Performance

Report

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| Name: | Baptistcare Bethel |
| Commission ID: | 7206 |
| Address: | 2 Bethel Way, ALBANY, Western Australia, 6330 |
| Activity type: | Assessment contact (performance assessment) – site |
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| Performance report date: | 20 November 2023 |
| Service included in this assessment: | Provider: 139 Baptistcare WA Limited  Service: 4734 Baptistcare Bethel |

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 A. Kasyan, 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 Assessment contact (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others;
* the provider’s response to the assessment team’s report received 13 October 2023;
* performance report following a Site Audit conducted from 21 to 23 February 2023.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

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

# Areas for improvement

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

**Standard 2 Requirement (3)(a):**

* Ensure all assessments and planning are complete in a timely manner when consumers enter the service to inform safe and effective care and service delivery.
* Ensure risks relating to chemical restraint usage is considered and captured as part of assessment and planning to inform the delivery of safe and effective care.

**Standard 3 Requirement (3)(a):**

* Ensure staff provide all personal and clinical care in accordance with consumers’ assessed needs and preferences, including in relation to consumer continence and toileting needs.

**Standard 3 Requirement (3)(b):**

* Ensure all high impact and high prevalence risks, including associated with delayed administration of medication, are managed effectively.

**Standard 7 Requirement (3)(b):**

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

**Standard 7 Requirement (3)(e):**

* Ensure staff performance is effectively monitored to identify deficits in staff practice. Ensure staff and management have the skills, knowledge and support to identify, report and action deficits in staff performance.

**Standard 8 Requirement (3)(c):**

* Ensure the workforce governance systems are effective and continuously reviewed for effectiveness.

# 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. | Not Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |

Findings

The service was found non-compliant in requirements 2(3)(a) and 2(3)(b) following a Site Audit conducted from 21 to 23 February 2023 where it was found:

* the service did not use assessments and charting effectively to inform care planning;
* the service did not demonstrate they included consumers in planning their end-of-life goals and preferences, and some palliative care plans were incomplete or did not have current information.

At this Assessment Contact, the assessment team have recommended requirements 2(3)(a) as not met and 2(3)(b) as met.

I have provided reasons for my findings in relation to the above requirements below, including consideration of evidence and information provided by both the assessment team and the provider.

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

Two consumers recently admitted to the service did not have assessments completed in a timely manner, and one consumer did not have a care plan published 2 months following their admission. The following deficits in assessment and planning were found for four consumers:

* Staff have not completed 20 of 26 assessments required, since Consumer A’s admission two months ago in July 2023, as per the organisational policy and procedure, including risk of developing pressure injury and weight loss.
* Assessment of Consumer B’s skin was not accurate, and risk of pressure injury was not re-assessed for almost 2 weeks after a wound was assessed as a pressure injury. In addition, strategies to minimise pressure injury risks were not recorded. Depression risk assessment was not accurately completed and did not reflect what the consumer reported they have been feeling like for at least 4 years. Whilst the consumer was at high risk of malnutrition, no plan was developed to manage risks associated with malnutrition, including guiding staff to monitor the consumer's oral intake.
* One consumer's medication profile assessment did not consider risk relating to time critical medication and include relevant information. The consumer did not receive their time sensitive medications within required timeframes on 4 occasions within 6 recent months with one dose administered one and a half days later.
* One consumer’s assessments were not completed in line with the admission planner with some assessments overdue by 22 days.

The provider has acknowledged that some improvements are in progress and have included a Plan for continuous improvement (PCI) in relation to the service’s ongoing improvement activities. The provider has submitted additional information and evidence relevant to my finding in this requirement, including but not limited to the following:

* Consumer A’s care plan was not completed in line with the policy and procedure due to a technical issue and the assessment team was shown a completed care plan by the end of the Assessment Contact. Despite not having all assessments completed, Consumer A’s care was planned. Moving forward, a designated clinical person will create the care plan template on all new consumers on admission and this will allow the base template to be automatically populated as each assessment is completed and dynamically mapped across. The purpose is to prevent the omission of all future care plans.
* Consumer B’s skin assessment and risk of developing pressure injuries were completed timely and accurately and strategies to reduce the risk of impaired skin integrity were planned and documented. Risks associated with malnutrition were assessed, and a plan was developed and implemented which included provision of supplements. The service is aware of the consumer’s low moods. Palliative care review notes, consult notes from the nurse practitioner and goals of care form has been attached to the provider’s response, along with supporting documentation in relation to skin and malnutrition assessment of risks.
* Medication assessments include a note to refer to the consumer’s medication profile. This is done to reduce the risk of medication errors by not having information that may contradict any changes made to the medication profile. There have been 3 not 4 medication incidents where time-sensitive medication was missed. All incidents were investigated, and corrective actions put in place.
* The consumer had all assessments completed within the required timeframe which is 28 days since entry to the service.

Based on the assessment team’s report and the provider’s response, I find the service is non-compliant with requirement 2(3)(a) because assessment and planning process is not effectively implemented for all consumers to inform the delivery of safe and effective care and services. I have placed weight on the evidence in relation to Consumer A.

Consumer A’s care plan and assessments were not finalised two months after the consumer’s entry into the service where the expected timeframe of 28 days. The error was not identified until after the assessment team brought this issue to the attention of the staff during the Assessment Contact.

I acknowledge the provider’s response and corrective actions proposed and taken to prevent a recurrence of similar incidents with incomplete assessments. However, while recognising the service’s efforts to address the issue, the improvement activities require monitoring and time to establish efficacy.

In relation to Consumer B, I find evidence and supporting documentation in the provider’s response demonstrated assessment and planning informed the delivery of safe and effective care. This was achieved through initial assessments, an individualised care plan addressing risks, preventive measures and interventions tailored to maintaining and improving skin integrity, addressing malnutrition risks and addressing mental health concerns; collaboration with healthcare professionals (podiatrist, nurse practitioner, occupational and physiotherapist, palliative care team, and dietician) and inclusion of the consumer and their representatives in the assessment and planning process.

In coming to my finding have also considered information in the assessment team’s report in Standard 3 Requirement 3(3)(b) in relation to Consumer C’s care planning that is relevant to this requirement. The consumer was commenced on a medication the service identified as chemical restraint. Whilst an informed consent was obtained, no charting has commenced to monitor and capture the consumer’s changed behaviours. Whilst the provider’s response included Behaviour Identification chart, a review of this document only shows specific type of behaviour observed. I find this evidence alone is not sufficient to demonstrate best practice assessment and planning of the consumer’s changed behaviours as the provider did not demonstrate how and if they understood the factors and triggers contributing to the changed behaviours and what interventions have been trialled before chemical restraint was commenced.

In relation to medication incidents, I find this evidence is relevant to Standard 3 and I considered it in coming to my finding in relation to requirement 3(3)(b).

Based on the reasons summarised above, I find requirement 2(3)(a) non-compliant.

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

The assessment team found assessment and planning process includes identification of the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. Consumers confirmed staff discussed their needs, goals and preferences, and care documentation reviewed included advance care planning, end of life planning and information on consumers’ current needs, goals and preferences. Care planning documentation showed staff follow the organisation’s process and refer consumers to palliative care specialists, general practitioner and other health care providers in a timely manner.

Based on the evidence summarised above, I find requirement 2(3)(b) compliant.

# 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. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission-based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

The service was found non-complaint in requirements 3(3)(a), 3(3)(b) and 3(3)(g) following a Site Audit conducted from 21 to 23 February 2023 where it was found:

* clinical care in relation to managing consumers’ medications, nutrition and hydration, bowel management and post falls management was not best practice;
* management of high-impact and high-prevalence risks in relation to pressure injuries and falls was not effective; and
* the service did not respond to a gastroenteritis outbreak in a timely manner and did not demonstrate best practice in treatment of urinary tract infection.

At this Assessment Contact, the assessment team have recommended requirements 3(3)(a), and 3(3)(b) as not met and requirement 3(3)(g) as met.

I have provided reasons for my findings in relation to the above requirements below, including consideration of evidence and information provided by both the assessment team and the provider.

**Requirement (3)(a)**

The assessment team found the service has provided education and training to staff, including leadership training but still found the service was unable to demonstrate that each consumer was provided with safe and effective personal and/or clinical care, which was best practice, tailored to their needs and optimised their health and well-being. The assessment team provided the following information and evidence relevant to my finding:

* Two consumers and one representative expressed dissatisfaction with continence care and assistance to use bathroom.
* Consumer A reported feeling discomfort due to being constipated. Staff were not aware of what consumer’s continence care needs were, and documentation showed consumer’s bowels were not regularly opened. Staff have not assessed or established the consumer’s usual bowel pattern, nor devised a bowel management plan in consultation with the consumer.
* Consumer B requires more than one staff members for toileting needs. The consumer and their representative reported they frequently wait for up to an hour to get staff assistance to use the bathroom which has led to incontinent episodes, and this makes the consumer feeling “stupid and embarrassed”. The consumer’s bowel charts reviewed for a 6-week period to 19 September 2023, showed the consumer had multiple occasions of 4 to 7 days between bowels open. Additionally, a staff member denied taking the consumer to the toilet and asked them to use their continence aid because they had no staff to assist the consumer to go to the toilet. Wound measurements were not regularly undertaken, and wound charts showed missed entries to evidence provision of wound care of up to 17 days.

The provider has acknowledged that some improvements are in progress and have included a PCI in relation to the service’s ongoing improvement activities. The provider has submitted additional information and evidence relevant to my finding in this requirement, including but not limited to the following:

* Continence training has been attended by majority of staff following the assessment contact visit and the training will continue until all staff are aware of the process and their responsibility.
* Consumer A’s bowel chart shows regular daily/ second daily bowel movement with only 3 occasions where bowels were not opened by 3 days.
* Consumer B on occasions denies assistance to go to bathroom when approached by staff. Bowel charts and wound charts attached to the response demonstrate that there was one time when the consumer’s bowel was not opened for six days, other days have not exceeded 3 days and the wound’s dressing was missed on one occasion. Consumer B is in a deteriorating stage and their oral intake is decreased impacting on bowels pattern.
* The provider recognises ongoing measurement of the consumer’s wound is not consistently completed and in accordance with the organisation’s standard and this was identified by the service’s internal audit completed prior to the Assessment Contact with PCI actions commenced.

Based on the assessment team’s report and the provider’s response, I find consumers do not consistently receive safe and effective personal care, clinical care, or both personal care, and the care consumers receive is not always best practice, tailored to their needs or optimises their health and well-being.

I have considered multiple consumers’ feedback expressing dissatisfaction with continence care outlined in the assessment team’s report in this requirement and requirement 7(3)(b). Three consumers and one representative reported dissatisfaction with assistance to manage the consumers’ continence care needs, citing significant delays (of up to an hour) with getting staff assistance, being denied assistance and told to use their continence aid and feeling of discomfort due to poorly managed constipation.

Furthermore, tailored clinical and personal care was not delivered to one consumer relating to their continence and toileting needs. Significant delays in receiving staff assistance resulted in a negative impact to the consumers’ well-being including feeling of embarrassment. Significant delays in getting assistance for toileting needs resulted in a negative impact to the consumers’ well-being, such as feeling of embarrassment due to soiled continence aids.

I am satisfied the information in the provider’s response shows wound care was provided to Consumer B in line with the wound care plan with only one occasion when dressing was missed. Whilst wound measurements are not always occurring in line with the organisation’s policies and procedures, the deviation from the expected standard of care did not cause adverse outcome to the consumer and the deficits have been identified by the organisation’s internal audit processes with remedial actions commenced prior to the Assessment Contact.

Based on the reasons summarised above, I find requirement 3(3)(a) non-compliant.

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

The assessment team found ineffective management of risks of developing pressure injuries, associated with unmanaged pain, medication errors, weight loss and swallowing.

In relation to management of pressure injury risks:

* Consumer B has acquired 2 pressure injuries since admission to the service in mid-2023, however staff did not review or update the consumer’s pressure injury interventions after the consumer acquired their first pressure injury and subsequently acquired a second pressure injury one month later. Whilst staff and management advised the consumer declined to be repositioned regularly, this has not been recorded and staff did not identify this as a risk factor to the consumer’s care. The assessment team observed the consumer did not have a pressure-relieving mattress to reduce the risk of further injury.

In relation to management of risks associated with pain:

* Consumer B stated they reported recent increased pain levels to staff. However, this was not acknowledged or actioned by staff.
* Two consumers reported they require strong analgesia for effective management of severe pain, it is often administered with the delay up to 2 hours which impacts on their well-being.
* Consumer C is prescribed pain-relieving medication to be administered prior to wound care. However, records showed inconsistency in medication administration. The consumer advised they are in pain and staff confirmed the consumer shows signs of pain during care provision, such as grimacing and pulling away when staff attend to the consumer’s needs.

In relation to risks associated with medication errors:

* Records showed 4 occasions when staff omitted to administer a consumer’s time sensitive medication, and the consumer has subsequently required the use of as PRN (as required) medication to alleviate their symptoms. The service has not considered falls risk related to incorrectly administered time sensitive medication.
* Consumer C was not administered their medications as prescribed with records showing medications prescribed to be given at 8.00am are often administered at around 12.00pm. Staff reported this is due to the consumer being more alert at lunch time.

In relation to management of weight loss risks:

* While the service identified Consumer B had a high risk of malnutrition following an assessment in September 2023, strategies implemented to mitigate risks were not sufficient.

In relation to swallowing risks:

* Staff reported Consumer C is not able to swallow their tablets anymore. The consumer’s family suggested staff crush medications to ensure the consumer is receiving them. However, not all tablets could be given in a crushed form which increased risk of unmanaged symptoms due to not ingested tablets.

Management advised they did not think of managing other consumer high impact or high prevalence risks, for example, falls, pressure injury risk, and weight loss.

The provider has acknowledged that some improvements are in progress and have included a PCI in relation to the service’s ongoing improvement activities. The provider has submitted additional information and evidence relevant to my finding in this requirement, including but not limited to the following:

In relation to ineffective management of pressure injury risks:

* Consumer B had one pressure injury as the second wound referred to in the assessment team’s report was a skin tear. Pressure relieving interventions were applied as soon as compromised skin integrity was noticed in early June 2023 which included heel raiser bootie provided to be worn when in bed with the consumer’s consent.
* The consumer was often denying wearing protective devices to support their skin integrity.
* The provider acknowledges staff did not commence a new wound chart when required. Following a period of deterioration, the wound has improved and is healing.

In relation to management of risks associated with pain:

* Staff is aware of Consumer’s B pain. Supporting evidence attached to the response shows pain is assessed, monitored, reviewed and managed with medications, both regular and “as required”, and non-pharmacological interventions in collaboration with the consumer/ their representative and other healthcare professionals, including general practitioner, physiotherapist and palliative care team.
* Consumer C has been commenced on both regular and “as required” analgesia following identified pain during activities of daily living and wound care. “As required” pain relieving medication was indicated for use around activities of daily living and wound care as needed.
* Plans were in place to implement a second medication cupboard to ensure the medications were closer and easily available to prevent delays with delivering “as required” analgesia that requires two clinical staff to sign. This has been completed following the assessment contact.

In relation to management of weight loss risks:

* Progress notes, referrals and assessment show once risk was identified, appropriate strategies have been implemented in collaboration with the consumer and multidisciplinary team, including evaluating the consumer’s dietary habits, weights, medical conditions, referring consumer to dietitian, modifying diet by offering nutritional supplements and encourage oral intake.
* Consumer B was reviewed multiple times by palliative team who acknowledged poor appetite but noted consumer voiced no discomfort due to it.

In relation to swallowing risks:

* It was not suggested by family but a nurse to have medications crushed and a general practitioner was notified prior to the assessment contact visit, and changes made appropriately to ensure medications are administered safely.

In relation to risks associated with medication errors:

* In relation to time sensitive medication, there have been 3 not 4 omissions in over 6 months. Omissions were identified within a short period of time during next medication round on the same day when incidents occurred. All incidents have been investigated with root cause analysis and remedial actions taken, and consumer was monitored for any signs of adverse impact. The consumer was reviewed by a general practitioner to assist in managing symptoms associated with one of the consumer’s diagnoses and “as required” dose of medication was charted. The use of “as required” medication the assessment team referred to in the report had no correlation to any omissions of time sensitive medication.
* The service acknowledges the discrepancy around medication timing of one consumer for whom morning medications being staggered and administered when the consumer was more alert, and safe to ingest the recommended medications. Corrective actions to be taken include conducting reviews with the general practitioner to determine if the medication can be adjusted to an alternate timing, or whether they can be consolidated to avoid polypharmacy.

In relation to the management of high impact high prevalence risks in general, the provider responded by including a list of 23 risks that are identified and managed, and these include pressure injury, falls and malnutrition. Additionally, the service has a risk board in the clinical station which identifies every consumer at the service and outlines their clinical risks.

Based on the assessment team’s report and the provider’s response, I find the service is non-compliant with requirement 3(3)(b) because consumers’ high impact risks associated with pain are not managed effectively.

Multiple consumers are waiting for their pain relief for up to 2 hours when they experience severe pain. I find the service is not managing pain related risks by not ensuring timely pain relief administration whilst consumers experiencing pain. The delay in pain relief administration, for multiple consumers and on multiple occasions, would have caused adverse outcomes including continued or prolonged discomfort and possibly elevated pain which can be more challenging to manage. I acknowledge the provider’s response and actions taken to reduce waiting time. However, while recognising the service’s efforts to address the issue, the improvement activities require monitoring and time to establish efficacy.

I find the service effectively manages pressure injuries risks, weight loss/malnutrition, swallowing and medication errors. The provider’s response and supporting evidence shows these risks are identified, assessed, and person-centred interventions implemented to mitigate/minimise risk of harm in collaboration with consumer/their representative and multidisciplinary team.

In relation to Consumer B, I find whilst evidence shows the pressure injury could have been prevented, the healing of the wound after a period of deterioration shows ongoing evaluation and improvement of pressure management strategies leading to the healing of the wound. I find evaluating the consumer’s dietary habits, weights, medical conditions, referring consumer to dietitian, modifying diet by offering nutritional supplements and encourage oral intake are effective measures in response to risk of malnutrition. Risks associated with medication errors, such as three missed doses of time sensitive medications were managed effectively by the provider demonstrating in its response timely assessment of the consumer, incidents analysis, conducting root cause analyses, implementing corrective action plans and ensuring ongoing staff training and communication.

I find Consumer C’s medication management is not best practice because medications prescribed to be given at 8.00am are often administered at around 12.00pm. However, I am satisfied the provider's action undertaken following the assessment contact have addressed the related risk.

Based on the reasons summarised above, I find requirement 3(3)(b) non-compliant.

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

The assessment team found the service uses standard precautions to prevent and minimise infection-related risks. The service supports an appropriate use of antibiotics by following best practice guidelines.

A comprehensive monthly infection report is completed by clinical staff for monitoring and analyses and results are discussed at the clinical meeting. Staff have infection control training at commencement of employment, and annually. Additional training has been provided during the COVID-19 pandemic including on donning/doffing of personal protective equipment.

Documents showed monthly audits of infection and antibiotic usage benchmarked against other organisations showed the service has low antibiotic usage.

Based on the evidence summarised above, I find requirement 3(3)(g) compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The service was found non-complaint in requirements 6(3)(b), 6(3)(c) and 6(3)(d) following a Site Audit conducted from 21 to 23 February 2023 where it was found:

* consumers and staff were not aware they have access to other methods for resolving and raising complaints including language and interpreter services;
* reports regarding staff behaviour towards consumers were not documented and actioned, and an open disclosure process was not consistently used when incidents or adverse events occurred;
* consumers were providing feedback, however did not feel their concerns were resolved and feedback provided by consumers did not drive continuous improvement.

The assessment team found the service has made the following improvements in relation to the non-compliant requirements:

* information relating to alternative complaint avenues and language services were provided or made available to consumers;
* staff have been educated regarding alternative complaint resolution avenues and language services available;
* staff was provided with training in complaints and feedback mechanisms and open disclosure;
* the service recommenced Resident and Relative meetings.

At this Assessment Contact, the assessment team found the service’s feedback and complaints mechanism was effective. Consumers confirmed they were aware of alternative avenues for resolving complaints and felt supported by management when they provided feedback. Consumers confirmed appropriate action is taken in response to complaints.

The service has policies and procedures in place to guide staff practices and staff described how they support consumers to provide feedback and make complaints using alternate methods for raising and resolving complaints.

Brochures of external complaint services including Advocare and the Aged Care Quality and Safety Commission were displayed in the main reception area for easy access of consumers and representatives. There is a process in place for ensuring complaints, compliments are collected in a timely manner. Documentation showed feedback and complaints are recorded, actioned at relevant forums and an open disclosure process is used when things go wrong.

Resident and relative meeting minutes reviewed showed complaints and feedback mechanisms including accessing external complaint resolution services, such as Advocare and translating and interpreting services were discussed with consumers and representatives.

Management described how information from feedback is used to improve the care of consumers. Whilst consumers and representatives did not provide specific examples of improvements made at the service, they said they felt confident feedback and complaints raised would result in change and improvement.

Based on the evidence summarised above, I find Requirements 6(3)(b), 6(3)(c) and 6(3)(d) compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Not Compliant |
| Requirement 7(3)(c) | The workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Not Compliant |

Findings

The service was found non-complaint in requirements 7(3)(b), 7(3)(c), 7(3)(d) and 7(3)(e) following a Site Audit conducted from 21 to 23 February 2023 where it was found:

* a number of consumers experienced negative interaction and practice from some of the care staff;
* staff did not administer medications competently and safely;
* staff could not describe the training they had undertaken specifically in relation to medication management and antimicrobial stewardship;
* regular monitoring of staff performance was not undertaken.

The assessment team found the service has made the following improvements in relation to the non-compliant requirements:

* management have undertaken performance management with staff members who were not demonstrating respect and care towards consumers. The service delivered training to staff in culture, respect and code of conduct;
* staff members responsible for medication errors have been supported in safe medication management through additional training and guidance of experienced clinical staff;
* additional training in response to staff identified learning needs was delivered.

At this Assessment Contact, the assessment team have recommended requirements 7(3)(b), 7(3)(c) and 7(3)(d) as not met and requirement 7(3)(e) as met.

I have provided reasons for my findings in relation to the above requirements below, including consideration of evidence and information provided by both the assessment team and the provider.

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

The assessment team found while some consumers said staff are kind, caring and respectful, a number of consumers said staff do not always treat them with kindness and respect and they feel hurt and dissatisfied. The assessment team provided the following information and evidence relevant to my finding:

* Six consumers reported staff are not always kind, and respectful of them and their needs. Examples provided included feeling frightened and upset when staff denied taking consumers to the toilet and being told by staff to use their continence aid instead.
* Documentation showed consumers complained about staff being unkind and not showing care.
* Observation showed a staff member dismissing a consumer’s request to fill their jug with water.

The provider responds by stating they recognise that further work is required to review, support and embed meaningful workforce interactions with consumers that are kind, caring and respectful of each consumer’s identity, culture and diversity. The provider has submitted additional information and evidence relevant to my finding in this requirement, including but not limited to the following:

* The service is in the process of rolling out “Diversity Training" and the “Phoenix package"" to support all staff knowledge.
* The provider accepts staff members interactions with consumers where they denied assistance with toileting and asked consumers to use their continence aids instead is not an appropriate interaction with consumers. A meeting with staff was held with staff in October 2023 to set the standard with staff around zero tolerance behaviour. Additionally, training sessions around appropriate continence management have been held to effectively demonstrate to staff appropriate strategies and interventions to support consumers’ continence care needs.
* In relation to observation of a staff member dismissing a consumer’s request, the staff member involved in this interaction had an ongoing performance improvement plan in place and an additional request to meet was arranged following the assessment contact visit.

Based on the assessment team’s report and the provider’s response, I find the workforce interactions with consumers do not consistently align with the intent of this requirement expecting interactions to be kind, caring and respectful of each consumer’s identity, culture and diversity. The reported experience of six consumers, who expressed feeling frightened and upset during instances when staff denied their requests to be taken to the toilet and suggested to use continence aids, shows staff interactions that lack compassion and respect.

I acknowledge the provider’s response and corrective actions proposed and taken to ensure staff interactions are always kind and caring, including when consumers ask for assistance and support. However, while recognising the service’s efforts to address the issue, the improvement activities require ongoing monitoring and feedback mechanisms to ensure sustained compliance with this requirement, promoting an environment where each consumer feels valued, heard and treated with dignity and respect.

Based on the reasons summarised above, I find requirement 7(3)(b) non-compliant.

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

The assessment team found staff are not competent and do not have knowledge to manage consumers’ pain, medications, pressure injuries and bowels. The assessment team provided the following information and evidence relevant to my finding:

* Four consumers provided feedback about ineffective pain management.
* Staff did not correctly identify pressure injury in one consumer and did not cover 2 wounds of another consumer with protective dressing to promote healing.
* Documentation showed staff have not administered medications for one consumer in line with medication directive and another consumer’s time critical medication was omitted on 4 occasions within 6 recent months and the consumer has subsequently required the use of as prn medication to alleviate symptoms.

The service acknowledges the discrepancy around medication timing of one consumer for whom morning medications being staggered and administered when the consumer was more alert, and safe to ingest the recommended medications. Corrective actions include conducting reviews with the general practitioner to determine if the medication can be adjusted to an alternate timing, or whether they can be consolidated to avoid polypharmacy.

In relation to not applying protective dressing, these have been applied, however the consumer was removing them. The provider responded to the rest of the information in its response to requirements 2(3)(a), 3(3)(a) and 3(3)(b).

Based on the assessment team’s report and the provider’s response, I find the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

Whilst the assessment team found consumers reported dissatisfaction with pain management and assistance with continence care needs, information and evidence in the assessment team’s report and the provider’s response does not show the root cause of it was staff lack of skills, knowledge or not adhering to protocols, policies and procedures.

Out of three medication errors (missed doses of time sensitive medications), two involved one nurse for whom additional training and supervision was provided to ensure competent medication management.

The provider’s response included evidence of completed skin assessments for the consumers mentioned in the assessment team’s report that are completed in line with the organisation’s policies and procedures.

The assessment team found staff is provided to ensure individual capabilities of the workforce, they are provided with appropriate training, including around clinical care and ongoing learning and development support. Staff said they have had training and documentation confirmed staff have had extensive training.

Whilst the assessment team report does not provide information and evidence in relation to whether each staff member possesses the necessary qualifications to perform their specific duties effectively, the provider asserts the members of their workforce have the qualifications to effectively perform their roles.

Based on the reasons summarised above, I find requirement 7(3)(c) compliant.

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

The assessment team found the workforce is recruited and trained during the onboarding process and on an ongoing basis. However, staff are not supported to deliver the outcomes for consumers in day-to-day care delivery. The assessment team provided the following information and evidence relevant to my finding:

* Eleven consumers provided feedback expressing their dissatisfaction with the way staff provide their day-to-day care needs. Specific examples provided included delays with administering medications and attending to their continence care needs because staff are very busy. Two representatives advised they do not think there is enough staff because they at times spend up to 15 minutes looking for care staff.
* One staff member advised it takes longer at times to get a medication for consumers as they may be busy, and they also need to leave the area go up 2 flights of stairs to access the medication.
* Roster documents showed unfilled shifts on 12 out of 14 reviewed days.
* One consumer’s sheet was observed stained with urine with the consumer lying in bed. Staff reported they have not had time yet to attend to the consumer’s continence care.

The provider responded by stating they recognise that given the recent review of the roster some staff would feel unsupported with this change due to the shift from the status quo. The service continues to conduct routine feedback sessions with staff to communicate the changes around the proposed roster and demonstrate the key factors that drive the shift in staff support, including the legislative 200-minute care requirement.

The provider disagrees with the assessment team’s finding that only 2 of the 14 days had a full complement of staff. The supporting evidence in the provider’s response shows three care staff shifts were not filled in the specified period.

Based on the assessment team’s report and the provider’s response, I find the service is compliant with the requirement. I find the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

I have considered the assessment team’s finding that the workforce is recruited and trained during the onboarding process and on an ongoing basis in line with the intent of this requirement. Additionally, evidence demonstrated ongoing training is provided to staff to ensure staff is equipped with the knowledge to provide safe and effective care and services, and staff training is scheduled and monitored.

I have also considered information and supporting evidence in the provider’s response showing the service has been consistently reviewing the training and education support for all staff with examples of the recent training completed around bowel management, wound management, clinical systems, and documentation.

The concerns raised by consumers about staff busyness and one staff member’s feedback about reasons for delayed administration of medication being the time it takes to access medication is more directly aligned with the requirement 7(3)(a) that states “ 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”. Requirement 7(3)(a) was not assessed as part of the assessment contact visit, and I encourage the provider to review their workforce planning and deployment strategies for effectiveness.

Based on the reasons summarised above, I find requirement 7(3)(d) compliant.

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

The assessment team found organisation has systems to ensure monitoring of staff performance is conducted. Documents showed that performance discussions are held with staff to discuss their roles and what professional development they would like or feel they require. This includes discussion following the probation period and regularly according to the organisation’s policy. Staff said they have a regular performance review and are contacted when it is due, and a day is organised for the review. Management described how they use incident reporting and feedback mechanisms to identify issues with staff performance.

Based on the assessment team’s report and the provider’s response in relation to requirements 2(3)(a), 3(3)(b), 7(3)(b) and 7(3)(c), I find the service does not effectively undertake regular assessment, monitoring and review of the performance of each member of the workforce.

Whilst the provider has systems and processes, such as performance appraisals, incidents reporting, feedback mechanism, training and professional development, these are not effective in identifying and addressing issues with staff performance.

I acknowledge, there are systems for monitoring staff performance and conducting discussions after a probationary period. However, multiple consumers’ feedback expressing dissatisfaction with various aspects of care and staff not kind nor caring interactions resulting in consumers feeling frightened, embarrassed and sad suggests these systems are not sufficient to ensure safe, effective and respectful care delivery.

I acknowledge the provider’s actions in response to the assessment team’s finding of staff not providing safe and quality care in line with the Quality Standards, such as arranging meetings with staff, providing training and arranging performance discussions. However, I find these actions are not sufficient to demonstrate ongoing efforts to ensure each staff member is performing their duties effectively.

Based on the reasons summarised above, I find Requirement 7(3)(e) non-compliant.

# Standard 8

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| Organisational governance | |  |
| 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. | Not Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

The service was found non-complaint in requirements 8(3)(c), 8(3)(d) and 8(3)(e) following a Site Audit conducted from 21 to 23 February 2023 where it was found:

* wide governance systems in relation to workforce governance, regulatory compliance, continuous improvement and feedback and complaints were not effective;
* risks management practices in relation to high impact risks, such as weight loss and infections were not effective;
* incidents were not consistently reported and actioned;
* reports of elder abuse were not escalated and responded to;
* staff were not sufficiently trained in antimicrobial stewardship;
* open disclosure was not consistently demonstrated following incidents and adverse events;
* and some policies and procedures were outdated.

The assessment team found the service has made the following improvements in relation to the non-compliant requirements:

* completed an extensive project plan and action plan to address previous deficits;
* reviewed and updated outdated policies and procedures;
* a root cause analysis tool has been developed to improve investigations and outcomes and overall incident management;
* staff have received further education on elder abuse, code of conduct training, roles and responsibilities in incident management and reporting of serious incidents;
* several policies to guide clinical care have been reviewed including medication management, nutrition and hydration, outbreak management, palliative and end of life care;
* additional clinical training and education has been provided to staff including on infection control, restrictive practice and open disclosure.

At this Assessment Contact, the assessment team have recommended requirements 8(3)(c) and 8(3)(d) as not met and requirement 8(3)(e) as met.

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

The assessment team found effective organisation wide governance systems relating to information management, continuous improvement, financial governance, regulatory compliance and feedback and complaints. However, workforce governance systems were found not effective. The assessment team provided the following information and evidence relevant to this finding:

* Eleven consumers and 2 representatives said there were not enough staff to meet their needs which impacted on all aspects of their wellbeing and quality of life.
* A range of clinical, care, and cleaning staff reported being regularly understaffed, and said they were unable to meet the needs of consumers.
* The assessment team found multiple consumers where high impact high prevalent risks were not well managed, risk management was not effective, and personal and clinical care was not best practice, and this related to a lack of trained, stable nursing workforce, clinical oversight and monitoring of staff, and overstretched care staff.
* The complaints and feedback register contained feedback from staff, since the previous Site Audit, indicating widespread problems with workplace culture, reports of unkind attitude of staff towards consumers, and staff struggling with the workload. Three reportable incidents were made to the Serious Incident Response Scheme (SIRS) relating to unkind and dismissive staff attitude towards consumers.

The provider responded by stating they have a plan to improve workplace culture, feedback and support and embed a kind and caring workplace and a number of actions have already been taken that have made considerable improvements around the Quality Standards. However, the provider acknowledges there remains some outstanding actions to be completed and imbedded.

Based on the assessment team’s report and the provider’s response, I find the service is non-compliant with the requirement because workforce governance systems are not effective.

I find the combination of understaffing, workforce culture issues, unkind attitudes and staff struggling with their workload collectively indicate a failure in maintaining effective organisation-wide governance systems related to workforce governance. I acknowledge the provider’s response and its efforts with implementing strategies for staffing, culture improvement and workload management. However, while recognising the service’s efforts to address the issue, the improvement activities require ongoing monitoring and feedback mechanisms to ensure sustained compliance with this requirement.

Based on the evidence summarised above, I find requirement 8(3)(c) non-compliant.

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

The assessment team found effective risk management systems and practices in relation to identifying and responding to abuse and neglect of consumers; supporting consumers to live the best life they can and managing and preventing incidents, including the use of an incident management system.

However, the assessment team found whilst systems and processes are implemented, these are not effective in managing high impact or high prevalence risks associated with the care of consumers because of the poor outcomes for consumers in relation to pain management, wound management, pressure area care, bowel management, medication management and malnutrition that have been identified in Standard 3.

The provider responding by stating they are confident the systems, processes, policies and governing supports in place are effective. However, they understand the significant impacts that stabilising and retaining a quality workforce have on the systems that would usually operate functionally well.

Based on the assessment team’s report and the provider’s response, I find requirement 8(3)(d) is compliant.

Whilst some consumers’ risks were not effectively managed and my finding in relation to this is included in Standard 3 Requirement 3(3)(b), these risks were limited to delayed administration of pain relief and pain management not meetings consumers’ needs and preferences.

Whilst the assessment team found consumers reported dissatisfaction with pain management and assistance with continence care needs, information and evidence in the assessment team’s report and the provider’s response does not show the root cause of it was ineffective risks management systems and practices.

In relation to management of other risks, such as pressure injuries, medications and malnutrition, my finding in requirement 3(3)(b) was that these risks are managed effectively at an individual level.

I have also considered the assessment team’s finding that there are systems and processes to manage high impact and high prevalence risks at the service level and these include a range of clinical policies and procedures, ongoing staff training, analysis of clinical indicators data, various clinical and multidisciplinary meetings, and clinical oversight of the risk management system at the organisation level.

Based on the reasons summarised above, I find requirement 8(3)(d) compliant.

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

The assessment team found the service demonstrated the clinical governance system was effective including in relation to antimicrobial stewardship, open disclosure and minimising restraint. The organisation has a clinical governance framework, policies and procedures and workflow charts to guide staff practice. There are appropriate organisation structures, including a clinical governance committee, clinical oversight at an organisational level, senior clinical staff, a clinical audit schedule and various clinical meetings and reporting mechanisms.

The service has established antimicrobial stewardship program, including protocols for appropriate use of antimicrobials, monitoring and reporting of antibiotic usage and ongoing education to staff. Documentation showed evidence of strategies and non-pharmacological initiatives aimed at minimising the use of restraint. Staff provided examples of effective open disclosure communications with consumers and their families in the event of adverse events or incidents.

Based on the evidence summarised above, I find requirement 8(3)(e) compliant.

1. The preparation of the performance report is in accordance with section 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)