Performance

Report

1800 951 822

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| Name of service: | Performance report date: |
| Bethel Lodge | 08 August 2022 |
| Commission ID: | Activity type: |
| 2054 | Site Audit |
| Approved provider: | Activity date: |
| Ashfield Baptist Homes Ltd | 14 June 2022 to 20 June 2022 |

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

**This performance report**

This performance report for Bethel Lodge (**the service**) has been considered by Melissa Buhagiar, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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

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

# Material relied on

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

* The Assessment Team’s report for the site audit undertaken 14 June to 20 June 2022; the site audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* The approved providers response to the Assessment Team’s report received on 26 July 2022.
* the following information given to the Commission, or to the Assessment Team for the site audit of the service. Eleven consumers and seven consumer representatives provided feedback to the Assessment Team.
* the following information received from the Secretary of the Department of Health (**the Secretary**): Exceptional Circumstances Determination dated 23 March 2021.

# Assessment summary

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

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

# Areas for improvement

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

Requirement 1(3)(a) The approved provider must demonstrate staff are available to assist consumers with personal care and that staff do not rush when assisting consumers with manual handling. Staff must demonstrate practical knowledge of manual handling.

Requirement 2(3)(a) The approved provider must demonstrate comprehensive assessment and care planning considers risk to the consumer’s health and well-being and are individualised and address risks and appropriate strategies when circumstances change.

Requirement 2(3)(b) The approved provider must demonstrate that assessment and care planning address all areas of care and services and the consumers’ individual preferences or needs. Consumers should have an advance care plan or directive.

Requirement 2(3)(e) The approved provider must demonstrate care plans are being reviewed on a regular basis and case conferences are occurring. Reviews of care and services must be conducted for effectiveness when circumstances change, or incidents occur that impact on the needs, goals, or preferences of consumers.

Requirement 3(3)(a) The approved provider must demonstrate that all consumers with skin integrity, pressure injuries and falls risks are being assessed and preventative strategies are documented.

Requirement 3(3)(b) The approved provider must demonstrate that risk assessments are conducted when consumer condition changes. Skin integrity is reviewed for consumers at high risk of pressure injuries to prevent or identify wound at early stage. Consumers with behaviours are assessed and behaviours are reported appropriately with appropriate strategies in place and evaluated for effectiveness.

Requirement 3(3)(c) The approved provider must demonstrate that consumers who are approaching end of life have appropriate individually tailored end of life plans and advance directives in place with referral to palliative care team and appropriate care is provided.

Requirement 3(3)(d) The approved provider must demonstrate staff can recognise and respond in a timely manner when the condition of a consumer changes or deteriorates.

Requirement 3(3)(f) The approved provider must demonstrate appropriate referrals to relevant health professionals are undertaken in a timely manner.

Requirement 3(3)(g) The approved provider must demonstrate that all staff comply with wearing PPE correctly and the service must ensure that there is enough sanitiser or wipes throughout the service and that staff undertake correct Infection Control procedures.

Requirement 4(3)(b) The approved provider must demonstrate that emotional support is provided to all consumers following behavioural incidents.

Requirement 4(3)(g) The approved provider must demonstrate that all equipment is safe, maintained, sanitised between use and regularly checked for suitability for consumers.

Requirement 5(3)(a) The approved provider must ensure that the environment is clean, safe, functional, welcoming and easy to navigate for consumers.

Requirement 5(3)(b) The approved provider must ensure that there are appropriate storage areas and equipment is not stored in consumer’s rooms. The provider must ensure that regular cleaning is in place for consumers rooms and the courtyards are free of debris to allow the consumers to enjoy being outside.

Requirement 6(3)(a) The approved provider must demonstrate that consumers, representatives and staff are aware of how to make a complaint wither internally or externally and all feedback and complaints are documented with evaluation of actions taken or follow up documented in the register.

Requirement 6(3)(b) The approved provider must demonstrate that consumers and representatives and all staff are made aware of how to access advocates and or interpreters.

Requirement 6(3)(d) The approved provider must demonstrate that feedback and complaints are reviewed and used to improve the quality of care and services and that the continuous improvement plan documents actions taken and outcomes before each item being closed off.

Requirement 7(3)(a) The approved provider must demonstrate that there are enough staff to meet the needs of consumers and that consumers are actively engaged.

Requirement 7(3)(c) The approved provider must demonstrate that staff can practically demonstrate their training through their work and have regular mandatory and refresher training to keep skills current. Staff are made aware of the risks to consumer for incorrect manual handling.

Requirement 7(3)(d) The approved provider must demonstrate that the service provides time for staff to complete mandatory training and competency in this training is assessed by observation.

Requirement 7(3)(e) The approved provider must demonstrate that regular assessment, monitoring and performance appraisals are conducted with staff.

Requirement 8(3)(a) The approved provider must demonstrate that there are opportunities, forums and feedback available to consumers to be engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

Requirement 8(3)(b) The approved provider must demonstrate that analysis, benchmarking and trends are provided to the Board and that audit results, complaints and feedback are reviewed by the Board. Issues taken to the Board should be documented in the continuous improvement plan and regularly reviewed and actioned.

Requirement 8(3)(c) The approved provider must demonstrate that there are effective organisation wide governance systems relating to information management; continuous improvement; financial governance; workforce governance; regulatory compliance; and feedback and complaints.

Requirement 8(3)(d) The approved provider must demonstrate that there are effective risk management systems and incident management systems and practices to address managing high impact or high prevalence risks; identifying and responding to abuse and neglect of consumers; supporting consumers to live the best life they can and managing and preventing incidents, including the use of an incident management system.

Requirement 8(3)(e) The approved provider must demonstrate that the clinical governance framework is effective in ensuring clinical care which is safe, effective or high quality.

# Standard 1

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

## Findings

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

**The following requirement has been found to be Non-compliant.**

* Requirement 1(3)(a) Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.

The Assessment Team interviewed consumers and representatives who mostly confirmed they were treated with dignity and respect, with their identity, culture and diversity valued. They said most staff were kind and caring and supported them to do the things that are important to them. Consumers confirmed they know about the charter of aged care rights and their right to have their identity, culture and diversity valued and supported.

Feedback from some consumers indicated that the staff generally go above and beyond to meet their needs and that the staff respect their identity, culture and dignity.

The Assessment Team however spoke to a representative and observed consumers who were not always treated with dignity and respect. One representative advised that staff are not available when the consumer wants to go to the bathroom and is unable to get to the bathroom unassisted. Other consumers were observed to incorrectly handled and rushed by staff when being assisted and not being acknowledged when consumers asked them about other meal options.

The approved provider responded to the Assessment Team’s report and advised that training will be conducted for staff in manual handling and staff have been reminded during handover to check resident’s Daily Care Guides and Manual Handling Instruction Card for consumers. Table menus have also been introduced for consumers for them to see available choices for meals.

I acknowledge the immediate actions that have been taken by the provider, however I find at the time of assessment that this requirement was not compliant.

**The following requirements have been found to be Compliant.**

* Requirement 1(3)(b) Care and services are culturally safe
* Requirement 1(3)(c) Each consumer is supported to exercise choice and independence, including to:

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

* Requirement 1(3)(d) Each consumer is supported to take risks to enable them to live the best life they can.
* Requirement 1(3)(e) Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.
* Requirement 1(3)(f) Each consumer’s privacy is respected and personal information is kept confidential.

The Assessment Team interviewed consumers and representatives who mostly considered that they can maintain their identity, make informed choices about their care and services and live the life they choose. Most consumers interviewed confirmed that they are treated with dignity and respect. They confirmed their personal information is kept private. Staff support them to do the things they want to do and things that are important to them. Consumers expressed high level satisfaction with staff, said they were very experienced in their job roles and very kind and caring when they deliver care and services. Consumers confirmed they can make informed decisions about care and services choices and that information provided to them is accurate.

The Assessment Team interviewed staff who were able to confirm the identity and culture of consumers sampled and articulate how consumers preferred their care and services to be provided. Care planning documentation included this information and more details about the consumers in the consumers’ social background sections, profiles, special needs section, spiritual care plans and charts and lifestyle care plans and charts.

Care staff and lifestyle staff interviewed in relation to consumers sampled were able to provide detail about how consumers are supported to make informed choices about their care and services. They said they know consumers well and what their preferences for activities of daily living are and that they verbally check with consumers about their choices before delivering care and services. Staff interviewed were aware of the family relationships important to the consumers, who came to visit them and who stayed in contact by telephone or zoom. They were also able to inform the Assessment Team about friendships between consumers and activity groups they liked to attend.

The Assessment Team observed staff interacting with a consumer who has cognitive limitations. They spoke in a calm manner and nice tone to direct the consumer back to the seat in the dining room. They spoke in short clear sentences in English and explained that they will serve dessert soon. The consumer understood straight away and returned to the seat and the staff member immediately presented the dessert to the consumer.

# Standard 2

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

## Findings

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

**The following three requirements have been found to be Non-compliant.**

* Requirement 2(3)(a) Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.

The Assessment Team reviewed care and service records for sampled consumers and identified that they did not provide evidence of comprehensive assessment and care planning that considers risk to the consumer’s health and well-being. Care plans and assessments were incomplete or were missing information. Information within completed sections of the care plans are not individualised. Risks were not being identified and appropriate strategies were not documented.

The Assessment Team interviewed consumers and representatives who overall said they had been involved in the process of assessment and care planning and were aware of assessment and care planning processes at the service.

It was identified whilst reviewing documentation that there were gaps in relation to wound management with absence of wound charts, or risk assessment completed when pressure injuries were identified.

The approved provider responded to the Assessment Team’s report and furnishing additional documentation to support their compliance with this requirement and it advised that pressure injury risk assessments and wound charts have been completed since the team were on site. The approved provider has advised that they were formulating a comprehensive assessment to identify consumer risks and further training in appropriate use of Waterlow Pressure Ulcer Risk Assessment.

I find that the approved provider is not compliant with this requirement at the time of assessment.

* Requirement 2(3)(b) Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.

The Assessment Team found that for the consumers sampled assessment and care planning does not adequately address all areas of care and services and does not address consumers’ individual preferences or needs. Some consumers did not have an advance care plan or directive.

The organisation has a policy and clinical guidelines on advanced care planning. Both the policy and guidelines were noted to have minimal information to guide staff.

The service has advanced care directives which are completed on paper and uploaded onto the electronic documentation system. The paper copies are stored in a folder in the care manager’s office. Management advised that discussions around advanced care planning are done upon admission to the service and are reviewed during the yearly case conference or when the condition of the consumer had changed.

The approved provider responded to the Assessment Team’s report with additional documentation and advised of updated care plans. It was noted that care planning processes will be included for education for the Registered Nurse Development day. The provider has also advised that the Advance Care Planning Policy has been updated for staff guidance.

I find that the approved provider is not compliant with this requirement at the time of assessment.

* Requirement 2(3)(e) Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

The Assessment Team found that the service demonstrated care plans are being reviewed on a regular basis and case conferences are occurring. The Assessment Team identified for the consumers sampled, care plans do not show evidence of comprehensive review for effectiveness when circumstances change, when incidents occur or when the needs of consumers changes. This was evident for wound management where risk assessments and wound charts were not always completed for consumers. For a consumer who sustained an injury following a fall, a mobility assessment was not accurate or updated following the fall.

The service provided their case conference schedule which shows four of 71 consumers have had a case conference in 2022. Two consumers have been booked to have a case conference and nine consumers have been offered a case conference and awaiting a reply. Case conferencing documentation showed consumers have had a case conference in 2021.

The approved provider responded to the Assessment Team’s report and advised that case conferences were not conducted early 2022 due to disruptions from COVID-19 outbreaks and lockdowns at the home. The service has focused on rescheduling case conferences to meet the completion rates reflected in 2021 where all residents had a case conference as in previous years. The approved provider advised that the mobility assessment had been updated and education for this and managing deterioration and clinical care would be agenda items on the upcoming Registered Nurse Development Day.

I find that the approved provider is not compliant with this requirement at the time of assessment.

**The following requirements have been found to be Compliant.**

* Requirement 2(3)(c) The organisation demonstrates that assessment and planning:

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

* Requirement 2(3)(d) The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.

The Assessment Team found that overall sampled consumers considered that they feel like partners in the ongoing assessment and planning of their care and services. Consumers and representatives confirmed they were included in assessment and planning and discussions about care. Consumers and representatives said outcomes of assessment were discussed with them and they have a copy of their care plan.

The Assessment Team reviewed care and services documentation which demonstrated consumers, other individuals, or providers of care are involved in the care of the consumer.

The Assessment Team interviewed clinical staff who were able to describe how they involve consumers and their representatives in assessment, planning and review. They said they also involve other members of the multidisciplinary team such as dieticians, physiotherapists, podiatrists and speech pathologists when required.

Management said they try and include the consumers as much as possible in discussions around their care. They said involve the representatives for those who are unable to be involved in decisions around their care.

# Standard 3

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

## Findings

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

**The following requirements have been found to be Non-compliant.**

* Requirement 3(3)(a) Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:

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

The Assessment Team found that the service was not able to demonstrate consumers get safe and effective personal care or clinical care that is tailored to their needs and preferences or is best practice. Consumers with wounds or pressure injuries are not being appropriately assessed and preventative strategies are not being documented. Wounds are not being measured and photographs are not being taken.

The Assessment Team reviewed care and service documentation and found that in some instances pressure injuries were not identified until at late stages or unstageable and measurements were not taken at the time of identification, photographs were not taken in line with the organisation’s weekly regime. Risk Assessments were not conducted when pressure injuries were identified.

The Assessment Team identified a consumer who had a fall and sustained injury, with no falls risk assessment completed until several days post fall and no wound charts completed for the injuries sustained, no pain assessments completed on the day of incident and neurological observations were only completed for 5 hours and not the 24 hours as per guidelines.

The Assessment Team found that the service does not demonstrate an understanding of effective management of restrictive practices. While there is indication that consumers’ psychotropic medication is monitored by the pharmacy, the service does not have processes in place to manage and monitor each consumers’ restrictive practice in line with legislative requirements.

The approved provider responded to the Assessment Team’s report and furnished documentation supporting their compliance with this requirement. The guidelines have been updated and most of the gaps in documentation were in place. It was not clear that consumers that were receiving psychotropic medication had an appropriate diagnosis as medication charts were provided, however not confirmed diagnosis. It was also not evident that pain assessment had been completed after incidents.

I have considered the documentation that has been provided and find that the approved provider is not compliant with this requirement at the time of assessment.

* Requirement 3(3)(b) Effective management of high impact or high prevalence risks associated with the care of each consumer.

The Assessment Team reviewed care and services documentation which showed high impact and high prevalence risks were not being managed appropriately and consumers were negatively impacted. Risk assessments are not being conducted when consumer condition changes. Pressure injuries are being identified at a late stage, neurological observations are not being attended for consumers who have fallen. Consumers with behaviours are not being assessed and behaviours are not being reported appropriately.

The service identified skin integrity, falls and behaviours as their high impact high prevalence risks. For consumers sampled, care and services documentation showed that these risks were not being managed appropriately.

The organisation has a falls prevention program guideline and an accident and incidents guideline. Both guidelines have information relating to post fall management. However, there is no information regarding when to transfer a consumer to hospital. The information regarding neurological observations does not state the frequency required. There were no references noted on this guideline. These issues were raised with management who acknowledged the feedback and said they would review the guidelines.

The approved provider responded to the Assessment Team’s report and provided further documentation to support their compliance. The provider has also updated the guidelines to reflect frequency of neurological observations and information in relation to transferring a consumer to hospital. The identified gaps in care planning documentation has been added as an agenda item for the Registered Nurses Development Day.

I find that the approved provider is not compliant with this requirement at the time of assessment.

* Requirement 3(3)(c) The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved.

The Assessment Team found that the organisation has systems in place for palliative care and end-of-life care. There were no consumers receiving end-of-life care during the site audit. A review of care and services documentation for consumers who had recently received end of life care showed appropriate care was not provided. Consumers who were at the end of life stage had delays in commencing an end of life management plan or did not have a plan. Referrals to palliative care were delayed and recommendations were not in the plan. A consumer who had respiratory distress did not have their comfort maximised.

The Assessment Team reviewed the organisation’s policy in relation to palliative care. The palliative care policy was noted to have minimal information to guide staff. They were noted to have been reviewed in 2021.

The organisation has clinical care guidelines in relation to palliative care and end of life care. The guideline for end of life care is a guide on how to care for a deceased person. It does not have any information regarding care that is to be provided to a consumer in the end of life stage.

The approved provider responded to the Assessment Team’s report and advised that the clinical care guidelines/end of life care have been updated. The provider also furnished additional documentation, in relation to referrals to palliative care and end of life management plan for one consumer.

The documentation provided has not however persuaded me that there are effective processes to ensure that consumers reaching end of life have appropriate processes documented and individualised plans to meet their needs.

**I find that the approved provider is not compliant with this requirement.**

* Requirement 3(3)(d) Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.

The Assessment Team found that the organisation has systems in place to ensure staff can recognise and respond in a timely manner when the condition of consumers change or deteriorate. However, a review of care and service documentation showed changes in consumer condition is not being identified and responded to in a timely manner. Changes in consumer skin integrity have not been recognised or identified which have resulted in pressure injuries or wounds. Consumers with blood glucose levels out of range have not been reviewed in a timely manner.

The approved provider responded to the Assessment Team’s report and advised that the Registered Nurses Development Day will address these gaps including skin integrity education, wound management, Diabetes and blood glucose level management.

**I find that the approved provider is not compliant with this requirement.**

* Requirement 3(3)(f) Timely and appropriate referrals to individuals, other organisations and providers of other care and services.

The Assessment Team found that care and services documentation showed appropriate referrals to relevant health professionals were not always undertaken or were not undertaken in a timely manner. However, most consumers and representatives provided positive feedback regarding access to health professionals. Staff were able to describe the processes for referring to other health professionals.

For the consumers sampled, care planning documents showed referrals to relevant health professionals were not always undertaken or they were not done in a timely manner. This was evident for consumers experiencing out of range blood glucose levels.

The Assessment Team interviewed staff who said that they inform the registered nurses straight away when they recognise a consumer requires further assessment and referrals. The registered nurses said that they involve different health care providers such as physiotherapists, medical officers and dietitians in consumer’s care when needed.

The approved provider responded to the Assessment Team’s report who advised that further education regarding blood sugar level monitor, documentation, and intervention will be scheduled in the Registered Nurses development day.

**I find that the approved provider is not compliant with this requirement.**

* Requirement 3(3)(g) Minimisation of infection related risks through implementing:

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

The Assessment Team found that the service has systems in place to manage an outbreak and minimise infection related risks. The service has practices in place to minimise the spread of infection and promote appropriate prescribing and usage of antibiotics. However, these practices were not always followed. Issues were identified in relation to COVID-19 preparedness and prevention. Staff were observed breaching infection control protocols.

The Assessment Team identified that the service’s floor plan did not include PPE donning and doffing stations. The service has health screening did not promote strong infection control compliance. A staff member was observed to have flu like symptoms at 2pm. This was raised with management who reported the staff member was sent home. Staff were observed to be performing the proper techniques for handwashing and hand sanitising.

The Assessment Team noted there were no glove holders at any of the hand washing basins and glove holders that were around the service were empty. There were no hand sanitisers observed in the common areas. The Assessment Team observed some staff wearing their masks under their chins. This was raised with management who accepted the feedback.

The approved provider responded to the Assessment Team’s report and advised that the service’s policies are reviewed every 2 years or as changes occur. The approved provider addressed the other gaps identified by the team and sent memo’s and updated signage for wearing masks correctly and cough etiquette.

I acknowledge the immediate actions taken by the provider however find that the approved provider was not compliant at the time of assessment.

**The following requirement has been found to be Compliant.**

* Requirement 3(3)(e) Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.

The Assessment Team found that while there are systems in place for communicating information about the care of consumers, these have not been effective for all consumers sampled. Sharing of information has not always occurred. Care and services documentation reviewed for sampled consumers did not always provide an adequate handover of consumer needs and preferences.

The Assessment Team were unable to find information for a consumer who was on a palliative pathway. Care planning documentation did not have any information to demonstrate the consumer had been reviewed. Management said the clinical nurse consultant had conducted telehealth consultations and correspondence was done via emails.

The approved provider responded to the Assessment Team’s report and provided copies of the Palliative care and clinical nurse reviews and has since added these to the care planning documentation.

I have considered the information that the provider has furnished and am persuaded that the appropriate reviews have taken place and the documentation was available however not in place.

I find that the approved provider is compliant with this requirement.

# Standard 4

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

## Findings

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

**The following two requirements have been found to be Non-Compliant.**

* Requirement 4(3)(b) Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.

The Assessment Team interviewed consumers and staff, reviewed care plans and through observations confirmed services and supports for daily living promote each consumer’s emotional, spiritual and psychological wellbeing. The Assessment Team found that serious incident reporting documentation indicates the service does not demonstrate emotional support is offered to consumers following incidents. Consumers’ care planning documentation indicates emotional requirements following serious incidents are incorrectly assessed as not requiring additional supports.

The Assessment Team reviewed incidents and serious incident reports which indicated that records for emotional support for victims and other people involved do not include details of emotional support being provided and potentially not being received by those that need it.

The serious incident form has a field ‘Were there any physical or psychological impacts’ – one for the victim and another for the offender. There are no other fields to capture details of emotional supports provided at the time of incident or for support after the incident in accordance with the service’s incident management system procedures.

The approved provider responded to the Assessment Team’s report and advised where emotional or physical impacts are noted, clinical staff make appropriate referrals using internal referral forms to the Diversional Therapist, Physiotherapist, Chaplain or External referrals as required. Additional training in completion of SIRS reports will be conducted during the Registered Nurse Development day.

I have considered the information that the approved provider has furnished, however do not find that the immediate social supports are evident following an incident.

**I find that the approved provider is not compliant with this requirement.**

* Requirement 4(3)(g) Where equipment is provided, it is safe, suitable, clean and well maintained.

The Assessment Team found that not all equipment provided is safe, clean and well maintained. All mechanical lifters were due for inspection in May 2022. Many wheelchairs and mechanical lifters were observed to be dirty and did not appear to be well maintained. Some mechanical lifter slings were observed to be worn, frayed and unsafe. Management confirmed that a new supply of lifter slings had been ordered and it was intended that each consumer have their own sling. Management did not provide information relating to how they are managing the risk to consumers using mechanical lifters that are overdue for inspection.

The Assessment Team observed equipment used for lifestyle services is safe, suitable clean and well maintained. However, the nature of some of the activities such as ball games do not allow the equipment (for example, the ball) to be cleaned between consumers.

The Assessment Team observed a wheelchair with significant signs of wear and tear without feet plates. The Assessment Team observed many issues with equipment that has not been logged into the electronic maintenance system indicating there are gaps in the maintenance system.

The approved provider responded to the Assessment Team’s report and advised that the service have made numerous attempts to book it in the mechanical lifter’s inspection with the service provider since before the service month of May. The service has recently received a delivery of new lifter slings, to replace slings, that were becoming worn. Then provider also advised that all lifestyle equipment is wiped down at the end of the day in preparation for next use.

I have considered the information that has been provided the approved provider, and acknowledge the recent purchases, however find at the time of assessment that the equipment was not safe, clean and well maintained.

I find the approved provider is not compliant with this requirement at the time of assessment.

**The following requirements have been found to be Compliant.**

* Requirement 4(3)(a) Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.
* Requirement 4(3)(c) Services and supports for daily living assist each consumer to:

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

* Requirement 4(3)(d) Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.
* Requirement 4(3)(e) Timely and appropriate referrals to individuals, other organisations and providers of other care and services.
* Requirement 4(3)(f) Where meals are provided, they are varied and of suitable quality and quantity.

The Assessment Team reviewed care plans and conducted observations which confirmed that consumers receive safe and effective services and support that meet consumers’ needs, goals and preferences. The care plans confirmed services and supports assist consumers to participate in their community and do things of interest to them. Interviews with staff confirmed consumers are supported to participate in activities within and outside the service and have social and personal relationships with other people.

Staff practices and interactions with consumers observed by the Assessment Team demonstrated staff promote consumers independence, health, wellbeing and quality of life.

Consumers and representatives interviewed confirmed they receive effective services and support that meets their needs and optimises their independence, promotes their health, wellbeing and quality of life. Consumers confirmed they are supported to participate in activities within and outside the service, to keep in touch with family and friends, maintain social and personal relationships and to do things that are of interest to them. Consumers sampled confirmed they feel that their condition, needs and preferences are effectively communicated in the service. Consumers confirmed meals are varied and of suitable quality and that there is always plenty of food and can ask care staff if they wanted more food between breakfast, morning tea, lunch, afternoon tea, dinner or after supper. One consumer’s representative confirmed that staff were wonderful and always kind and caring when they assisted the consumer to eat.

Staff and consumer interviews and documents reviewed by the Assessment Team confirmed consumers are being referred to individuals and external service providers in a timely manner when required.

# Standard 5

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

## Findings

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

**The following requirements have been found to be Non-compliant.**

* Requirement 5(3)(a) The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.

The Assessment Team found the service environment is not welcoming, is not easy to understand and does not optimise consumers’ independence, interaction and function. The service environment is not safe, clean and well maintained which significantly impacts negatively on how welcoming the environment is and limiting the consumers’ sense of belonging and function.

The Assessment Team observed there was some navigation signs to the different communities but none to return to the reception entry. The environment was difficult to navigate. The dementia support unit was a part of the main layout of the service with it separated by locked coded doors.

The Assessment Team did not observe any consumers using the three courtyards available to them through the site audit. The Assessment Team observed the courtyards to be unwelcoming, unsafe and hazardous because they were not clean and not well maintained. Some of these areas were tidied up during the site audit.

The approved provider responded to the Assessment Team’s report and advised that they have just completed a major renovation upgrade to the downstairs administration area behind the reception. During this renovation many of the upstairs areas were used as temporary offices and storage in which the consumers were made aware of. The approved provider advised that consumers can access courtyards/balconies however the weather during the site audit period was cold with periods of rain, and not conducive to outdoor activities.

I have considered the approved provider’s response, and acknowledge that the refurbishment works may have made it difficult for navigation, however also note that the courtyards, were deemed to be unwelcoming, unsafe and hazardous because they were not clean and not well maintained and quotes have since been obtained to address this.

**I find at the time of assessment, that the approved provider was not compliant with this requirement.**

* Requirement 5(3)(b) The service environment:

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

The Assessment Team partially audited a random sample of the environment on 17 June 2022 on level 1 and ground floor and found a live cockroach in one consumer’s bathroom and used facecloth on the floor. There was significant chips and paint damage to many skirting boards and lower doors. There are numerous signs in consumers’ rooms and shared areas that are falling due to blue tac or tape losing its adhesiveness. The Assessment Team found that the courtyard surface was dirty in the courtyard adjoining the dementia support unit.

The Assessment Team observed one of the balcony’s doors was obstructed by chairs and one of the doors was damaged. The dining room door to the adjoining balcony was broken - staff said it does not close and they put a chair against it to stop the wind coming in. There were 5 mechanical lifters lined up in the corridor outside consumer’s rooms and were blocking the handrail. Two batteries chargers were being stored there also. A personal protective equipment cupboard near stored old and broken equipment, pictures and empty personal protective equipment packets.

Many of the items above were addressed when reported to management but most were still outstanding at the end of the site audit.

The approved provider responded to the Assessment Team’s report and advised that most of the issues have been rectified with signage being replaced by Perspex signage holders and a dedicated area to store lifters and battery storage currently being explored. The provider advised that the doors were functional, and the courtyard has since been cleaned.

I acknowledge the actions taken to address the issues identified with the service environment, however find that the approved provider is not compliant with this requirement at the time of assessment.

**The following requirement has been found to be Compliant**

* Requirement 5(3)(c) Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.

The Assessment Team found that not all furniture, fittings and equipment provided is safe, clean and well maintained. Observations and consumer feedback confirmed furniture and fittings were not well maintained and suitable for the consumer. The call bell system was being improved and work was presenting hazards and displacing consumers from their rooms. Three courtyards and the outdoor furniture were observed to be unusable due to uncleanliness. Many wheelchairs and mechanical lifters were observed to be dirty and did not appear to be well maintained. Some mechanical lifter slings were observed to be worn, frayed and unsafe.

The Assessment Team interviewed consumers who confirmed they feel safe in the environment and it was kept clean. They did not comment on any other aspects of the environment.

I have considered the information that the Assessment Team and approved provider have furnished and due to the refurbishment works, and the flooding, I consider that the issues that have been raised in this requirement have also been addressed in Requirements 5(3)(a) and 5(3)(b), which were found to be not compliant.

I therefore find that the approved provider is compliant with this requirement.

# Standard 6

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

## Findings

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

**The following requirements have been found to be Non-compliant.**

* Requirement 6(3)(a) Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.

The Assessment Team found that most consumers and representatives indicated they were aware they could make a complaint and provide feedback through the services feedback and complaints forms. A limited number of these forms were observed throughout the service for this to occur. However, consumers and representatives were not aware of processes for making external complaints including to the Commission. The Assessment Team observed that there were no Commission ‘Do you Have a Concern’ brochures on display at the service although there was a Commission poster in some areas of the service.

The Assessment Team interviewed staff who said that if a consumer raised a complaint, they would tell the registered nurse. They were unaware if complaints were followed up or actioned.

The feedback and complaints register for 2021/2022 reviewed had limited information about how complaints have been managed including any escalation, actions taken or outcome for the consumer. Minimal information was provided under the section ‘resolved’ for each item such as “monitoring and redirect other resident” or “refresher training” and often this was just completed with a tick and a date. No evaluation of actions taken or follow up was documented in the register.

Two resident meeting minutes for December 2021 and March 2022 were provided to review, however neither meeting minutes document any consumer or representative feedback.

The approved provider responded to the Assessment Team’s report and advised that additional displays will be set up on the first floors of the facility for easy access and will include additional brochures with access to language services and how to raise a complaint externally. The provider also advised that the complaint register has been updated to include evaluation of actions taken and escalation required, where applicable. This will be monitored through the Operations meeting as a standing agenda item.

I acknowledge the immediate actions that the provider has taken, however find that the approved provider is not compliant at the time of assessment.

* Requirement 6(3)(b) Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.

The Assessment Team found the service does not provide adequate information to consumers regarding access to advocates, language services or other methods for raising and resolving complaints. Brochures or posters on advocacy services such as Older Persons Advocacy Network (OPAN) or Translating and Interpreting Service (TIS) were not displayed or provided to consumers.

The Assessment Team interviewed consumers and representatives who were unaware of any external services that could assist them if they had a concern. Two representatives said they would assist consumers who were no longer able to communicate in English or who had reverted to their original language.

The Assessment Team interviewed staff who advised that no one has been referred to advocacy services. Staff said they are not aware of advocacy services used by consumers but that they know consumers very well and sometimes consumers who can no longer communicate verbally use gestures to make their wishes known or raise concerns.

The approved provider responded to the Assessment team’s report and advised that additional complaints and advocacy brochures will be sourced from appropriate services. The provider will also develop a draft Advocacy Policy & procedure as a guide for staff.

**I find that the approved provider is not compliant with this requirement at the time of assessment.**

* Requirement 6(3)(d) Feedback and complaints are reviewed and used to improve the quality of care and services.

The Assessment Team found that the service has not ensured that feedback and complaints are reviewed and used to improve the quality of care and services. Some representatives have complained on more than one occasion before any actions have been taken.

The service’s continuous improvement plan for 2021/2022 indicates that most opportunities for improvement have not been fully actioned or analysed to ensure outcomes have been achieved.

The Assessment Team interviewed consumers and representatives, with several complaints not appearing on the feedback or complaints register or if a complaint had been entered, there was no information in relation to how the complaint had been investigated or evaluated.

The Assessment Team reviewed relative and staff surveys for April 2022. Survey results are benchmarked with similar services and comments recorded. The relative survey for April 2022 indicates the service is below benchmark for assessment and care planning, meals and dining and complaints and feedback. The services continuous improvement plan identifies some planned actions for care planning and case conference reviews that are recorded as “in progress” with review dates for September 2022. No other planned actions are recorded since the April 2022 survey regarding complaints and feedback.

The approved provider responded to the Assessment Team’s report and advised that the complaint register has been updated to include evaluation of actions taken and escalation required, where applicable. This will be monitored through the operations meeting as a standing agenda item. The provider also advised that survey feedback actions have been added to the continuous improvement plan with a facilitation implementation date of August 2022 and end of 2022 to evaluate effectiveness of improvement activities.

I find that the approved provider is not compliant with this requirement, as it has not been demonstrated that feedback and complaints have been used to improve the quality of care and services.

**The following requirement has been found to be Compliant.**

* Requirement 6(3)(c) Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

The Assessment Team found that the service was unable to demonstrate appropriate action or investigation is undertaken in response to feedback and complaints, or that open disclosure is always used when things go wrong.

The Assessment Team interviewed several representatives who have made a complaint who said that they have received an apology from management although they have sometimes complained more than once before any action has been taken. Other representatives said they do not feel that the service is being completely transparent when communicating with them regarding consumer’s care when they make a complaint.

The Assessment Team interviewed staff and although, open disclosure is included in mandatory training provided annually, several staff were unable to describe what open disclosure means and the actions taken in response to complaints.

The approved provider responded to the Assessment Team report and furnished clarifying information for the issues raised in the report.

I find that the approved provider is compliant with this requirement.

# Standard 7

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

## Findings

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

**The following four requirements have been found to be Non-compliant.**

* Requirement 7(3)(a) The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.

The Assessment Team interviewed consumers and representatives who mostly stated staff are kind and caring but there are not enough of them. Several consumers and representatives provided information about staff shortages impacting on consumer care and services. The Assessment Team identified deficits in Standard 2 and 3 which has resulted in the services inability to demonstrate that sampled consumers receive the appropriate delivery and management of safe quality care and services.

Information provided, and documentation reviewed, shows workforce planning occurs. However staffing records indicate that there are constant staff shortages and shifts are not always filled. Staff retention has been a challenge for the service.

The Assessment Team interviewed staff who mostly said that they are always short of staff and staff are required to do double shifts when staff are not replaced.

The Assessment Team observed staff rushing and very busy throughout the site audit and often found it difficult to find staff to speak with them. The Assessment Team observed on some occasions up to 10 consumers unsupervised in the activities are with the tv on with several consumers asleep in their chairs and not engaged.

The care governance committee meeting of May 2022 recorded absenteeism as a major staffing issue. It identified that there were vacant shifts on the roster, that staff were furloughed due to the outbreak or if close contacts or exposure and due to staff resignations.

The approved provider responded to the Assessment Team’s report and advised that it has processes and procedures to recruit, induct and train new and current employees. There is also a process that is strictly followed when it comes to staff shortages. The provider furnished information to support their compliance with this requirement, however I must place weight on the information provided by the consumers and staff in relation to staff shortages impacting on the delivery and management of safe and quality care and services.

**I find the approved provider is not compliant with this requirement.**

* Requirement 7(3)(c) The workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

The Assessment Team found that the service has a system to ensure staff have qualifications and training for their roles, including induction, mandatory and refresher training. However, documentation reviewed, and staff practices observed identify that staff do not always have the skills and knowledge to effectively perform their roles.

The Assessment Team interviewed consumers and representatives. Some consumers and representatives thought that staff know what they are doing and appeared well trained, however, some consumers did not. One representative stated that staff have a lack of understanding in relation to dementia have caused the consumer distress. Some consumers and representatives have commented on the inconsistency of staffing care when new staff come in from other areas and do not have knowledge of the consumer they are caring for.

The Assessment Team interviewed staff who advised they rely on the summary support plan in consumer’s cupboards to understand the needs of consumers. The Assessment Team observed that not all consumers have the summary care plan in their cupboard.

Staff were observed using poor manual handling practices on two occasions where staff were assisting consumers by placing their hands under their armpits. The Assessment Team observed inadequate staff practices with assisting consumers with eating and pushing a consumer in a wheelchair.

The approved provider responded to the Assessment Team’s report and furnished documentation to support their compliance. The provider also advised that behaviour management training is organized for August 2022.

I have considered the approved provider’s response however, find that the observations and feedback received does not persuade me that the workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

**I find that the approved provider is not compliant with this requirement.**

* Requirement 7(3)(d) The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

The Assessment Team observed that the service has systems and process in place to provide training to deliver outcomes required by these Standards. However, the service’s electronic training records did not provide sufficient information for management to ensure that all staff had received mandatory training in the required timeframe.

The Assessment Team found some consumers and representatives have raised concerns where they felt staff are not adequately trained, particularly in understanding dementia. Some staff commented regarding insufficient staff and its impact on the ability of staff to perform their roles including being up to date with training.

The Assessment Team found that most staff had attended mandatory training on a regular basis and received refresher training as required. Several staff did not have a good knowledge of open disclosure or antimicrobial stewardship Some staff were not able to describe either process. One clinical staff member had a good understanding of antimicrobial stewardship and open disclosure.

Mandatory education is provided to staff online and face to face. However, the organisation’s monitoring of staff completion of mandatory and competency training is fragmented and did not clearly indicate if staff had completed training in the required timeframe.

The service does not have a schedule for regular competency training. Competency training for the next 12 months is determined at clinical governance education meetings each year, with the exception of fire training and manual handling which are done annually.

Current program competencies for 2022 include wounds, medication, ADLs, hand washing, infection control, eyedrop and manual handling. Minimal staff have completed training offered this year.

The approved provider responded to the Assessment Team’s report advising that understanding dementia training is organised for August 2022. The provider also advised that open disclosure is completed during mandatory training and not all staff need to understand antimicrobial stewardship as it does not apply to their roles.

**I have found that the approved provider is not compliant with this requirement.**

* Requirement 7(3)(e) Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

The Assessment Team found that the organisation is unable to demonstrate that it undertakes regular assessment, monitoring and review of the performance of each member of the workforce.

The chief executive officer advised that staff appraisals are completed after three to five months for new staff. The Assessment Team were not provided with any staff appraisal schedule or records to review although these had been requested.

There were inconsistent responses from staff in relation to when the last performance appraisal had been completed. No documentation including staff records were provided to the Assessment Team to indicate that appraisals had been completed in the last 12 months.

The approved provider responded to the Assessment Team’s report and provided the performance review policy which also includes a Performance Management flowchart that informs the process. The provider also furnished the Performance review Registers for 2021 and 2022, however it is noted that performance reviews for 2022, have only commenced following the site assessment.

I find that the approved provider is not compliant with this requirement.

**The following requirement has been found to be Compliant.**

• Requirement 7(3)(b) Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.

The Assessment Team found that overall most consumers and representatives interviewed stated that staff are kind, caring and respectful of them, although some consumers and representatives said staff are busy although they do their best, they are not able to have one on one time with consumers.

The Assessment Team generally observed staff to be caring and respectful in interacting with consumers and representatives. However, when staff were busy they were unable to provide care.

# Standard 8

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

## Findings

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

**The following requirements have been found to be Non-compliant.**

* Requirement 8(3)(a) Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

The Assessment Team found that the organisation was unable to demonstrate that consumers at the service are involved in the design, delivery or evaluation of care and services.

The service was unable to provide information regarding consumers or representatives involvement in service level representation to the Board in decision making such as a consumer engagement document which includes how consumers can contribute to decisions that make a difference at each service and how this information influences the organisation and governance decisions.

The Assessment Team interviewed management who advised they engage with consumers and representatives through resident meetings and surveys. However, evidence provided did not indicate consumers and representatives are actively engaged or represented in corporate decision making in their care and services. Several representatives said they did not attend resident meetings, and some said they did not think the organisation is always transparent in their communications with them. The service was unable to demonstrate that actions are taken by the service when feedback is received.

The organisation has not yet implemented a Partners in Care program allowing for the possibility of visitation of essential carers during the outbreaks. Several representatives commented that they were not allowed visitation during lockdown even though they were providing essential care such as support consumers with their meals or emotional support.

The approved provider responded to the Assessment Team’s report and advised that Ashfield Baptist Homes has developed a Partners in Care Program and will be piloting a new Partners in Care Program being developed by Sydney Local Health District RACF Outreach Team (currently on hold due to increased workload of Covid-19). The provider did not furnish any details on their Partners in care Program only their person-centred care policy.

I have reviewed the information included with the response, however do not see evidence of how engagement with consumers has reflected the development, delivery and evaluation of care and services.

**I find that the approved provider is not compliant with this requirement.**

* Requirement 8(3)(b) The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

The Assessment Team found that the deficiencies identified across the Quality Standards demonstrate that the services currently delivered do not provide a culture of safe, inclusive and quality care and services or that the governing body is accountable for their delivery. While the governing body has systems to provide it with information about services, and has identified some deficiencies at Bethel Lodge, actions to address deficiencies have not been commensurate with the risks at the service as demonstrated through recommendations of non-compliance across the Quality Standards.

The Assessment Team discussed with management how the governing body promotes a culture of safe, inclusive and quality care and asked a number of specific questions in relation to this. Management advised that the Board's primary ways of satisfying itself that the Quality Standards are being met is through reports from the care governance committee, the finance and investment committee and nomination and governance committee, which meets regularly and considers a range of information in relation to services including accounting and audit reporting, clinical information and interactions with the Commission. The meetings proceedings are reported to the Board.

The Assessment Team however noted that there were gaps in relation to the information reported to the Board including audits results and trends for complaints. Policy reviews were broadly reported, and critical incidents register and visiting restrictions updates were provided verbally to the Board.

The Assessment Team noted feedback from the most recent Board meeting did not address clinical governance, feedback and complaints or critical incidents. It was not apparent that the governing body had identified the extent of issues at the service and while some actions were taken, they have not been commensurate with the risks as demonstrated by the recommendations of non-compliance during the site audit.

The approved provider responded to the Assessment Team’s report and advised during the abovementioned meeting, there was significant care related discussion given the COVID outbreak. There is robust discussion at Board level each time the board meets. I have reviewed the information that the provider has furnished and meeting minutes of care governance and board meetings and note that the Quarterly report identifies trends, however but did not identify individual audit results showing deficiencies in relation to individual services.

**I find that the approved provider is not-compliant with this requirement.**

* Requirement 8(3)(c) Effective organisation wide governance systems relating to the following:

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

The Assessment Team found that the organisation is unable to demonstrate that it has effective governance systems in relation to information management, continuous improvement activities, workforce governance, regulatory compliance and feedback and complaints.

The Assessment Team found that clinical documentation is inconsistent, monitoring charts are not routinely completed, and referrals are not made in a timely manner to meet consumer needs. It was also identified that communication at handover meetings did not provide sufficient information regarding all consumer care needs to update staff. Policies and procedures mainly provide one-page overarching statements of policy and roles and responsibilities. They do not provide sufficient information regard procedures to guide staff in their roles. The organisation’s systems for information management does not provide sufficient, consistent or readily available information for staff and management to perform their roles effectively.

The Assessment Team interviewed management who advised opportunities for improvements are identified through a range of measures included feedback from various meetings, surveys, feedback forms, audit data and legislative changes. The Assessment Team noted that meetings have not been held regularly. The service does not have effective continuous improvement systems in place. The service’s systems to collect and review the feedback of consumers and their experience is not included as part of the quality improvement system. The continuous improvement plan has not been evaluated for the effectiveness of actions taken despite being recorded as closed.

The service provided information regarding financial reporting and budgets. Policies provide guidelines for delegations of approval. Management said it was identified the need to progressively replace single beds with king singles. This issue was taken to consumers and approved by the Board.

The Assessment Team identified issues in relation to sufficiency of staff, staff competency and knowledge, effectiveness of staff training and support and monitoring and review of staff performance demonstrate that governance systems in relation to workforce management have not been effective.

The Assessment Team interviewed management in relation to regulatory compliance who advised that the organisation tracks changes in aged care law through peak body and industry alerts and the organisation's internal legal teams.

While management outlined changes made and education provided in relation to the introduction of SIRS, not all incidents which appear to fit the criteria of a SIRS incident are reported as such. Incident management does not routinely include analysis of incidents to identify contributing factors and the development of effective measures to prevent future occurrences.

Investigations into incidents do not indicate that emotional support is being provided as necessary to all parties involved in an incident including consumers or staff as a result of an incident. Incidents where staff are involved are recorded separately. There is no evidence that emotional support is provided to staff involved in incidents where they may have been injured physically or emotionally. There were no guidelines for SIRS reporting available to staff.

The Assessment Team identified deficiencies in relation to the consumers being made aware of avenues for raising concerns and being made aware of advocacy and other services that may assist in raising concerns. Issue were also identified in relation to actions to resolve complaints, staff knowledge of open disclosure and initiating improvements in response to complaint processes.

The approved provider responded to the Assessment Team’s report and provided a copy of the Infection Control manual (last updated 2020), Equipment and Maintenance Manual and Clinical Care Guidelines and reflected on responses of other requirements throughout the report.

I find that the approved provider does not demonstrate that there are effective organisation wide governance systems that address this requirement.

**I find that the approved provider is not compliant with this requirement.**

* Requirement 8(3)(d) Effective risk management systems and practices, including but not limited to the following:

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

The Assessment Team found that the organisation provided a documented risk management framework. However, while the organisation has policies and procedures in relation to risk management, deficiencies identified during this site audit show that the procedures are not always followed to ensure risks are identified and managed.

The Assessment Team identified that incident management does not routinely include analysis of incidents to identify contributing factors and development of effective measures to prevent future incidents are not always occurring. In addition, when consumers experience multiple incidents, which indicate that existing prevention measures are not effective, there is no review of existing measures or development of new interventions.

Risk assessments and measures to mitigate risks are generally undertaken when consumers elect to undertake activities that present a risk to them.

Some incidents have not been identified and reported as SIRS incidents where the incidents documentation indicates they would fit the criteria for SIRS reports.

The approved provider responded to the Assessment Team’s report and referred to other requirements where they had furnished documentation. I have reviewed this documentation and have not been persuaded that there are effective risk management systems and practices to manage high impact and high prevalence risks, to support consumers to live the best life they can and manage and prevent incidents with the use of an effective incident management system.

**I find that the approved provider is not compliant with this requirement.**

* Requirement 8(3)(e) Where clinical care is provided—a clinical governance framework, including but not limited to the following:

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

The Assessment Team identified that while the organisation has a clinical governance framework in place, deficiencies identified in relation to Standard 2 and 3 requirements demonstrate that the clinical governance framework has not been effective in ensuring clinical care which is safe, effective or high quality.

While some clinical staff were able to demonstrate knowledge of antimicrobial stewardship, not all care workers were familiar with the term despite having had training. Most staff did not have a reasonable knowledge of open disclosure. One staff member said “AMS is about making sure the residents have the appropriate antibiotics. I will sometimes call the doctors and ask them to delay starting a course until pathology has come back”.

The Assessment Team also identified that open disclosure has not always been practiced in a timely manner.

The approved provider responded to the Assessment Team’s report and disputed the Assessment Team’s findings, however did not provide additional information to address this requirement.

I find that the approved provider is not compliant with this requirement.

1. The preparation of the performance report is in accordance with section 40A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)