumers had the equipment to support their daily needs. Management also described the process for preventative and reactive maintenance of equipment.
* Staff confirmed they check equipment prior to use to ensure it is safe, clean and well-maintained, and demonstrated knowledge of the process for raising equipment maintenance requests.

The provider did not respond to the Assessment Team’s report.

Based on the above evidence, I find the service compliant with Requirement (3)(g) in Standard 4 Services and supports for daily living.

# STANDARD 5 Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

The Assessment Team assessed Requirement (3)(b) in this Standard at this Assessment Contact. As all other Requirements in this Standard were not assessed, an overall rating of the Standard has not been completed.

The purpose of the Assessment Contact was to assess the service’s performance in relation to Requirement (3)(b) in this Standard. This Requirement was found non‑compliant following a Site Audit conducted on 8 March 2021 to 10 March 2021, where it was found the service had not demonstrated the service environment is clean, well-maintained and comfortable, and enables consumers to move freely, both indoors and outdoors.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended the service meets Requirement (3)(b) in this Standard.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and I find the service compliant with Requirement (3)(b). I have provided reasons for my finding under the specific Requirement below.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

The service was found non-compliant with Requirement (3)(b) following a Site Audit conducted on 8 March 2021 to 10 March 2021, as the service did not demonstrate the service environment was clean and enabled consumers to move freely outdoors. Specifically, four sections of the environment were locked and restricted consumer access to garden areas, and a representative complained of malodour or urine and urine on the floor of a consumer’s room.

At the Assessment Contact, the Assessment Team undertook observations, conducted interviews with consumers, representatives and staff, and reviewed documentation, and was satisfied with the effectiveness of measures implemented in response to the previous non-compliance. The Assessment Team was also satisfied this evidence demonstrated the service environment is clean, well maintained and comfortable, and enables consumers to move freely, both indoors and outdoors. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and representatives interviewed confirmed the service has made improvements to the overall cleanliness and have access to all areas of the service environment.
* Management explained the preventative and reactive maintenance processes, including prioritisation of urgent requests.
* Documentation showed cleaning and preventative maintenance is regularly scheduled. While there were five outstanding maintenance issues at the time of the Assessment Contact, they were categorised as non-urgent.
* Cleaners were observed attending to consumers’ rooms, at a time that was in line with each consumer’s preferences.

The provider did not respond to the Assessment Team’s report.

Based on the above evidence, I find the service compliant with Requirement (3)(b) in Standard 5 Organisation’s service environment.

# 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 Requirements (3)(a), (3)(b), (3)(c) and (3)(d) in this Standard at this Assessment Contact. As all other Requirements in this Standard were not assessed, an overall rating of the Standard has not been completed.

The purpose of the Assessment Contact was to assess the service’s performance in relation to Requirements (3)(a), (3)(b), (3)(c) and (3)(d) in this Standard. These Requirements were found non‑compliant following a Site Audit conducted on 8 March 2021 to 10 March 2021, where it was found the service had not demonstrated the numbers and mix of staff were sufficient to ensure the delivery of quality care and services, the workforce was competent and had sufficient knowledge in relation to restrictive practices, pain assessment and wound identification and management, and staff performance was effectively monitored. As a result, sanctions were imposed.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended the service meets Requirements (3)(a), (3)(b), (3)(c) and (3)(d) in this Standard.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and I find the service compliant with Requirements (3)(a), (3)(b), (3)(c) and (3)(d). I have provided reasons for my finding under the specific Requirements 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 service was found non-compliant with Requirement (3)(a) following a Site Audit conducted on 8 March 2021 to 10 March 2021, as the service did not demonstrate there were sufficient staffing numbers to ensure quality and timely care is delivered to each consumer. The service has since implemented a number of strategies to address deficits identified by the Assessment Team. For example:

* Additional staff have been added to the roster and rostering processes have been reviewed to fill shits more efficiently.
* Staffing in one area of the service have been prioritised based on consumers’ needs and complexities in care.
* Staff across multiple disciplines have been recruited and the casual pool is being increased.
* Recruitment and orientation processes have been reviewed to expedite commencement and training of new staff.

At the Assessment Contact, the Assessment Team conducted interviews with consumers, representatives and staff, reviewed documentation and undertook observations, and 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:

* Consumers and representatives interviewed considered there were enough staff to provide quality care and services, and reported they have seen recent changes following the sanction, including an increase in staffing numbers, timely call bell response times and familiar staff in one area of the service.
* Staff reported positive changes to the number of staff rostered and described improvements that have been recently implemented, including planning the number and mix of staff based on consumer needs per area, increasing permanent staff numbers and assigning clear responsibilities to minimise risks to consumers.
* Call bell audit reports did not demonstrate any deficits in relation to call bell response times.
* The Assessment Team observed staff numbers appeared to be adequate in each area of the service throughout the Assessment Contact. During meal service, there were enough staff to assist consumers with their meals.

The provider did not respond to the Assessment Team’s report.

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

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

The service was found non-compliant with Requirement (3)(b) following a Site Audit conducted on 8 March 2021 to 10 March 2021, as the service did not demonstrate staff were kind and caring in their interactions with consumers. Representatives and consumers felt staff were often rushed when providing care to consumers and documentation demonstrated staff were not always respectful of each consumer’s identify, culture and diversity. The service has since implemented a number of strategies to address deficits identified by the Assessment Team. For example:

* Performance management processes have commenced for staff identified as treating consumers in a way that is not kind, caring and respectful.
* Behavioural expectations have been set out, and training sessions and huddles have been conducted with staff.
* Staffing numbers have increased to allow for more one on one time with consumers and ensure staff do not rush when providing care.
* A survey has been conducted, which demonstrated a 30% increase of responses stating that care is ‘above average’.

At the Assessment Contact, the Assessment Team conducted interviews with consumers, representatives and staff, and undertook observations, and was satisfied the service demonstrated the workforce interactions with consumers are kind, caring and respectful of each consumer’s identify, culture and diversity. The Assessment Team provided the following evidence relevant to my finding:

* All consumers and representatives interviewed reported staff treat consumers in a way that is kind and caring. While most consumers considered they are treated with respect, one consumer reported agency staff do not always knock on their door before entering their room.
* In addition to the abovementioned strategies implemented as a result of deficiencies identified at a previous Site Audit, management reported a monthly dance concert has been organised for all consumers in one area of the service with the aim to promote meaningful engagement between staff and consumers.
* Training records demonstrate culture and diversity training has been provided to all staff.
* Staff were observed interacting with consumers in a way that was kind, caring and respectful, including demonstrating patience and engaging positively.

The provider did not respond to the Assessment Team’s report.

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

### Requirement 7(3)(c) Compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

The service was found non-compliant with Requirement (3)(c) following a Site Audit conducted on 8 March 2021 to 10 March 2021, as the service did not demonstrate the service had systems in place to identify whether the workforce have the skills, qualifications and knowledge to undertake their role. It was identified that clinical staff were not competent in their knowledge surrounding the use of restrictive practices, and management and identification of pressure injuries, and further, did not demonstrate that pain assessments were completed in an accurate and timely manner. The service has since implemented a number of strategies to address deficits identified by the Assessment Team. For example:

* Training sessions have been provided to staff, including incident management systems, pressure injury classification, identification and management, pain and behaviour management and restrictive practices.
* A review of pain relief administration has been undertaken.
* Staff knowledge and competency has been reassessed and a comprehensive approach to promotion of skin integrity has been developed.
* The service is currently implementing a process to focus on staff on probation, including monitoring competency and knowledge.

At the Assessment Contact, the Assessment Team conducted interviews with staff and reviewed documentation, and was satisfied the service demonstrated the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. The Assessment Team provided the following evidence relevant to my finding:

* All staff interviewed confirmed they have received additional training in relation to the use of restrictive practices, dementia, behaviour management and pressure area care. Staff reported a reduction in the use of psychotropic medication and prevalence of pressure injuries since completion of the training.
* Staff reported restrictive practices are to be used as a last resort and there are a number of alternative strategies in place for each consumer prior to the administration of psychotropic medication. Staff considered the mandatory training gave them a greater insight into the types of non‑pharmacological strategies that can be prior to administering psychotropic medication.
* Documentation demonstrated staff across all disciplines have undertaken training in relation to best practice pressure injury care, behaviour management, pain charting and assessment, chemical restraint, pressure relieving devices and wound management.
* For consumers subject to restrictive practices, care planning documentation included non-restrictive strategies and demonstrated the restrictive practice was used as a last resort.

The provider did not respond to the Assessment Team’s report.

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

### Requirement 7(3)(d) Compliant

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

The service was found non-compliant with Requirement (3)(d) following a Site Audit conducted on 8 March 2021 to 10 March 2021, as the service did not demonstrate processes were in place to identify the need for and monitor the effectiveness of staff education in relation to minimisation of restraint, pressure area care, pain and personal care. The service has since implemented a number of measures to address deficits identified by the Assessment Team.

At the Assessment Contact, the Assessment Team conducted interviews with staff, and reviewed documentation, and was satisfied with the effectiveness of measures implemented in response to the previous non-compliance. The Assessment Team was also satisfied this evidence demonstrated the service’s workforce is competent and have the qualifications and knowledge to effectively perform their roles. The Assessment Team provided the following evidence relevant to my finding:

* Management provided the following feedback to the Assessment Team:
  + Staff knowledge in relation to promotion of skin integrity, minimisation of restraint and pressure injuries have been reassessed, and the results used to identify areas where further training is required.
  + Processes are now implemented to gain staff feedback on the adequacy of education sessions.
  + Incident management has been added to the agenda of all clinical meetings. Staff have received training on the service’s incident management system and competency is monitored by reviewing all incidents entered into the system.
  + Clinical indicator reports are reviewed to identify the need for additional staff training.
  + Higher volumes of staff have been engaged in the performance management process.
* Quick reference guides for restrictive practices and pressure injury management were observed in each nurse’s station.
* Documentation demonstrated education and training sessions provided to staff have been reviewed and processes have been implemented to provided training to staff where gaps in knowledge are identified.

The provider did not respond to the Assessment Team’s report.

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

# STANDARD 8 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 Requirements (3)(b), (3)(c), (3)(d) and (3)(e) in this Standard at this Assessment Contact. As all other Requirements in this Standard were not assessed, an overall rating of the Standard has not been completed.

The purpose of the Assessment Contact was to assess the service’s performance in relation to Requirements (3)(b), (3)(c), (3)(d) and (3)(e) in this Standard. These Requirements were found non‑compliant following a Site Audit conducted on 8 March 2021 to 10 March 2021, where it was found the service had not demonstrated its governing body was accountable and the workforce governance systems in place were effective to ensure safe and quality care was delivered to consumers. Additionally, the service did not demonstrate that all regulatory requirements were met, risk management systems were effective in managing high impact and high prevalence risks and the organisation’s clinical governance framework was effective in ensuring staff were working to minimise the use of restraint. As a result, sanctions were imposed.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended the service meets Requirements (3)(b), (3)(c), (3)(d) and (3)(e) in this Standard.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and I find the service compliant with Requirements (3)(b), (3)(c), (3)(d) and (3)(e). I have provided reasons for my finding under the specific Requirements below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(b) Compliant

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

The service was found non-compliant with Requirement (3)(b) following a Site Audit conducted on 8 March 2021 to 10 March 2021, as the service did not demonstrate the organisation’s governing body was accountable for the delivery of safe, inclusive and quality care and services. The service has since implemented a number of measures to address deficits identified by the Assessment Team.

At the Assessment Contact, the Assessment Team conducted interviews with management and was satisfied with the effectiveness of measures implemented in response to the previous non-compliance. The Assessment Team was also satisfied this evidence demonstrated the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. The Assessment Team provided the following evidence relevant to my finding:

* Management provided the following feedback to the Assessment Team:
  + Processes have been implemented to ensure clinical information, including the use of restrictive practices, is escalated upwards to the clinical governance committee and the board.
  + There is a focus on sharing information to learn about areas of concern across sites and site wide case studies have been incorporated in clinical review meetings. Outcomes of root cause analyses are also shared with staff via newsletters.
  + Restraint charting has commenced which allows the organisation to monitor restrictive practices and ensure they are being used in line with policies and procedures.
  + The wound care program has resulted in a positive increase in compliance with wound management best practice and procedures.
  + Policies and procedures have been reviewed and updated to ensure responsibilities and practices for informed consent in relation to the use of restrictive practices are understood by staff.
  + A consumer advisory group has been established, to provide feedback in relation to specific care and services where areas of improvement have been identified.

The provider did not respond to the Assessment Team’s report.

Based on the above evidence, I find the service compliant with Requirement (3)(b) in Standard 8 Organisational governance.

### Requirement 8(3)(c) Compliant

*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.*

The service was found non-compliant with Requirement (3)(c) following a Site Audit conducted on 8 March 2021 to 10 March 2021, as the service did not demonstrate workforce governance systems were effective in identifying the numbers and mix of staff were adequate to provide safe and quality care to consumers. Additionally, the service did not demonstrate its regulatory obligations are met in relation to minimisation of restraint.

At the Assessment Contact, the Assessment Team conducted interviews with staff and management, and reviewed documentation and was satisfied with the effectiveness of measures implemented in response to the previous non-compliance. The Assessment Team was also satisfied this evidence demonstrated organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance, and feedback and complaints are effective. The Assessment Team provided the following evidence relevant to my finding:

* In relation to information management, staff described where all policies and procedures are accessed. Management described the process for ensuring staff are aware of updates to policies and procedures, and provided an example of how relevant information is communicated to staff in a timely manner.
* Opportunities for continuous improvement are identified through feedback from consumers, representatives, staff and information obtained from internal and external audits. Management reported there is a plan for continuous improvement (PCI) at the organisational and service level, and they are working towards ensuring the organisational level PCI gets filtered down to the service.
* In relation to financial governance, management reported the Services Review Committee has budget oversight and receives budget reports every six weeks. Additionally, a capital expenditure budget is accessible for urgent matters.
* The service ensures staff understand their responsibilities and accountabilities through reviewing job descriptions with staff on employment and when they have been updated. The service has implemented processes and procedures to monitor staff performance and competencies.
* In relation to regulatory compliance:
  + The restrictive practices register demonstrates the number of restraints used has dramatically reduced. Documentation for sampled consumers showed their restrictive practices are reviewed every three months or as required, restrictive practices are monitored by staff and alternative strategies were put in place to help minimise the use of restrictive practices.
  + The SIRS register demonstrated reportable incidents were reported in line with legislative requirements.
  + The organisation has a governance team, which monitors changes to legislation and disseminates information to appropriate parties in a timely manner. The service is a member of a body that provides legal, government and corporate information.
* A register is maintained to monitor the progress of feedback and complaints from consumers, representatives and staff. Management reported this feedback is used to identify areas for continuous improvement and provided examples of when this has occurred. The service’s feedback and complaints, and open disclosure policies guide staff in the receipt, management and recording of feedback and complaints.

The provider did not respond to the Assessment Team’s report.

Based on the above evidence, I find the service compliant with Requirement (3)(c) in Standard 8 Organisational governance.

### Requirement 8(3)(d) Compliant

*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.*

The service was found non-compliant with Requirement (3)(d) following a Site Audit conducted on 8 March 2021 to 10 March 2021, as the service did not demonstrate risk management systems and practices for high impact and high prevalence risk was always used or undertaken effectively. Specifically, staff did not follow processes and procedures in relation to the management of restrictive practices, pain and pressure injury prevention and management.

At the Assessment Contact, the Assessment Team conducted interviews with staff and management, and reviewed documentation and was satisfied with the effectiveness of measures implemented in response to the previous non-compliance. The Assessment Team was also satisfied this evidence demonstrated risk management systems and practices were effective in managing high impact or high prevalence risk, identifying and responding to abuse and neglect of consumers, supporting consumers to live the best life they can and managing and preventing incidents. The Assessment Team provided the following evidence relevant to my finding:

* In relation to managing high impact or high prevalence risk:
  + The service has conducted a review of individual risks and associated interventions pertaining to each consumer to determine their effectiveness. A snapshot of consumer risks has been put together so staff can access this information quickly if needed.
  + The use of restraint has been closely monitored and has resulted in a reduction in physical restraint from 35 to five consumers. The number of consumers subject to chemical restraint has dramatically reduced and is being administered in line with legislative requirements.
  + The volume of pressure injuries has reduced from 23 to nine during the period of March 2021 to September 2021.
* All staff interviewed could provide examples of what would constitute elder abuse. The service’s policy guides staff on the identification, management and reporting of elder abuse. The incident management system demonstrated all allegations of elder abuse were reported in line with regulatory requirements.
* Management reported the service has a dignity of risk policy and template to guide staff in relation to dignity of risk and supporting consumers to live the best life they can. Staff use the customer choice agreement form to identify and discuss informed consent in relation to risks associated with consumers’ choices. Information from this agreement is transferred into the consumer’s care plan to inform staff that provide care to the consumer.
* An incident management system is in place to record and manage incidents, which demonstrated incidents were actioned in line with regulatory requirements. Training records demonstrate staff had been provided with training of the reporting and management of different types of incidents.

The provider did not respond to the Assessment Team’s report.

Based on the above evidence, I find the service compliant with Requirement (3)(d) in Standard 8 Organisational governance.

### Requirement 8(3)(e) 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 service was found non-compliant with Requirement (3)(e) following a Site Audit conducted on 8 March 2021 to 10 March 2021, as the service did not demonstrate it always used restrictive practices as a last resort.

At the Assessment Contact, the Assessment Team conducted interviews with staff and management, and reviewed documentation and was satisfied with the effectiveness of measures implemented in response to the previous non-compliance. The Assessment Team was also satisfied this evidence demonstrated an effective clinical governance framework is in place, including in relation to minimising the use of restraint. The Assessment Team provided the following evidence relevant to my finding:

* Restrictive practices, open disclosure and antimicrobial stewardship policies have been implemented and guide staff in the use, application and monitoring of restraint, management of complaints and feedback, and minimising the use of antibiotics.
* Staff interviews and training records demonstrate staff have received training in relation to minimisation of restraint and antimicrobial stewardship. Staff provided examples of how they minimise the use of restrictive practices.
* Documentation demonstrated chemical, physical and mechanical restraints are reviewed every three months.

The provider did not respond to the Assessment Team’s report.

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

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is, however, required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.