Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Bethanie Subiaco |
| Service address: | 45 Bishop Street JOLIMONT WA 6014 |
| Commission ID: | 7445 |
| Approved provider: | The Bethanie Group Incorporated |
| Activity type: | Site Audit |
| Activity date: | 16 May 2023 to 18 May 2023 |
| Performance report date: | 3 July 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 Bethanie Subiaco (**the service**) has been prepared by M Glenn, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff and management;
* the provider’s response to the Assessment Team’s report received 12 June 2023. The response included commentary relating to the deficits identified by the Assessment Team, actions taken/and or planned in response, and supporting documentation. The response also included a Plan for continuous improvement outlining planned actions, planned completion dates and outcomes to address the deficits identified; and
* a Performance Report dated 14 March 2023 for an Assessment Contact undertaken on 16 February 2023.

# Assessment summary

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

* Ensure consumers are supported to understand the risks relating to activities they choose to partake in, and the consequences of these risks are discussed and agreed management strategies implemented in consultation with consumers and/or representatives.
* Review processes, policies and procedures relating to supporting consumers to take risks to enable them to live the best life they can.

**Standard 6 requirements (3)(c) and (3)(d)**

* Ensure all feedback and complaints are captured, and appropriate, prompt action is taken in response, including liaising with the complainant.
* Ensure open disclosure processes are applied, where required, in response to feedback and complaints, as well as incidents.
* Ensure feedback and complaints are documented, including actions taken, and follow-up with the complainant to ensure satisfaction is achieved.
* Review processes to ensure all feedback and complaints are captured to enable emerging trends and improvement opportunities to be identified.

**Standard 8 requirement (3)(d)**

* Review the organisation’s risk management processes in relation to supporting consumers to live the best life they can and managing and preventing incidents.

**Standard 1**

|  |  |  |
| --- | --- | --- |
| 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. | Non-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**

The Quality Standard is assessed as non-compliant as one of the six specific requirements has been assessed as non-compliant. The Assessment Team recommended requirement (3)(d), in Standard 1 Consumer dignity and choice not met.

**Requirement (3)(d)**

The Assessment Team were not satisfied risk mitigation strategies to reduce potential harm had been implemented for four consumers who regularly leave the service independently. The Assessment Team’s report provided the following evidence gathered through interviews, observations, and documentation relevant to my finding:

* Consumer A is assessed as a very high risk of falls and as lacking some safety awareness. The care file does not detail how staff are to support the consumer to continue to mobilise outside independently. While the consumer had a fall while out walking in February 2023, support arrangements were not reviewed in response. A mobility review in May 2023 indicated the consumer remained a falls risk when taking regular longer walks off site; there is no information to show risk mitigation strategies have been considered.
* Consumer B, assessed as having a cognitive impairment, lacking insight into their own capability, and not understanding risks, mobilises by propelling their wheelchair backwards. Progress notes include incidents where Consumer B had fallen from the wheelchair in the service, was observed leaving the service alone, and propelling backwards to a local shop. While progress notes show staff have identified this activity may have inherent risks, risks are not identified or documented.
* While risks have been discussed at Clinical team meetings, actual risks and mitigation strategies were not documented. Staff were unable to describe actions taken to support Consumer B to continue to do this activity and to reduce the associated risk of harm.
* Consumers C and D were observed walking out of the service alone. Care files indicate both consumers are at risk of falls and require supervision when mobilising. Customer choice agreements or documented risk mitigation strategies were not included in either consumers’ care file.
* Consumers C and D were observed leaving and/or returning to the service without either signing out on departure and/or signing back in on return, in line with the service’s process.

The provider acknowledged the Assessment Team’s recommendation. The provider’s response included, but was not limited to:

* Reviewed the four highlighted consumers. This included, but was not limited to, consultation with consumers and/or representatives, Physiotherapy reviews and completion of Customer choice agreements and risk assessments. Staff are to be educated on the strategies identified.
* Provided a training session to Administration and Concierge staff on safe entry and exit for consumers.

I acknowledge the provider’s response. However, I find each consumer was not effectively supported to take risks safely. I acknowledge that for the consumers highlighted, their wishes and preferences relating to risks they choose to take, that is leaving the service independently, have been respected, However, I have considered that consultation processes have not been undertaken with the consumers to help them understand the risks involved in the activities they choose to partake in or how these risks could be managed to assist them to undertake these activities safely. Consumers A, C and D have all been assessed as at risk of falls, and Consumer B is noted as having a cognitive impairment with a lack of insight into their own capabilities. However, risk mitigation strategies to support them to safely leave the service independently had not been implemented. I have also considered that despite Consumer A sustaining a fall while walking outside of the service, this did not trigger a review of support strategies. I acknowledge the actions taken by the provider in response to the deficits identified, however, I have considered that these improvement actions were initiated in response to the Assessment Team’s report and not as a result of the service’s own monitoring processes.

I acknowledge the provider has submitted a Plan for continuous improvement (PCI) to remedy the deficits identified and planned completion dates have been set. However, I consider that time will be required to establish efficacy, staff competency and improved consumer outcomes with the planned actions related to these requirements.

For the reasons detailed above, I find requirement (3)(d) in Standard 1 Consumer dignity and choice non-compliant.

**In relation to requirements (3)(a), (3)(b), (3)(c), (3)(e) and (3)(f)**, consumers sampled considered they are treated with dignity and respect, with their identity, culture and diversity valued and celebrated. Staff sampled were familiar with consumers’ backgrounds and described specific strategies implemented to maintain their identity, culture and diversity. Staff were observed to provide care and assistance to consumers in a dignified manner whilst treating them with kindness and respect.

Staff are guided by policies, procedures and a model of care which reflects organisational values of respect for culture, and the accountability of staff in the delivery of care in a culturally safe way. Staff demonstrated an understanding of cultural safety, were knowledgeable of specific cultural needs of sampled consumers and could describe how this influences the delivery of care and services.

Consumers sampled felt they are supported to exercise choice and independence and said they have been consulted and involved in making decisions about their care and service delivery. Staff described how they support consumers to exercise choice and maintain relationships and described tools and documentation available to assist consumers in decision-making.

Consumers confirmed they are provided information, which is clear, easy to understand and enables them to make choices about their care. Information is provided through a range of avenues, including meeting forums and noticeboards. Consumer meeting minutes sampled demonstrated a range of information is communicated, including policy updates, workforce changes, feedback and complaints, activities, meals, special celebrations and hospitality services. There are processes to ensure consumers’ privacy is respected and personal information kept confidential.

For the reasons detailed above, I find requirements (3)(a), (3)(b), (3)(c), (3)(e) and (3)(f) in Standard 1 Consumer dignity and choice compliant.

**Standard 2**

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

**Findings**

Care files sampled demonstrated a range of assessments which consider personal, clinical and lifestyle aspects of care are completed on entry and on an ongoing basis. A range of validated risk assessment tools are also used to inform care planning. Information gathered from consultation with consumers and/or representatives and assessment processes is used to develop a care plan which incorporates each consumer’s needs, preferences, goals and strategies to manage identified risks. Consumers and representatives said they receive regular contact from management, and staff are encouraged to be involved in discussions relating to care planning and to assist with identification of risks.

Assessment and planning identify and address consumers’ current needs, goals and preferences, including advance care planning and end of life planning. Consumers are supported and encouraged to share consumers’ end of life and palliative care wishes on entry and on an ongoing basis. Care files sampled included consumers’ preferences and current care needs, including things and people important to them to maintain their health and well-being.

Care files sampled demonstrated consumers and representatives, and other organisations, individuals and providers of care participate in assessment and care planning processes on entry and on an ongoing basis. Where other providers of care had been involved, care plans had been updated to reflect recommendations to ensure delivery of care and services in line with consumers’ assessed needs.

There are processes to ensure the outcomes of assessment and planning are communicated to consumers, staff and others and documented in a care plan which is readily available to staff to guide provision of care and services and to consumers and/or representatives. Care plans are updated in response to incidents, changes in consumers’ health and well-being, and routinely on an annual basis. When updated, care plan information is provided to the consumer and/or representative during the regular case conference review process for acknowledgement and to provide an opportunity for comment. Care files demonstrated consumer and representative meetings had been held where care plans and the outcome of assessments are reviewed and discussed. Consumers and representatives were satisfied they are informed of the outcome of assessments and whenever changes in the way care is to be delivered occur.

Based on the Assessment Team’s report, I find all requirements in Standard 2 Ongoing assessment and planning with consumers compliant.

**Standard 3**

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

**Findings**

Requirement (3)(b) was found non-compliant following an Assessment Contact undertaken on the 16 February 2023, where effective management of high impact or high prevalence risks associated with the care of each consumer in relation to use of chemical restraint was not demonstrated. The Assessment Team’s report for the Site Audit provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Allocated a dedicated Registered nurse one day a week to review consumers subject to restrictive practice.
* Implemented a Clinical knowledge training program for new and existing staff where gaps in practice have been identified. The program covers best practice strategies related to restrictive practice, challenging behaviours, as required medication management, falls prevention, clinical deterioration, wounds and pressure area care management.
* Commenced regular audits to monitor, trend and report on consumer clinical care, including falls and wound management and implementation of restrictive practices.

At the Site Audit, consumers and representatives were satisfied with the care consumers receive, with personal and clinical care found to be safe and effective, in line with best practice, tailored to consumers’ needs, and optimising their health and well-being. Care files were reflective of consumers’ individualised personal care needs and demonstrated appropriate management of specific aspects of clinical care, including wounds and diabetes, and evidenced input from General practitioners and Allied health specialists. Staff described care needs for consumers allocated to their care, with the information provided by staff noted to align with consumers’ care plans.

High impact or high prevalence risks associated with the care of consumers are identified through assessment processes and management strategies are developed and documented in care plans to ensure care and services are delivered in line with consumers’ assessed needs and preferences. Care files demonstrated appropriate assessment and strategies to mitigate risks relating to falls, behaviours and restrictive practices. Staff described the main risks for the consumers sampled, as well as how the risks are managed.

The service collaborates with General practitioners, as well as the Nurse practitioner and external palliative care teams to ensure the needs, goals and preferences of consumers nearing the end of life are recognised and addressed. Preferences for one consumer who is currently palliating were documented and an End-of-life pathway in place to enable staff to meet the consumer’s wishes as they reach the end-of-life phase, including maintaining multidisciplinary comfort measures, pain management and specific wishes following their death. The consumer said they are regularly reviewed by the General practitioner and Nurse practitioner which include management of symptoms associated with their disease process, and staff ensure they remain comfortable and pain free, and respect their wishes. The consumer’s representative confirmed staff have discussed and updated the consumer’s end of life preferences and said they are happy with the current comfort care measures being provided.

Where changes to consumers’ health are identified, care files demonstrated prompt recognition and response, including referrals to General practitioners and/or Allied health specialists. Where changes to consumers’ care and service needs occur, there are processes to ensure these are communicated to staff and care plans updated to reflect any changes to consumers’ care and service needs. Staff demonstrated an understanding of their roles and responsibilities, including identifying and escalating signs of deterioration, and consumers and representatives said staff are aware of consumers’ care needs and how they like care to be delivered, and said they are supported to access external providers when and as required.

An effective infection prevention and control program is in place that aligns with the nationally recognised guidelines and applicable governing standards. The service has a designated Infection prevention control lead who has responsibility for overseeing staff training and monitoring staff practice. Antibiotic therapy is only prescribed when a consumer is symptomatic, has a history of infection related illness, or has a confirmed infection through pathology assessment. Consumer infections are monitored and reviewed monthly to identify trends. Policies and procedures related to antimicrobial stewardship, appropriate monitoring of infection and for the prescribing of antimicrobials are in place to guide staff practice, and staff were observed to apply appropriate infection prevention and control processes throughout the Site Audit.

Based on the Assessment Team’s report, I find all requirements in Standard 3 Personal care and clinical care compliant.

# Standard 4

|  |  |  |
| --- | --- | --- |
| 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 and representatives were satisfied services and supports for daily living meet consumers’ needs, goals and preferences, and they receive the emotional, spiritual and psychological support they need to promote and maintain their mental well-being. A schedule is maintained identifying consumers who are unable to participate in broader scheduled activities, with ongoing engagement provided by staff through one-to-one activities and conversations, to support consumers’ psychological and emotional well-being. Activity schedules demonstrated multi-denominational religious services are provided and church volunteers visit the service to provide consumers one-on-one spiritual support. Staff described consumers’ interests and preferences, in line with information documented on lifestyle care plans, and were observed providing emotional support to consumers throughout the Site Audit.

Consumers confirmed they are supported to participate in the community, have personal and social relationships and do things that are of interest to them. Care files identified family, friends and other consumers and people who are important to consumers and staff were able to identify activity preferences for sampled consumers and describe how they support them to maintain social and personal relationships.

Information about consumers’ condition, needs and preferences is documented and communicated within the service and with others where responsibility is shared and, where required, there are processes to ensure appropriate and timely are referrals are initiated. Care files included sufficient information to support and guide staff in the delivery of effective and safe care and staff said they are kept informed of updates to consumer care and services. Consumers and representatives sampled felt staff were competent and understood consumers’ care needs and preferences.

Most consumers provided positive feedback regarding food, stating meals are varied and of suitable quality and quantity, and felt comfortable asking for variations or alternatives as they pleased. Meals are prepared onsite daily, in line with a seasonal menu which has been approved by a Nutritionist. Consumers are consulted on upcoming menus during monthly meeting forums and hospitality staff said changes to menus are made in response to feedback received, in conjunction with nutritional approval. Meals were observed to be well-presented with at least two main options available, as well as alternatives.

There are processes to ensure equipment, required to support delivery of services, is clean, safe and suitable for consumer use. Reactive and preventative maintenance and cleaning processes ensure equipment is clean and well maintained. Consumers and representatives sampled said consumers feel safe when using equipment and maintenance are responsive in managing required repairs.

Based on the Assessment Team’s report, I find all requirements in Standard 4 Services and supports for daily living compliant.

# Standard 5

|  |  |  |
| --- | --- | --- |
| 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

The service environment was observed to be welcoming, and supportive of consumers by way of lighting, wayfinding signage, and comfortable spaces indoors and outdoors for interaction with others or for quiet time alone. All corridors lead to communal dining areas and sitting rooms, enabling easy navigation and consumers were observed using the lift, which had large buttons and clear signage, independently. Consumer rooms were spacious and personalised with natural light and individual heating and cooling systems. Consumers and representatives said consumers feel at home in the service, the environment feels very comfortable and were happy with the décor and feel of the service environment.

The environment was observed to be safe, clean and well maintained, and consumers were observed to move freely both indoors and outdoors. Cleaning is undertaken in line with run sheets and there are reactive and preventative maintenance processes in place. Staff described how they report maintenance issues and hazards, in line with the service’s processes. Furniture, fittings and equipment was observed to be safe, clean and well maintained. Consumers and representatives stated consumers feel safe in the service and are satisfied with furniture, fittings and equipment, and with cleaning and maintenance of the environment.

Based on the Assessment Team’s report, I find all requirements in Standard 5 Organisation’s service environment compliant.

# Standard 6

|  |  |  |
| --- | --- | --- |
| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | 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 two of the four specific requirements have been assessed as non-compliant. The Assessment Team recommended requirements (3)(c) and (3)(d) in Standard 6 Feedback and complaints not met.

**Requirement (3)(c)**

Consumers and representatives were not confident the organisation acts promptly and appropriately when responding to feedback and complaints. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* Most consumers were not confident action is taken to resolve their issues as they are not kept informed of actions taken. Feedback from three representatives included having to report the same issues on multiple occasions before feeling they were resolved; not consistently made aware of actions taken, and sometimes they see changes have been made, but are not asked about their satisfaction directly; and information relating to actions taken to prevent a repeat of an incident has not been provided.
* Complaints reported to the Assessment Team by one representative were not recorded in the Feedback register or in progress notes.
* The Feedback register and progress notes did not record all actions taken to resolve issues, involvement with consumers or representatives in the resolution process or that issues had been resolved to the satisfaction of the complainants.
* Care worker meeting minutes for May 2023 show feedback relating to three consumers had been discussed. Progress notes for these consumers did not document open communication throughout the resolution practice, in line with service’s policies nor were they recorded on the Feedback register.
* Staff examples of complaints handling did not show knowledge of the service’s processes. Staff said they would try and resolve any issues raised immediately but would not always document this into the electronic feedback system.
* All staff said unresolved feedback was escalated to the manager. Management said they select which complaints and feedback are entered into the electronic feedback register, indicating generally only unresolved complaints were recorded.
* Management said verbal handover and discussion at clinical team meetings are used to ensure complaints are followed up and appropriate action taken. However, management were not aware that one representative was still awaiting information about the resolution of an issue, and another had not been fully informed of actions taken to prevent reoccurrence of an incident. Management contacted both representatives during the Site Audit.

The provider accepted the Assessment Team’s recommendation. The provider’s response included, but was not limited to:

* Followed up with the representatives highlighted.
* Introduced a new Registered nurse role as a Customer engagement nurse who will be responsible for handling complaints and family engagement in collaboration with the Facility manager.
* All complaints will be escalated to the Facility manager to ensure timely resolution and follow-up to the complainants’ satisfaction.
* Plan to undertake discussions relating to the complaints handling policies and procedures with staff.

I acknowledge the provider’s response. However, I find the service did not demonstrate a best practice system for managing and responding to complaints. In coming to my finding, I have considered feedback from representatives demonstrating appropriate follow up and action of complaints is not consistently undertaken. While complaints have been raised, these have not been consistently captured in the Feedback register or in progress notes. This was further supported by feedback from staff who demonstrated a lack of knowledge of the service’s complaints handling processes, indicating they do not always record feedback which I find does not enable the service to ensure appropriate response and actions have occurred. I have also considered that while there are processes to ensure complaints are followed up and actioned, management were not aware that consultation in relation to resolution of a complaint and actions taken in response to an incident had not occurred with two representatives. As such, I find the evidence demonstrates appropriate and timely action is not taken in response to feedback and complaints, or complaints are monitored to provide the service opportunities to find and act on things that can improve their systems.

For the reasons detailed above, I find requirement (3)(c) in Standard 6 Feedback and complaints non-compliant.

**Requirement (3)(d)**

The Assessment Team were not satisfied the service demonstrated an effective system to track and document feedback. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

* The Feedback register for the period January 2023 to May 2023 did not reflect all feedback submitted during this period, with a total of 10 compliments and two complaints recorded. The register did not include the investigation or identify if there were any process improvements identified from the complaints. Both complaints were noted as ‘closed’ and ‘resolved’.
* Management provided six examples of recent complaints and resolutions recorded in progress notes. None of these were listed on the Feedback register. Management advised there were further examples, however, were unable to recall the details to locate them in the progress notes of individual consumers.
* Missing clothing items were identified by a manager as a trending complaint since commencing with the service seven months ago. There were no related complaints or feedback recorded in the Feedback register for January 2023 to May 2023.
* Several plans for continuous improvement have been submitted based on issues with laundry. However, consumers and representatives were unaware of improvements being implemented and staff sampled identified complaints about missing clothing remains a common occurrence.
* Consumers and representatives were unaware of what service improvements have been identified following their feedback.
* Feedback and complaints data is not reviewed and analysed to identify trends and areas for improvement.

The provider generally accepted the Assessment Team’s recommendation. The provider’s response included, but was not limited to:

* All improvements being implemented from complaints to be discussed at consumer and staff meeting forums and added to monthly newsletters.
* Processes are in place to report missing laundry items. A site-wide audit for February 2023 to May 2023 has been conducted to find any misplaced clothes with actions implemented.

I acknowledge the provider’s response. However, I find the service has not actively used avenues available to them to enable improvements to the quality of care and services to be identified. In coming to my finding, I have considered while a Feedback register is maintained, complaints data received is not consistently captured and documented on the register. Complaints raised are documented in individual consumer’s progress notes, and as highlighted in requirement (3)(c) of this Standard, management indicated they will select which complaints and feedback are entered into the register, which generally only includes unresolved complaints. As such, I find the service’s processes do not enable sufficient oversight of complaints data to enable emerging trends and improvement opportunities to be identified.

For the reasons detailed above, I find requirement (3)(d) in Standard 6 Feedback and complaints non-compliant.

**In relation to requirements (3)(c) and (3)(d)**, I acknowledge the provider has submitted a PCI to remedy the deficits identified and planned completion dates have been set. However, I consider that time will be required to establish efficacy, staff competency and improved consumer outcomes with the planned actions related to these requirements.

**In relation to requirements (3)(a) and (3)(b)**, consumers and representatives confirmed they are supported to provide feedback and make complaints and felt confident and comfortable to do so without fear of reprisal. Consumers are encouraged to provide feedback and complaints, including through meeting forums and use of feedback forms, and feedback deposit boxes were located on each floor to enable feedback and complaints to be lodged anonymously. Management maintains an ‘open door’ policy and consumers and representatives regularly approach management to provide feedback. Staff described ways in which they support consumers to provide feedback, including directing them to the available resources, assisting them to complete feedback forms and documenting or escalating matters to management, if required.

The Aged Rights Advocacy Service visits the service every six-months, and the service’s website includes information on how to make a complaint and how to contact the Commission where consumers and/or representatives are not satisfied with the response from the service. Information relating to advocacy support and language services was not readily available. Information relating to other methods for raising and resolving complaints was observed on the ground and first floor, however, not on the second floor. Staff said they would work with management to engage any service required to support a consumer to provide feedback and representatives sampled were aware of avenues to provide feedback and complaints, including external avenues.

For the reasons detailed above, I find requirements (3)(a) and (3)(b) in Standard 6 Feedback and complaints compliant.

# Standard 7

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

Findings

Adequate staffing levels across the service were demonstrated, with contingencies and strategies in place for planned and unplanned leave. A centralised organisational master roster is maintained, ensuring consistency with staffing coverage and delivery of mandated care minutes. Staffing sufficiency is monitored through feedback, observations and review of incident data, with the ability to implement short term roster changes to address operational needs and ensure the needs of consumers are met. Staff were satisfied with the level of staff indicating they have sufficient time to effectively complete their duties, and consumers and representatives were happy with staffing levels and mix and response to call bells.

Consumers and representatives spoke positively of staff, indicating staff know consumers’ needs and treat them with respect, and observations confirmed staff are kind, caring and respectful when interacting with consumers. The organisation’s mission and values are explained to staff as part of the onboarding process, and expectations of staff behaviour and how they are to treat consumers is set from commencement of employment.

There are processes to ensure the workforce is competent and have the qualifications and knowledge to effectively perform their roles. To ensure delivery of safe and effective care to consumers, ongoing staff competency is supported by the utilisation of Clinical nurse educators, a Nurse practitioner, and an aged care Clinical mentor. Staff competency is monitored through direct observation, review of staff performance appraisals, feedback, audits, and review of incidents and clinical indicators. All staff felt supported by management and indicated they have received sufficient training to undertake their roles. Overall, consumers sampled felt confident staff were skilled and they deliver care and services that meet their needs.

A comprehensive onboarding process is undertaken for all new staff which includes mandatory training, an induction and buddy shifts. Training is undertaken on an ad hoc basis, in response to identified need, for example, training has been implemented for staff in response to outcomes of a wound audit and to manage a consumer with a specific medical device. Training records show all staff complete mandatory training components with completion monitored and non-attendance followed-up. Overall, consumers and representatives have confidence in the ability of permanent staff to deliver consumers’ care and services.

The service has a staff performance management framework which ensures staff performance is regularly assessed, monitored and reviewed. Staff performance is monitored through feedback processes, incident and complaints data, audits and observation of staff practice. While formal performance appraisal processes for care and registered staff are currently overdue, a schedule has been created to manage completion. There are processes to manage under-performance which includes support from management and intervention from the organisational Human resource team.

Based on the Assessment Team’s report, I find all requirements in Standard 7 Human resources compliant.

**Standard 8**

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

**Findings**

The Quality Standard is assessed as non-compliant as one of the five specific requirements has been assessed as non-compliant. The Assessment Team recommended requirement (3)(d), in Standard 8 Organisational governance not met.

**Requirement (3)(d)**

Effective risk management systems and practices relating to recognising and responding to high impact or high prevalence risks and identifying and responding to abuse and neglect were demonstrated. However, effective risk management systems and practices relating to supporting consumers to live their best life and managing and preventing incidents were not demonstrated. The Assessment Team’s report provided the following evidence gathered through interviews and documentation relevant to my finding:

Supporting consumers to live the best life they can:

* Staff were not following the organisation’s policy relating to Customer choice agreements and identification and documentation of risk mitigation strategies to support consumers to undertake activities which include an element of risk. Staff had limited understanding that supporting consumers to engage in activities where risk of harm had been identified required them to identify potential consequences, discuss with the consumer how it may impact them and identify, implement and document measures to reduce harm.

Managing and preventing incidents:

* All eight incident reports sampled did not consistently include information about the resulting investigation and information relating to investigations to identify the root cause of the incident was not evident. Documentation showing actions identified and implemented to prevent reoccurrence were not evident for all incidents.
* A consumer and their family were unaware if any investigation had been undertaken following a medication incident in May 2023 or if actions to prevent reoccurrence had been identified. While the incident form rated the incident as a high priority, information about the incident investigation was not included, there was no information in progress notes to show the root cause of the incident had been identified and addressed or if the risk of reoccurrence had been reduced.
* A consumer left the service unaccompanied in January 2023 and again in March 2023. Incident records and progress notes do not show any root causes were identified for either incident and while the consumer is now closely monitored, actions to prevent reoccurrence of this type of incident have not been clearly identified.
* One consumer experienced a fall in February 2023, while out walking. The incident investigation process did not initiate a review of the consumer’s ability to mobilise outside alone, or of the risk mitigation strategies in place to reduce the risk of reoccurrence.
* Management provided three examples of incidents where investigations had been documented. Actions for these incidents tended to focus on immediate actions rather than a thorough analysis of the incident to prevent reoccurrence.
* Information relating to incident investigation is documented in a variety of places outside of the incident management system.

The provider accepted the Assessment Team’s recommendation. The provider’s response included, but was not limited to:

* Undertaking a multidisciplinary approach to work through existing choice agreements and any that need to be raised as indicated through risk assessments.
* Plan to conduct training relating to incident management to all clinical staff and implemented changes to the incident management system to simplify documenting investigation, corrective actions and outcomes.
* Working through a Clinical governance maturity plan with a distinct focus on incident investigation and management. The plan includes updated policies and procedures to ensure standardisation of how incident management is documented.

I acknowledge the provider’s response. However, I find effective risk management systems and practices relating to supporting consumers to live the best life they can and managing and preventing incidents were not demonstrated.

While there are processes to support consumers to live the best life they can, staff have not consistently followed organisational policies, procedures and guidelines to ensure consumers who choose to partake in activities which include an element of risk are supported to undertake these activities safely. As highlighted in Standard 1 Consumer dignity and choice requirement (3)(d), consultation with four consumers who choose to leave the service independently had not been undertaken to assist them to understand the associated risks and strategies to mitigate risks had not been implemented. As such, I consider this has not ensured the possibility of risks and the impact to consumers is reduced.

I acknowledge incident reports sampled demonstrated prompt actions had been taken to ensure the immediate safety of consumers. However, I have considered the organisation’s incident management system has not been effectively used to prevent similar incidents occurring. Causative factors are not consistently identified or mitigating strategies implemented in response to incidents reported. Information relating to the investigation of incidents is also documented in a variety of places, outside the incident management system, which does not provide management sufficient oversight of incident data to identify trends and opportunities for improvement. As such, I find this has not ensured that all incidents are effectively monitored to ensure risks to consumers’ health and well-being are being minimised and/or eliminated.

I acknowledge the provider has submitted a PCI to remedy the deficits identified and planned completion dates have been set. However, I consider that time will be required to establish efficacy, staff competency and improved consumer outcomes with the planned actions related to this requirement.

For the reasons detailed above, I find requirement (3)(d) in Standard 8 Organisational governance non-compliant.

**In relation to requirements (3)(a), (3)(b), (3)(c) and (3)(e),** consumers are engaged in the development, delivery and evaluation of care and services through feedback processes, care plan review process, meeting forums and surveys. To further enhance consumers’ engagement, a Resident advisory committee has recently been established to enable consumers to identify and discuss issues they feel are important. Consumers and representatives considered the service to be well run, and stated management are approachable and easy to talk to.

The governing body promotes a culture of safe, inclusive, and quality care and services and is accountable for their delivery. A range of reporting mechanisms are in place to ensure the Board is aware and accountable for the delivery of care and services provided.

The organisation has a governance structure to support all aspects of the organisation, including information management, continuous improvement, financial governance, workforce and clinical governance, and regulatory compliance. There are processes to ensure these areas are monitored and reported on. While not all feedback and complaints were actioned, tracked or documented, the organisation was found to have a feedback and complaints framework, inclusive of policies and procedures, to guide management and staff in relation to feedback and complaint processes.

A clinical governance framework is supported by policies and procedures to guide staff practice, including in relation to antimicrobial stewardship, minimising use of restraint and open disclosure. Management and staff awareness of organisational policies and procedures relating to clinical governance was further demonstrated through evidence presented in other Standards.

For the reasons detailed above, I find requirements (3)(a), (3)(b), (3)(c) and (3)(e) in Standard 8 Organisational governance compliant.

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