Bupa Ballina

Performance Report

148 North Creek Road
Ballina NSW 2478
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**Commission ID:** 0980

**Provider name:** Bupa Aged Care Australia Pty Ltd

**Site Audit date:** 1 February 2022 to 4 February 2022

**Date of Performance Report:** 7 April 2022

# Performance report prepared by

Dean Saunders, 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** | **Non-compliant** |
| Requirement 1(3)(a) | Non-compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Non-compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Non-compliant |
| **Standard 4 Services and supports for daily living** | **Non-compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Non-compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Non-compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Non-compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Non-compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Non-compliant |
| Requirement 6(3)(d) | Non-compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Non-compliant |
| Requirement 7(3)(d) | Non-compliant |
| Requirement 7(3)(e) | Non-compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | Non-compliant |

# Detailed assessment

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

The following information has been taken into account in developing this performance report:

* the Assessment team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 16 March 2022

# STANDARD 1 NON-COMPLIANTConsumer 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 sampled the experience of consumers, asking them about the requirements, reviewing their care planning documentation (for alignment with the feedback from consumers) and tested staff understanding and application of the requirements under this Standard. The Assessment team also examined relevant documentation and drew relevant information from other consumer interviews and the assessment of other Standards.

Overall, sampled consumers consider that they can maintain their identity, make informed choices about their care and services and live the life they choose.

Consumers/representatives said consumers are encouraged and supported to maintain their independence and are confident that staff know what is important to them.

Consumers described the ways their social connections are supported, both inside and outside of the service, and said their decisions about when and who are involved in discussions about their care and services is supported and respected by the service.

Consumers said the service supports them to exercise choice, including in relation to the way their care and services are delivered and taking risks to enable them to live the life they choose.

Consumers/representatives said the information provided to them is current, accurate and timely, and enables them to make informed decisions about the consumer’s care and services.

However, some consumers said they do not consistently feel respected by staff or that they are treated in a dignified manner. Also, most consumers said their cares and services are not consistently delivered in a way which respects their personal privacy, and they did not express confidence that their personal information is kept confidential.

The Quality Standard is assessed as Non-compliant as two of the six specific requirements have been assessed as Non-compliant.

## Assessment of Standard 1

### Requirement 1(3)(a) Non-compliant

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

The service was not able to demonstrate consumers are consistently treated with respect and dignity. Some sampled consumers described feeling disrespected and provided examples of how staff practices, such as rushing their care delivery, failing to deliver cares and services in accordance with their preferences, and how staff interacted with them, impacted their dignity. The Assessment team observed some staff treating consumers in a manner that did not demonstrate respect or consideration of consumers’ dignity.

A named consumer stated their preferences were not met, they were rushed during care delivery and spoken down to by staff.

A named consumer stated they were not showered in accordance with their preferences and that they felt conscious because of this.

Three consumers/representatives expressed concern and dissatisfaction about consumers being left in soiled continence aids for extended periods of time.

Staff confirmed that due to being understaffed on most shifts, they do not have the capacity to attend to consumers’ preferences for care in a timely manner, they often have to hurry and rush consumers, and they are not able to spend time with consumers to ensure they feel valued and respected.

The Assessment team observed consumers being referred to by their room number rather than by name and also observed staff yelling the status of consumer care progress in a manner not consistent with privacy.

In its response to the site audit report the Approved provider outlined a number of remedial actions in relation to the named consumers and of staff training generally. The Approved provider stated that its November 2021 consumer survey scores in relation to consumers being treated with respect is above the desired benchmark.

In light of the gravity of the site audit findings and the alignment of consumer/ representative feedback and staff feedback I find this requirement is Non-compliant.

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

*Care and services are culturally safe.*

### Requirement 1(3)(c) Compliant

*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.*

### Requirement 1(3)(d) Compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

### Requirement 1(3)(e) Compliant

*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.*

### Requirement 1(3)(f) Non-compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

The service was not able to demonstrate consumers’ privacy is respected and information is kept confidential. Consumers/representatives expressed dissatisfaction with the processes in place to protect and respect their privacy.

A named consumer explained they could outline other consumer’s care, services and medical conditions as they overhear staff discussing those matters loudly.

Three named consumers/representatives stated staff do not knock on doors before entering their rooms.

The Assessment team observed sensitive consumer information being loudly discussed by staff during shift handover and observed staff entering consumer rooms without knocking.

In its response to the site audit report the Approved provider stated it has responded to the site audit report and implemented a number of remedial actions, including education and spot checks.

As consumers’ privacy was not respected as outlined above I find this requirement Non-compliant.

# STANDARD 2 COMPLIANT 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 sampled the experience of consumers reviewing their care planning documents in detail, asking consumers about how they are involved in care planning, and interviewing staff about how they use care planning documents and review them on an ongoing basis.

Overall, sampled consumers consider they feel like partners in the ongoing assessment and planning of their care and services.

Consumers feel they, and those they wish to be involved, are included in the assessment and planning process.

Outcomes of assessment and planning are discussed with consumers, and they have access to their care and services plan if they wish.

Initial assessments are completed to identify each consumer’s needs, goals and preferences and any risks to consumers. Assessments include discussions of consumer’s advance care planning and end of life wishes. Care and services plans are reviewed on a three monthly basis or as each consumer’s needs change and the service has access to external services and allied health professionals as required to support consumer care.

The Quality Standard is assessed as Compliant as five of the five specific requirements have been assessed as Compliant.

## 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.*

### Requirement 2(3)(b) Compliant

*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.*

### Requirement 2(3)(c) Compliant

*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.*

### Requirement 2(3)(d) Compliant

*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.*

### 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.*

# STANDARD 3 NON-COMPLIANTPersonal 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 sampled the experience of consumers – their care plans and assessments were reviewed, and staff were asked about how they ensure the delivery of safe and effective care for consumers. The Assessment Team also examined relevant documents.

Most consumers/representatives sampled confirmed consumers receive the care they need and advised consumers have access to a medical officer and other health professionals when needed.

Review of sampled consumer clinical records demonstrates they receive appropriate personal and clinical care in relation to their end of life care needs, and when they have experienced a deterioration or change in their status. Timely and appropriate referrals have been made to medical officers, a range of allied health and other medical professionals.

For most sampled consumers, recommendations/directives made by medical officers and other health professionals are reflected in care and services plans.

Information regarding consumers’ needs and preferences is communicated and documented within the service and with others as required.

However, the service was not able to demonstrate clinical care delivery is best practice in relation to the management of restrictive practices and, for one consumer, management of their skin integrity. Staff did not demonstrate a shared understanding of the legislative requirements and organisational policies related to restrictive practices.

The service was not able to demonstrate effective management of high impact and high prevalence risks in relation to the monitoring of consumers who experience a fall and consumers who exhibit challenging behaviours.

The service was not able to demonstrate there are adequate infection control precautions in place to minimise infection related risks. Deficiencies identified by the Assessment team related to incorrect use of personal protective equipment by staff, ineffective screening processes for staff and visitors entering the service, and inadequate clearing of used crockery throughout the service.

The Quality Standard is assessed as Non-compliant as three of the seven specific requirements have been assessed as Non-compliant.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-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.*

On commencement of the audit the Approved provider was not able to supply accurate information regarding the number of consumers requiring restraint. In relation to restrictive practices and psychotropic medication usage, interviews with management, staff and consumers/representatives, and review of associated documentation (including sampled consumer files) identified that multiple consumers were subject to restrictive practice without requisite authorisations in place.

Review of restrictive practice authorisations for 19 sampled consumers who are subject to environmental and/or chemical restraint identified 15 consumers had out of date or incomplete restraint assessment and authorisation documentation, and do not have behaviour support plans in place which align with legislative requirements. The site audit report identifies a number of deficiencies in respect of named consumers.

In relation to skin integrity one named consumer assessed as requiring repositioning every two to fours hours was observed for extended periods without repositioning. The consumer was not assisted from bed until 11:30am daily due to staff shortages. The consumer was observed to be sitting in a wheelchair for extended periods of time. The consumer advised they were consistently not repositioned in accordance with their assessed need and had consequently suffered a pressure injury in February 2022.

In its response to the site audit report the Approved provider apologised for the supply of incorrect information and outlined a number of remedial actions taken in response to the audit findings.

In light of the extent of restrictive practice related deficiencies I find this requirement Non-compliant.

### Requirement 3(3)(b) Non-compliant

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

The service was not able to demonstrate effective management of high impact or prevalence risks in relation to assessment and management of consumers who experience a fall and consumers who exhibit challenging behaviours.

Staff are not consistently monitoring consumers’ physical and neurological observations in line with organisational policy when a consumer experiences a fall.

For two consumers who exhibit challenging behaviours, staff are not monitoring and recording behaviours, following behavioural support plan directives, and staff were observed on two occasions to not provide assistance to one consumer who was exhibiting challenging behaviours.

A named consumer undertook review by an external dementia specialist in November 2021. A number of recommendations were made. The recommendations however were not reflected in the consumer’s behaviour support plan. Management advised the Assessment team that despite this, staff would understand what the consumer’s individualised behaviour management strategies would be. When asked by the Assessment team care staff could not identify any of the individualised strategies recommended for the consumer.

Staff interviews disclosed that staff could describe the most significant clinical and personal care risks for the consumers sampled; however, did not consistently demonstrate knowledge of how those risks are managed or mitigated. A care staff member described how a named consumer could have verbal ‘outbursts’ identified strategies to deal with this however was not aware of how this information could be included in a behaviour support plan. A registered nurse interviewed described the follow up care provided to consumers who experience a fall, however, the monitoring of physical and neurological observations they would undertake did not align with organisational policy.

The service has policies reviewed at an organisational level to guide staff in delivering care related to high impact and high prevalence risks for consumers, including a ‘Falls Prevention and Management’ policy which outlines the processes for completion of consumer observations following a fall. Whilst staff confirmed they have access to and have read these policies, review of care planning documentation does not demonstrate the policies are consistently being followed.

In its response to the site audit report the Approved provider advises it has addressed the specific deficits identified for names consumers and undertaken education as a remedial practice.

For the reason identified by the Assessment team I find this requirement Non-compliant.

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

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

### 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.*

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

*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.*

### Requirement 3(3)(f) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 3(3)(g) Non-compliant

*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.*

Whilst the service has an outbreak management plan and an IPC Lead, the service was not able to demonstrate there are adequate infection control precautions in place to minimise infection related risks. Deficiencies identified by the Assessment team related to incorrect use of PPE by staff, ineffective screening processes for staff and visitors entering the service, and inadequate clearing of used crockery throughout the service.

The Assessment team observed their screening on entry to the service to be deficient. The staff member conducting the tests did not use PPE appropriately and did not use the RAT tests in accordance with the instructions. The staff member had not received training on the correct use of the RAT. The Assessment team observed several visitors and staff entering the service without undertaking temperature screening, wearing required PPE and/or completing a RAT.

The Assessment team observed multiple staff to not be wearing face masks correctly.

The Assessment team observed used tableware (specifically cups) left throughout various areas of the service, including resting on handrails, hand washing basins, on entry to the service where RATs were being conducted, and on the counter of nurses’ workstations.

In its response to the site audit report the Approved provider advised that it was responding to the identified deficiencies by responsive education and monitoring processes.

For the reasons identified by the Assessment team I find this requirement Non-compliant.

# STANDARD 4 NON-COMPLIANTServices 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

At audit the Assessment team sampled the experience of consumers, observations were made, consumers were asked about the things they like to do and how these things are enabled or supported by the service and staff were asked about their understanding and application of the requirements. The Assessment team also examined relevant documents.

Overall, sampled consumers consider they receive the services and supports for daily living that are important for their health and well-being and that enable them to do the things they want to do.

Consumers/representatives said they were supported to engage in activities they are interested in, both inside the service and in the wider community.

Consumers said the service supports and facilitates them to maintain personal and social relationships and remain in contact with people who are important to them.

Most consumers/representatives said the lifestyle program is adequate to meet the consumers’ needs and preferences, and that the service involves other individuals and external organisations to supplement the activity schedules as required or when beneficial to the consumer.

Consumers said the service meets their emotional, social, spiritual and psychological needs by way of the internal support provided by staff, other consumers, and volunteer workers.

Care planning documentation demonstrates each consumer’s condition, needs and preferences are effectively communicated within the organisation and with others who provide services and supports for daily living, and timely and appropriate referrals are made to other providers of care and services as required.

The Assessment team observed lifestyle and leisure supports and equipment to be clean, well-maintained, safe and suitable to the needs of the consumer cohort.

Most consumers/representative provided negative feedback in relation to the food and meal service. Specifically, consumers/representatives said the meals do not consistently align with the consumers’ preferences or dietary requirements. The Assessment team identified food items in the main kitchen which were expired and still in use by kitchen staff.

The Quality Standard is assessed as Non-compliant as one of the seven specific requirements have been assessed as Non-compliant.

## Assessment of Standard 4

### 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.*

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

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

### Requirement 4(3)(c) Compliant

*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.*

### Requirement 4(3)(d) Compliant

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 4(3)(e) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 4(3)(f) Non-compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

The service was not able to demonstrate that meals provided are varied and of suitable quality. Information obtained through interviews with consumers/representatives and staff identified dissatisfaction with the quality of meals and the way in which consumers requests and preferences are not respected and adhered to.

A named consumer requiring a lactose free and gluten free diet was provided with foods containing lactose and gluten.

A named consumer’s representative brings food to the service for the consumer as the meals provided were considered by the consumer to be bland and tasteless.

Four consumers had raised complaints regarding the quality of meals.

Whilst kitchen staff generally could explain specific dietary needs and preferences for sampled consumers, and how these should be accommodated, management advised this cannot consistently occur due to staffing shortages in the kitchen. The service is aware there is often insufficient kitchen staff and there complaints and feedback received from consumer/representatives as a result of this. There is currently a recruitment drive underway, and management is of the view that additional kitchen staff will resolve consumers’/representatives’ concerns.

In its response to the site audit report the Approved provider acknowledged the dissatisfaction of some residents and outlined a range of improvements aimed at lifting the dining experience, food preferences and menu options. Specific surveys on meals have commenced and will continue.

I find this requirement Non-compliant as there are a number of consumers identifying concerns with quality of meals and staff shortages are acknowledged as impacting on the ability to meet consumer needs and preferences.

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

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

# STANDARD 5 NON-COMPLIANTOrganisation’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 observed the service environment, spoke with consumers about their experience of the service environment and interviewed care staff about the suitability and safety of equipment. The Assessment team also examined relevant documents.

Overall, sampled consumers consider they belong in the service, and feel safe and comfortable in the service environment.

Consumers confirmed they feel safe living at the service and they can access indoor and outdoor areas, should they choose to do so.

Consumers/representatives sampled reported the service environment, equipment and furniture is well-maintained.

Consumers/representatives confirmed visitors are welcome in the service and they have various areas where they can sit comfortably and enjoy each other’s company.

The Assessment team observed furniture and equipment to be clean, well-maintained and suitable to the needs of the consumer cohort.

Staff interviewed demonstrated an awareness of how to report items requiring maintenance. Documentation identified reactive maintenance is attended to in a timely manner and preventative maintenance is undertaken as scheduled.

However, most consumers/representatives sampled said the service environment, particularly consumer rooms and bathrooms, are not cleaned to their satisfaction. As a result, consumers are cleaning their own toilets as this is not being completed regularly by cleaning staff. This feedback was confirmed by way of observations made by the Assessment team.

The Quality Standard is assessed as Non-compliant as one of the three specific requirements have been assessed as Non-compliant.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Non-compliant

*The service environment:*

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

Whilst the service was able to demonstrate the environment is designed to enable consumers to move freely both indoors and outdoors, they were not able to adequately demonstrate the service environment is safe, clean and well maintained.

The Assessment team observed consumer rooms and bathrooms to be unclean and dusty. A number of toilet assistive devices, such as over-toilet seats, and toilets were observed to be unclean. Most floors of consumer rooms were sticky, dirty and marked.

Several consumers/representatives raised concerns about the cleanliness of their rooms and the service environment more generally. Whilst these consumers/ representatives acknowledged cleaning staff “do the best they can”, the consumers/ representatives are required to clean their own bathrooms and toilets as it is not regularly completed by cleaning staff.

Cleaning staff said whilst they endeavour to clean all consumer rooms and the service environment in accordance with the service’s cleaning schedule and consumer preferences, it is not possible to complete all cleaning duties as a result of insufficient cleaning staff. As a result, the cleaning of consumer rooms and bathrooms is often missed and/or not completed to a high standard.

The Approved provider in its response to the site audit report explained that further contract cleaning staff will be employed and that care staff will be redirected in the interim to raise cleanliness standards.

I find this requirement Non-complaint, for the reasons identified by the site audit report. The service environment was not found to be clean.

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 NON-COMPLIANTFeedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

The Assessment team sampled the experience of consumers asking them about how they raise complaints and the organisation’s response. The Assessment team also examined the complaints register, complaints trend analysis and tested staff understanding and application of the requirements under this Standard.

Overall, sampled consumers/representatives consider they are encouraged and supported to give feedback and make complaints, and demonstrated an awareness of the internal and external avenues available for them to do so.

However, most sampled consumers/representatives said they do not consider that appropriate or timely action is taken in response to feedback or complaints, nor that their feedback is consistently used to improve the quality of care and services.

Consumers/representatives who have recently made a complaint or provided feedback expressed dissatisfaction with the significant delay in the resolution of their complaint and the lack of communication from management regarding actions taken by the service.

Consumers/representatives could not provide examples of improvements or changes made at the service following the provision of feedback and complaints.

Through interviews with management and staff, and review of relevant policies, procedures and complaints-related documentation, the Assessment team identified:

Complaints, feedback and suggestions made by consumers/representatives are not consistently documented, investigated and resolved in a timely manner or, on occasion, at all. This includes complaints, feedback and suggestions made by individual consumers/representatives through the use of internal complaints processes and concerns raised at consumer/representative meetings.

Complaints, feedback and suggestions are not used to continually improve care and services. The service’s process for continuous improvement does not reflect improvement actions following receipt of consumer/representative feedback, complaints and suggestions.

Whilst management and staff demonstrated a shared understanding of the principles of open disclosure, review of relevant documentation and interviews with consumers/representative do not demonstrate an open disclosure is consistently applied when required nor in accordance with organisational policy.

The Quality Standard is assessed as Non-compliant as two of the four specific requirements have been assessed as Non-compliant.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

### Requirement 6(3)(c) Non-compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

The service was not able to demonstrate appropriate and timely action is consistently taken in response to consumer feedback or complaints, nor that an open disclosure process is consistently applied following the making of complaint.

Most consumers/representatives sampled expressed dissatisfaction with how the service has managed complaints and concerns they have raised. Consumers/ representatives said the service does not endeavour to address or resolve their concerns in a timely manner, and management and staff do not always provide an apology, communicate with them regarding the issues or involve them in the resolution process. Four consumers interviewed said the same issues are consistently raised each month at the meetings (particularly in relation to meals, the cleanliness of the service environment, and the insufficiency and professionalism of staff), and the service does not act to resolve these issues nor provide an explanation for why no action has been taken

Management was able to describe the process followed when feedback or a complaint is received, including documenting details of the complaint, feedback or suggestion in the service’s electronic complaint management system, investigating and resolving the complaint within seven days, and applying an open disclosure process to ensure the complainant’s satisfaction. However, review of the complaints register and process for continuous improvement documentation identifies the service does not consistently document complaints and feedback, implement actions in a timely manner, nor engage in ongoing communication or follow up with the complainant/s to ensure their satisfaction. Staff across various roles expressed frustration in having to provide ongoing reassurance to consumers/representatives as a result of the delay in receiving a response or communication regarding actions taken from management.

At audit management was not able to provide an explanation for why the actions outlined above had not occurred in a timely manner following the initial concerns and complaints being brought to management’s attention.

In its response to the site audit report the Approved provider expressed regret in relation to the experience of consumers, undertook to investigate the complaint management process generally and take specific remedial action in relation to particular complaints raised by consumers interviewed by the Assessment team.

I find this requirement Non-compliant for the reasons identified in the site audit report. The report identified strong evidence that complaints were not being responded to with appropriate action.

### Requirement 6(3)(d) Non-compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

The service was not able to demonstrate feedback and complaints made by consumers/representatives are consistently reviewed and used to improve the quality of care and services.

Whilst consumers/representatives sampled said they feel supported to make feedback and complaints, they do not believe feedback and complaints are used to improve the quality of care and services provided to consumers. Two named consumers gave examples of complaints that were not acted upon to improve the quality of care and services.

Management could not demonstrate effective actions have been taken to resolve concerns raised by consumers (including the ongoing concerns raised at consumer/representative meetings), or to implement suggestions to improve the quality of care and services. Whilst management advised the service trends and analyses feedback and complaints on a monthly basis, they acknowledged that in circumstances where feedback and complaints are not consistently being recorded, the analysis processes are ineffective and prevent the service from initiating and evaluating continuous improvement actions.

A review of the complaints register and continuous improvement process showed the complaints register not include information evidencing how feedback and complaints is consistently used to improve the quality of care and services, or that improvement actions are evaluated for effectiveness. The ongoing concerns raised by consumers/representatives during meetings and individual complaints, feedback and suggestions are not reflected in the complaints register. Whilst a continuous improvement action was implemented in November 2021 to address complaints about meals the service has not considered the effectiveness of this improvement action in circumstances where complaints in relation to food are continuing to be received.

Management updated the complaints register and process for continuous improvement processes whilst the Assessment team was on site.

In its response to the site audit report the Approved provider stated that education for all staff on complaint management has been revitalised and that a pilot engagement and feedback program is being implemented.

I find this requirement Non-compliant for the reasons identified in the site audit report: the report identified that complaints were not being reviewed and used to improve quality and care.

# STANDARD 7 NON-COMPLIANTHuman 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 spoke with consumers about their experience of the staff, interviewed staff, and reviewed a range of records including staff rosters, training records and performance reviews.

Overall, sampled consumers/representatives consider they receive care and services from staff who are knowledgeable, capable and caring. However, most sampled consumers/representatives said there is insufficient staff to deliver timely care and services that align with their preferences and care and services plans.

During the Site Audit, most interactions between management, staff and consumers/representatives were observed to demonstrate a kind and caring approach to care and service delivery.

Not all members of the workforce were able to demonstrate competency and knowledge in relation to key areas of their roles and responsibilities. Deficiencies were identified in relation to the requirements for the use of restrictive practices, managing high impact and high prevalence risks, and infection control practices.

Processes to monitor and ensure the completion of mandatory training are ineffective. Several staff members have not completed, or are overdue in completing, training modules and competency assessments deemed mandatory by the organisation. Newly recruited staff and agency staff interviewed said they have not received adequate training or support to effectively perform their roles.

Staff performance is not regularly being assessed, monitored or reviewed, including through probationary and performance appraisal processes. Most staff confirmed they have not been involved in a performance appraisal (either following probation or annually thereafter) within the last 12 months.

The Quality Standard is assessed as Non-compliant as four of the five specific requirements have been assessed as Non-compliant.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Non-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 not able to demonstrate the workforce is planned nor adequate in number to enable the delivery and management of safe and quality care. Consumers/representatives sampled said there is insufficient staff to provide cares in accordance with their preferences and in a timely manner, to afford them with dignity and to maintain a clean service environment. Feedback received from consumers/representatives was corroborated by staff interviewed.

Interviewed consumers stated there were insufficient staff which led to slow delivery of hygiene cares, particularly that consumers are not assisted with regular showers in accordance with their hygiene needs and preferences. Some consumers stated they were showered every three days instead of their preference for daily showers. A number of consumers stated their toileting needs were not assisted in a timely way leaving them in a soiled state for extended periods of time.

Most staff interviewed expressed concerns regarding staffing levels at the service and said they do not consistently have sufficient time to undertake their allocated roles and responsibilities. Staff confirmed consumers are not consistently receiving hygiene care, assistance in mobilising throughout the service and to lifestyle activities in line with their preferences.

Cleaning staff said there is often at least one unfilled shift across the service each day which prevents cleaning staff from ensuring the service environment and consumer rooms (including bathrooms) are cleaned in accordance with the cleaning schedule and to a high standard.

Kitchen staff said as a result of there often being unfilled kitchen staff shifts, staff are not able to consistently prepare or provide meals that align with consumers’ preferences.

Interviews with management confirmed the service has identified the need to recruit more staff for the purpose of ensuring safe and effective care delivery for the current and future consumer cohort, to fill unplanned leave and vacant shifts as they arise, and to support the workforce.

In its response to the site audit report the Approved provider explained that it has experienced high staff turnover and faces challenges in attracting candidates. The provider has implemented a recruitment and workforce strategy to respond to the matters raised in the site audit report.

I find this requirement Non-compliant for the reasons identified in the site audit report: the report identified that the number of members deployed in the workforce is insufficient to ensure the delivery of safe and quality care.

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

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

### Requirement 7(3)(c) Non-compliant

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

The service was not able to demonstrate all members of the workforce are competent and have the required knowledge to effectively perform their roles. Processes in place to assess and monitor staff competencies are not consistently or effectively occurring, particularly in relation to infection control practices and restrictive practices.

Two named consumers stated that agency staff are not aware of their care needs and preferences.

Interviews with recently recruited staff and agency staff disclosed that they do not believe they have the knowledge to effectively perform their roles. A number of staff, including registered staff and agency staff, advised that online learning modules are not all mandatory and that their shifts commenced before completing these.

Staff interviewed did not demonstrate a shared understanding of key topics relevant to their roles; for example, the requirements for the use of restrictive practices nor of the recent legislative changes, and the Quality Standards more generally. Interviews with staff, management and review of education records demonstrates previous training delivered on these topics have not been mandatory and have had low attendance.

A review of the service’s skill matrix demonstrates staff have not completed mandatory competency assessments within the last 12 months and/or since their commencement with the service.

Interviews with management confirmed that monitoring of processes of staff training were ineffective and that remedial actions would be taken.

The Approved provider in its response to the site audit report stated all registered nurse staff have been registered to undertake training in a range of clinical and regulatory areas.

I find this requirement Non-compliant as both some consumers and some staff have reported that staff do not have knowledge to effectively perform their roles. This is consistent with mandatory training not having been undertaken.

### Requirement 7(3)(d) Non-compliant

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

The service was not able to demonstrate all members of the workforce have received training and support to safely and effectively deliver the outcomes required by the Quality Standards, particularly in circumstances where several mandatory training modules and competency assessments are overdue and have not been completed by relevant staff.

Most consumers/representatives sampled expressed confidence in the abilities of the staff delivering their care and services and could not provide examples of areas in which staff may require additional training. However, two named consumers said most agency staff do not know the consumers or their care needs and preferences.

Several staff across various roles said they have not completed and/or received training deemed mandatory by the organisation and to effectively undertake their roles. Five care and registered staff, whose employment at the service ranges from less than six months to in excess of three years, said they have not completed all required training modules and competency assessments despite being informed they are mandatory. Staff confirmed they receive formal communication from management when a mandatory online training module becomes overdue. However, staff said they can ignore this communication for an extended period of time (that is, in excess of several months) before they receive a warning of removal from the roster.

Three staff who have been employed at the service for less than six months described the orientation and onboarding process as confusing, difficult to navigate and that it did not prepare them for the role and what is required of them.

Review of the skills matrix (the register to monitor completion of competency assessments) identified high percentages of staff have not completed the initial and/or annual competency assessments.

Management when interviewed advised the service will revise its orientation and onboarding process whereby newly recruited staff will provide evidence of completed competency assessments on the first day of orientation and will thereafter be assigned four buddy shifts. Management is of the view that increased structure and monitoring of these processes will ensure newly recruited staff are adequately guided, trained and supported through their initial phase of employment.

In its response to the site audit report the Approved provider outlined that monitoring of mandatory training would increase, an education calendar will be introduced, and onboarding and recruitment processes will be improved.

I find this requirement Non-compliant as deficiencies in training and support have been identified at audit and this impacts on the delivery of outcomes required by the Quality Standards. I note the remedial actions taken by the Approved provider however until the effect of these have been tested I am not dissuaded from the view of non-compliance.

### Requirement 7(3)(e) Non-compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

The service was not able to demonstrate the performance of each member of the workforce is regularly assessed, monitored and reviewed in accordance with organisational policy. Interviews with staff demonstrated most staff have not been involved in a performance appraisal within the last 12 months, and for some staff since their commencement at the service.

Management advised organisational policy and expectation requires all staff to undergo a formal performance appraisal at the conclusion of their probationary period (which is six months) and annually thereafter. The performance appraisal process involves staff engaging in a self-assessment, management evaluating their performance, and devising a plan to address and support any training and development the staff member may need to further their skills and knowledge. However, management advised that as a result of inadequate monitoring of the performance appraisal process and competing priorities (specifically resulting from the COVID-19 pandemic), performance appraisals have not been completed for the majority of staff at the service.

Most staff confirmed they have not been involved in a performance appraisal within the last 12 months and/or since the conclusion of their probationary period, nor has their performance been discussed in other informal settings.

In its response to the site audit report the Approved provider acknowledged the deficiencies identified above. Remedial actions commenced include a competency tracking and mandatory training protocol as well as other initiatives.

I find this requirement Non-compliant as review, assessment and monitoring of workforce effectiveness is not undertake regularly.

# STANDARD 8 NON-COMPLIANTOrganisational 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

At audit the Assessment team spoke with management and staff and reviewed relevant systems and processes relating to the organisational governance underpinning the delivery of care and services.

Overall, consumers/representatives consider that the organisation is well run and they can partner in improving the care and services the consumers receive.

Consumers/representatives sampled said they can choose to be involved in the development and evaluation of the care and services the consumers receive, such as through their participation in meetings, consumer experience surveys, and by utilising complaints and feedback avenues.

The governing body sets the strategic priorities and expectations for the organisation and meets regularly to identify and review risks at an organisational and service level. The governing body monitors and evaluates how the service performs against the Quality Standards through monitoring and reporting processes, and promotes a culture of safe, inclusive and quality care and services through its leadership and directions set for the organisation.

The organisation has implemented risk and incident management systems and practices to support the service in identifying, reporting, preventing and managing risks to the health, safety and well-being of consumers and incidents, including incidents that are reported in accordance with legislation and the SIRS.

Whilst the service and its workforce are guided by a suite of frameworks, policies and procedures, the organisation’s governance systems do not effectively support or ensure the service’s compliance and understanding of these documents. Specifically, the organisation was unable to demonstrate that overarching governance and oversight occurs in relation to continuous improvement, workforce governance, regulatory compliance, and feedback and complaints.

The organisation has not ensured that effective and consistent clinical oversight at a service level is occurring in accordance with the organisation’s clinical governance framework, specifically in relation to minimising the use of restrictive practices.

The Quality Standard is assessed as Non-compliant as two of the five specific requirements have been assessed as Non-compliant.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

### 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.*

### Requirement 8(3)(c) Non-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 not able to demonstrate there are effective organisation wide governance systems in place as deficiencies were identified in relation to continuous improvement, workforce governance, regulatory compliance, and feedback and complaints. Information management and financial governance systems are sound

**Continuous improvement**

At audit service management advised the governing body receives various information and consolidated reports from governance committees on a monthly basis which outlines information relating to the service’s internal and external audit results, consumer/representative and staff feedback and complaints, process for continuous improvement and corrective action plan initiatives, reported hazards and risks, and clinical and incident data analysis. The governing body uses this information to identify the service’s compliance with the Quality Standards and to initiate improvement actions to enhance performance. However, as the service is not accurately documenting feedback and complaints and clinical data (primarily data relating to the use of restrictive practices, as considered further under Requirements 3(3)(a) and 8(3)(e)), the governing body cannot be assured of the accuracy of the information received and the service’s compliance.

The Assessment team identified that complaints, feedback and suggestions made by consumers/representatives are not consistently used to inform continuous improvement actions, nor are reflected in the service’s process for continuous improvement. These include complaints, feedback and suggestions raised through individual avenues and in group settings, such as through consumer/representative meetings. This is considered further under Requirement 6(3)(d).

In response to the findings the Approved provider, in its response to the site audit report, explained that it was developing a process for continuous improvement to address the concerns of consumers, representatives and the matters identified by the Assessment team.

**Workforce governance, including the assignment of clear responsibilities and accountabilities**

Whilst the organisation has various documented policies and procedures relating to human resources, these are not consistently or effectively being applied or monitored at a service and organisational level. As identified above under Standard seven, the workforce is not sufficient to ensure the care needs of consumers are met in a timely manner and in accordance with their preferences and care and services plans. Not all members of the workforce are competent nor have the knowledge to effectively perform their roles. Staff are not consistently being trained, supported or equipped to deliver the outcomes required by the Quality Standards. Staff performance is not regularly being assessed, monitored or reviewed, including through probationary and performance appraisal processes.

These matters collectively demonstrate that workforce governance is not effective

In its response to the site audit report the Approved provider undertook to introduce workforce governance measures aimed at addressing the matters identified here.

**Regulatory compliance**

Staff did not demonstrate a shared understanding of the legislative requirements regarding the categorisation, management, use and monitoring of restrictive practices, including the legislative changes which came into effect on 1 July 2021 and 1 September 2021.

The systems in place to monitor the use of restrictive practices at the service (including a psychotropic register and BSP tracker) are ineffective for the following reasons. The information outlined in the documents are inaccurate and not reflective of the restrictive practices used at the service. For example, one consumer who is prescribed a psychotropic medication and is subject to chemical restraint has not been included on the psychotropic register. The systems have not been effective in identifying staff knowledge deficiencies in relation to restrictive practices.

Review of sampled consumers’ care planning documentation and documentation to monitor the use of restrictive practices at the service identified several consumers who are subject to environmental and/or chemical restrictive practices do not have current assessment, consent and authorisation documentation which complies with legislative requirements.

The evidence above has been considered further under Requirements 3(3)(a) and 8(3)(e).

**Feedback and complaints**

At audit management advised the regional manager and organisational committees monitor the feedback and complaints and resolution processes at the service through access to the electronic complaints management system. However, in circumstances where the service is failing to consistently document feedback and complaints received from consumer/representatives, these monitoring processes are ineffective.

The service was not able to demonstrate systems and processes are in place to ensure appropriate and timely action is consistently taken, an open disclosure process is applied, and improvements are initiated at the service as a result of consumer/representative feedback. These matters are addressed in more detail in Standard 6.

### 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.*

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

*Where clinical care is provided—a clinical governance framework, including but not limited to the following:*

1. *antimicrobial stewardship;*
2. *minimising the use of restraint;*
3. *open disclosure.*

At audit the service provided:

* a documented clinical governance framework which outlines the core elements of effective clinical governance;
* a policy relating to minimising the use of restrictive practices;
* a policy relating to antimicrobial stewardship; and
* an open disclosure policy

Staff were asked whether these policies had been discussed with them and what they meant for them in a practical way. Despite education and attendance records demonstrating most staff have not received education in relation to these policies, staff were largely able to provide examples of the relevance of the policies to their work.

**Clinical oversight**

Staff and management were able to describe their accountabilities and responsibilities for the effectiveness, safety and quality of clinical services relevant to their role, noting the clinical care manager provides the overarching clinical oversight at the service.

The clinical care manager was able to explain the monitoring processes and systems in place to ensure staff’s compliance with organisational policies and procedures that guide clinical practices. However, these clinical monitoring processes and systems have not been effective as they have failed to identify the deficiencies brought forward by the Assessment team. These deficiencies were considered further under Requirements 3(3)(a), 3(3)(b), 3(3)(g) and 7(3)(c).

**Infection control**

Staff were able to describe strategies to minimise the risk of infections, such as ensuring strict adherence to hand hygiene practices, appropriate donning and doffing of PPE, identifying and escalating PPE breaches, and timely identification of infection-related symptoms. However, during the Site Audit, the Assessment team observed several staff, across all areas of the service, not appropriately donning PPE nor were senior staff and management personnel addressing these breaches to prevent recurrence. This was considered further under Requirement 3(3)(g).

**Restraint**

Staff did not demonstrate a shared understanding of the requirements for the use of restrictive practices nor of the recent legislative changes. All staff, except for three registered nurses, said they have not received education on restrictive practices. This was evident through review of staff education and attendance records.

Despite the organisation having updated the policies and procedures relevant to restrictive practices to reflect recent legislative changes, review of sampled consumers’ care planning documentation identified the management, monitoring and use of restrictive practices is not consistently best practice and does not meet legislative requirements.

The clinical care manager advised the service maintains a psychotropic register and BSP tracker to monitor the use of restrictive practices at the service. However, review of these documents identified out of date and inaccurate information relating to consumers subject to restrictive practices.

On the final day of the Site Audit, and following feedback received from the Assessment team regarding the inconsistencies and deficiencies in restrictive practices documentation, management advised they were not able to provide current and accurate information in relation to the use of restrictive practices and completion of behavioural support plans at the service. This is considered further under Requirement 3(3)(a).

In its response to the site audit report the Approved provider advised that a second clinical care manager has been employed and that further organisational supports have been put in place to address the deficiencies identified.

The deficiencies identified above demonstrate that whilst a clinical governance framework exists it is not effective across all areas of governance. For this reason, I find this requirement Non-compliant.

# 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 1(3)(a)
* Requirement 1(3)(f)
* Requirement 3(3)(a)
* Requirement 3(3)(b)
* Requirement 3(3)(g)
* Requirement 4(3)(f)
* Requirement 5(3)(b)
* Requirement 6(3)(c)
* Requirement 6(3)(d)
* Requirement 7(3)(a)
* Requirement 7(3)(c)
* Requirement 7(3)(d)
* Requirement 7(3)(e)
* Requirement 8(3)(c)
* Requirement 8(3)(e)