Performance

Report

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| Name of service: | Bethel Lodge |
| Service address: | 31 Clissold Street ASHFIELD NSW 2131 |
| Commission ID: | 2054 |
| Approved provider: | Ashfield Baptist Homes Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 1 August 2023 to 3 August 2023 |
| Performance report date: | 15 September 2023 |

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

**This performance report**

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

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

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

# Material relied on

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

* the assessment team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 29 August 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Not applicable as not all requirements have been assessed** |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Compliant** |

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

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Standard 1

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

Findings

Requirement 1(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumer care plans documented consumer’s identity, culture and diversity and demonstrated how staff treat them with dignity and respect. Staff were knowledgeable about consumer preferences, cultural background, and values, and could describe how they apply this information when assisting consumers.

There was mixed feedback from consumers and/or representatives around consumers being treated with dignity and respect. Most consumers and/or representatives stated the staff are lovely and very respectful, however, one consumer provided an example of an incident that made the consumer feel disrespected and unappreciated. Other consumers stated long call bell wait times have impacted on them in an undignified manner.

The Approved Provider responded with additional information and documentation.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 1(3)(a) is found Compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

Requirement 2(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation has policies and procedures which guide staff practice when conducting assessments and developing consumer care plans. Documentation reviewed reflected these policies and procedures are consistently adhered to. Consumers have risk care plans that address specific risks to the consumer's health and wellbeing, and these risk care plans are used to inform the delivery of safe and effective care and services.

Requirement 2(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Care and service documentation consistently and adequately addressed all areas of consumer care and services and contained consumers' individual preferences or current needs. Consumers and/or representatives provided positive feedback in relation to their needs, goals and preferences being met. Staff could describe the current needs or preferences of consumers. Consumers and/or representatives stated they had been given the opportunity to discuss end-of-life care and their preferences for end-of-life care and services.

Requirement 2(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service has a consumer assessment policy that guides the clinicians to assess consumer care and services regularly and when their needs change. The service has a care plan review schedule guiding staff on when reviews are due. Clinical staff provided the schedule to The Assessment Team to review and spoke about reviewing care plans regularly and as needed due to changes or when an incident occurs. Results of the service's internal quality audits confirmed assessments and care plans are being reviewed and up to date.

# Standard 3

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

Findings

Requirement 3(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated that consumers get safe and effective personal care or clinical care tailored to their needs and preferences and is best practice. Consumers and/or representatives expressed positive feedback about clinical care and staff practices around their care management. Documentation reviewed for consumers with wounds, pressure injuries, restrictive practices, pain management, and complex care needs, demonstrated that the care provided aligned with each consumer's care plan and best practices.

Requirement 3(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Management identified falls, pressure injuries, skin tears and behaviours as their high impact, high prevalence risks. Consumers and/or representatives provided positive feedback about their clinical care, and staff knowledge around high impact, high prevalence risks and strategies to mitigate those risks. Observations and documentation confirmed these risks are being managed effectively.

The service has a high impact, high prevalence risk register. It contains information on all consumers, their identified risks, and strategies to mitigate the risks. The clinical consultant stated the care managers will regularly review and update the register. Information on high impact high prevalence risk is identified from the clinical indicators report and managed accordingly.

Requirement 3(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service was able to demonstrate a process for recognising and addressing the needs, goals and preferences of consumers nearing the end of life. Consumer care and service records reflect that their comfort was ensured, and dignity preserved when receiving end-of-life care. The consumer's wishes and directives were incorporated into their care and services records, and associated documents show a substitute decision-maker was noted. Consumers and/or representatives confirmed they are being consulted regarding their end-of-life wishes. Staff described strategies they use while delivering end-of-life care, including involving the palliative care team and using end-of-life care medication to minimise pain and discomfort.

Requirement 3(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated deterioration or change in a consumer's condition is recognised and responded to in a timely manner. Consumers and/or representatives provided positive feedback regarding the service's actions when there was a change in their condition. Staff were able to describe escalation processes such as informing the registered nurse, getting consumers reviewed by a medical officer or calling an ambulance. Care and service documentation confirmed deterioration or changes in a consumer's condition are recognised and actioned in a timely manner. Staff were observed attending to consumers in a timely manner when a change in their condition was reported.

Requirement 3(3)(f) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

A review of care and services documentation showed appropriate referrals to relevant health professionals were undertaken in a timely manner. Consumers and/or representatives provided positive feedback regarding access to health professionals. Staff were able to describe the processes for referring consumers to other health professionals and services when required.

The care manager reported referrals are made to dieticians, speech pathologists, dentists, physiotherapists, geriatricians, neurologists, pain clinic and wound care specialists, and aged care emergency and palliative care consultants as required.

Requirement 3(3)(g) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service has infection prevention and control policies and procedures in place, that document the process for staff to follow for standard precautions. The service has an outbreak management plan, and the service has two staff working as infection prevention control leads with the care manager providing additional support as required. The care manager checks all the outbreak kits, and the service has a monitoring system for consumer and staff vaccinations.

The registered nurses and care staff demonstrated a good understanding of antimicrobial stewardship, infection control and standard precaution. Staff were observed using correct hand hygiene practices when delivering care to consumers and were using correct and appropriate personal protective equipment.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Requirement 4(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives described how the service supports and promotes each consumer’s emotional, spiritual, and psychological well-being. Care staff, registered nursing staff, lifestyle staff and the chaplain provide ongoing support for consumers and are available for consumers at times of need, such as settling into the service, end of life, bereavement, or trauma.

The chaplain conducts religious services regularly, and representatives from local churches also visit. Care planning documentation recorded consumers’ individual emotional support needs, identified strategies and how these strategies are implemented. Staff were observed providing emotional support to consumers during the Assessment Contact.

Requirement 4(3)(g) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The lifestyle coordinator advised any damaged or broken lifestyle equipment are logged into the electronic maintenance system. Lifestyle staff have a budget and access to a corporate credit card to purchase items for the lifestyle program. Lifestyle staff have a program for the cleaning of the equipment used for the lifestyle program and a sample of these signing sheets were sighted by the Assessment Team. Consumers and/or representatives advised they felt the equipment available was kept clean and well maintained.

# Standard 5

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

Findings

Requirement 5(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Outdoor furniture was observed to be clean, in good repair and easy to use. Consumers and representatives were observed throughout the Assessment Contact making use of the central communal area near the café. Consumers and/or representatives advised they could walk around the building if they wanted to do so and did not feel restricted. Several consumers reported they had lived at the service for some months or longer and were able to find their way around the service with ease.

A review of the internal and external environment has been undertaken to determine cleaning and maintenance issues. Policies and processes for cleaning and maintenance, including accountabilities for various tasks, were reviewed to ensure all areas of the service were being monitored and appropriate action taken.

Requirement 5(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The maintenance supervisor advised the service has transitioned to an electronic maintenance system allowing staff to access the system via the organisation’s intranet. This system enables staff to add maintenance reports when they observe issues, and they are able to track the completion of any items they log in the system.

The maintenance supervisor stated he cannot close out any items until these are completed. He will note in the comments section if any issues are delayed due to waiting on external contractors or replacement parts. Several staff confirmed they were able to record maintenance matters. The maintenance supervisor advised there are regular meetings with senior management which include monitoring the completion of maintenance tasks.

Internal doors within the service were unlocked and consumers are able to mobilise around the building if they choose to do so. Doors to external courtyards and verandas were observed to be unlocked, and consumers were able to access these if they wished to do so.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Requirement 6(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives confirmed they understand how to give feedback or make a complaint. They stated they feel confident the clinical care manager and the chief executive officer would address their concerns and respond to them promptly. The service describes the internal and external complaints process in the consumer handbook and consumer admission paperwork.

The service demonstrated that consumers, representatives, and staff are encouraged and supported to provide feedback and make complaints. Staff described how they respond when a consumer raises an issue or concern, and staff demonstrated knowledge of the service’s complaints policy and process.

Requirement 6(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives were aware of advocacy services available to them. Management stated they promote advocacy services and interpreter services available to consumers and/or representatives, and information on these services were observed around the service environment and is also included in the consumer handbook.

Requirement 6(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives confirmed feedback and complaints are used to improve the quality of care and services. The management team explained feedback and complaints are incorporated into the continuous improvement process and recorded on the plan for continuous improvement. The process is overseen by the management team and discussed at all meetings.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirement 7(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated an effective system in place to fill unexpected staff absences to ensure there is a full complement of staff on each shift. A base roster in line with the new care minute hours has been developed and has been implemented. Call bell responses are monitored by the organisation’s executive care manager and the service’s clinical care manager. Consumers and/or representatives stated staff are meeting the care needs of consumers and that they are satisfied with the staffing numbers.

The Assessment Team reviewed the rosters and the daily allocation sheets for the two weeks prior to the Assessment Contact, which indicated all shifts were filled utilising the service’s own and agency staff. Agency staff are scheduled to work when there is a large training program being conducted and large numbers of staff have been rostered onto the training.

Requirement 7(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated effective systems are in place to ensure the workforce is qualified and competent to perform their roles. Staff confirmed they have been provided with training and have access to information to ensure they are able to care for consumers safely and appropriately. Consumers and/or representatives were satisfied that staff are meeting the needs of consumers and were satisfied that staff are trained and competent to deliver the care and services they require.

The service monitors staff competency and training completion, as well as observe staff practices to ensure staff are effectively performing their roles. All staff are required to complete annual skills competency assessment for hand hygiene, personal protective equipment, and manual handling and are all rostered to attend a three-day mandatory training course covering a large range of topics.

Requirement 7(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

New staff participate in a comprehensive orientation program and are supported with a minimum of three or four buddy shifts, or more if needed, depending on experience. Buddy shifts assist new staff members to get to know the consumers, and the processes and procedures needed to complete their role. Staff confirmed they have participated in training provided at the service, and that they have the resources and equipment they need to deliver appropriate care to consumers.

The service employs a full-time human resource and learning development coordinator to develop and manage the training program. The ongoing training program for staff include annual mandatory training, additional training in response to identified needs, training by external trainers, and on the job training.

Requirement 7(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated there is a formal process in place to review staff performance. All staff participate in an initial performance appraisal during their probationary period and then on the anniversary of their employment. The management team stated staff performance is also reviewed using consumer, representative and staff feedback, investigation of incidents, review of clinical data, staff meetings, and observations by senior staff. The people culture team monitor when staff performance appraisals are due, and a notification and reminder is sent the management team to ensure timely completion of the appraisals.

# Standard 8

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

Findings

Requirement 8(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation demonstrated that consumers are engaged in the development, delivery and evaluation of care and serves and are supported in that engagement. The organisation is utilising questions from the consumer experience questionnaire to seek more in-depth feedback from consumers and/or representatives regarding service provision.

In May 2023, the management team held initial discussions with consumers and/or representatives in relation to the organisation’s strategic plan for 2023-2026. Consumers and/or representatives were invited to be part of a consumer advisory committee. This process includes obtaining expressions of interest from consumers regarding their interest in participating in the advisory committee, creating a direct path from resident meetings to the board, and a board member to attend the resident meeting to receive feedback directly from the consumers and representatives.

Requirement 8(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation has systems in place to monitor service provision through conducting a program of audits and the monitoring of various clinical indicators, including those required under the national aged care mandatory quality indicator program. The organisation also uses an external benchmarking audit program to conduct routine audits across a range of clinical matters and those related to monitoring service provision against the Quality Standards.

Reports from various committees including the care governance committee, finance and investment committee, nomination and governance committee are provided to the board for review. The board is provided with detailed information to enable them to monitor actions being taken by the management team.

Requirement 8(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation has information systems to ensure staff have access to the information they need. There are communication processes for staff which include the electronic clinical documentation system and handover at each shift.

Management advised that opportunities for improvement are continuing to be obtained through surveys, feedback forms, complaints, feedback through various meetings, issues arising through the incident management system, data from the clinical indicators, audit results and changes in legislation. The organisation is also utilising the consumer experience questions in the consumer meetings to seek further feedback from consumers.

The quality advisor stated there is ongoing review of the continuous improvement plan and that evaluation of improvements are being undertaken to monitor their effectiveness.

The organisation has systems in place for financial management and will consider consumer care needs in relation to expenditure. Reports on expenditure and financial matters are referred to the board, and guidelines are in place for delegates regarding expenditure.

Information is provided to the board on staffing, including reporting on the recruitment and termination of staff across both services within the organisation. Monitoring the provision of care minutes and registered nurse minutes to comply with the workforce requirements will continue as a routine report to the board.

The chief executive officer advised that the organisation has memberships with two peak aged care industry bodies who provide regular updates and information on legislative changes. Information is received through updates from various government departments, such as state and federal health departments. Information is discussed at board meetings, and a register of key legislative dates is maintained to track the completion of various requirements.

Requirement 8(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation has developed an organisational risk register which is reviewed and discussed as part of the board meeting. The chief executive officer advised that there will be further enhancements to the risk management process as part of the introduction of a new computerised management system.

The organisation has policies in relation to person-centred care which promote consumers being able to live the best life they can through maintaining a sense of control over care provision and staff respecting individual preferences.

The organisation has an incident management system. Management advised there was greater analysis of incidents to determine if there were any contributing factors or if consumers required referral to specialist services such as Dementia Services Australia. Information is referred to the board for further review when required.

Requirement 8(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The chief executive officer advised that information in relation to restrictive practice, complaints and infection rates are discussed at the board meetings. Queries from the board are referred back to the relevant staff for further action. The organisation has a clinical governance framework in place and staff demonstrated a clear understanding in regard to antimicrobial stewardship, restrictive practices, and open disclosure. Education on updated policies with regard to antimicrobial stewardship, open disclosure and restrictive practices has been provided to relevant staff.

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