Performance

Report

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| Name of service: | Baptistcare Bethel |
| Service address: | 2 Bethel Way ALBANY WA 6330 |
| Commission ID: | 7206 |
| Approved provider: | Baptistcare WA Limited |
| Activity type: | Site Audit |
| Activity date: | 21 February 2023 to 23 February 2023 |
| Performance report date: | 21 April 2023 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Baptistcare Bethel (**the service**) has been prepared by T Wilson, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Site Audit; the Site Audit report was informed by site assessment, observations at the service, review of documents, and interviews with staff, consumers/representatives and others;
* the provider’s response to the assessment team’s report received 27 March 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

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

# Areas for improvement

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

**Standard 2 Requirements (3)(a) and (3)(b)**

* Assessments and charting are completed and used to effectively inform care plans to ensure the delivery of safe and effective care.
* Care plans contain current and relevant information and planning is undertaken for advance care planning and end of life care.

**Standard 3 Requirements (3)(a), (3)(b), (3)(e) and (3)(g)**

* Policies are followed to provide best practice care for consumers, particularly in relation to neurological observations.
* Effective management of high prevalence high impact risks for consumers, particularly in relation to medication management.
* Staff have the information required to provide safe and effective care for consumers.
* Outbreaks are managed in line with organisational policies and government procedures.

**Standard 6 Requirement (3)(b), (3)(c) and (3)(d)**

* External complaint mechanism and advocacy information are known and understood by consumers and representatives.
* Record actions and monitor complaints and incidents in line with the service’s policy to ensure satisfaction.
* Use consumer, representative and staff feedback for continuous improvement.

**Standard 7 Requirements (3)(b), (3)(c), (3)(d) and (3)(e)**

* Interactions between staff and consumers are kind, caring and respectful of consumers.
* Ensure each staff member has up-to-date competencies and actions are taken when things go wrong.
* Complete mandatory training in line with requirements and address any training deficits that are identified.
* Monitor staff to identify any areas of improvement required with staff performance.

**Standard 8 Requirements (3)(c), (3)(d) and (3)(e)**

* Continue to improve governance to ensure the service is following organisational and legislative requirements.
* Understand elder abuse and apply policies to ensure it does not occur. Manage all risks effectively, including high impact high prevalence risks. Action follow up and analyse incidents in full.
* Have an effective clinical governance process to ensure open disclose is used for all incidents.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Consumers and representatives confirmed staff are generally good and treat consumers with dignity and respect, however, there were reports that staff were being rude to consumers. Consumers confirmed staff delivered care that was culturally appropriate for them, and they are supported to make choices, including risks, about their care and services and who should be involved. Consumers confirmed that information is provided to them in a way that is clear, easy to understand and enables them to exercise choice, and their privacy is respected.

Staff interviewed could describe consumers, including their individual personalities and preferences and how they speak of them with kindness and respect, along with the individual preferences for culturally safe care. Staff could demonstrate how they engage consumers in making choices about their care and services and how they support them to take risks they wish to take. Staff confirmed they assist consumers to understand information provided, especially for those who cannot receive it in a conventional way and how they ensure consumers’ privacy is respected and personal information is kept confidential.

Care planning information reviewed showed consideration for consumer preferences, such as female or male carers, and identified consumers’ cultural needs to be undertaken when delivering care and services. They included information on consumer preferences in relation to care needs, leisure and lifestyle, and relationships of importance. Most risks were recorded in care planning information, including the forms for consumers to acknowledge the risks they wish to undertake and mitigating strategies for the risks.

Consumers and staff were observed to be engaging with one another, holding conversations and laughing with each other. Staff were observed knocking and seeking permission before entering rooms and closing doors when undertaking clinical tasks.

I have considered the information provided in both the provider’s response received 27March 2023 and the assessment team’s report and I agree with the assessment team’s recommendations. Overall, consumers are satisfied that their dignity and choice are met. Whilst there were reports of limited staff being rude to consumers, this was addressed under Standard 7 Requirement 7(3)(b). Staff were knowledgeable about consumers and their choices, including those related to cultural preferences and could explain how they assist consumers to make choices. Care planning documentation included information to guide staff to ensure they meet the dignity and respect for each consumer.

Accordingly, Standard 1 Consumer dignity and choice, is Compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Non-compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Non-compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

The assessment team recommended Requirements (3)(a), (3)(b), (3)(c) and (3)(e) in Standard 2 Ongoing assessment and planning with consumers not met.

The assessment team were not satisfied that assessments and charting were used effectively to inform care planning, specifically in relation to depression, sleep and bowel management risks. Consumers sampled were found to not have advance care directives or palliative care plans in place, and goals of care were not consistently noted in each care plan, with some not containing up-to-date information. Care planning was not consistently undertaken in conjunction with consumers and others they wished to be involved in their care and care is not always reviewed for effectiveness following incidents or changes in circumstances. The assessment team included the following information in relation to their recommendations:

* Consumer A did not have a bowel or food and fluid chart prior to a hospitalisation for acute kidney failure and sub-acute bowel obstruction. They are receiving palliative care and whilst they have been seen by the palliative care team, their recommendations have not been documented. They did not have an updated care plan for a recent change in diet and their care was not reviewed for effectiveness on return from hospital.
* Consumer B was found to not have a plan of care for when their bowels were not opened, and had nine recent falls with only five having an updated falls risk assessment with no new intervention following each fall. Staff found it difficult to recall the falls strategies.
* Consumer C was not screened for depression after being identified as having a low mood and also had a sleep inducing medication stopped, however, the service did not undertake a three day sleep assessment as requested despite the consumer being recorded as having poor sleep.
* Consumer D expressed a low mood and had not been screened for depression. They have also consented to comfort care, but the service has not discussed their end of life wishes. The palliative care subsection of the care plan was completed almost two years ago and it does not contain their current end of life wishes. There was also conflicting information about their dietary needs.
* Consumer E lost weight and while reviewed, was not referred to a dietician.
* Consumer F lost weight and while they were reviewed, their nutrition and hydration care plan was not updated following malnutrition screening.
* Two other consumers who have recently passed away were also included, one who did not have a palliative care plan in place and another who had generic goals of care for palliative care.

The assessment team asserted that assessment and planning is not consistently based on ongoing partnership with the consumer and others they wish to involve. Six consumer files reviewed did not contain documented evidence that consumers or their representatives are involved in assessment and planning. Four of 10 consumers and representatives said they were not involved in assessment and planning processes. Three representatives acknowledged the service will sometimes contact other family members to discuss care and services. One representative confirmed staff do contact them at care plan reviews and said they are happy with the level of involvement.

There is an electronic care system upgrade to improve the areas of care planning previously identified as requiring improvement.

The provider’s response included, but was not limited to, continuous improvement, actions undertaken for sampled consumers, issues where no actions were identified, care plans, progress notes, charts and assessments. Information provided includes:

* The provider refuted Consumer A did not have a bowel chart prior to their admission to hospital and there was no clinical indication for them to complete a food and fluid chart. They also assert Consumer A was reviewed on their return to the service. Documentation to support their claims was provided, including bowel charts, hospital handover information, vital sign charts and skin assessments. The service has updated the care plan with respect to bowel management, nutritional and dietary needs, and end of life care plan. They have also ensured the care plan and kitchen information align.
* Consumer B’s response included care plan information with a toileting, bladder and bowel management section from 9 February 2023 which showed that staff were to monitor their bowels daily if not open in two to three days, aperients may be required to assist them. In relation to Consumer B’s falls, the provider states staff identified the strategies for the falls without being in front of the documentation and provided three incident reports dated 13 and 16 February and 8 March 2023 for the falls where additional strategies for falls management were considered.
* A sleep chart for Consumer C was provided, dated 11 to 13 February 2023 and stamped as scanned into the electronic care system on 14 March 2023. Whilst the response stated there was a nurse practitioner progress note, it could not be located in the documentation provided.
* Consumer D has now had a depression assessment completed in March 2023 and end of life goals have been captured. The service has also aligned the care plan and kitchen instruction for nutritional and dietary needs.
* Consumer E has been referred to a dietician on 13 March 2023 following a weight loss of 4.4kg over a three month period. Redness and blisters were identified in a wound in February 2023 and no adverse event form or wound chart was commenced and the representative was not notified.
* Consumer F’s progress notes show they were referred to a dietician on 2 February 2023 with a malnutrition screening commenced the same day. The review was for advice on the consumer’s 3.55kg weight loss over the last three months. The care plan update following the malnutrition was not commented on by the provider.

I have considered the assessment team’s report and the response from the provider, and I find Requirements (3)(a) and (3)(b) Non-compliant. However, I have come to a different view than the assessment team as I find Requirements (3)(c) and (3)(e) Compliant. I acknowledge the service is on a journey of continuous improvement and has commenced action where they see it necessary to improve. My reasons for the findings are as follows:

**Requirement 2(3)(a)**

It is acknowledged that the service undertook assessments and charting in the areas outlined by the assessment team post the Site Audit. Whilst I was provided with some information that showed that assessment and planning had been considered in informing safe and effective care for Consumer A prior to the Site Audit, for other consumers, such as Consumers B, C and D, charting and assessment had not occurred, and risks were not considered in care planning until after the Site Audit. For Consumer B, bowel charting was not used to better inform the management of the consumer’s bowels which resulted in occasions where the consumer was constipated for up to five days at a time.

**Requirement 2(3)(b)**

The service has also now undertaken a project to ensure all the goals, needs and preferences of consumers nearing the end of life have this information recorded in their care plans. However, the assessment team was able to demonstrate this had not occurred for the sampled consumers, with two since having passed away with no documented goals of care and Consumers A and D who are now on comfort care. For Consumers A and D, it put the consumers at risk as the dietary information was not populated into the care plan, yet it was in the kitchen making the information in the care plan out-of-date. I am not satisfied that the goals, needs and preferences of consumers nearing end of life is recorded and other information kept up-to-date.

**Requirement 2(3)(c)**

I considered the information and came to a different view than that of the assessment team. Both consumers and representatives predominately expressed satisfaction with the care and services consumers receive. I was provided with the information for two of five consumers and two of five representatives said they were not involved in the assessment and planning process. However, three representatives acknowledged that sometimes other family members are contacted in relation to consumer’s care and another confirming consultation is completed with them. I was not provided any examples of where a consumer or representative disagreed with the care or stated they missed out on care due to lack of consultation. With the numbers of interviews provided by the assessment team, on balance it showed that for the most part, consumers and representatives are satisfied with their level of involvement with the assessment and planning process.

**Requirement 2(3)(e)**

I have come to a different view than the assessment team as I was provided with evidence from the provider to show that Consumer A was followed up upon their return from a recent hospitalisation. Electronic records showed that assessments and charting were entered onto the electronic care system and included observations, medication and diet information and the hospital handover. The consumer was reviewed by the registered nurse which included post catheter care. Consumer B was reviewed with an incident report following each fall. Whilst the strategies may not have been updated, I can see through the incident reports that the strategies in place were considered. Information included in the provider’s response shows the consumer does not wait for assistance and tried to do things themselves which is the major cause of their falls. Staff are aware and, on many occasions, they intervene to stop or lessen the impact of the fall. In relation to Consumer B’s bowels, the assessment team provided conflicting information to the care plan information, and I have already considered that information under the context of Requirement (3)(a) in this Standard. I have also considered the information in relation to dietary referrals for Consumers B and F under Standard 3 Requirement 3(3)(e) as the information more aligns with that Requirement. As Consumer E did receive treatment in relation to the wound discovered this shows the service has followed up on the wounds, however, I acknowledge documentation was lacking in this circumstance.

Accordingly, Standard 2 Ongoing assessment and planning with consumers is Non-compliant.

I am satisfied Requirement 2(3)(d) is Compliant:

Consumers and representatives confirmed they are always notified of the outcome of assessments and planning, including following falls, medication reviews and skin assessments. Consumers and representatives said they were confident if they asked for a copy of the care plan, it would be provided, however, none had reviewed the care plan or been provided a copy.

**Standard 3**

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Non-compliant |

Findings

The assessment team recommended Requirements (3)(a), (3)(b), (3)(d), (3)(e), (3)(f) and (3)(g) as not met.

The assessment team were not satisfied consumers received safe personal care, best practice was not followed in relation to urinary tract infections, blood pressure readings were not always taken when consumers were unwell and neurological observations were not completed as per policy. The service did not demonstrate effective management of medication, nutrition and hydration or bowel care. Two consumers did not have their deterioration managed in a timely manner. Staff did not feel that information about consumers was shared effectively. Referral to other providers of care was not always completed as per policy and minimisation of infection and appropriate antibiotic prescribing could not be demonstrated.

Under Requirement 3(3)(a), the assessment team outlined that several consumers had suffered unexplained bruising, skin tears and other abuse that led to them not receiving safe and effective personal care. However, they also documented that consumers and representatives expressed satisfaction with personal care. I have considered the information provided in relation to this under Standard 7 Requirement 7(3)(b) and Standard 8 Requirement 8(3)(d) where I find this information is more relevant. The assessment team also outlined how best practice antibiotic prescribing does not always take place under 3(3)(a) and I will only be considering this in the context of Requirement 3(3)(g) of this Standard.

Under Requirement 3(3)(b) for bowel management, Consumer A was identified as not having a bowel or food and fluid chart maintained before or after a hospital admission, nor were there directions for bowel management. Additionally, Consumer B did not have a documented plan for when bowels were not opened which I have considered under Standard 2 as this is more relevant to assessment and planning documentation rather than the care consumers receive.

The assessment team provided the following information relevant to my finding:

* Consumer A did not have vital sign monitoring for 3.5 hours when they were unwell and then subsequently transferred to hospital due to being unwell and included being diagnosed with a bowel obstruction. On five occasions, the consumer did not have the falls procedure followed following a fall which included taking neurological observations as per the policy. The consumer had two medication errors made on one occasion, a pain patch was omitted to be applied and another where two pain patches were insitu for two days. Staff did not complete monitoring, observation or bowel charting following a rapid deterioration prior to a hospital transfer in January 2023, and when the consumer had low blood pressure readings that were repeated four times in three hours and was not done until 24 hours later.
* For Consumer C, it was identified that staff did not respond to abnormally low blood pressure readings for a 14 hour period and on another occasion, staff did not take observations for a 1.5 hour period despite low oxygen saturations and rapid pulse.
* Consumer D had two medication errors where a pain patch and oral medication were missed. The consumer also lost 4.6kg in one month following gastroenteritis and was not referred to a dietician. A urinalysis was conducted post two days as proof of cure following prescription for antibiotics for a urine infection.
* Consumer F did not have neurological observations undertaken post fall as per the organisation’s policy despite the consumer on one occasion being described as having a lump on the back of their head. They also lost 8.15kg over two months but was not weighed more frequently.
* Consumer H had two occasions where time sensitive medication was omitted with staff attempting to administer at the wrong time resulting in the consumer having difficulty moving, speaking and was more confused. The consumer stated this occurs more frequently than these two occasions resulting in them shaking with reduced mobility and it takes them all day to get back to normal.
* Clinical and care staff interviewed were not satisfied that the shared information enabled them to provide consumers with the best of care, specifically in relation to handover information resulting in Consumer A being given thin fluids by an agency nurse when they should not have been. Other care and services staff do not have access to consumer care files, but they do not think this impacts consumer care.
* Referrals are not always completed in a timely manner as outlined with Consumers D, E and F in relation to dietician referrals.
* The service did not effectively manage a gastroenteritis outbreak as 33 consumers and 26 staff were affected and management could not tell the assessment team what lessons were learnt as a result.

The provider’s response included, but was not limited to, continuous improvement, actions undertaken for sampled consumers, issues where no actions were identified and additional response to deficits identified. Information provided includes:

* In relation to Consumer A, the provider submitted a substantial amount of additional information which included progress notes showing that the consumer had their vital signs monitored prior to a sudden deterioration and hospitalisation. They also provided documentation which showed the consumer was monitored for vital signs when low blood pressure was detected, however, this was in two separate places and not all on the vital sign charts.
* The service is providing open disclosure with blood pressure readings for Consumer C.
* The provider asserts Consumer F gained weight on entry to the service. The consumer lost 6.6kg in one month and was reviewed by the dietician and has since gained weight.
* Consumer D’s general practitioner requested the urinalysis to be undertaken as proof of cure, it was not instigated by the service.
* Open disclosure was completed in relation to medication management with Consumer H.
* The provider refutes that referrals were not made in a timely manner for Consumers D, E and F. Documentation was provided to support their claims.
* Documentation has been provided to show that staff have been counselled in relation to medication management. It had previously been identified through an audit in January 2023 that there was a trend of rising medication incidents.
* There is an electronic care system upgrade to improve the already identified areas of care planning which will provide better information for staff.
* The electronic care system is being updated to only include clinically justified testing for urinalysis on entry to the service as opposed to testing everyone.

I have considered the assessment team’s report and the provider’s response, and I find Requirements (3)(a), (3)(b), (3)(e) and (3)(g) Compliant. However, I have come to a different view than the assessment team in relation to Requirements (3)(d) and (3)(f). I acknowledge the service is on a journey of continuous improvement and has commenced action where they see it necessary to improve. My reasons for the findings are as follows:

**Requirement 3(3)(a)**

For Consumers A and G, the falls policy and procedures as documented by the provider were not followed on several occasions. Consumer A had one occasion where no observations were taken and two occasions where they were only taken a few times. Consumer G had one occasion where only one observation was taken and another where the consumer sustained a head injury and the procedure was not followed in full. Staff confirmed they know the procedure for a fall with a head strike but on this occasion, it had not been completed in full. Procedures are put in place to ensure that consumers receive the care and services they require and in this case they have not. It was noted that as stated by the provider it is acknowledged that Consumer A was monitored in his rapid decline which was evidenced in progress notes.

**Requirement 3(3)(b)**

The assessment team outlined three consumers who had medication errors made by staff. The most compelling is Consumer H who receives time sensitive medication which is often late impacting their well-being. During interview, the consumer stated the late administration of medication affects them and it takes them all day to recover from this. The consumer is allowed to self-medicate some medication but for others they are reliant on staff to provide them at the right time and even staff conceded this does not always happen. It is acknowledged that the service is now working with the consumer to improve medication delivery. Medication errors have been under review by the service as it was identified in an audit conducted in January 2023 that medication errors were a concern. Whilst they have now reduced, and actions have been undertaken the consumer has not had their medication managed effectively resulting them having unsatisfactory outcomes which affect their well-being. I have considered the information for nutrition and hydration under Requirement 3(3)(f) as it primarily relates to referrals.

**Requirement 3(3)(d)**

I have come to a different finding than the assessment team and find this Requirement Compliant. Documentation provided in the response for Consumer A shows that during their decline over a period of approximately four hours until the transfer to hospital took place, Consumer A’s vital signs and bowels were checked on three occasions each. The progress notes showed prior to the first vomit there was no indication that the consumer was unwell. Bowel charts showed that the day before Consumer A had a medium size bowel movement which did not indicate there was a bowel obstruction occurring then. Progress notes also show that the clinical nurse undertook a regular review of the consumer the day prior. The morning staff recorded a progress note stating there were nil concerns with the consumer on the day they became unwell.

In relation to the blood pressure monitoring and falls, whilst there was a gap in the readings taken, progress notes showed the consumer had stated they were not dizzy or unwell. The consumer did not have their neurological observations monitored as per policy which was considered under Requirement 3(3)(a). The consumer suffered no adverse effects from the lack of blood pressure readings.

Consumer B did suffer a sudden deterioration but initially did not want to go to hospital until the pain worsened later at which time staff called an ambulance to take them to hospital. The period of time was one and a half hours which I do not think was unreasonable in the circumstances. In relation to the low blood pressure readings for this consumer, whilst there was a gap in the readings taken again there was no deterioration or adverse effects to the consumer.

It was also noted that at the time the provider did not have a deterioration policy for staff to follow but they have since released one to staff and staff have undertaken deterioration management since the Site Audit.

**Requirement 3(3)(e)**

Whilst management explained they have changed staff handover to only clinical staff who are supposed to provide handover to other staff, they advised that staff have not vocalised their concerns. Other staff were strong in vocalising their dissatisfaction with the handover process as they stated often information is missed, or if it is done via an agency clinical staff member the information is not complete. Staff stated this is impacting consumer care and provided examples where consumer care has been affected. The staff feeling there is a lack of communication could also be because there have not been staff meetings for a year, and they do not feel there are any ways to communicate unless it is individually. Staff need to feel like they are receiving the correct information to ensure consumers are provided with safe and effective care.

**Requirement 3(3)(f)**

I have come to a different view than that of the assessment team for this Requirement. Consumer D’s documentation included in the provider’s response shows following contracting gastroenteritis, Consumer D was weighted and identified as having lost a lot of weight. Interventions were put into place and the consumer subsequently gained weight. The interventions remain in place and their weight is monitored. Consumer E was being monitored for weight loss and progress notes showed that if further weight loss occurred after February 2023, the consumer should be referred to a dietician which has now occurred. The provider states the consumer gained approximately 7kg when they entered the service and upon losing weight was reviewed to a dietician in January 2023. Upon review in February 2023, the consumer was again referred to a dietician.

**Requirement 3(3)(g)**

The policy for outbreak management was not followed by the service. Whilst it is difficult to cohort consumers, if they are isolated and appropriate precautions are taken it can prevent the spread of disease. Ideal outbreak management does not seem to have occurred on this occasion. Whilst feedback from staff around the outbreak varied, it was expressed by one staff member that they did not think the outbreak was managed well and stated, ‘they all got it’. They also stated as it was the weekend, they did not have access to additional stocks of cleaning products and additional cleaning did not commence immediately. The requirement to notify the Department of Health was not undertaken immediately and as the service only had a fax number, this indicates they may not have been prepared fully for the outbreak. One of the most valuable things to do post outbreak is to analyse what occurred and plan how to do it better in the future, however, this was not provided. The number of consumers and staff affected by the outbreak demonstrates that effective transmission precautions did not always occur. It is acknowledged the outbreak management plan is currently being updated to be completed by 1 June 2023.

I have considered the information provided in 3(3)(a) along with the information in this Requirement and I am not going to make a finding in relation to antimicrobial stewardship. I acknowledge the provider is updating information to ensure only clinically indicated testing is completed on entry to the service.

Accordingly, Standard 3 Personal care and clinical care is Non-compliant.

I am satisfied Requirement 3(3)(c) is Compliant:

Whilst the goals and preferences for nearing the end of life are not documented, consumers confirmed they are receiving comfort care that is suitable to them. Staff could describe how they maximise comfort and preserve dignity during end of life. Information corroborated in progress notes shows the service works closely with consumers, their families, the general practitioner and the local palliative care team to ensure quality care is provided.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Consumers confirmed they are supported to engage in activities of choice and are encouraged to optimise their independence. Consumers and representatives described staff as generally supportive of consumers’ well-being and had access to services and supports that were meaningful to them. Consumers said they are supported to maintain social interactions both within the service and externally with family, friends and via engagement with community groups or organisations. They also said their needs are known by staff and representatives stated they are kept informed of changing needs of consumers. Most consumers agreed the food was of suitable quality and quantity and equipment is safe for their use.

Staff could describe the services and supports for consumers, strategies to assist them to maintain their independence and how they support them with their emotional well-being. Staff provided examples of how they support consumers to undertake activities of choice and remain engaged with their chosen social circles. Staff were able to describe ways in which they share information and are kept informed with changes and preferences of consumers, although they said it is not as comprehensive now, they only receive a paper handover. Consumer feedback is welcomed by staff in relation to the food menu and to ensure consumers are satisfied with the meals provided. Staff could describe how equipment is kept safe, clean and well maintained.

Care planning records showed consumers’ goals and preferences, with information regarding services and supports and how consumers choose to undertake them, which also included their spiritual and emotional needs. Documentation also recorded consumers’ preferred activities and interests, and people of importance to them to maintain their social well-being. Information is available to others where a consumer’s care is shared, and care planning documentation also contained records of referral to other providers. Observations of consumer interactions demonstrated participation in activities of choice, such as crafts, cooking, bingo, exercising, plus sessions with the service Chaplin. Mobility aids were observed to be safe, clean and functional.

I have considered the information provided in both the provider’s response and the assessment team’s report and I agree with the assessment team’s recommendations. Consumers confirmed they are receiving the service and supports for daily living which allows them to maintain their independence and support their well-being. Overall, consumers showed satisfaction with the food, activities and equipment provided. Staff were knowledgeable about the services and supports consumers require and documentation contained the information to guide them in the delivery of care.

Accordingly, Standard 4 Services and supports for daily living, is Compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

Representatives and consumers confirmed the service is welcoming and supportive of consumers’ independence and they are able to move about the service freely, both indoors and outdoors. They also expressed satisfaction with the cleanliness of the service and said the furniture and equipment is well maintained, clean and safe to use.

Staff could describe how they assist consumers to interact within the service environment and maintain their independence. Staff confirmed they know how to log maintenance issues via a maintenance form and how to escalate and report any urgent hazards or emergencies directly to management. Staff could explain their responsibilities within each of their roles to clean and maintain the hygiene of equipment.

Documentation showed there are yearly schedules for preventative maintenance and a log for day-to-day maintenance. Staff had schedules for daily cleaning which included process for increased cleaning during infectious outbreaks.

Consumers’ rooms were observed to be personalised with various photos, mementos, artworks, books and furniture items. Communal areas provided a range of seating options and places to rest, as well as covered verandas and patios with well-maintained gardens and lawned areas. Consumers were observed interacting, walking around and sitting together either independently or with the assistance of staff.

I have considered the information provided in both the provider’s response and the assessment’s team report and I agree with the assessment team’s recommendations. Consumers are satisfied with the environment and are able to move about freely. Staff are aware of their expectations to report hazards and keep the service clean. Documentation supported that maintenance is maintained and staff have documentation to guide them. The service was observed to be clean and well maintained.

Accordingly, Standard 5 Organisation’s service environment, is Compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Non-compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Non-compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Non-compliant |

Findings

The Quality Standard is assessed as Non-compliant as three of the four specific Requirements have been assessed as Non-compliant. The assessment team recommended Requirements (3)(b), (3)(c) and (3)(d) in Standard 6 Feedback and complaints as not met.

The assessment team found all consumers and most staff members interviewed were not aware of external advocacy or language services available even though the service provides information about advocates and interpreter services in the Resident admission pack and displays information and brochures regarding external advocates in the main foyer and noticeboards.

The service was not recording or addressing numerous complaints made by staff and consumers in relation to the behaviours of staff towards consumers adequately which was supported by interviews and documentation. They could also not show that open disclosure is always used which was supported by evidence in relation to three consumers. Staff confirmed that they do not always inform of medications incidents if there are no adverse outcomes for consumers.

Whilst the service states they report on their complaints and feedback monthly and uses the data for continuous improvement, there were no items recorded in the plan for continuous improvement that had any involvement with staff or consumers’ feedback. This was also confirmed verbally by staff, representatives and consumers.

The service provided a response to the issues raised. The provider acknowledged that meetings to discuss advocacy and other services may have dropped away due to outbreaks. The service plans to include improvements, such as discussions about advocacy during case conferences, provide brochures and ensure resident meetings occur and the information is passed on.

There will be targeted training sessions in relation to complaints management, with a workshop for service leadership and other sessions for all staff to improve their knowledge of the complaints management process. Additional visits to the service will be scheduled to ensure senior and executive management are regularly visiting the service. They also plan to raise awareness about feedback options and will conduct training for staff on open disclosure.

Training will also be delivered in relation to the importance of continuous improvement and processes will change to ensure trends are reported and analysed by upper management. The working project groups will ensure that the continuous improvement plan is an agenda item at each meeting.

I have considered both the assessment team’s report and the provider’s response and I agree with the assessment team that Requirements (3)(b), (3)(c) and (3)(d) are Non-compliant.

While I note the **provider has taken some action and has planned other actions in response** to the information raised in the assessment team’s report, I was not provided sufficient evidence to satisfy me that the **service has addressed all of the deficiencies identified** at the Site Audit. I find that both staff and consumers were not aware of external organisations available to assist them and that verbal complaints, especially of the importance of consumer abuse were not consistently documented and investigated by the service. I also find that consumers and staff feedback does feed into continuous improvement to ensure it is what they want. I acknowledge that individual complaints that were raised have been addressed by the service.

Accordingly, Standard 6 Feedback and complaints, is Non-compliant.

I am satisfied Standard 6 Requirement (3)(a) is Compliant.

Consumers and representatives said they were able to and supported to provide feedback about care and services, including complaints. Staff described ways they support consumers to make complaints. Documentation and observations confirmed feedback is encouraged and supported.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Non-compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant |

Findings

The assessment team recommended all Requirements in Standard 7 Human resources not met.

Most consumers, representatives and staff interviewed stated there are not enough staff, especially in the evenings and on weekends. While most consumers, representatives and staff members from various disciplines said that staff were kind and caring in general, a number of consumers experienced negative interactions and practices from some care staff. Staff are not always competent as multiple medication errors have been made by staff over the three months prior to the Site Audit, and deterioration is not always responded to and recognised. Staff do not always receive the training they require to perform their role. Staff have not been monitored effectively nor review of performance undertaken following incidents or when complaints about staff behaviours are made.

The assessment team provided the following information relevant to my finding:

* Five consumers and representatives stated there are not enough staff stating there are long call bell delays; a representative of a consumer who falls said they cannot find staff on weekends and most falls are in the afternoon; cleaning is not completed satisfactorily; and some staff can be quite lazy in comparison to other staff which has been reported to management.
* Thirteen staff stated there are not enough staff providing examples, such as many consumers require complex assistance and cannot be rushed; they cannot always supervise consumers or answer call bells quickly if there is someone receiving help who is a two assist; and three stated they have witnessed multiple incidents in the memory support unit (MSU) as there is not enough staff to assist.
* Observations included low staff numbers in the MSU in the afternoon and one staff member assisting two consumers with meals at the same time.
* Whilst consumers said some staff are kind and caring, others were reported to be rough, uncaring, rude, argumentative, disrespectful, frustrated and short tempered when consumers receive assistance during the night.
* Six staff members have raised concerns about the treatment of one consumer stating they had witnessed other staff being rough. The consumer is non-communicative.
* One staff member made 28 of the 32 medication incidents over a three month period prior to the Site Audit but nothing was done to ensure their competency.
* One consumer stated they do not get their time sensitive medication on time, with errors occurring frequently, and another said that staff do not watch them take their medication.
* Clinical staff stated they have not received training or education on medication management or been competency assessed as per the organisation’s policy and procedure.
* Staff are not competent to recognise or respond to consumers’ deterioration.
* Staff could not recall training being undertaken in relation to the Serious Incident Response Scheme (SIRS), restrictive practices, elder abuse or clinical requirements, such as medication management and antimicrobial stewardship.
* Despite numerous consumers and staff making complaints in relation to the way staff treated consumers, including naming the staff member, no monitoring was undertaken of their performance. Staff were not effectively monitored post incidents.

The provider’s response included, but was not limited to, continuous improvement which includes a review of staff and their roles, face-to-face training to embed the learning from online training and additional oversight and support to enable management to effectively manage staff. Further information provided included:

* The service is providing more than 200 minutes of direct care per consumer per day. It is not that the service does not have enough staff, it is that it does not have enough registered nurses. The result is that the staff mix has an over-representation of enrolled nurses and care partners.
* Review of registered nurse competencies and a program to support new registered nurses.
* Allocation sheets were provided to show that the MSU has adequate staffing levels for the number of consumers in the unit.
* Action was undertaken immediately upon the allegations of abuse to ensure that all staff are kind and caring. Investigation of the named staff member saw them stood down immediately upon investigation whilst another staff member was identified and stood down. Another was counselled about the way they spoke to a consumer.
* Audits have commenced in January 2023 for clinical staff for competencies in relation medication management, along with a variety of other actions, such as wound care. An additional and new continuous improvement item was implemented to ensure competency for staff. Records to show the staff member at the centre of the medication errors went through the competency process post audit.
* The provider is addressing the registered nurse shortage which the provider feels has contributed to the poor culture in the service.
* Implementation of a learning and development plan focussed on areas of concern, including but not limited to, medication management, SIRS and clinical deterioration.
* Improvement to monitoring through training with management and better oversight from upper management of the service.

I have considered the assessment team’s report and the provider’s response, and I agree with Requirements (3)(b), (3)(c), (3)(d) and (3)(e). However, I have come to a different view than the assessment team in relation to Requirement (3)(a) I acknowledge the service is on a journey of continuous improvement and has commenced action where they see it necessary to improve. My reasons for the findings are as follows:

**Requirement 7(3)(a)**

After consideration of the information and on balance of the evidence, I am not convinced the service does not have enough staff to deliver safe and effective care to consumers. The information provided by consumers and representatives does not explicitly explain any deficits in care or outline the impacts to consumers from the lack of staffing. The representative of the consumer who falls stated they note it occurs more on the weekends, but the staffing levels remain the same for care and clinical staff from weekday to weekends.

What was more noteworthy was the comments from a representative which stated that some staff do not do as much as other staff, which is an issue, they confirmed they have raised with management. Even staff themselves stated that some staff do not work as a team, and some are not doing what they should be doing which does impact on consumer care.

Whilst staff members who regularly work in the MSU stated lack of staff was the cause of medications not being issued on time and behavioural incidents occurring between consumers, the lack of information about behavioural incidents in the report does not highlight how staffing is contributing to these issues or how the issues are impacting the consumers concerned.

I consider it reflects more in the monitoring and training of staff and oversight by management rather than there not physically being staff present. I have considered the attempts of the service to attract and retain registered nursing staff is positive and acknowledge they are filling with agency staff where possible.

I have considered the information from this Requirement in relation to competency of staff in Requirement 7(3)(c) and monitoring of staff in Requirement 7(3)(e).

**Requirement 7(3)(b)**

As outlined in the assessment team’s report, consumers provided examples of where staff were not kind or caring. This was confirmed though interview with staff themselves who had witnessed other staff not being kind and caring.

While I note the **provider has acted in response** to the information raised both on site and through the assessment team’s report, I am not satisfied that the issue has been resolved in full.

**Requirement 7(3)(c)**

I consider that staff have not been competent in delivery of medication, particularly in relation to consumers with time sensitive medications. The consumer’s welfare is affected by the late delivery of the medication, and it impacts their quality of life.

I acknowledge the service has taken action to remedy the medication errors, including review of medication competencies, but until it is fully implemented, I am not satisfied the issue has been resolved.

**Requirement 7(3)(d)**

The service has now taken action to address the issues as raised in the assessment team’s report and have commenced ensuring all staff are up-to-date with mandatory training and have updated the orientation of staff. Additional training sessions have been scheduled with some completed to address the knowledge in relation to areas of deficit as identified in the assessment team’s report.

While the plan is being implemented, I have not been provided with any information to show that it is working effectively and I consider more time is needed to show that the provider is Compliant with this Requirement.

**Requirement 7(3)(e)**

Monitoring has not been undertaken to ensure staff have not been rough or verbally abusive with consumers. Whilst there were complaints made by both consumers and staff, there was no evidence to show that staff, prior to the Site Audit, who were the subject of the allegations were monitored to ensure they were treating consumers as they should.

Whilst I understand that the service has a shortage of registered nurses, it is not only up to them to monitor staff, but also up to management as well. Staff on the floor did as they were supposed to and reported what they were seeing but this did not prompt management into action.

While one staff member who made multiple medication errors did receive counselling for this, another who made the majority of errors did not have anything done until after the Site Audit.

I consider the staff have not been monitored effectively or counselled in relation to deficits identified.

Accordingly, Standard 7 Human resources, is Non-compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Non-compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Non-compliant |

Findings

The assessment team recommended Requirements (3)(c), (3)(d) and (3)(e) not met.

Whilst some areas of clinical governance were found to be effective the areas of workforce governance, regulatory compliance, feedback and complaints or continuous improvement were recommended as not met. Risk management systems and processes were ineffective in the management of high impact or high prevalence risks associated with care of consumers, identifying and responding to abuse and neglect of consumers and managing and preventing incidents. Clinical governance is not effective in relation to antimicrobial stewardship or open disclosure. The assessment team provided the following information relevant to my finding:

* Governance systems for feedback and complaints did not identify that the procedures to manage complaints were no being followed or investigation undertaken to ensure all complaints were investigated and reviewed.
* The continuous improvement system did not contain items from complaints and feedback or other reviews, such as the clinical monthly analysis.
* Whilst information about regulatory compliance was disseminated to the service, they have not always fulfilled their regulatory responsibilities.
* Workforce governance did not ensure that staffing numbers are adequate, staff are competent and effectively trained and monitored.
* Although monitoring, such as audits and meetings took place, the service had not consistently identified or addressed clinical deficiencies
* The service did not act upon allegations of abuse to minimise harm to consumers despite a number of complaints by consumers and staff.
* Where incidents were reported, investigations, actions and outcomes were not consistently documented.
* Whilst there are specific policies and procedures to guide and direct the service in outbreak management and staff practice in relation to the prevention and control of infections, the service could not demonstrate these are effective.
* The service did not use open disclosure in relation to numerous medication incidents.

The provider’s response included, but was not limited to, continuous improvement which includes new governance procedures, staff training and review of policies. Further information provided included:

* An action plan to review governance processes to ensure they are effective.
* An extensive review of human resources, however, states there are no issues with workforce governance.
* Review of mandatory training to ensure it is all complete.
* Education in relation to continuous improvement, SIRS, elder abuse and the outbreak management policy, including coaching for staff on outbreak management.
* Monthly report to upper management for complaints and continuous improvement to ensure process are being followed with continuous improvement to be recorded in the updated Bethel project plan.
* A checklist for post outbreak evaluation and review.
* Increased oversight to be introduced for risk management with new nurse manager roles.
* Recruitment of a behaviour support specialist for behaviour support.
* New incident form on electronic system where it does not allow to opt out of open disclosure.

I have considered the assessment team report’s and the provider’s response, and find Requirements (3)(c), (3)(d) and (3)(e) Non-compliant. My reasons for the findings are as follows:

**Requirement 8(3)(c)**

The organisation does have governance procedures in place and these been effective in ensuring that complaints are actioned, investigated resolved and used for continuous improvement. However, workforce governance processes were not ensuring that staff had completed all mandatory training or had the skills and competencies to complete their roles. Regulatory compliance was not always completed as it should have been despite the organisation providing the service with the information.

**Requirement 8(3)(d)**

Whilst staff and consumer were reporting incidents of abuse, at the time of reporting action was not undertaken to prevent this from occurring. Whilst I acknowledge actions have been taken since the Site Audit it was not occurring prior. The incident management system has not been used effectively to ensure that all incidents reported were investigated with the actions and outcomes documented and governance procedures did not recognise this was not being completed. In relation to medication incidents, while this was identified as an issue in an audit conducted in January 2023. These audits identifying issues with high impact high prevalence risk were only undertaken following a serious incident that occurred in the service. Whilst actions were commencing at during the Site Audit, the processes were not embedded.

**Requirement 8(3)(e)**

Open disclosure was not undertaken for all medication incidents which was acknowledged by the provider and now open disclosure has taken place. Outbreak management processes have been updated and reviews will now become a standard part of practice.

While I note the **provider has acted in response** to the information raised in the assessment team’s report and audits conducted by the organisation, I was not provided sufficient evidence in the provider’s response to satisfy me that the **service has addressed all of the deficiencies identified** and embedded all the processes to ensure governance and risk management is effective.

Accordingly, Standard 8 Organisational governance, is Non-compliant.

I am satisfied Requirements (3)(a) and (3)(b) are Compliant.

Most consumers and representatives confirmed, for the most part, they are satisfied with the organisation’s level of communication and engagement. Whilst it was said that surveys and audits are undertaken to engage consumers and representatives to assist in the development of care and services, no documentation of this was provided.

The organisation has policies and procedures and feedback mechanisms in place to enable the Board to ensure they are promoting a culture of safe, inclusive and quality care and services. Meetings are held to discuss incidents within the service and how they can improve with care.

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