Bethanie Waters

Performance Report

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

**Commission ID:** 7276

**Provider name:** The Bethanie Group Incorporated

**Site Audit date:** 1 March 2022 to 3 March 2022

**Date of Performance Report:** 04 May 2022

# Performance report prepared by

Janine Renna, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

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

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others; and
* the provider’s response to the Site Audit report received on 12 April 2022.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

The Quality Standard is assessed as compliant as six of the six specific Requirements have been assessed as compliant.

Overall, consumers considered they are treated with dignity and respect, can maintain their identity and live the life they choose. Consumers and representatives said consumers are supported and encouraged to do things for themselves and provided examples of how their privacy is maintained by staff, how their care and services are culturally safe and how they are supported to exercise choice, take risks and maintain relationships.

Staff spoke about consumers in a respectful manner, described their personal circumstances, background and preferences, and provided examples of how they ensure care and services are culturally safe. Staff explained how they maintain consumers’ privacy and support them to exercise choice and take risks.

Sampled care plans documented consumers’ cultural needs and preferences and were reflective of how they want their care to be delivered. Care plans provided strategies for staff to support consumers in taking risks.

Documentation, observations and interviews with consumers, representatives and staff, demonstrated consumers are provided information to assist in making choices regarding meals, activities and their personal and clinical care.

Based on this evidence, I find the service compliant with all Requirements in Standard 1 Consumer dignity and choice.

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

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

*Each consumer is supported to exercise choice and independence, including to:*

1. *make decisions about their own care and the way care and services are delivered; and*
2. *make decisions about when family, friends, carers or others should be involved in their care; and*
3. *communicate their decisions; and*
4. *make connections with others and maintain relationships of choice, including intimate relationships.*

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

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

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

*Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.*

### Requirement 1(3)(f) Compliant

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

# STANDARD 2 COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

The Quality Standard is assessed as compliant as five of the five specific Requirements have been assessed as compliant.

The Assessment Team has recommended the service does not meet Requirement (3)(a) in Standard 2, as the service was unable to demonstrate assessments resulted in development of interventions or strategies to inform delivery of safe and effective care and services.

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

In relation to all other Requirements in this Standard, the Assessment Team found overall, consumers confirmed they feel like partners in the ongoing assessment and planning of their care and services. Consumers and representatives reported they have spoken to staff regarding advance care planning and representatives are contacted when there are changes to the consumer’s condition.

Most consumer files sampled identified and addressed consumers’ needs, goals and preferences relating to care and services and there are processes to identify consumers’ preferences relating to advance care planning and end of life planning. However, information and evidence presented by the Assessment Team under Requirement (3)(a) in Standard 4 Services and supports for daily living showed two consumers did not have a lifestyle care plan that identified their needs, goals and preferences in relation to supports for daily living. I have placed weight on the provider’s response that demonstrates the following:

* One consumer’s lifestyle supports were not immediately identified upon entry due to an influx of consumers. The organisation’s policy requires this be undertaken within 28 days after entry, which was not until the last day of the Site Audit; and
* One consumer’s preference to walk outside was not documented, however, progress notes evidenced that this occurred.

I have considered evidence in the Assessment Team’s report and provider’s response in relation to the two consumers and find that it does not indicate systemic deficiencies in relation to Requirement (3)(b) in this Standard.

Care files demonstrated staff work with the consumer and/or representative to ensure care and service provision is in line with consumers’ needs and preferences. Involvement of other providers of care, including Speech pathologist and Dietitian was also noted.

There are processes to ensure the outcomes of assessment and planning are communicated to consumers and documented in a care plan which assists staff to deliver care and services in line with consumers’ preferences. Care files demonstrated discussions relating to care and services are undertaken with consumers and/or representatives after entry, at six monthly care plan review meetings or when consumers’ circumstances change.

There are processes to ensure care plans are up-to-date and meet the consumer’s current needs, including when changes are required due to an adverse event or a change in the consumer’s health condition. However, information and evidence presented by the Assessment Team under Requirement (3)(a) in Standard 3 Personal care and clinical care showed one consumer did not have a wound assessment and care plan following a shaving cut. I have considered evidence in the Assessment Team’s report and find that this one occurrence does not indicate systemic deficiencies in relation to Requirement (3)(e) in this Standard.

Based on this evidence, I find the service to be compliant with Requirements (3)(b), (3)(c), (3)(d) and (3)(e) in Standard 2 Ongoing assessment and planning with consumers.

## Assessment of Standard 2 Requirements

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

*Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.*

The Assessment Team was not satisfied the service demonstrated 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. While evidence demonstrates that regular and ongoing assessments are conducted by staff, the Assessment Team considered this information is not used to develop interventions or strategies to deliver safe and effective wound care. The Assessment Team provided the following evidence relevant to my finding:

Consumer A

* Following identification of a blister on the consumer’s right heel, a skin assessment was undertaken which identified the consumer as having some risk of developing pressure injuries. Interventions were to apply moisturiser twice daily, regular podiatry and foot care, regular repositioning and pressure area care.
* When the wound had deteriorated to unstageable, regular wound reviews and assessments were undertaken and did not identify further interventions or action to reduce the consumer’s risk of skin impairment. However, support was provided from a nursing outreach service.
* Documentation showed further strategies to reduce the consumer’s risk of skin impairment were not identified until three months after the wound had deteriorated to unstageable. Strategies included use of a pressure relieving mattress and weekly skin assessments.
* The wound has since reduced in size, however, it is noted to be offensive.

Consumer B

* Skin assessments undertaken following identification of a stage three pressure injury recorded the same interventions as consumers with no injury.
* Further interventions to reduce the risk of skin impairment were not introduced until five months after the wound was identified.

Consumers E and F

* Risk assessments were not undertaken in relation to two consumers identified as using low line beds.

The provider acknowledges the Assessment Team’s findings in relation to lack of risk assessments for the use of low line beds, however, maintains that assessment and planning processes considered risks associated with two consumers’ skin integrity and informed the delivery of safe and effective care and services. The provider’s response includes the following information and evidence to refute the Assessment Team’s assertions:

Consumer A

* Care plan to demonstrate personalised strategies to manage the consumer’s wound and risk of developing pressure injuries were included.
  + It cannot be determined whether the information in the care plan was in place at the time of the Site Audit or completed after.
* Risk assessment interventions document demonstrating suggestions for best practice interventions for each level of risk identified were consistent with the care the consumer received.
* Progress notes demonstrating a pressure relieving mattress was introduced when the wound was identified as unstageable, not three months later, as indicated by the Assessment Team.
* Root cause analysis conducted prior to the Site Audit demonstrating incorrect staging of the wound, delay in assessment and lack of prevention strategies.

Consumer B

* Progress notes to demonstrate the consumer was assessed as having moderate risk of pressure injuries one month prior to identification of a pressure injury. In response, additional pressure relieving strategies were introduced, including a pressure relieving mattress, tilted wheelchair with specialised cushion, repositioning, bed cradle and calf cushions.

Consumers E and F

* Progress notes demonstrating the consumers did not require low line beds and have since had them removed.
* Continuous quality improvement document demonstrating trial of a bed height indicator tool in response to deficiencies identified by the Assessment Team.

I acknowledge the provider’s response and associated information provided. In coming to my finding, I have considered evidence presented in the Assessment Team’s report and the provider’s response, which demonstrates the service is compliant with this Requirement.

In relation to Consumer A, I have considered evidence in the Assessment Team’s report does not indicate the consumer did not receive safe and effective care and services which resulted from deficiencies in assessment and planning processes. While skin assessments did not document new strategies when the wound had deteriorated, external input was sought, new strategies were implemented, and the wound has since improved. I have also considered that prior to the Site Audit, a root cause analysis was undertaken in relation to management of Consumer A’s wound. Some deficiencies in assessment and planning processes were subsequently self-identified and improvements implemented.

In relation to Consumer B, I have placed weight on evidence included in the provider’s response which demonstrates the consumer was assessed as having moderate risk of pressure injuries and this informed the delivery of safe and effective care and services, as pressure relieving strategies were introduced.

The provider acknowledged that the associated risk had not been considered for two consumers using low line beds, as they were not an assessed requirement and have since been removed. Additionally, the service has implemented processes to ensure staff are aware of the correct bed height for all consumers using a low line bed. I find the service’s actions reasonable and consider it is not proportionate to suggest that assessment and planning processes do not inform the delivery of safe and effective care and services based on two consumers that had no negative outcome.

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

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

*Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.*

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

*The organisation demonstrates that assessment and planning:*

1. *is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and*
2. *includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.*

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

*The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.*

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

*Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.*

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

The Quality Standard is assessed as non-compliant as one of the seven specific Requirements has been assessed as non-compliant.

The Assessment Team has recommended the service does not meet Requirements (3)(a) and (3)(b) in Standard 3, as the service was unable to demonstrate:

* each consumer gets safe and effective personal care, clinical care or both personal care and clinical care that is best practice, tailored to their needs, and optimises their health and well-being; and
* effective management of high impact or high prevalence risks associated with the care of each consumer.

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

In relation to all other Requirements in this Standard, the Assessment Team found overall, consumers sampled considered they receive personal and clinical care that is safe and right for them. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* the needs, goals and preferences of consumers nearing end of life have been recognised;
* consumers have access to relevant providers of care and services when needed; and
* health screening of visitors is undertaken on entry to ensure the spread of infection risk to consumers is minimised.

The service has processes to ensure the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, with their comfort maximised and their dignity preserved. Care planning documentation sampled demonstrated specialist palliative care services are accessed as required for additional support, and advance care and end of life wishes are documented to guide staff.

Palliative care assessments are completed in consultation with consumers and/or representatives and includes goals, strategies, spiritual, cultural, and psychological aspects of care and planned personal and clinical care management strategies. Care staff described monitoring processes and end of life care wishes for one consumer who recently passed away and the care they provided, including repositioning and pressure area care and oral care.

Where changes to consumers’ health are identified, care files sampled demonstrated, assessments and monitoring processes are implemented and referrals to relevant health professionals initiated. Additionally, where changes to consumers’ care and service needs occur, there are processes to ensure these are communicated to staff.

The organisation has protocols and policies to guide staff in relation to antimicrobial stewardship, and standard and transmission-based precautions to prevent and control infection. The Assessment Team observed appropriate infection prevention and control practices.

Based on this evidence, I find the service to be compliant with Requirements (3)(b), (3)(c), (3)(d), (3)(e), (3)(f) and (3)(g) in Standard 3 Personal care and clinical care.

### Assessment of Standard 3 Requirements

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

*Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:*

1. *is best practice; and*
2. *is tailored to their needs; and*
3. *optimises their health and well-being.*

The Assessment Team was not satisfied the service demonstrated each consumer gets safe and effective clinical care that is best practice, tailored to their needs and optimises their health and well-being, specifically in relation to administration of psychotropic medication. The Assessment Team provided the following evidence relevant to my finding:

Consumer G

* The consumer was prescribed psychotropic medication for the purposes of settling their behaviour. Documentation showed the consumer was administered the medication on 11 occasions during February 2022.
* Behaviour charting demonstrates six episodes of behaviour during February 2022.
* The consumer’s care plan directs staff to check that pain is not a contributing factor and states the consumer usually responds well to a hot pack and analgesia.
* Documentation showed all non-pharmacological strategies listed in the consumer’s care plan, such as application of a heat pack, were not trialled before administering psychotropic medication.
* Documentation showed the effectiveness of non-pharmacological strategies and psychotropic medication were not consistently recorded.
* Despite multiple progress notes stating the medication was ineffective, the Medical officer had not reviewed the consumer’s medication in the three months since it was prescribed.

Consumer H

* Documentation showed the consumer returned from hospital with an as required order of psychotropic medication. The Assessment Team did not document the purpose of this prescription.
* Documentation showed the psychotropic medication was administered on two occasions following behaviours of agitation.
* Management said agency staff administered the psychotropic medication on both occasions and reported informed consent had not yet been obtained.

Consumer A

* The consumer was prescribed an anti-depressant medication to treat behaviours, including grabbing onto hoist whilst being transferred.
* Documentation showed the medication had not been administered as ordered.

Consumer I

* The consumer reported having a cut after being observed to have a dressing on their cheek.
* A wound chart or progress note in relation to the wound could not be located.
* Management reported the consumer cut their face whilst shaving and staff had dressed it, forgetting to add a progress note and commence a wound assessment and care plan.
* There was no evidence indicating an incident form had been completed.

Consumers E and F

Evidence in the Assessment Team’s report under Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers, Requirement (3)(a) in Standard 4 Services and supports for daily living, and Requirement (3)(c) in Standard 7 Human resources is relevant to this Requirement and demonstrates the following:

* Consumers E and F were identified as having low line beds in use.
* The Assessment Team observed Consumer E calling out and trying to stand up from their bed that was lowered to the floor level. Staff interviewed said the consumer’s bed is lowered to prevent falls. The representative said they were not informed about staff lowering the consumer’s bed to floor level and would never have agreed to it.
* Consumer F reported when trying to get into bed, they need to stoop down and fall onto their bed and when trying to get out, they need to roll and hold onto furniture to stand.
* There was no restraint authority in place consenting to this practice.

The provider did not agree with the Assessment Team’s findings and maintains the service is compliant with this Requirement. The provider’s response includes the following information to refute the Assessment Team’s assertions:

Consumer G

The consumer’s medication is effective and while staff did try multiple non-pharmacological strategies prior to administering psychotropic medication, they did not try all documented strategies. A memorandum has been sent to all staff to remind them of the correct procedure to follow prior to administering psychotropic medication. Evidence was provided to demonstrate ongoing review and assessment to ensure the consumer’s chemical restraint is administered appropriately.

Consumer H

The consumer was prescribed psychotropic medication by the hospital to treat delirium and it was administered by two agency staff as a result of agitation. The representative has been difficult to contact to ascertain informed consent; however, this has since occurred.

Consumer A

The consumer’s medication had not been administered due to a medication error and is now available and being administered as per Medical officer orders.

Consumers E and F

The provider’s response under Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers and Requirement (3)(a) in Standard 4 Services and supports for daily living acknowledges the use of a low line bed was not an assessed requirement and states they have since been removed.

The provider’s response does not address the use of the low line bed without discussing associated risks with the consumers’ representatives.

I acknowledge the provider’s response and associated information provided. In coming to my finding I have considered evidence presented in the Assessment Team’s report and the provider’s response, which demonstrates that at the time of the Site Audit, each consumer did not receive safe and effective care that was best practice, tailored to their needs and optimised their health and well-being.

I have considered that psychotropic medication administered to Consumer G was not used as a last resort, as required under the *Quality of Care Principles 2014*. While evidence demonstrates some non-pharmacological interventions were trialled before administering psychotropic medication, not all were, specifically those that would have been most beneficial if the behavioural trigger was pain.

I have considered that psychotropic medication administered to Consumer H falls within the definition of chemical restraint as per the *Quality of Care Principles 2014*, as it was used to treat anxiety, which is not consistent with the medication’s approved use. I have also considered that regulatory obligations under the *Quality of Care Principles 2014* had not been met, as informed consent was not obtained prior to the use of chemical restraint.

In relation to Consumer A, I have also considered information and evidence provided by the Assessment Team under Requirement (3)(b) in this Standard. While I acknowledge that the failure to administer prescribed medication to the consumer was an error, documentation does not show frequent or escalating behaviours that highlight a need to administer the medication nor does it demonstrate any adverse impact to the consumer. Therefore, evidence in the Assessment Team’s report does not indicate that best practice and tailored care that optimises the consumer’s health and well-being were not provided.

In relation to Consumer I, I find that information and evidence does not indicate the consumer did not receive care that was best practice, tailored to their needs and optimised their health and well-being. I have considered the evidence under Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers and Requirement (3)(c) in Standard 7 Human resources, which reflect the core deficiencies.

I have considered that despite not being an assessed need, a low line bed was being used and positioned at floor level for Consumers E and F which resulted in their inability to get out of bed independently. Additionally, the risks associated with use of low line beds had not been discussed with either consumers’ representatives prior to implementation.

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

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

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

The Assessment Team was not satisfied the service demonstrated high impact or high prevalence risks associated with the care of each consumer were effectively managed, specifically in relation to wounds. The Assessment Team provided the following evidence relevant to my finding:

Consumer A – Wound management

* Following identification of a blister on the consumer’s left heel, a wound assessment was undertaken, and care plan developed. Strategies to manage the risk included application of moisturiser, regular podiatry and foot care and regular repositioning. Documentation showed staff followed directives stated in the consumer’s care plan.
* Two weeks after the blister was identified, clinical staff identified it had deteriorated to an unstageable wound and was black and offensive. In response to the deterioration, regular wound reviews and assessment were undertaken and support was provided from a nursing outreach service.
  + Documentation showed the consumer’s skin assessment did not identify further interventions or action to reduce the consumer’s risk of skin impairment.
* Documentation showed that further strategies to reduce the consumer’s risk of skin impairment were not identified until three months after the wound had deteriorated to unstageable. Strategies included use of a pressure relieving mattress and weekly skin assessments.
  + Documentation showed weekly skin assessments were conducted for the two weeks after these strategies were implemented, however, none have been undertaken in the six weeks from the last skin assessment until commencement of the Site Audit.
* The wound has since reduced in size, however, it is noted to be offensive.
* Management said the consumer’s wound should have been identified at an earlier stage and as a result, a full root cause analysis was conducted which resulted in staff training and improvements to skin assessment processes.

Consumer A – Medication management

* The consumer was prescribed an anti-depressant medication to treat behaviours, which included grabbing onto hoist whilst being transferred.
* Behaviour charting for a five-month sampled period shows two instances of behaviours, including grabbing and agitation.
* Documentation showed the consumer was reviewed by an Occupational therapist, who provided staff with strategies to reduce behaviours whilst being transferred.
* Documentation showed the anti-depressant medication had not been ordered or administered. Management reported this was a medication error and arranged commencement of the medication during the Site Audit.
* The representative was satisfied with the consumer’s care and thought the medication had been administered to the consumer, as their behaviours had reduced.
* Three staff were unaware of the consumer’s grabbing behaviours and reported the consumer is in physical decline.

Consumer A – Nutrition

* The consumer had not been provided their supplement drink three times per day in the 11 days prior to the Site Audit. Staff reported they are unable to access the consumer’s supplements and are trying to provide an alternative supplement.
* Documentation showed the consumer had lost 1kg in the month prior to the Site Audit.

Consumer B – Wound management

* Documentation demonstrated the consumer had a stage three pressure injury.
* Skin assessments undertaken four months following identification of the wound had the same interventions as consumers assessed as being at minimal risk of skin impairment, including application of moisturiser, regular podiatry foot care and regular repositioning.
* Five months after identification of the pressure injury, a pressure relieving mattress was introduced.
* Documentation shows the consumer’s wound is healing.

Consumer C – Wound management

* Documentation showed the consumer’s change in skin integrity was identified and Medical officer immediately notified, who noted it appeared to be related to pressure.
* The following day, the change in skin integrity was photographed, and a wound assessment and management plan was implemented.
* At the time the consumer’s change in skin integrity was identified, the most recent skin assessment was conducted approximately four months prior. The skin assessment stated the consumer had a mild risk of pressure injury and included interventions of moisturiser twice per day, regular podiatry and foot care, and regular repositioning.

Consumer D – Wound management

* Documentation demonstrated the consumer had a large area of bruising with small central break. Measurements of the wound taken 14 days after identification showed an increase in size, however, they were not taken in a manner consistent with initial measurements and photographs did not clearly indicate whether the wound was healing.
* Documentation showed the consumer’s wound was being treated in accordance with their care plan.

The provider did not agree with the Assessment Team’s findings and maintains the service is compliant with this Requirement. The provider’s response includes the following information and evidence to refute the Assessment Team’s assertions:

Consumer A

* Two days after the wound was identified, the consumer was reviewed by a Medical officer and Dietitian who advised to continue pressure area care and commence nutritional supplements three times per day.
* Fourteen days after the wound was identified, a wound swab was taken and sent to pathology and a Serious Incident Response Scheme (SIRS) report was submitted. On the same day, the consumer was referred to a nursing outreach service and reviewed by an Occupational therapist where padded footplates were ordered and a pressure relieving mattress was introduced.
  + Progress notes were provided demonstrating a pressure relieving mattress was introduced 14 days after the wound was identified, not three months as indicated by the Assessment Team.
* Fifteen days after the wound was identified, the nursing outreach service’s recommendations were implemented, wound swab results were returned, and the consumer was commenced on antibiotics.
* Eighteen days after the wound was identified, a root cause analysis was completed.
  + Minutes of a Clinical care team meeting was provided demonstrating findings of the root cause analysis were discussed, including incorrect staging, wound deterioration, delay in assessment and lack of prevention strategies. Actions were discussed, which included continued monitoring, staff education and reminders, ensure wound chart reviews are undertaken, regular checks of wounds for deterioration and escalation where appropriate.
* The consumer’s wound continues to improve and is currently stage three.

Consumer B

* One month prior to identification of a pressure injury, the consumer was assessed as having moderate risk of pressure injuries. In response, additional pressure relieving strategies were introduced, including a pressure relieving mattress, tilted wheelchair with specialised cushion, repositioning, bed cradle and calve cushions. Progress notes were provided to support this statement.
* The unstageable pressure injury was identified following removal of a plaster cast. A Remediation report was provided to support this statement.
* Following identification of the pressure injury, the nursing outreach service assisted with the management of the wound. The consumer was referred to a diabetic ulcer clinic, but the representative cancelled the appointment. Progress notes and a Remediation report were provided to support this occurred.
* Seven months after the wound was first identified, further deterioration was noted, and the consumer was re-referred to the nursing outreach service.

Consumer C

* The presence of excoriation is an isolated incident for the consumer and does not indicate safe and effective care is not being provided. The wound was identified and promptly reviewed and treated, with completion of multiple skin assessments that include appropriate interventions to support safe and effective clinical care.
* Following identification of redness, the area was reviewed by a Nurse practitioner and Medical officer and treatment was commenced. Sixteen days after the wound was identified, it was noted to be much improved.

Consumer D

* The consumer’s wound has completely healed and there was no evidence indicating safe and effective care had not occurred.

I acknowledge the provider’s response and associated information provided. In coming to my finding I have considered evidence presented in the Assessment Team’s report and the provider’s response, which demonstrates the service is compliant with this Requirement.

In relation to management of Consumer A’s wound, I have placed weight on information and evidence in the provider’s response which demonstrates that upon identification of the wound, external input was sought, and strategies were implemented, and when the wound deteriorated, an investigation was conducted, and actions were taken to address self-identified deficiencies. I consider evidence provided by the Assessment Team does not demonstrate that deficiencies in care caused the wound to deteriorate and showed the wound was improving. While the Assessment Team found the consumer’s skin assessments and care plan did not include further interventions to manage the wound commensurate to its level of deterioration, there was no evidence demonstrating the consumer was not receiving the care they required. I find this evidence is more aligned with Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers.

In relation to medication prescribed to treat Consumer A’s behaviours, I have considered that documentation does not highlight frequent or escalating behaviours that demonstrate a need to administer the medication. This is supported by representative and staff feedback that the consumer’s behaviours had reduced, and they were in physical decline. I find the failure to order or administer the medication has had no adverse impact to the consumer and does not indicate ineffective management of high impact or high prevalence risks.

In relation to Consumer A not receiving their nutritional supplement for 11 days prior to the Site Audit, I have considered that the service was aware of supply issues and was trying to provide an alternative. Information in the Assessment Team’s report and provider’s response show the supplement was commenced to address weight loss and wound deterioration. There is no evidence indicating the lack of supplement has contributed to further weight loss or wound deterioration.

In relation to management of Consumer B’s wound, I have placed weight on information and evidence in the provider’s response which demonstrates that prior to identification of the consumer’s wound, their moderate risk of pressure injuries was known, and strategies were implemented to minimise the risk. It was not until a cast was removed that an unstageable pressure injury was identified and in response, external input was sought. Evidence in the Assessment Team’s report does not demonstrate that deficiencies in care caused the wound to deteriorate and while the wound had been ongoing for approximately nine months at the time of the Site Audit, documentation showed the wound was healing.

In relation to management of Consumer C’s wound, I consider that while the consumer was assessed as having minimal risk of pressure injury and subsequently had a change in skin integrity, there was no evidence indicating deficits in clinical care. On the contrary, evidence demonstrates that changes in skin integrity were identified early and when this occurred, steps were taken to minimise the risk of further deterioration.

In relation to management of Consumer D’s wound, I have considered that while the Assessment Team’s report indicates improvements in relation to best practice wound documentation, there is no evidence demonstrating ineffective wound management.

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

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

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

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

*Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.*

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

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

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

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

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

*Minimisation of infection related risks through implementing:*

1. *standard and transmission based precautions to prevent and control infection; and*
2. *practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.*

# STANDARD 4 NON-COMPLIANT Services and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

The Quality Standard is assessed as non-compliant as one of the seven specific Requirements has been assessed as non-compliant.

The Assessment Team has recommended the service does not meet Requirement (3)(a) in Standard 4, as the service was unable to demonstrate each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimises their independence, health, well-being and quality of life.

I have considered the Assessment Team’s findings; the evidence documented in the Assessment Team’s report and the provider’s response and find the service non-compliant with Requirement (3)(a). I have provided reasons for my findings under the specific Requirement below.

In relation to all other Requirements in this Standard, the Assessment Team found overall, consumers sampled considered the service supports consumers to do the things they want to do, and which are important for their health and well-being. For example:

* Five consumers and representatives provided examples of how consumers’ emotional, spiritual and psychological well-being are supported.
* Four consumers and representatives provided examples of the support consumers receive to enable them to do the things they want to do.
* Consumers said they were confident information about their preferences is shared between staff and external providers of care.
* Overall, consumers were satisfied with the meals provided and considered the menu caters for their preferences.

Consumers are provided with appropriate services and supports for daily living that promote each consumer’s emotional, spiritual and psychological well-being, including participating in their internal and external communities, doing things of interest to them and maintaining social and personal relationships within the service and in the community. Activities are provided either in a group setting or one-to-one with individual consumers. The activity program is regularly evaluated and reviewed, taking into consideration consumer feedback.

Consumer files sampled demonstrated information about consumers’ conditions, needs and preferences is documented and communicated within the service and with others where responsibility is shared and, where required, appropriate and timely referrals are initiated.

Care files sampled reflected consumers’ dietary needs and/or preferences. Staff sampled knew where to access information relating to consumers’ food and fluid preference and described dietary needs and preferences of consumers in line with documentation sampled.

There are processes to ensure equipment, required to support delivery of services, is clean, safe and suitable for consumer use. Equipment appeared to be clean and well maintained.

Based on the above evidence, I find the service compliant with Requirements (3)(b), (3)(c), (3)(d), (3)(e), (3)(f) and (3)(g) in Standard 4 Services and supports for daily living.

## Assessment of Standard 4 Requirements

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

*Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.*

The Assessment Team found most consumers receive services and supports for daily living that meet their needs, goals and preferences and optimise their independence, health, well-being and quality of life. However, the Assessment Team was not satisfied lifestyle supports meet the preferences of two consumers that had recently entered the service. The Assessment Team provided the following evidence relevant to my finding:

Consumer J

* The consumer was observed lying in their bed and said they do not like living at the service and only leave their room for lunch and dinner. The consumer reported they want to watch television, however, there is not one in their room.
* The representative said the only thing that would make the consumer happy is television and while they are aware televisions are not provided by the service, they would be happy to bring one from home, but it is too big and would not fit in the wardrobe space.
* The representative also said no one has approached them regarding supports for daily living to make the consumer happy and improve their quality of life and has observed the consumer lying in bed every day watching the wardrobe in front of them.
* The consumer’s care plan did not contain information regarding their lifestyle supports and preferences.
* There were no activities recorded for the consumer on the Activities chart.
* One staff said the consumer has not attended any activities since entry, as they refuse. The staff said the consumer stays in their room all day and only comes out for lunch and dinner.
* Another staff said they will invite the representative to discuss lifestyle supports once all relevant assessments had been completed. The staff said there have been a number of new consumers recently and assessments have had to be prioritised.
* Documentation shows the consumer has had one-to-one support from lifestyle staff and on the most recent visit, which occurred two weeks before the Site Audit, the consumer said they would like to have a television in their room.
* There was no evidence indicating any actions had been taken to assist the consumer to access a television in line with their reported preferences.

Consumer E

* The representative reported when they visit the consumer, they are always in bed. The representative felt the admission process was rushed and despite already residing in the service for 40 days, no one has approached her to talk about the consumer’s care or lifestyle supports.
* The representative stated the consumer enjoys walking outside, however, is unsure whether he is assisted with this as he would require a wheelchair.
* One staff reported, and documentation showed, the consumer’s care plan does not identify that the consumer enjoys going for walks outside, nor is there any evidence of this occurring.
* The Assessment Team observed the consumer calling out and trying to stand up from a bed that was lowered to the floor level. Staff interviewed said the consumer’s bed is lowered to prevent falls. The representative said they were not informed about staff lowering the consumer’s bed to floor level and would never have agreed to it.

The provider did not agree with the Assessment Team’s findings and maintains the service meets this Requirement. The provider’s response includes the following information and evidence to refute the Assessment Team’s assertions:

Consumer J

The provider acknowledges that while the consumer’s desire to have a television in their room was not yet identified, organisational policy requires lifestyle supports to be discussed with the consumer within 28 days of entry and this occurred within this timeframe. While a copy of the organisation’s policy was not provided, I note that the consumer’s 28th day at the service was the last day of the Site Audit.

The provider maintains the service is not obliged to provide a television for consumers and those in the common areas are available to be utilised. Additionally, families are encouraged to bring in furniture, and entertainment supports upon admission.

The response explains when Consumer J entered the service, there was a large influx of admissions. As a result, each consumer’s physical safety aspects were addressed, and other factors were prioritised according to high impact or high prevalence risks.

The response includes an Activities chart to demonstrate that Consumer J had attended two group and one individual activity on their second day after entry. The Activities chart does not indicate the consumer attended any further activities for 25 days until commencement of the Site Audit.

Consumer E

The provider maintains the consumer was well supported since entry to ensure lifestyle supports are in line with their preferences.

The response states initial lifestyle strategies were screened on entry to support the consumer’s transition to care. Since entry, an Occupational therapist has been working with the consumer to identify relevant equipment needed to support daily living, in addition to lifestyle preferences.

The response includes an Activities chart to demonstrate the consumer attended eight activities in the 40 days from entry until commencement of the Site Audit, however, notes that this is not a reflection of day-to-day supports from all staff that promote lifestyle as part of everyday care. The response includes an extract from progress notes prior to the Site Audit to demonstrate staff were taking the consumer for a walk outside.

I acknowledge the provider’s response and associated information provided. In coming to my finding, I have considered evidence presented in the Assessment Team’s report and the provider’s response, which demonstrates at the time of the Site Audit, each consumer did not receive safe and effective services and supports for daily living that met their needs, goals and preferences and optimised their independence health, well-being and quality of life.

In relation to Consumer J’s desire for a personal television, I have considered that evidence does not indicate the consumer’s preferences were not supported. The representative demonstrated an awareness that personal televisions are not provided by the service, however, there was no evidence demonstrating whether they raised their concerns with management nor was there any evidence they were not supported to bring in their own entertainment unit.

I acknowledge the organisation’s policy requires lifestyle supports to be discussed with consumers within 28 days after entry and that at commencement of the Site Audit, Consumer J had only resided at the service for 26 days. However, when a consumer enters a service, the service has an immediate obligation to ensure the consumer gets safe and effective services and supports for daily living that meets their needs, goals and preferences and optimises their independence, health and well-being. I find this did not occur for Consumer J, despite staff being aware they only leave their room for meals and documentation showed they only participated in activities on one day since entry. I have considered that risk to the consumer’s health and well-being was not identified and did not prompt consideration of how they can be supported during the 28-day period.

In relation to Consumer E, I have placed weight on evidence in the provider’s response which demonstrates the service was working with the consumer and representative to identify appropriate services and supports, and that staff were taking the consumer for walks outside in line with their preferences. I note the representative was not present on every occasion this occurred.

While evidence in the Assessment Team’s report shows both consumers’ needs, goals and preferences in relation to supports for daily living had not been captured in their care plan, I find this evidence is more aligned with Requirement (3)(b) in Standard 2 Ongoing assessment and planning with consumers.

I have also considered evidence in the Assessment Team’s report in relation to the use of a low line bed for Consumer E is more aligned with Requirement (3)(a) in Standard 3 Personal care and clinical care.

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

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

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

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

*Services and supports for daily living assist each consumer to:*

1. *participate in their community within and outside the organisation’s service environment; and*
2. *have social and personal relationships; and*
3. *do the things of interest to them.*

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

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

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

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

### Requirement 4(3)(f) Compliant

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

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

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

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

The Quality Standard is assessed as compliant as three of the three specific Requirements have been assessed as compliant.

Consumers feel they belong in the service and feel safe and comfortable in the environment. Consumers reported the environment feels homely and welcoming, is clean and well maintained, and they are encouraged to personalise their rooms. Overall, consumers also confirmed they feel safe, and the furniture and equipment they use are clean and well maintained.

Staff provided examples of how they make consumers feel at home and how they ensure the service environment and equipment are safe and clean, including the process for actioning and prioritising internal and external maintenance.

The environment was observed to be clean, safe and welcoming, with outdoor areas including seating and shaded areas. Consumers were observed moving around the environment freely and their rooms were personalised and comfortable. Furniture, fittings and equipment appeared to be safe, clean, well maintained and suitable for consumers.

Based on the above evidence, I find the service compliant with all Requirements in Standard 5 Organisation’s service environment.

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

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

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

# STANDARD 6 COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

The Quality Standard is assessed as compliant as four of the four specific Requirements have been assessed as compliant.

Consumers consider they are encouraged and supported to give feedback and make complaints, and appropriate action is taken to address feedback and complaints. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* they can provide feedback and complaints about consumers’ care and services in various ways, feel comfortable doing so and are confident their concerns would be rectified in a timely manner;
* they are aware of external complaints services if needed;
* their feedback and complaints have resulted in satisfactory changes and an apology is offered when appropriate; and
* their feedback has been used to improve the quality of care and services, including meals, providing free rapid antigen tests to frequent visitors and air-conditioning.

Staff described how they assist consumers in making a complaint and providing feedback and demonstrated an understanding of open disclosure. Staff described improvements that have been made in response to complaints and feedback made by consumers.

Information relating to internal and external complaints processes and advocacy services was observed in communal areas.

Based on the evidence above, I find the service compliant with all Requirements in Standard 6 Feedback and complaints.

## Assessment of Standard 6 Requirements

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

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

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

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

### Requirement 6(3)(c) Compliant

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

### Requirement 6(3)(d) Compliant

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

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The Quality Standard is assessed as non-compliant as one of the five specific Requirements has been assessed as non-compliant.

The Assessment Team has recommended the service does not meet Requirements (3)(a), (3)(c) and (3)(d) in Standard 7, as the service was unable to demonstrate:

* the workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services;
* the workforce is competent and members of the workforce have the qualifications and knowledge to effectively perform their roles; and
* the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

I have considered the Assessment Team’s findings; the evidence documented in the Assessment Team’s report and the provider’s response and find the service non-compliant with Requirement (3)(a) and compliant with Requirements (3)(c) and (3)(d). I have provided reasons for my findings under the specific Requirements below.

In relation to all other Requirements in this Standard, the Assessment Team found consumers and representatives considered staff interactions with consumers were kind, caring and respectful. Staff were observed respecting consumers’ privacy and interacting with them in a positive and gentle manner.

The service has a performance framework, supported by policies and procedures, to ensure staff performance is reviewed periodically and underperformance is addressed. Management said consumer and representative feedback, incident reports, surveys and internal audits influence the assessing, monitoring and reviewing of staff performance. Management provided examples where performance management processes were used in response to behavioural concerns.

Based on the evidence above, I find the service compliant with Requirements (3)(b), (3)(c), (3)(d) and (3)(e) in Standard 7 Human resources.

## Assessment of Standard 7 Requirements

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

*The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.*

The Assessment Team was not satisfied the service demonstrated the workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. The Assessment Team provided the following evidence relevant to my finding:

* Eleven of 13 consumers interviewed reported there are not enough staff and they need to wait for assistance. The consumers provided examples of how they are impacted, which included, but were not limited to, incontinence, feelings of being unwanted, frustration and delays in receiving pain relief.
* Twenty-three staff said they are busy and regularly short staffed, and at times, it impacts the delivery of care provided to consumers.
  + The staff provided examples, which included, but were not limited to, delays in showering consumers, responding to sensor mat alarms and call bells, conducting spot cleans instead of full cleans and cancellation of activities.
  + One staff said an additional shift was implemented for one area of the service as a result of previous sanctions, however, this shift was ceased at the beginning of 2022 without notice. The staff said there has been an increase in incidents pertaining to behaviour management in this area of the service, as staff are busy and are missing the triggers, which has at times resulted in physical injury between consumers and/or staff.

Documentation showed in January 2022 and February 2022, two and nine SIRS reports were lodged respectively, as a result of challenging behaviours in the corresponding area of the service.

* Management reported the service was ‘flooded with staff’ to assist when sanctions were applied, however, once they were overturned, the roster was reviewed and some of the shorter shifts were ceased.
* Staff rosters for a two-week sampled period showed four, 15, 34, 25 and six vacant permanent shifts for Enrolled nurses, Registered nurses, carers, hospitality and laundry respectively.
  + Management reported the service is actively recruiting to address staff shortages.
* Management reported if shifts are unable to be filled, they will extend existing shifts, access staff from the organisation’s casual staffing pool or engage agency staff.
* Call bell data for the two weeks preceding the Site Audit demonstrated 194 call bells that exceeded 10 minutes. The report demonstrates:
  + One consumer who requires full assistance had to wait over 10 minutes for assistance on 32 occasions.

The consumer said they understand that staff may not always be able to assist them in a timely manner and as a result, they evacuate in their continence pad.

Staff said the consumer presses the call bell for ‘any little thing’ and management could not provide evidence of how call bell data has been analysed to identify reasons behind the consumer’s frequent call bell use.

* Management reported call bell data is analysed monthly and response times over 10 minutes are flagged for discussion with staff. Management said the last month’s call bell data had not been reviewed and they were unable to describe how call bell data analysis is used to implement improvements to response times.

The provider did not agree with the Assessment Team’s findings and maintains the service meets this Requirement, as staffing ratios and targets have been reviewed and set which are being achieved. The response includes the following information and evidence to refute the Assessment Team’s assertions:

* Call bell response times are reviewed regularly to understand the cause of the delay and feedback is provided to consumers and staff. Peak times of calls are monitored to ensure roster patterns continue to meet consumers’ needs.
  + Call bell report for the month preceding the Site Audit was provided to demonstrate prompt answering of call bells.
* During a sampled period of 27 December 2021 to 15 March 2022, only five shifts were unfilled, and, on these occasions, staff worked as a team instead of being assigned to a dedicated wing and tasks are prioritised by management.
  + Master roster and vacancies document was provided for the period 28 February 2022 to 6 March 2022 to demonstrate 10 unfilled shifts and a reduction in vacancies. The response states this report includes additional carer shifts that are above the current master roster.
* The service is working on a cultural journey with staff to help them recognise that staffing ratios in place while effecting change during the sanction are not sustainable and current staffing numbers are sufficient to provide safe and quality care.
* New consumers in one area of the service have resulted in temporary change to behaviours, which can be an outcome of a change in cohort.

I acknowledge the provider’s response and associated information provided. In coming to my finding, I have considered evidence presented in the Assessment Team’s report and the provider’s response, which demonstrates that at the time of the Site Audit, the workforce was not 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.

I acknowledge the service is actively recruiting to fill vacancies and that call bell response times are analysed to understand the cause, however, there was no evidence indicating how this analysis is used to improve the delivery of care and services. I have considered that 11 of 13 consumers and 23 staff reported staffing numbers to be inadequate to enable the delivery of quality care and services and provided examples of the impact this has to consumers. The provider’s response did not address examples of incontinence, delays in delivery of pain relief and showering, cancellation of activities and spot cleaning.

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

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

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

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

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

The Assessment Team found systems were in place to ensure members of the workforce have relevant qualifications and certifications to complete their role. However, the Assessment Team was not satisfied the service identified gaps in knowledge and competency or provide adequate training to ensure staff effectively perform their roles. The Assessment Team provided the following evidence relevant to my finding:

* Staff interviewed were not able to demonstrate competence or appropriate knowledge and understanding of the organisation’s policies and guidelines, and regulatory obligations in relation to the use of restraint.
  + Consumer H was administered psychotropic medication without obtaining informed consent.
  + Consumers E and F’s beds were lowered to the floor to prevent falls despite not having an assessed need for this to occur and without obtaining informed consent.
  + Staff did not follow care directives and provide alternative pain management interventions to Consumer G prior to administering medication or documenting its effectiveness.
* Staff were unable to describe falls management strategies for Consumer H, despite experiencing 11 falls during February 2022.
* Staff did not record or complete an incident report or commence a wound chart for Consumer I following identification of a wound on their face.
* Staff did not identify Consumer A’s wound at an early stage, resulting in it progressing to unstageable.
* The service reported training records are used to monitor staff competency. Training records demonstrated 44% of staff had not completed mandatory training and were regarded non-compliant.

The provider does not agree with the Assessment Team’s findings and maintains the service is compliant with this Requirement. The provider’s response for Requirement (3)(b) in Standard 3 Personal care and clinical care states that following identification of Consumer A’s wound, a root cause analysis was completed and found deficiencies in relation to staging, timeliness of assessment and lack of prevention strategies. Actions were taken in response to the findings, which included continued monitoring, staff education and reminders, ensuring wound chart reviews are undertaken, regular checks of wounds for deterioration and escalation where appropriate.

I acknowledge the provider’s response and associated information provided. In coming to my finding I have considered evidence presented in the Assessment Team’s report and the provider’s response, which does not demonstrate that at the time of the Site Audit, staff were not competent, and members of the workforce did not have the qualifications and knowledge to effectively perform their roles.

While evidence demonstrates all non-pharmacological strategies were not trialled prior to administration of psychotropic medication to one consumer, that beds were positioned at the lowest height for two consumers without having an assessed need, and informed consent was not obtained for three consumers prior to the use of restraint, I have considered these deficiencies as an area for improvement under Requirement (3)(a) in Standard 3 Personal care and clinical care. I find it is not proportionate to consider the whole staff cohort to be incompetent based on these deficiencies alone.

I have considered that staffs’ inability to describe falls management strategies for Consumer H does not demonstrate incompetence. The Assessment Team’s report does not include any context to demonstrate the consumer had been appropriately assessed, that falls management strategies were in place or documented in a care plan and the consumer’s risk of falls should have been widely known.

In relation to Consumer I, I have considered that while staff did not initiate a wound assessment and care plan following identification of a cut on their face, it is not indicative of incompetence. I have also considered evidence presented by the Assessment Team under Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers and Requirement (3)(a) in Standard 3 Personal care and clinical care, which demonstrates staff are competent in undertaking assessments and updating care plans in response to consumers’ changing needs or incidents.

In relation to Consumer A’s wound, I have considered that prior to the Site Audit, the service undertook an investigation and actions were taken to address identified deficiencies, which included staff education.

In relation to staff being regarded as non-compliant with mandatory training, there is no evidence demonstrating that the training modules not completed by staff correlate to deficits in care.

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

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

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

The Assessment Team found systems were in place to recruit and provide orientation to staff. However, the Assessment Team was not satisfied the service demonstrated the workforce is trained, equipped and supported to deliver the outcomes required by these Standards. The Assessment Team provided the following evidence relevant to my finding:

* Management reported all staff have current police, visa and professional registration checks completed prior to onboarding, and on commencement of employment, staff undertake corporate and site-specific induction.
* Management reported staff are required to complete annual mandatory training, with optional learning and development programs available.
  + Training records demonstrate mandatory training had not been completed by 44% staff, which included manual handling, fire and safety and dysphagia.
  + Management was not able to obtain up-to-date staff training and attendance records from head office for review.
* While most staff said they had received training in relation to SIRS and were able to describe their role to ensure incidents are reported to appropriate personnel, three staff said they did not recall receiving this training but were aware of SIRS and what to do in response to an incident.
* Three staff said they had not received training in relation to restrictive practices.
  + Management reported restrictive practices training has been removed from the online training program and will be recommenced.

The provider does not agree with the Assessment Team’s findings and maintains the service is compliant with this Requirement. The provider’s response under Requirement (3)(e) in Standard 8 Organisational governance includes the following evidence relevant to my finding:

* New starter modules for commencing employees post 7 September 2020 to demonstrate restrictive practices are included.
  + The evidence does not demonstrate whether the restrictive practices are part of mandatory or optional training.
* Education overview of training undertaken in 2021 demonstrating 98% staff attendance for restraint management.
  + The evidence is not dated to demonstrate when it occurred.

I acknowledge the provider’s response and associated information provided. In coming to my finding, I have considered evidence presented in the Assessment Team’s report and the provider’s response, which does not demonstrate that at the time of the Site Audit, the workforce was not recruited, trained, equipped and supported to deliver the outcomes required by these Standards.

I have considered that while training records demonstrate 44% of staff have not completed mandatory training and three staff said they had not received training in relation to SIRS, there is no evidence demonstrating that this correlates to deficits in care. I question the validity of the 44% statistic at the time of the Site Audit, as the Assessment Team reported that management could not obtain up-to-date training and attendance records for review. Management’s inability to obtain up-to-date training and attendance records is concerning, however, further information was not provided to demonstrate whether this is an isolated occurrence.

While the provider’s response includes documentation to show new starter modules include restrictive practices, it is unclear whether this training is mandatory or optional. The response also included documentation to show 98% of staff attended restraint management training, however, the evidence was not dated to demonstrate when the training occurred. While evidence in the Assessment Team’s report identified deficits in relation to the use of restrictive practices, I have considered this as an area for improvement under Requirement (3)(a) in Standard 3 Personal care and clinical care. I find it is not proportionate to consider this Requirement is non-compliant based on these deficiencies alone.

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

### Requirement 7(3)(e) Compliant

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

# STANDARD 8 COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

The Quality Standard is assessed as compliant as five of the five specific Requirements have been assessed as compliant.

The Assessment Team has recommended the service does not meet Requirements (3)(c), (3)(d) and (3)(e) in Standard 8, as the service was unable to demonstrate:

* effective organisation wide governance systems relating to workforce governance and regulatory compliance;
* effective risk management systems and practices in relation to managing high impact or high prevalence risks associated with the care of consumers; and
* a clinical governance framework, specifically in relation to minimising the use of restraint.

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

In relation to all other Requirements in this Standard, the Assessment Team found overall, consumers consider the organisation is well run and they can partner in improving the delivery of care and services. Consumers and representatives confirmed they are supported, engaged and are a partner in the provision of care, they feel comfortable speaking with staff and described various ways they are able to provide feedback and suggestions.

Documentation showed the organisation’s governing body is accountable for and promotes a culture of safe, inclusive and quality care and services by overseeing organisational culture to identify areas for improvement and ensuring changes implemented are effective and result in safe, inclusive and quality care for consumers.

Based on the evidence above, I find the service compliant with all Requirements in Standard 8 Organisational governance.

## Assessment of Standard 8 Requirements

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

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

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

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

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

*Effective organisation wide governance systems relating to the following:*

1. *information management;*
2. *continuous improvement;*
3. *financial governance;*
4. *workforce governance, including the assignment of clear responsibilities and accountabilities;*
5. *regulatory compliance;*
6. *feedback and complaints.*

The Assessment Team found the organisation’s governance systems were effective in relation to information management, continuous improvement, financial governance and feedback and complaints. However, the Assessment Team was not satisfied the service demonstrated effective governance systems in relation to workforce governance and regulatory compliance. The Assessment Team provided the following evidence relevant to my finding:

Workforce governance, including the assignment of clear responsibilities and accountabilities

* Management reported systems are in place to ensure professional registrations, police clearance certificates, vaccinations and any other credentials are checked on commencement of employment and as required.
* The organisation does not have workforce governance systems in place to ensure there are sufficient numbers of staff to provide safe and quality care and services. Corporate management was not aware an extra shift in one area of the service had ceased at the beginning of 2022.
* Staff training is not tested for effectiveness and additional sessions are not scheduled in a timely manner to ensure compliance. Staff are not monitored to ensure they understand and practice their responsibilities and accountabilities and are following policies and procedures.

Regulatory compliance

* The organisation’s policies and procedures in relation to restrictive practices have been updated to reflect changes in regulatory requirements, however, the service was unable to confirm whether staff completed relevant training or understood their procedural and regulatory obligations.
* The organisation has a SIRS policy and procedure, however, some staff reported they had not received SIRS training. The service’s SIRS register demonstrated all sampled reportable incidents were reported within the correct timeframes.

Information management

* Staff reported the service’s intranet is accessible and contains policies, procedures and forms to guide them in their role. Staff confirmed changes to this information are communicated via various means.
* Staff reported, and management acknowledged, data integrity issues in relation to consumer information in the electronic care management system as compared to daily handover sheets. Management reported a communication project is being launched to address the issue.
* The organisation has policies and procedures to guide staff in relation to data protection and use of information technology.
* Management reported consumers, representatives and staff are informed of things of importance via multiple channels.

Continuous improvement

* Management reported opportunities for improvement are identified through various methods, including key performance indicators, feedback and complaints, surveys and audits.
* Monthly quality and staff meetings are held to discuss feedback and suggestions for improvement.
* Staff said they are encouraged to provide suggestions and continuous improvement is discussed at relevant meetings.

Financial governance

* Management reported the organisation uses an electronic management program for all financial transactions, which is used to compile monthly finance reports for the Board.
* Management reported the service has a budget that covers staffing, running costs and capital expenditure. Any changes to budget requirements are risk rated and discussed with management for consideration prior to procurement.

Feedback and complaints

* Interviews with consumers and representatives demonstrated they are encouraged to provide feedback and complaints and have various channels to do so.
* Staff have access to policies and procedures to guide them in relation to complaints management.
* Feedback and complaints are reviewed and discussed by a multidisciplinary team, with continuous improvement considered.

While some deficits identified by the Assessment Team are acknowledged, the provider maintains the service is compliant with this Requirement. The provider’s response includes the following information and evidence to refute the Assessment Team’s assertions:

* Call bell response times are reviewed regularly to understand the cause of the delay and feedback is provided to consumers and staff. Peak times of calls are monitored to ensure roster patterns continue to meet consumers’ needs.
* Staffing ratios in place while effecting change during the sanction are not sustainable and current staffing numbers are sufficient to provide safe and quality care.
* Restrictive practices training is included in new starter modules for commencing employees and 98% of staff undertook the training in 2021. New starter modules for commencing employees post 7 September 2020 and Education overview of training documents were provided in support of this statement, however, it cannot be determined whether the new starter modules are mandatory or optional and the 2021 Education overview is not dated to evidence when it occurred.

I acknowledge the provider’s response and associated information provided. In coming to my finding I have considered evidence presented in the Assessment Team’s report and the provider’s response, which does not demonstrate that at the time of the Site Audit, the organisation’s governance systems in relation to workforce governance and regulatory compliance were ineffective.

I have considered that evidence in the Assessment Team’s report does not indicate how the lack of training, monitoring and numbers of staff relates to deficits in the organisation’s governance systems. I have considered evidence in the Assessment Team’s report under Requirement (3)(a) in Standard 7 Human resources, which demonstrates workforce governance systems are effective, as the organisation is aware of workforce shortages and is actively recruiting to fill vacancies.

I have also considered that while the service did not identify deficits in staff knowledge in relation to restrictive practices, evidence in the Assessment Team’s report under Requirement (3)(b) in Standard 3 demonstrates one example where education was provided to staff in response to identification of incorrect staff practices.

While evidence in the Assessment Team’s report under Requirement (3)(d) in Standard 7 Human resources demonstrates all staff have not completed mandatory training and three staff said they had not received training in relation to SIRS, there is no evidence demonstrating this correlates to deficits in care.

In relation to regulatory compliance, evidence in the Assessment Team’s report demonstrates systems are in place to make sure the organisation understands their regulatory obligations, including subscribing to relevant bodies and updating policies and procedures. While regulatory obligations in relation to restrictive practices were not met, there is no evidence indicating how this relates to deficits in the organisation’s governance systems.

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

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

*Effective risk management systems and practices, including but not limited to the following:*

1. *managing high impact or high prevalence risks associated with the care of consumers;*
2. *identifying and responding to abuse and neglect of consumers;*
3. *supporting consumers to live the best life they can*
4. *managing and preventing incidents, including the use of an incident management system.*

The Assessment Team found risk management systems and practices were effective in identifying and responding to abuse and neglect of consumers, supporting consumers to live the best life they can, and managing and preventing incidents. However, the Assessment Team was not satisfied the service demonstrated effective risk management systems in relation to managing high impact or high prevalence risks associated with the care of consumers. The Assessment Team provided the following evidence relevant to my finding:

* Management reported the service undertakes weekly reviews of incidents to identify signs of deterioration, prompt assessments and/or referrals, and identify trends. There was no evidence demonstrating actions taken to reduce the risks of incidents from reoccurring.
  + Documentation showed Consumer H sustained 11 unwitnessed falls in just over one month and was administered psychotropic medication on two occasions without informed consent being obtained.
  + One of 11 falls incidents was sampled, which demonstrated the consumer was documented as a high falls risk, however, no new interventions were implemented to mitigate the risk and their falls risk was subsequently lowered to ‘most likely to be at risk of falling’. The incident was subsequently closed.
  + Management acknowledged the risk rating and closing of incidents need more work and this process will be improved going forward.
* Further strategies to mitigate the risk of wound deterioration were not implemented until Consumer A’s wound had deteriorated to unstageable.
* The service did not demonstrate safe and effective pressure area care was provided to Consumer C.
* The organisation has policies and procedures to guide staff in supporting consumers to take risks. Interviews with management and documentation demonstrated examples of two consumers supported to take risks in line with these policies and procedures.

The provider did not agree with the Assessment Team’s findings and maintains the service is compliant with this Requirement. The provider’s response, including under Requirements (3)(a) and (3)(b) in Standard 3 Personal care and clinical care, includes the following information and evidence to refute the Assessment Team’s assertions:

* Clinical incidents are reviewed daily, weekly and monthly to understand its risk profile of clinical indicators, including sentinel events, behaviours, hospital transfers, nutrition, medication, infections, falls, skin integrity and wounds. Clinical KPIs document was provided in support.
* Extensive work has been undertaken at an organisational level to reduce the risk of incidents recurring. Change plan on a page document was provided in relation to post falls to demonstrate prior to the Site Audit, a need to have clear direction on falls management was identified. Strategies implemented included clarity on action to be taken based on frequency of falls, and post fall care and assessments. While this document was not dated, the timeline indicates the review stage occurred in January 2022.
* Consumer H has a Choice agreement for non-compliance with falls management and is identified on the Risk register.
* Eighteen days after Consumer A’s wound was identified, a root cause analysis was completed, and actions were taken in response to self-identified deficiencies, including continued monitoring, wound chart reviews and regular wound checks. The consumer’s wound continues to improve.
* In relation to Consumer C, the presence of excoriation is an isolated incident, and the wound was identified and promptly reviewed and treated, with completion of multiple skin assessments that include appropriate interventions to support safe and effective clinical care. Following identification of redness, the area was reviewed by a Nurse practitioner and Medical officer and treatment was commenced. The wound was noted to be much improved 16 days after identification.

I acknowledge the provider’s response and associated information provided. In coming to my finding I have considered evidence presented in the Assessment Team’s report and the provider’s response, which does not demonstrate that at the time of the Site Audit, risk management systems and practices were not effective in managing high impact or high prevalence risks associated with the care of consumers.

In relation to Consumer H, I have considered that evidence in the Assessment Team’s report demonstrates a high number of falls had occurred, with no new interventions implemented. However, there was no further information demonstrating whether, following each fall, current measures were assessed for effectiveness and whether new interventions were considered. Evidence in the Assessment Team’s report does not demonstrate that deficits in risk management systems and practices resulted in ineffective management of the consumer’s falls risk. In coming to my finding, I have placed weight on the provider’s response stating the consumer has a Choice agreement for non-compliance with falls management.

I placed weight on evidence in the Assessment Team’s report under Requirement (3)(b) in Standard 3 Personal care and clinical care and the provider’s response, which demonstrates risk management systems and practices were effective in managing Consumer A’s wound and in preventing deficits in wound care going forward. Following identification of the wound, the service conducted a root cause analysis to detect deficits in care. Actions were taken in response to their findings, which included, continued monitoring, wound chart reviews and regular wound checks.

In relation to Consumer C’s wound, I have placed weight on evidence in the Assessment Team’s report under Requirement (3)(b) in Standard 3 Personal care and clinical care and the provider’s response which demonstrates there was no evidence indicating ineffective risk management systems and practices, or deficits in clinical care. On the contrary, evidence demonstrates that changes in skin integrity were identified early and when this occurred, steps were taken to minimise the risk of further deterioration.

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

### Requirement 8(3)(e) Compliant

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

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

The Assessment Team found the organisation has an effective clinical governance framework in relation to antimicrobial stewardship and open disclosure. However, the Assessment Team was not satisfied the organisation’s clinical governance framework was effective in relation to minimisation of restraint. The Assessment Team provided the following evidence relevant to my finding:

* Management reported Restraint management guidelines are in place to guide staff in relation to options that must be considered and strategies to trial before using a restraint.
* Management reported that only three consumers were subject to mechanical restraint, however, the Assessment Team observed a further two consumers with their beds lowered to the floor and noted informed consent had not been obtained. Staff reported they were lowered due to being a falls risk.
* Documentation showed psychotropic medication administered to Consumer G was not administered as a last resort.
* Documentation and interviews with management showed informed consent had not been obtained before administering psychotropic medication to Consumer H.
* Interviews with staff demonstrated an overall understanding of restrictive practices and the service’s approach in relation to minimising the use of restraint, however, three staff confirmed they had not attended training. The Assessment Team was unable to verify staff attendance and completion of training in relation to restrictive practices.

The provider did not agree with the Assessment Team’s findings and maintains the service is compliant with this Requirement. The provider’s response states that evidence presented in the Assessment Team’s report demonstrates isolated occasions and is not reflective of overall practice. The response included the following evidence to refute the Assessment Team’s assertions:

* Extracts from an unknown source demonstrating four occasions prior to the Site Audit when non-pharmacological strategies were implemented prior to administering psychotropic medication.
* Screen shot of new starter modules for commencing employees post 7 September 2020 to demonstrate inclusion of restrictive practices.
  + The evidence does not demonstrate whether the restrictive practices are part of mandatory or optional training.
* Explanation that restrictive practices was only recently added as a ‘compliance course’, however, staff completed the training last year. An Education overview of training undertaken in 2021 was provided but not dated.

I acknowledge the provider’s response and associated information provided. In coming to my finding I have considered evidence presented in the Assessment Team’s report and the provider’s response, which does not demonstrate that at the time of the Site Audit, the organisation’s clinical governance framework in relation to minimisation of restraint was ineffective.

I have considered that while the service did not identify regulatory obligations were not being met in relation to the use of restrictive practices for four consumers, there is no evidence demonstrating how these issues correlate to failure in the organisation’s clinical governance framework. I find it is not proportionate to consider this Requirement non-compliant based on these deficiencies alone.

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

# 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 3 Requirement (3)(a)**

* Ensure staff have the skills and knowledge to:
* Recognise restrictive practices and understand their regulatory obligations as required under the *Quality of Care Principles 2014*.
* Ensure care plans are accurate and reflective of each consumer’s current care and service needs.
* Ensure policies, procedures and guidelines in relation to restrictive practices are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to restrictive practices.

**Standard 4 Requirement (3)(a)**

* Ensure all consumers, regardless of how long they have resided at the service, get safe and effective services and supports for daily living that meet their needs, goals and preferences, and optimise their health and well-being.

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

* Ensure appropriate and adequate staffing levels and skill mix are maintained to deliver care and services in line with consumers’ needs and preferences.