Performance

Report

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| Name of service: | Bupa Baulkham Hills |
| Service address: | 4 The Cottell Way Baulkham Hills NSW 2153 |
| Commission ID: | 1014 |
| Approved provider: | Bupa Aged Care Australia Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 22 November 2022 to 23 November 2022 |
| Performance report date: | 16 December 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 Bupa Baulkham Hills (**the service**) has been prepared by M. Buhagiar, 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 conducted 22 to 23 November 2022, 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 14 December 2022
* the following information given to the Commission, or to the Assessment Team for the Assessment Contact - Site of the service: Performance Report dated 20 January 2022 following a Site Audit 29 November to 2 December 2021; Non-Compliance Notice dated 9 February 2022.

**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 | **Non-compliant** |
| **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 | **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 3(3)(b) The approved provider must ensure that all staff can effectively demonstrate classification and deterioration of wounds and weight loss management and that staff can demonstrate effective manual handling of consumers to prevent high impact or high prevalence risks associated with the care of each consumer.
* Requirement 8(3)(d) The approved provider must ensure that the risk management systems and practices, are effective to manage high impact and high prevalence risks and that the consumers are supported to live the best life they can by identifying when system processes fail and impact on the consumer.

**Other relevant matters:**

A Site Audit was conducted on the service on 29 November 2021 to 2 December 2021. There were 18 Non-compliant Requirements across 7 Quality Standards. This Assessment Contact conducted 22 to 23 November was to assess those Non-compliant Requirements.

**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 |
| 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 |

**Findings**

These requirements were found to be non-compliant following a Site Audit from 29 November 2021 to 2 December 2022. The service was unable to demonstrate how each consumer was consistently treated with respect and their culture and diversity valued. In particular, it was identified staff were entering consumers rooms at night without knocking to restock continence aid supplies, and some consumers and representatives felt this did not respect consumers’ dignity. There was a lack of respect in staff interactions with consumers, from a culturally and linguistically diverse (CALD) background, where they could not understand consumers’ request and told consumers to ‘speak English’.

It was also established the service was unable to demonstrate that staff knew the cultural backgrounds of consumers or were aware of their cultural needs. There was a lack of knowledge of how care is tailored to meet cultural needs. There was also a lack of signage and notices in languages relevant to CALD consumers.

The service was unable to demonstrate there was an effective system to ensure consumers are supported to maintain their independence and exercise choice or make decisions about their own care and the way care and services are delivered. Staff lacked an understanding of consumer choice, and this was reflected in documentation with consumers choice reflected as refusal of care.

In response to the findings of non-compliance identified at the Site Audit the service has implemented several actions, including that continence aids are restocked in the afternoon, so consumers are not disturbed at night. Education has been provided to staff in relation to respecting consumers culture and diversity. A review of training records showed 100% of staff have completed the culture and diversity training. The induction program has been reviewed to ensure new staff are supported to get to know the consumers culture, background, needs and preferences.

Management accessed an indigenous group to provide support for indigenous consumers and education for staff. The indigenous group have a number of programs such as performance of indigenous dance and first nations awareness education. Management have arranged for the group to visit the service every 2 months. Education has been provided to staff regarding culture and diversity. Each community (wing) at the service has been supplied with an electronic tablet to assist with translation and communication between staff and consumers.

The provider has implemented training to staff on choice and decision making. A review of the training records showed 100% of staff have completed this training. Education has been provided on behaviour management to help staff understand the link between choice and decision making and responsive behaviours. A review of training records showed 100% of staff have completed this training. Education has also been provided in relation to documentation, so staff use the appropriate language to reflect consumer choice and put any behaviours in context.

At the Assessment Contact conducted on 22 November 2022 to 23 November 2022 consumers and their representatives interviewed said they were treated with dignity and respect. They confirmed staff knew them well and respected their culture and background. Care planning documentation included information about the sampled consumers’ background, culture and individual preferences. Staff interviewed demonstrated they knew the consumers well and described how they supported the culture and diversity of the consumers.

Consumers and representatives provided feedback that the consumers felt at home living at the service and consumers were treated with dignity and respect. They confirmed staff knew consumers well and respected their culture and background.

The Assessment Team observed an acknowledgment of country displayed at the entrance to the service. Decorations and photographs from NAIDOC week were on display throughout the service. The customer services manager stated they have accessed a volunteer who speaks Korean to assist at the service. The service has arranged for 4 volunteers from the Community Visitors Scheme to regularly visit CALD consumers. These include Arabic, Farsi/Persian, Italian, and Hindi speakers. The service celebrates a range of cultural days relevant to the consumers throughout the year. The religious and cultural events calendar is on display in the service. These special events are coordinated with the catering service to provide appropriate food/meals with the events. The service identifies consumers’ cultural needs through the assessment process when they come to the service. A review of a sample of care documents showed cultural needs are identified and regularly reviewed.

The Assessment Team interviewed consumers and representatives who confirmed they are supported to make decisions about their own care and the way care and services are delivered. The service has policies and procedures, including a dignity of risk procedure, to support consumers to exercise choice and independence. The service identifies consumers’ needs, goals and preferences through the assessment process. These are discussed with the consumers and/or their representatives and recorded in their care documentation. A review of a sample of documentation found these are in place. Staff interviewed demonstrated a good knowledge of the consumers they care for and described the individual needs and preferences of these consumers. Management and staff interviewed explained ways they support consumers to make decisions about their care, make decisions about who is involved in their care, communicate their decisions and maintain relationships of choice.

I find that the approved provider is compliant with these requirements following the actions implemented above.

**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 |

**Findings**

These requirements were found to be non-compliant following a Site Audit from 29 November 2021 to 2 December 2022. The service was unable to demonstrate that consumers’ responsive behaviour risks are assessed appropriately to inform the delivery of safe and effective care and services. Inconsistencies were identified in the behaviour monitoring of a consumer. The service was able to demonstrate that assessment and planning addressed consumers end of life planning, and mostly identified consumers’ current needs and preferences however consumers’ specific goals were not included in their care plans.

The service has implemented several actions in response to the non-compliance identified at The Site Audit between 29 November to 2 December 2021 and were able to demonstrate how consumers’ responsive behaviour risks are assessed. The service reallocated the areas in which the care managers had accountability. One care manager was allocated responsibility for the memory support unit (MSU). Management have reviewed staff skill mix and ensure there are regular staff who work in the MSU to ensure there is continuity of care and staff are more knowledgeable on supporting consumers behaviours. Staff have attended education in relation to behaviour management and responsive behaviours and how staff can approach consumers who are displaying responsive behaviours. Staff interviewed confirmed they attended behaviour management education. All consumers who require a responsive behaviour support plan (BSP) have one in place. The BSP is an assessment/care planning tool inclusive of risk and behaviours.

The service was able to generally demonstrate consumer specific goals within the consumer care plan and have implemented an upgraded electronic care planning program system in May 2022. The new system has forms linking to each other making the care planning process more effective.

During the Assessment Contact 22 November to 23 November 2022 the service demonstrated assessment and planning that generally considered risks to consumers health and well-being such as falls, responsive behaviours, high and low blood glucose levels, skin integrity, co-morbidities, and previous medical history to facilitate safe, effective care delivery. However, for one consumer the risks associated with a pressure injury had not been effectively assessed and this has been considered under requirement 3(3)(b).

The Assessment Team reviewed consumer files which demonstrated that assessment and planning reflects consumers’ goals and preferences. Advance care directives and/or end of life discussion outcomes are in place for sampled consumers. Representatives indicated that during the monthly case conference/spotlight (consumer of the day) the registered nurse discusses consumer goals. They also indicated they can obtain a copy of the consumer care plan and review content if they choose. One representative indicated they had obtained a copy of the consumer care plan and agreed with the content. Representatives expressed satisfaction with the process.

I find that the approved provider is compliant with these requirements following the actions implemented above.

**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. | Non-compliant |

**Findings**

These requirements were found to be non-compliant following a Site Audit from 29 November 2021 to 2 December 2022. The service was unable to demonstrate that each consumer’s care was provided using best practice models, particularly for consumers who experience behaviours of concern. Behaviour management strategies were not tailored to consumers’ specific needs. Staff were not aware of consumers’ specific needs and preferences or their life story. Psychotropic medication management was not consistent with best practice and legislative requirements. The service did not demonstrate understanding of the use of chemical restraint. Care planning documentation did not reflect individualised care that was safe, effective and tailored to the specific needs and preferences of the consumer.

The service was not able to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. The clinical management team had considered high impact or high prevalence risks associated with the care of some consumers, however other consumers whose care was associated with high impact and high prevalence risk were not identified on the service’s risk register. Consumers whose care was associated with high risks such as pressure injuries, taking psychotropic medications, falls risks and who experience responsive behaviours were not consistently effectively managed. This resulted in negative outcomes for consumers.

The service has implemented several actions in response to the non-compliance identified at the Site Audit between 29 November to 2 December 2021 and were able to generally demonstrate behaviour management support strategies are tailored to consumer needs. Documentation indicated psychotropic medication management consistent with best practice and legislative requirements. The service demonstrated an understanding of the use of chemical restraint. Staff did not demonstrate knowledge of interventions to effectively manage risks related to complex/resistive behaviours. Psychotropic medications are discussed at registered nurses meeting and registered nurses will be supported by the care managers as required. All consents are in place for all consumers who require a chemical restraint

The care managers will continue to conduct an audit of all medication charts and authorities to ensure accurate documentation Psychotropic register has now been published. The care managers and medical officers reviewed all current psychotropic medications used at the service and ensuring that the correct medication is being administered for the correct diagnosis. As a result of the review there has been a reduction in the use of psychotropic medications. Medications that were no longer required have now been ceased.

The service implemented education for staff on identifying, documenting and ongoing management of skin integrity, with 100% of staff have attended skin integrity training. Wound care management and recognising a deteriorating consumer training was also conducted.

During the Assessment Contact 22 November to 23 November 2022 documentation reviewed indicated that overall consumer clinical care is generally effective, safe, meets their needs and optimises their well-being. However, documentation does not consistently support care that is tailored to consumers’ needs; and optimises their health and well-being in relation to wound management and this has been assessed and considered under Requirement 3(3)(b) in relation to high impact risks associated consumer care. Psychotropic medications are discussed at registered nurses meeting and registered nurses will be supported by the care managers as required. All consents are in place for all consumers who require a chemical restraint

During the Assessment Contact from 22 November to 23 November 2022 the Assessment Team identified deficits in the management of high impact or high prevalence risks associated with consumer care. A lack of effective clinical oversight was evident when reviewing consumers with high impact or high prevalence risks in relation to pressure injury incident and wound management. Weight monitoring for unintended weight loss and the oversight of consumers weight was not always aligned to the protocol of the service/organisation. Incident review and management strategies to minimise risks for consumers is not evident for all consumers sampled. The system/process implemented as part of the Plan for Continuous Improvement (PCI) in relation to wound management is not being effectively implemented. The Assessment Team raised with the care managers that despite all the education that has occurred for staff in relation to skin integrity, wounds and pressure injuries staff are not identifying pressure injuries at stage 1, when preventative intervention may mitigate the risk of significant breakdown in a consumer’s skin integrity. They acknowledged that pressure injuries were a high impact/prevalent risk and further education/monitoring of practice is required.

A representative advised the Assessment Team of an incident that had occurred for a consumer which resulted in a negative impact, which had not been raised with the Assessment Team. This was not addressed by the approved provider.

The approved provider responded to the Assessment Team’s report and reported that since the Assessment Contact, they have actioned additional improvements, where the Clinical Care Managers conducted a 100% review of all pressure injuries and wounds, it confirmed 1 pressure injury was incorrectly classified and 12 were correctly classified. Additional training and education were scheduled for November and December 2022. I have considered the provider’s response; however, it is not demonstrated that the extensive training has maintained sustained compliance for these high impact and high prevalence risks.

I find that the approved provider is compliant with requirement 3(3)(a), however is non-compliant with requirement 3(3)(b).

**Standard 4**

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

**Findings**

These requirements were found to be non-compliant following a Site Audit from 29 November 2021 to 2 December 2022. The service was unable to demonstrate the activities program was meeting the needs, goals and preferences of consumers. Consumers reported there were not enough activities, and some said the activities were not of interest to them. Care planning documents did not always include information about the services and supports consumers need to help them do the things they want to do, or information was not current. The service was unable to demonstrate that each consumer is assisted to participate in their community and do things of interest to them. There are no group activities scheduled outside the service environment and consumers with cultural diversity and other interests are not supported to connect with outside services.

The service was unable to demonstrate that information about the consumer’s condition, needs and preferences is effectively communicated. Some documentation was inconsistent or lacking in detail.

In response to the findings of non-compliance identified at the Site Audit the service has implemented several actions, that include the introduction of the position of lifestyle coordinator to oversee the lifestyle program provided at the service. Lifestyle activities are discussed at all resident/relative meetings. Consumers are invited to provide feedback and input into the activities program. Resident of the day process has been re-established. This is now called ‘spotlight’ and each consumer is reviewed by the care team, including lifestyle officers, each month. The ‘spotlight’ allows consumers to update the preferences, Map of Life (personal story), and care choices, and includes their engagement with the lifestyle program. There has been improved oversight of the lifestyle program and documentation with the introduction of the lifestyle coordinator, the reintroduction of the monthly ‘spotlight’ review, and the introduction of lifestyle documentation audits every 3 months.

Activities programs were reviewed and updated to ensure consumers’ interests are incorporated into the programs. Self-directed activities have been introduced and includes bird feeding, gardening, chess games, poker games, and painting/artwork. All care plans were reviewed in consultation with consumers and/or their representative.

In further response to the non-compliance relating to documentation lacking detail and inconsistent, the electronic clinical documentation system was updated in May 2022 to provide a more efficient information platform. It provides clearer and more detailed information, including more detailed tracking of consumer participation in the lifestyle program. The new system sends alerts to staff each month when a ‘spotlight’ review is due. All staff have been trained in the use of the updated system.

At the Assessment Contact conducted on 22 November 2022 to 23 November 2022 consumers and their representatives interviewed stated they are satisfied with the activities program and indicated it is meeting their lifestyle needs, goals and preferences. Staff interviewed had a good knowledge of consumers individual lifestyle needs and preferences. Lifestyle staff and management explained ways they ensure each consumers lifestyle needs, goals and preferences are supported. Consumers and their representatives interviewed indicated they are satisfied they are supported to participate in their community, have social and personal relationships, and do things that are of interest to them. Staff interviewed had a good knowledge of consumers; what was important to them and how to support them. Lifestyle staff and management explained ways they ensure each consumer is assisted to participate in their community, have social and personal relationships, and do things of interest to them.

The service has 5 communities with one lifestyle officer allocated to each community. The lifestyle team prepare a common calendar for the whole service including large group activities such as special events and cultural days. The lifestyle officers will then add to this and plan the activities for their communities in consultation with the consumers from their communities. Normally there is one activity in the morning and one in the afternoon. The lifestyle calendar records the various options for the 5 communities, providing consumers with greater variety of activities to choose from. Consumers are free to participate in activities in the different communities.

The activities program includes group activities, self-directed activities, outdoor activities, outings, spiritual and cultural activities. Lifestyle activities are also tailored to cater for consumers with special needs. Consumers living in the MSU’s have a more flexible program to accommodate the changing needs of the consumers in these communities. Consumers from these communities can join in activities in the other communities as well. The Assessment Team observed consumers in the MSU’s engaged in different activities such as, karaoke, pancake making, music therapy, and walking independently in the garden area.

Management have introduced an ‘on the house’ dining function for each consumer. Each year they can invite 2 or 3 family members to meal in the private dining room and choose their own menu. Management stated this initiative has been very popular.

The Assessment Team identified that staff are kept up to date and informed of any changes to consumer’s condition through handover at each shift. The leadership team, including the lifestyle coordinator, meet daily, and relevant changes are communicated to staff.

The Assessment Team reviewed 5 lifestyle files which showed each consumer had individualised lifestyle assessments completed. This included assessment for leisure and lifestyle, spiritual and cultural, relationships, and ‘my life story’ with the consumer’s needs, goals and preferences identified for each area. Each file had a record of participation in daily activities and a ‘spotlight’ review including review of lifestyle needs and participation.

I find that the approved provider is compliant with these requirements following the actions and improvements that have been implemented.

**Standard 6**

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

**Findings**

This requirement was found to be non-compliant following a Site Audit from 29 November 2021 to 2 December 2022. The service was unable to demonstrate that processes for open disclosure were being followed when things went wrong. Many staff had not received any training in relation to open disclosure and were not aware of the principles of open disclosure.

In response to the findings of non-compliance identified at the Site Audit the service has implemented several actions, including education provided to all staff regarding open disclosure. This included scenarios of how to respond when things go wrong. A review of training records shows 100% of staff have completed this training. Staff interviewed confirmed they had received this training and were aware of the principles of open disclosure.

Open disclosure has been added as an agenda item for meetings to remind staff of the need for an open and transparent approach to communication about care and management conducted spot checks to test staff knowledge about open disclosure.

At the Assessment Contact conducted on 22 November 2022 to 23 November 2022 consumers and their representatives interviewed stated they are encouraged and supported to give feedback and make complaints. They confirmed management is responsive when complaints are made. Staff interviewed confirmed they had received training in relation to open disclosure and were aware of the principles of open disclosure. Management explained how they respond to complaints and gave examples of how open disclosure is applied.

The Assessment Team observed feedback and complaints mechanisms throughout the service. This included notices and brochures in different languages. The service has a complaints management process and an open disclosure process, which includes the principles of open disclosure and the elements of open disclosure.

Management stated the leadership team attend resident and relative meetings each month to invite feedback and respond to any matters raised. They said they also provide a remote meeting by video call for relatives each month.

I find that the approved provider is compliant with this requirement following the actions and improvements that have been implemented.

**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)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

**Findings**

These requirements were found to be non-compliant following a Site Audit from 29 November 2021 to 2 December 2022. The service was unable to demonstrate it had sufficient staff to ensure the delivery and management of safe and quality care and services, which contributed to falls and altercations between consumers. A lack of registered nurses was identified within the MSU that had high behavioural support needs, ineffective hygiene care and a lack of meaningful engagement activities for consumers. The Assessment Team found that since January 2020 there had been a significant reduction of care.

The organisation was unable to demonstrate that all care staff and registered nurses were familiar and conversant with consumers’ backgrounds, their identity, culture and diversity. Some staff demonstrated a lack of respect in their interactions with consumers who were of a culturally and linguistically diverse (CALD) background. If they could not understand consumers’ requests, they told them, ‘To speak English’. Consumers said many of the staff do not understand or speak English well negatively impacting their ability to understand each consumer’s identity, culture and diversity and deliver care and services accordingly.

The organisation was unable to demonstrate that the workforce was competent and had the knowledge to effectively perform their roles. Several consumers and representatives provided feedback on their dissatisfaction with consistently high staff turnover, inexperienced staff not knowing consumers’ needs in areas such as management of complex behaviours, and a lack of staff to engage consumers in meaningful activities. The Assessment Team found registered nurses and other care staff did not consistently demonstrate knowledge related to documentation of effective behaviour support plans, restrictive practice requirements, and incident reporting requirements including the Serious Incident Response Scheme (SIRS). All new care staff had not completed their mandatory training.

The organisation was unable to demonstrate it had effective recruitment and training systems in place to deliver the outcomes required by the standards for consumers in the MSU living with dementia and complex behavioural needs.

The service implemented several actions in response to the non-compliance identified at the 2021 Site Audit. Management and the clinical team reviewed staffing at the service and allocated regular registered nurses, enrolled nurses and care staff to the MSU to ensure continuity of care is provided to the consumers, reflected in the roster. A dedicated care manager position was allocated to the MSU on 1 April 2022.

The PCI noted and it was confirmed by management that a staffing review was conducted. The review concluded it was confident the staffing levels were adequate to meet the assessed needs of the consumers. Cultural diversity training was delivered. Care documentation was regularly reviewed to ensure the use of culturally sensitive language. Lifestyle coordinator conducted quarterly reviews of 10% of lifestyle documentation to ensure they were aligned to the cultural and diversity needs and preferences of consumers.

The service introduced mandatory training modules in key areas of care and compliance. The induction program was reviewed and improved by the introduction of 3 to 4 structured buddy shifts with an experienced staff member covering morning, afternoon and night shifts. The number of buddy shifts is flexible to meet the learning needs of each new employee. The service introduced a comprehensive competency assessment framework to be completed by staff during their induction, as well as by other staff in key areas such infection control, donning and doffing, SIRS, risk and incident management and behaviour support.

During the Assessment Contact on 22 to 23 November 2022 the service demonstrated that on balance its workforce is planned and the number and mix of staff deployed enables the delivery and management of safe and effective care and services and the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

The Assessment Team interviewed consumers and representatives who mostly said they felt there were sufficient staff at the service. However, one consumer and their representatives said they did not feel there are sufficient staff at the service to meet their care needs. The representative advised that a staff member did not demonstrate competence with manual handling to meet the consumer’s needs.

Registered nurses and care staff interviewed confirmed there were enough staff at the service but acknowledged there are sometimes vacant shifts when staff call in sick just before they are rostered to start their shifts, and there is not enough time for the service to organise a replacement. They said management has recruited more staff for its casual pool and offers staff the opportunity to do a double shift and/or requests staff to come in a few hours earlier than their rostered shift to assist with care. Review of staff attendance records for the week preceding the Assessment Contact showed there were no vacant shifts, and for the two weeks prior to that there were very few vacant shifts.

The Assessment Team interviewed consumers and representatives who said they were treated with dignity and respect. They confirmed staff knew them well and respected their culture and background. Care planning documentation reviewed included information about consumers’ culture background and preferences, and staff interviewed were able to describe how they support specific consumers’ cultural needs and preferences. Review of training records showed 100% of staff attended training on respecting consumers’ culture and identity.

Registered nurses and care staff interviewed confirmed they had received training in the areas identified as skill knowledge gaps and were able to explain to the Assessment Team the concepts of open disclosure, anti -microbial stewardship, and SIRS legislation and procedures, and how they apply to their job. Registered nurses described the training and toolbox talks they received on behaviour support including using behavioural support plans to assist consumers who are resistive to care.

Consumers and representatives confirmed staff at the service know what they are doing and did not identify additional staff training was needed to meet their care needs.

I find that the approved provider is compliant with these requirements following the actions and improvements that have been implemented.

**Standard 8**

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

**Findings**

These requirements were found to be non-compliant following a Site Audit from 29 November 2021 to 2 December 2022. The organisation demonstrated that it had policies and procedures to promote a culture of safe, inclusive and quality care. However, the governing body did not demonstrate its accountability to promote this culture as it did not ensure there were sufficient staff with the appropriate knowledge of the systems and processes to deliver safe, inclusive and quality care.

The organisation was unable to demonstrate that all its organisation wide governance systems were effective in ensuring the provision of safe, quality and effective care and services to consumers. The service’s information systems were not effective in identifying and documenting consumers’ care needs to ensure that staff are providing safe and quality care specific to their individual needs. Behaviour support plans for many consumers were not completed meaning that current information about consumers’ behaviour support needs was unavailable to staff responsible for their care. Consumer and representative feedback indicated there were not enough staff to provide safe quality care and there was high staff turnover.

There were gaps in the service’s compliance with legal and regulatory requirements in key areas. Behaviour support plans were not completed for all consumers who required them under the new Restrictive Practices legislation. The service failed to ensure all staff and consumers were effectively educated in SIRS and the incident management system and procedures and did not make reports for incidents involving consumers that met the legislative criteria for reporting. The service did not have an onsite infection prevention control (IPC) lead in line with legislative requirements.

The Assessment Team found that although the service had a comprehensive risk management framework in place, it was not able to demonstrate effective management and prevention of high impact or high prevalence risks and incidents, including, the effective use of an incident management system to ensure the health safety and wellbeing of all consumers. There were not enough staff with the knowledge and experience to effectively manage high impact high prevalence risks, identify and respond to the abuse and neglect of consumers, provide behavioural support including understanding behavioural triggers, to protect consumers from incidents occurring, and support them to live their best life.

The organisation had clinical governance policies and procedures in areas such as restrictive practices and open disclosure in place, but they were not always followed by staff. Some staff did not know about open disclosure, SIRS, and incident management and prevention policies and procedures, nor where to reference them. The service did not demonstrate an effective process for identifying, minimising and managing restrictive practices. Psychotropic medication management was not consistent with best practice and legislative requirements and the service did not demonstrate an understanding of chemical restraint.

The service implemented several actions in response to the non-compliance identified at the 2021 Site Audit. The new electronic care planning system had been implemented with a super-numerary registered nurse monitoring staff during the transition period. Consumers’ behaviour support plans were updated and reviewed for each ‘resident of the day’ to ensure that they met the consumer’s current care needs. Communication with next of kin was reviewed and contact details were updated for better communication.

The service delivered several training programs, including mandatory and additional specialled training and competency assessments on dementia and behaviour support, SIRS training, incident management (including incident management system training), to close skill gaps identified in those areas.

The service transferred all paper-based reporting of psychotropic medications to the new electronic medication management system. Open disclosure training was conducted for staff.

Weekly clinical risk meetings commenced to ensure governance was ‘applied to systems and processes.’ Monthly falls meetings commenced with clinical audit and trending.

The electronic incident management system was reviewed daily by the care manager, general manager and regional manage to check for potential SIRS incidents. The corporate office subject matter expert also reviewed incidents that met SIRS criteria to be flagged with the service. Also, new staff identified as having a lack of SIRS documentation knowledge were mentored and provided with continued support.

During the Assessment Contact on 22 to 23 November 2022 on balance the service demonstrated that the governing body had demonstrated accountability for improving the quality of care and services by allocating targeted financial grants to the service and implementing service recommendations regarding simplification of systems and processes to improve the effectiveness of care and services.

The general manager said the managing director had developed a project called ‘Simplify, designed to obtain ideas from people across the organisation for ways of simplifying processes and procedures to provide more effective care and services; and for the organisation to work more effectively as a whole. The general manager said the managing director asked him for his top 8 ideas for system simplification and he implemented all of them.

The Assessment Team reviewed consumer files that demonstrated assessment and planning reflects consumers’ goals and preferences. Advance care directives and/or end of life discussion outcomes are in place for sampled consumers. The service now has one care manager who is responsible for MSU, and there are regular staff rostered to work in the MSU to ensure there is continuity of care and staff are more knowledgeable on supporting consumers behaviours. The service now has a care manager who is a certified infection prevention and control (IPC) lead. The service demonstrated effective processes and practices for identifying, minimising and managing restrictive practices.

The Assessment Team noted significant improvements in the risk management systems and practices in relation to identifying and responding to abuse and neglect of consumers, supporting consumers to live their best life, management of falls, responsive behaviours, and high and low blood glucose levels. However, the service was unable to demonstrate effective management and clinical governance of high impact or high prevalence risks associated with wound management and weight management for some sampled consumers The systems and processes implemented by the service as part of the PCI, including multiple training programs to remove skill gaps in the areas of wound identification and management and unintended weight loss have not been effective.

The Assessment Team found stage 1 pressure injuries are still not being identified by care staff and registered nurses, nor are they being effectively identified in clinical reviews by care managers. Weight monitoring and clinical oversight and management of unintended weight loss was not always consistent with the service’s policies and procedures to minimise risks to consumers’ health safety and wellbeing.

The Assessment Team reviewed the SIRS register and electronic risk register which showed accurate categorisation of SIRS incidents, investigations, and actions to mitigate recurrence. However, just before the end of the Assessment Contact, the Assessment Team were informed of a potential SIRS incident occurred in the evening two days earlier. When the Assessment Team asked the general manager and regional manager about the incident, it did not seem they had been informed about it. They both made inquiries to find out what happened. Service management said an investigation of the incident will occur within the next 28 days. As the service was yet to carry out its investigation of the incident and the late stage of the Assessment contact, the Assessment Team was unable to further review the incident. However, the lack of governance oversight of the incident at multiple managerial (general manager and regional manager) levels was not consistent with the daily incident/risk register reviews the service confirmed had commenced, in the PCI.

The approved provider responded to the Assessment Team’s report and advised that they have conducted a review of the wounds and noted that only 1 was incorrectly classified. In response to weight management, the service advised that there were gaps in the documentation, however the service has been following the policies and procedures. The service also advised that they have effective clinical oversight and the potential SIRS matter had since been reported and investigated with toolbox education for staff on managing challenging behaviours.

I acknowledge the provider’s feedback, however, note that the identified gaps were identified at the previous Site Audit and do not appear to have been effectively managed as there are still gaps with managing high impact and high prevalence risks associated with the care of consumers, and experienced staff do not have the manual handling competency expected of them for training new staff. The training has made some improvement, from the previous Site Audit, however it does not appear to be sustainable.

I find the approved provider is complaint with requirements 8(3)(b), 8(3)(c), 8(3)(e), however non-compliant with requirement 8(3)(e) as the actions implemented and training provided have not been effective.

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