Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Bupa Queens Park |
| Service address: | 142 Carrington Road WAVERLEY NSW 2024 |
| Commission ID: | 2420 |
| Approved provider: | Bupa Aged Care Australia Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 30 November 2022 to 5 December 2022 |
| Performance report date: | 18 January 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 Bupa Queens Park (**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 Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the Assessment Team’s report received 9 January 2023
* the following information given to the Commission, or to the Assessment Team for the Site Audit of the service: Directions Notice dated 23 July 2021, following Assessment Contact 11 June 2021, Performance report dated 16 September 2021 following Assessment Contact 19 August 2021.
* the following information received from the Secretary of the Department of Health and Aged Care (**the Secretary**): Exceptional Circumstances determination dated 25 February 2022, 17 August 2022.

**Assessment summary**

|  |  |
| --- | --- |
| 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 | **Compliant** |
| **Standard 6** Feedback and complaints | **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)(d) The approved provider must demonstrate that accurate record of discussion in relation to risks is documented.

Requirement 2(3)(e) The approved provider must demonstrate that care and service documentation show comprehensive review of care plans is conducted for effectiveness when circumstances change, or incidents occur that impact on the needs, goals or preferences of consumers.

Requirement 3(3)(b) The approved provider must demonstrate that behaviour support plans contain triggers and strategies to prevent the incidents from reoccurring following investigation and evaluation.

Requirement 3(3)(e) The approved provider must demonstrate that information about consumers’ condition is shared with the appropriate staff and included on handover sheets.

Requirement 3(3)(g) The approved provider must demonstrate that staff and representatives are made aware at earliest occasion of potential Covid 19 risks.

Requirement 4(3)(c) The approved provider must ensure that activities meet the needs of all consumers and are regularly reviewed to provide mentally stimulating and individually tailored programs.

Requirement 7(3)(c) The approved provider must ensure that all staff can demonstrate practical competence from their training and that policies and procedures are well understood and staff can identify and act on triggers for behaviours to mitigate the behaviours from occurring.

Requirement 8(3)(c) The approved provider must demonstrate that the organise wide governance systems are effective in particular relating to information management and workforce governance to ensure that care and services documentation includes relevant information to support consumers needs and preferences and triggers for incidents.

Requirement 8(3)(d) The approved provider must demonstrate that the risk management systems and practices are effective to manage high impact and high prevalence risks and investigation is conducted and mitigation strategies developed to prevent the risks from reoccurring.

Requirement 8(3)(e) The approved provider must demonstrate that the clinical governance framework is monitored and reviewed for effectiveness and that clinical care optimises the health and well-being of consumers.

**Standard 1**

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

**Findings**

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

The Assessment Team found that the service was able to demonstrate that overall, each consumer is treated with dignity and respect, their identity culture and diversity valued. Most care plans reflect the diversity of consumers, including information about the cultural and religious beliefs and preferences, however some were incomplete. Staff were observed interacting with consumers respectfully and were familiar with consumers backgrounds.

The Assessment Team observed consumers who were not considered to be treated with dignity and respect however upon raising this with management a toolbox talk on dignity and respect was delivered to staff.

The service demonstrated that care and services are culturally safe. Staff were able to identify cultural and religious backgrounds and preferences of consumers. Care plans reviewed included information on consumers individual care services preferences, relevant cultural and religious beliefs The Assessment Team interviewed representatives who confirmed that cue cards are used by staff when required or contact was made with family for communication. Representatives also confirmed that staff who deliver care and services understand the consumer’s needs and preferences and know what to do to make sure they feel respected, valued and safe. The Assessment Team reviewed care plans which demonstrated phonetics charts are used to assist with communication.

The Assessment Team interviewed consumers who confirmed they have a say in the care and support that is provided to them. Consumers said staff respect their decisions and choices regarding their preference for care and when they choose to attend an activity. The staff gave examples of how they help consumers make day-to-day choices and help with access to any support consumer needs to live the best life.

The Assessment Team found that the service could demonstrate that 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. Consumers confirmed they are involved in meetings and encouraged to ask questions and provide input into discussions. Consumers advised they receive information through resident meetings, information on noticeboards and in person. The service provided evidence of choices being offered to consumers including catering, lifestyle services and recreational activities.

The Assessment Team interviewed consumers who confirmed the service protects the privacy and confidentiality of their information. Staff demonstrated a sound understanding of how to respect consumers privacy and ensure personal information is kept confidential. Overall staff interactions and consumers observed by the Assessment Team demonstrated respect for consumer privacy and confidentiality. The Assessment Team observed staff knocking on doors before entering consumers rooms and using the services signage to hang on the doors of consumers rooms which stated personal care is attended to and privacy as requested. The Assessment Team also observed consumer information is stored securely in the nurse’s station and other areas of the service with electronic information all having restricted access and password protected.

The following requirement was found to be non-compliant.

* Requirement 1(3)(d)

The service demonstrated that consumers are supported to take risks to enable them to live the best life they can. Care planning documentation described areas in which consumers are supported to take risks in accordance with their preferences. However, whilst care plans show details of consumers and their representative’s involvement in key decision-making about the consumers care there were discrepancies in relation to the conversations recorded.

The Assessment Team identified that dignity of risk forms did not contain an accurate record of the discussion with the representative identifying the consumer’s risk when the consumer lacked ability to make informed decisions.

The Assessment Team reviewed the care planning documentation for consumers who are supported to take risks. These showed no or minimal consideration of risk or lack of comprehensive risk assessment.

The approved provider responded to the Assessment Team’s report and provided further context in relation to the findings. The provider advised that discussions in relation to dignity of risk have taken place and education has occurred with staff in regard to completion of dignity of risk in the electronic system. I have considered the provider’s response, however, understand that it will take some time to reflect compliance with this requirement to ensure that accurate completion of documentation will be sustained.

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

**Standard 2**

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

**Findings**

The quality standard is assessed as non-compliant as one of the five specific requirements have been assessed as non-compliant.

The Assessment Team found that the organisation has policies and procedures in relation to conducting assessments. Consumers and representatives provided positive feedback in relation to assessment and planning. However, care and services documentation did not provide evidence of comprehensive assessment and care planning that considers risks to the consumers health and well-being. The Assessment Team reviewed care plans and found that most consumers did not have an initial care plan or the care plan was incomplete. Some consumers with high risks did not have the risks identified on admission and there was no comprehensive assessment completed.

The approved provider responded to this requirement advising that many consumers that had been with the service prior to the introduction of the electronic system and had paper based initial care plans which had been archived when the electronic system was introduced and replace with a comprehensive care plan. Comprehensive documentation including paper-based initial care plans for consumers and assessment and care plans with consideration of risks or dignity of risk for consumers were provided in response. Responsive Behaviour Risk Plans were provided with detailed information responding to the identified risks.

Review of assessment and planning documentation shows consumer care planning documentation does not routinely record address all consumers current needs, goals and preferences. Assessment and care planning do not adequately address all areas of care and services and does not address consumers individual needs or preferences. It was identified that consumers nutrition and hydration plan does not always have consumers dietary preference listed. Behaviour support plans do not always contain information around behaviours of concern. Advance care planning and discussion did not take place for one consumer until deterioration had occurred.

The approved provider responded to the Assessment Team’s report with comprehensive documentation addressing this requirement. This documentation provided further context for consumer’s choice and their dignity of risk. Responsive Behaviour Risk Plans contained strategies to address current risks and ceased risks with strategies also available if the managed risk returns.

The Assessment Team found assessment and planning is based on ongoing partnership with consumers, the people they wish to be involved in the care and other organisations and providers of care. The Assessment Team reviewed care and services documentation which provided evidence of case conferences, involvement of consumers and others they wish to be involved and a range of other health providers such as dietitians, speech pathologists and wound consultants. The Assessment Team interviewed consumers and representatives who confirm they had been involved in the care planning and their needs were being met.

The Assessment Team found the service has processes in place to enable outcomes of assessment and planning to be documented on a care and services plan and communicated to the consumer. Some consumers and representatives provided feedback that outcomes of assessment and planning had been communicated to them however documentation showed this is not always apparent. Most consumers and representatives said they did not receive a copy of the care plan and could not recall receiving a copy or were not aware of what a care plan was. This was raised with management who sent an email to all representatives informing them that care plans were available at any time. Education was conducted with registered nurses to ensure copies of the care plan were offered all during spotlight conversations.

The following requirement was found to be non-compliant.

* Requirement 2(3)(e)

The Assessment Team interviewed consumers and representatives who provided mixed feedback about being informed when things change. Care and services documentation showed comprehensive review of care plans is not conducted for effectiveness when circumstances change, or incidents occur that impact on the needs, goals or preferences of consumers. The service provided their assessment review report. A review of this report showed multiple assessments have not been reviewed as per the organisation’s monthly schedule. The approved provider responded to this requirement and advised to ensure that all consumers assessments are reviewed regularly for effectiveness and reflective of care and services when circumstances change the plan for continuous improvement has been updated.

I have considered the provider’s response, however, acknowledge that this will take time for the improvements in the plan for continuous improvement to reflect compliance.

I find the approved provider is non-compliant with this requirement.

**Standard 3**

|  |  |  |
| --- | --- | --- |
| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | 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. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Non-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. | Non-compliant |

**Findings**

The quality standard is assessed as non-compliant as three of the seven specific requirements have been assessed as non-compliant.

The Assessment Team found the service was not always able to demonstrate the consumers gets safe and effective personal or clinical care that is tailored to their needs and preferences or is best practice. The Assessment Team raised concerns in relation to restrictive practices for mechanical restraints where consumers beds were noted to be against a wall. Management advised that these consumers were either non-ambulant or could still get out of the other side and were not restricted. Environmental restraint was also raised with management with respect of not all consumers having access to keypad pin to access front door, management advised that this has now been rectified with the pin number being discreetly available. Availability of urinary catheter bags was raised as a concern by a consumer, management advised that there has never been an occasion where these have been not available, however they were currently on back order.

The Assessment Team found that the service was able to demonstrate 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. For the consumers sampled, care and service documentation showed changes in consumers’ condition were identified and responded to in a timely manner. Consumers and representatives confirmed the service is responsive when consumers are unwell and notifies them of any changes as they occur. Staff could describe their actions if a consumer’s condition changed including informing the medical officer, referring to other health professionals or transferring the consumer to hospital.

The service demonstrated timely and appropriate referrals to individuals, other organisations and providers of other care and services is undertaken. A review of care and services documentation showed appropriate referrals to relevant health professionals were undertaken in a timely manner. Consumers and representatives provided positive feedback regarding access to health professionals. Staff were able to describe the processes for referring consumers to other health professionals.

The organisation has systems in place for palliative care and end-of-life care. Management advised there were no consumers receiving end of life care during the Site Audit. Representatives provided positive feedback and staff were knowledgeable regarding end-of-life care. However, a review of care and services documentation for consumers who had received end of life care showed care provided was not documented. The approved provider responded and acknowledged that the documentation oversight had been pre-identified by clinical management during the clinical monitoring and review, noting progress notes recorded care provided. Further education was provided to registered nurses on documentation completion on 7 November 2022 and no further end of life documentation was found to have gaps.

The following requirements were found to be non-compliant.

* Requirement 3(3)(b)
* Requirement 3(3)(e)
* Requirement 3(3)(g)

The service identified falls, pressure injuries and behaviour support management as their high impact, high prevalence risks. Consumers and representatives provided positive feedback about their clinical care, and staff knowledge around high impact, high prevalence risks. However, observations and documentation reviewed showed high impact, high prevalence risks were not being managed appropriately and consumers were negatively impacted.

Observations and a review of care and service documentation for consumers with changed behaviours showed these are not being managed appropriately. Consumers with changed behaviours were observed to have a behaviour support plan which is embedded within a cognitive and behaviour care plan. A review of behaviour support plans showed individualised information around behaviours exhibited, triggers and strategies to mitigate behaviours are not always included in the plan or there is not enough information in relation to what the trigger may be. Behaviour monitoring charts do not always contain behaviours exhibited, interventions implemented, or evaluations of strategies implemented by staff. Investigations did not evidence root cause analysis as to behavioural triggers and strategies used by care staff were not identified or assessed for effectiveness. Documentation in behaviour support plans and behaviour monitoring charts showed a lack of staff understanding around the legislative requirements for behaviour support plans. The lifestyle staff interviewed were not aware of responsive behaviour support plans and their correlation with lifestyle activities. When the Assessment Team asked if the lifestyle team were involved in the development of positive intervention strategies for the behaviour support plans, the lifestyle regional manager said, ‘no we are not, but that sounds like a really good idea’.

The approved provider responded to the Assessment Team’s report and advised the information provided by the lifestyle team was not well understood and the lifestyle team are involved with activities related to the responsive behaviour support plans. The provider has undertaken education with lifestyle team and commenced behaviour huddles ensuring the lifestyle team are a part of this. The provider has also updated the plan for continuous improvement. I have considered the provider’s response however understand it will take some time to reflect that high prevalence and high impact risks are managed appropriately with investigation and analysis occurring to identify triggers for incidents and find this requirement non-compliant.

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 and information about consumers’ needs and preferences is not always documented. Information about consumers’ condition is not always shared with the appropriate staff for all consumers sampled. The Assessment Team found that when some assessments have been completed and this had not been shared or documented on handover sheets. Care and services documentation including behaviour support plans did not have the needs and preferences documented for some consumers. The approved provider responded to the Assessment Team’s report advising to enable the safety and well-being of all consumers and ensuring that sharing of information is a clear informative process, this has been added to the plan for continuous improvement which will be monitored for sustainability. I acknowledge the provider’s response however understand it will take some time for the service to demonstrate that information related to consumers is shared effectively and find this requirement non-compliant.

The Assessment Team found that the organisation has a suite of policies and procedures in relation to infection control and antimicrobial stewardship. The service has practices in place to minimise the spread of infection however, these practices are not always followed. Staff can describe strategies to minimise infection and demonstrated a good understanding of antimicrobial stewardship. Consumers and representatives provided positive feedback regarding the prevention and management of infections. However, care and services documentation for consumers with infections or infectious diseases showed policy is not always followed. The service was made aware that a staff member had tested positive when the Assessment Team were on site and worked the previous three days. The provider failed to notify staff and representatives that there was a covid positive case or undertake any contact tracing until 24 hours after receipt of information, this posed a risk to other staff and the consumers. The approved provider undertook rapid antigen testing on all consumers and communicated to all staff members that there has been an increase in community transmission requiring testing for staff and consumers. The approved provider states that the measures they took were effective as there were no further positive cases with staff or consumers. I have considered the provider’s response, however, feel that waiting 24 hours following receipt of information before undertaking any contact tracing, placing signs or informing staff to wear surgical masks did not demonstrate that the service is minimising the risk of infection. I find that the approved provider is non-compliant with this requirement.

**Standard 4**

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

**Findings**

The quality standard is assessed as non-compliant as one of the seven specific requirements have been assessed as non-compliant.

The Assessment Team found that overall consumers were satisfied they receive safe and effective services that enhance and maintain their independence, well-being and quality of life. Care planning documentation included individual preferences, past interests and current interests, social, cultural and spiritual needs and traditions that are important to the consumer. Staff demonstrated a sound knowledge of individual consumers’ needs and preferred activities and how they support consumers to meet their needs, goals and preferences.

The Assessment Team interviewed consumers and representatives who mostly had positive feedback about the laundry and cleaning services. However, one consumer said their jumper had shrunk in the wash, but it was replaced by the service. Consumers overall were happy with the meal service and were happy with the dining experience. Two of the consumers said they appreciate the resident meetings where they are able to provide feedback on services and supports, they receive. Two other consumers said they do not attend resident meetings but are comfortable to provide feedback to the staff and management team as the need arises.

All consumers interviewed said they feel well supported by the service to observe their religious practices and feel supported by staff to celebrate days that are meaningful to them. The consumers are satisfied the services and supports promote their spiritual, emotional and psychological wellbeing. Anglicare has volunteers who come to the service and facilitate songs of faith, which lifestyle attendance records indicate it is very popular with the consumers. Catholic mass is held once a month at the service. Care plan documentation indicate the service engages a professional psychologist and psychiatrist for consumers who require professional emotional support.

Consumers interviewed said they are satisfied their condition needs and preferences are effectively communicated within the service and with others who are responsible for care. Staff interviewed were able to describe ways in which they share information and are kept informed of the changing condition, needs and preferences for each consumer.

Staff said they are made aware of any changes of consumers needs and preferences through verbal and documented handover processes, information available in the electronic care management system (ECMS) and communication books. The service ECMS encompasses all care planning documentation and is available for staff, and external organisations where services for daily living is shared. This includes allied health professionals. The Assessment Team observed notes in the ECMS made by physiotherapist, speech therapist and psychological services.

The Assessment Team found the service has made links with organisations to connect consumers with services and supports the wider community provides. This includes referral to Anglicare emotional well-being for older people to provide emotional support to some consumers. The service also refers consumers to the community visitors scheme for those consumers who they have identified would benefit from developing their social connections.

Consumers provided positive feedback about the food and meal service. The service provides opportunities for consumers to give feedback about the food, both at the resident monthly meetings and obtaining feedback from consumers after every meal, with the feedback used to adjust the meals to reflect the consumers’ needs and preferences. Care plan documentation is consistent with the consumer preferences and dietary needs. Overall, consumers interviewed expressed satisfaction with the variety, quality and quantity of food being provided at the service. Comments from consumers included, ‘the food is pretty good’, ‘I enjoy the variety of meals that are on the menu’.

Consumers confirmed that they felt safe when using the service’s equipment and said it was easily accessible and suitable for their needs. Consumers said they were comfortable raising issues if equipment needed repair, knew the process for reporting an issue and said items were replaced when necessary. Equipment used for activities of daily living were observed to be safe, suitable, clean and well-maintained.

The maintenance staff described the preventative maintenance schedule and how they ensure equipment is safe, clean, and well maintained. Maintenance said the organisation is very responsive to any requests for servicing, maintaining, and replacing equipment and approves any reasonable requests to ensure the equipment at the service is fit for purpose.

The following requirement was assessed as non-compliant.

* Requirement 4(3)(c)

The Assessment Team found that some of the consumers sampled felt supported to participate in their community within and outside the organisation’s service environment and have social and personal relationships. However, some consumers sampled did not feel the service provided activities of interest to them. Feedback from some consumers included that the bingo, exercise classes and occasionally the singalongs are enjoyable although a lot of the activities are ‘childlike’. Another consumer said that the activities are often ‘very boring’ but attends just for the sake of ‘doing something’. Some feedback from consumers included that the activities at the service are targeted at consumers with a cognitive impairment and some activities are not mentally stimulating.

The lifestyle team interviewed said the activities calendar is developed based on the feedback from the consumers and their lifestyle assessments. For those consumers who are not interested in the group activities they try to provide one-to-one activities for the consumers. They have a one-to-one trolley and also a table near the nurse’s station on each level for the consumers to pick activities of interest to them such as jigsaw puzzles, colouring in, quizzes, books or magazines to read.

The Assessment Team observed the activities table on level 2 of the service, which had colouring in pages from hello kitty (a children’s fictional character) and a bluey’s jigsaw puzzle (an animated children show). There was no adult colouring in activities on offer. A review of lifestyle assessments showed they were not updated within the service’s monthly schedule or when circumstances changed. This was raised with management who said all assessments are reviewed during the service’s monthly spotlight conversations including the lifestyle assessments and would not have a recent review date unless there had been a change and the assessment was updated. However, some of the spotlight conversations reviewed by the Assessment Team did not have lifestyle as part of the review. There does not appear to be a connection between assessed needs (where this has occurred) and the activities program provided to individual consumers.

The approved provider responded to the report and advised that no concerns had been captured from the quarterly resident and relative surveys, where overwhelmingly consumers and their representatives consider their care home is well run and that the leisure and lifestyle program is meeting their needs. The provider advised that feedback from consumers has been considered with the program and adjusted to suit the needs of consumers with a recent example of this being additional sports including cricket games and those consumers who chose to be able to watch the grand final of the football World Cup having access to watch it with refreshments available.

The provider has followed up with named consumers from the Assessment Team’s report to ascertain satisfaction with the activities. The service has continued with consumer’s leisure and lifestyle assessments and have not identified any concerns. I acknowledge the provider’s response and improvements put in place as result of feedback however understand it will take some time to reflect that the activities are meeting the needs of consumers. I find the approved provider is non-compliant with this requirement.

**Standard 5**

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

**Findings**

The quality standard has been assessed as compliant as three of the three specific requirements have been found to be compliant.

The Assessment Team observed the service environment to be welcoming and comfortable. Consumers provided feedback that there are adequate private areas, both indoors and outdoors for consumers and visitors to utilise when socialising. All consumers have their own bedroom with ensuite which they were able to furnish with their own personal items. There is a large living room on each of the 3 levels of the service which were suitable for group activities as well as small living areas for quiet conversations or quiet reflection. There is a garden area on level 2 of the service with a gazebo for consumers to access if they choose. On level one and 2 of the service there are balconies with potted plants and outdoor furniture for consumers and their visitors to sit if they choose too. On level 3 of the service there is a rooftop garden with a large sitting area and BBQ facilities. The service has recently updated the rooftop garden with new plants and tables.

The consumers and representatives said the service is well presented and maintained. The common areas, and consumers rooms were observed to be clean, clutter free and comfortable. The maintenance officer demonstrated that effective preventative and responsive maintenance systems are in place to ensure all areas of the service are safe and well maintained and attended to within an appropriate timeframe.

The Assessment Team observed the front door to the service to be locked. A keypad was noted beside the door. There was no code beside the keypad. Management advised there are 7 consumers subjected to an environmental restraint and all the other consumers who are not environmentally restrained were provided the code to the front door. However not all authorised representatives said the consumers had received a code to the front keypad.

The Assessment Team observed consumers tending to their potted plants and enjoying the sunshine whilst reading.

The Assessment Team observed the furniture, fittings and equipment to be safe, clean, well maintained and suitable for consumers. Consumers interviewed were satisfied with the furniture, fittings and equipment. Management and staff demonstrated effective systems in place for the cleaning and regular maintenance of the furniture, fittings, and equipment.

**Standard 6**

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

**Findings**

The quality standard has been assessed as compliant as four of the four specific requirements have been found to be compliant.

The Assessment Team found that the service demonstrated consumers, their families and friends are encouraged and supported to provide feedback and make complaints. Overall consumers and their representatives were positive about the response and assistance they receive from care staff and registered nurses when they raised concern about the consumers care. The Assessment Team observed brochures in multiple languages on how to provide feedback and make complaints, how to access language support services and how to access consumer advocacy services located through the service. Staff were able to describe how they respond appropriately if a consumer raises an issue or concern.

Overall, the service demonstrated consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.

Consumers and representatives expressed a strong preference for raising their concerns with a trusted staff member rather than using the other complaint mechanisms available. Staff were able to describe the feedback and complaints process and services available to support consumers such as interpreters, and other aged care advocacy organisations. Consumers sampled generally did not describe how they would make a complaint if they felt uncomfortable raising concerns with staff at the service. However, they consistently said they preferred to raise concerns with their nominated care staff member or registered nurse rather than through other methods.

Care staff and RNs interviewed said consumers who have difficulty communicating or who live with cognitive impairments are helped to provide feedback or make complaints by their representatives, or by other staff who spoke their language, and through the use of picture boards to assist with communication.

The service demonstrated appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. Consumers confirmed their concerns were addressed and responded to appropriately and an open disclosure process was used. Staff were able to explain the importance of using open disclosure when responding to complaints. The service’s feedback and complaints policy incorporate open disclosure.

Review of the complaints register showed the service takes appropriate action in response to complaints.

The Assessment Team found on balance, feedback and complaints are reviewed and used to improve the quality of care and services. Review of resident and relative meeting minutes showed that consumer and relative feedback was largely positive. The service has a consumer food committee that chooses a certain number of identified dishes to be included each time the menu is changed.

The plan for continuous improvement provided by the service showed that one of 14 action items was sourced directly from consumer feedback. An action dated 22 August 2022, noted consumer feedback was that a regular visit by a therapy dog organisation would ‘be very beneficial to residents,’ with a due date of 31 December 2022. There is a progress record that confirms forms and a donation have been paid to the organisation, and the service is awaiting confirmation regarding their availability to attend.

**Standard 7**

|  |  |  |
| --- | --- | --- |
| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Non-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**

The quality standard has been assessed as non-compliant as one of the five specific requirements have been found to be non-compliant.

The Assessment Team found that on balance, the service demonstrated it has a workforce that is planned with the number and mix of staff deployed to deliver and manage safe and quality care and services*.* There were mixed responses from consumers, and their representatives, regarding whether there is a sufficient number of staff to provide all consumers with safe and quality care and services. However overall, they were not able to provide examples of how this impacted consumers. Some care staff raised concerns about staffing levels, particularly between 1:00pm and 3:00pm each day in two wings. However, except for some increases in the voluntary staff turnover rate amongst registered nurses, the data reviewed by the Assessment Team did not show there were insufficient staffing levels to meet consumers’ care and service needs.

The Assessment Team received feedback from some sampled consumers and representatives that there are constant changes to staff providing their care and services (care staff and registered nurses). A review of the voluntary staff turnover report showed some increases in registered nurse turnover (but this fluctuated), and a relatively low turnover of care staff.

The service demonstrated its workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. Representatives provided feedback that the service is welcoming, offering tea and biscuits and sometimes dinner. Another representative said that they had only seen patience and compassion from staff providing care. Overall, throughout the Site Audit, the Assessment Team observed staff to be engaging in a kind, caring and respectful manner with consumers.

The Assessment Team found that on balance the service demonstrated its workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

Training completion records showed 100% of staff are up to date with their mandatory eLearning modules in areas such as, Person first Dementia Second, infection control, incident awareness, managing complaints, and the Bupa code of conduct. The induction program has a 100% completion rate. Completion rates for other mandatory training programs such as role specific manual handling, donning and doffing, and fire safety are at 90 to 100%. Care staff and registered nurses interviewed said they were satisfied with the amount and quality of training they receive, and topics are regularly reviewed in toolbox discussions. Review of attendance records showed there are minimal shift vacancies, and service management confirmed they are actively recruiting care staff for casual and permanent positions.

The Assessment Team found that the service demonstrated that regular assessment, monitoring and review of the performance of most members of the workforce is undertaken. However, the Assessment Team found members of the clinical management team, who are responsible for clinical oversight at the operational level, demonstrated gaps in knowledge and understanding in relation to key areas of clinical documentation, incident investigation and management, and effective behaviour support for consumers living with Dementia with responsive behaviours placing themselves and others health and safety at serious risk. These gaps had not been picked up by the general manger or senior management in monitoring and review of their performance.

Records showed 90% of staff have current performance appraisals. The general manager said the balance would be completed by the end of 2022. Staff interviewed confirmed they had completed their annual performance appraisal discussions with the general manager.

However, it was identified that some performance appraisals and review of performance had not occurred which has negatively impacted the quality of clinical governance and consumer outcomes at the service, given the gaps in understanding and consequences for consumer care, demonstrated by clinical management and noted throughout this report.

The approved provider responded to the Assessment Team’s report and advised that all appraisals have now been conducted for staff other than two who are not currently working. The clinical management performance appraisal has been completed with the general manager. I have considered the providers response and note that the Assessment Team’s report and gaps in the quality of clinical governance and consumer outcomes have been addressed in requirement 7(3)(c), I find requirement 7(3)(e) to be compliant.

The following requirement was found to be non-compliant.

* Requirement 7(3)(c)

The Assessment Team found that the service’s workforce has the qualifications to effectively perform their roles. However, there were significant competence gaps demonstrated by members of the care staff, registered nurses and members of the clinical management team in the management of some high impact high prevalence risks. The clinical management team displayed gaps in their understanding of the legal and ethical requirements for clinical documentation.

Competency gaps were found in the management of high impact, high prevalence risks including effective documentation of behaviour support plans and use of behavioural support strategies for consumers with responsive behaviours, incident investigation and documentation, dignity of risk, and recognising and putting effective supports in place for consumer’s mental decline and falls prevention and management.

Consumer representatives provided feedback saying the staff are excellent, some staff need further training to be able to effectively care for consumers needs and sometimes the representative has to explain what is triggering the consumer’s frustration and behaviours.

The Assessment Team found that incident investigation reports did not display comprehensive root cause analysis had occurred to identify triggers of responsive behaviours and evaluation of the effectiveness of behaviour support strategies deployed by staff.

The approved provider responded to the Assessment Team’s report and provided details of staff induction/orientation and training completion rates. The provider also advised that thorough investigation had occurred into behavioural incidents, however it was not always identified if triggers had been considered and feedback from representatives stated that in some circumstances the representative would advise the care staff of what triggered behaviour. This does not demonstrate practical competence of the training, or the mitigating strategies evaluated from the investigation. I find that the approved provider is non-compliant with this requirement.

**Standard 8**

|  |  |  |
| --- | --- | --- |
| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | 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 has been assessed as non-compliant as three of the five specific requirements have been found to be non-compliant.

The Assessment Team interviewed management who described how consumers are actively engaged in the development, delivery and evaluation of care and services and are supported in that engagement. The management team discussed that consumers are involved in care planning, food focus groups/committee, monthly resident/relative meetings, quarterly resident/representative surveys and through feedback and complaint forms.

Management also said that six weeks after admission to the service, consumers and their representatives are given a satisfaction survey to complete, that the service considers in its plan for continuous improvement.

The Assessment Team received feedback from consumers and representatives and reviewed documentation to confirm consumers engagement in service development, delivery and evaluation.

The organisation demonstrated that its governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. Management provided examples to support this advising that the board approved the roll out of the new version of the electronic care planning system providing a single source of truth for consumer care information. The board approved the purchase of a new medication management system across its services to decrease medication incidents. The board approved a recent restructure that saw quality education managers introduced to each residential aged care service to provide quality and education support at the operational level, where it is needed, and will have the greatest positive impact on the quality of care and services.

The Assessment Team reviewed weekly email updates from the managing director to all staff. The emails demonstrated the commitment of the governing body to promote a culture of safe, quality care and services. This included news items about awards given to certain services under categories such as ‘resident and family experience’, as well as results from the consumer survey highlighting improved consumer engagement; and the completion of the roll out of the organisation’s electronic care planning system. The managing director noted benefits of the system including ‘improved data analytics’ to improve care outcomes, ‘enabling ‘better and more trusted and transparent communication with our families.’

Management said, the director of quality provides education, work instructions, and policies (endorsed by the board) to the service. The regional manager, general manager, clinical care manager and quality and education manager ensure the information is embedded in the service through education, staff updates and other tools such as the new incident management flip card booklets.

The following requirements are non-compliant.

* Requirement 8(3)(c)
* Requirement 8(3)(d)
* Requirement 8(3)(e)

The service demonstrated there were significant gaps in information management in relation to the quality, accuracy and completeness of clinical care records for some sampled consumers. These gaps were not identified and rectified by the service’s clinical governance systems and processes, placing consumers’ health, safety and wellbeing at risk. The gaps in documentation identified were not consistent with the service’s information governance policy. Some examples of the gaps in information management included that the care and services documentation including behaviour support plans did not have the needs and preferences documented for some consumers, not all falls were recorded on the incident management system as falls.

In relation to workforce governance, the service has comprehensive job documentation that covers job purpose, responsibilities, required qualifications and training, reporting lines, key relationships, agreed core competencies, modelling the organisation’s values and compliance requirements. However, staff, consumers and their representatives reported there are issues regarding sufficient staffing at certain times of the day and lack of competence in behavioural support and documentation of behavioural support plans, monitoring charts and dignity of risk documentation. Staff and consumers/representatives provided feedback about insufficient staffing numbers to provide effective quality care and services to consumers in some wings, particularly immediately following lunch, when consumer care needs such as assistance with toileting, increase. Management said that there is flexibility to extend rostered time for those staff on the morning shift that finish at 1:00pm and/or to arrange for afternoon staff to start their shift early. However, feedback from staff and consumers was that this is an ongoing problem requiring a sustained rostering solution rather than one that occurs occasionally.

The Assessment Team found that learning outcomes from training and education programs have not been effective in providing staff and clinical managers with the level of competence required to provide effective behaviour support to consumers with responsive behaviours. The approved provider responded to this requirement and disagreed with the findings listing the training completed to achieve competence, however feedback and review of documentation does not support that this has been practically applied in all instances. The provider also advised that the behaviour support plans have been reviewed by Dementia Services Australia, Geriatricians and Psycho Geriatricians and other behaviour specialists, however it appears that the mitigation strategies or triggers are not identified or acted upon to prevent the behaviour reoccurring, indicating that the information management system has failed despite having expert advice. I find that the approved provider is non-compliant with this requirement.

The Assessment Team found on the whole, the service was able to demonstrate effective risk management in relation to wound management and skin integrity, pain management, diabetes care and SIRS incidents. However, there were significant gaps in the management, documentation and clinical oversight of responsive behaviours and associated falls incidents, and gaps in effective and timely risk management when a staff member tested positive for COVID-19 during the Site Audit. The service identified falls, pressure injuries and behaviour support management as their high impact, high prevalence risks. Consumers and representatives provided positive feedback about their clinical care, and staff knowledge around high impact, high prevalence risks. However, observations and documentation reviewed showed some high impact, high prevalence risks were not being managed appropriately and consumers were negatively impacted.

The service’s clinical management team demonstrated significant gaps in their knowledge and understanding regarding the purpose of and best practice for dignity of risk discussions and documentation. This was particularly evident in relation to the service developing dignity of risk forms and/or agreements with some consumers and/or their representatives, when those consumers are living with dementia and are assessed to have limited or no capacity to understand, decide on and take responsibility for the risks to themselves and others posed by their responsive behaviours.

Management responded that the dignity of risk discussions was an opportunity to explain the risks associated with behaviours such as refusal of care and assistance to consumers and their representatives and to clarify mitigating strategies and further stated that the clinicians had the skill to assess the capacity of consumers living with dementia and displaying responsive behaviours to comprehend and make decisions about their actions, consequences and risk mitigation. This was in spite of the assessment information in the consumers’ care plans and dignity of risk forms that documented the consumers’ lack of capacity to do so.

The incident investigation reports completed by clinical management on the electronic risk management system are not aligned to the service’s incident management policy. The Assessment Team identified some sampled consumers had multiple falls incident reports with investigations containing identical information; showing that the investigations were not specific to each incident. This directly conflicts with the principles of incident analysis and investigation outlined in the organisation’s incident management policy. The policy states the ‘goals of incident analysis are to ‘understand how and why the incident occurred,’ ‘identify ways of improving systems to prevent recurrence and/or minimise the harm resulting from a similar incident,’ ‘to identify trends or potential links related to incident types, and/or to highlight the need for further actions.’ The policy highlights the importance of root cause analysis in the investigation and analysis process, defining it as, ‘a systematic investigation technique that looks beyond the individuals concerned and seeks to understand the underlying causes and environmental context in which the incident happened and what changes are required to prevent re-occurrence.’ Failure to investigate and record specific findings for each incident misses the opportunity to gain maximum insight about incident triggers and causes and to identify strategies (however subtly different) that may prevent or reduce further similar incidents.

The approved provider responded to the Assessment Team’s report and disputed the findings of the team, providing further commentary to the team’s report. I have considered the providers response; however, it does not provide me with further evidence that persuades me of the compliance for this requirement. I find that the approved provider is non-compliant with this requirement.

The Assessment Team found that the organisation has a documented clinical governance framework that describes the clinical roles, responsibilities and accountabilities and how clinical care and services are continuously measured, monitored and improved to ensure their safety and quality in order to promote optimal consumer outcomes. The clinical governance framework includes information on antimicrobial stewardship, minimising use of restrictive practices, and the organisation’s commitment to open disclosure. However, the service was unable to demonstrate that its clinical governance system and practices were effective at the operational level, negatively impacting the health, safety and wellbeing of consumers.

Sampled consumers were not receiving best-practice care tailored to their needs and optimising their health and well-being in the areas of behaviour management, and identification and management of mental health decline. Clinical and care documents did not provide evidence of comprehensive assessments that consider the risk to the consumers’ health, safety and wellbeing of some sampled consumers. There were ongoing gaps in clinical documentation and review, evidenced in monitoring charts, care plans and incident reporting in the area of behavioural management.

The Assessment Team identified evidence of a breach of the service’s code of conduct and legal documentation requirements, by clinical management who are responsible and accountable for operational clinical governance and clinical supervision and staff coaching and training at the service. In this instance a staff member recorded in a consumer’s progress notes that they had a discussion with a representative during the Site Audit, that did not occur. The staff member later returned to the Assessment Team and confirmed they had not had the discussion as documented and said they would delete the progress note and replace it with an accurate version. The manager’s actions and intention to alter the original record instead of adding an amendment, were a clear breach of the Bupa code of conduct provided to the Assessment Team by the Regional Manager, that states, ‘Act with integrity and transparency.’ The regional manager confirmed the service takes the misconduct displayed by the staff member very seriously and had commenced counselling the staff member, to be followed up after the Site Audit with a formal performance discussion and a formal file note recorded on the staff member’s personnel file. The approved provider responded to the Assessment Team’s report and advised that a discussion has taken place with the staff member and a file note placed on their personal file. I acknowledge the providers response, however, find that this is a serious breach of integrity and transparency, and the providers response does not satisfy me that this behaviour has not previously occurred and have not advised on how they will ensure this does not occur in the future. The provider did not provide further feedback in relation to the clinical governance framework and the lack of comprehensive assessments to identify behaviour management and mental health decline. I find the approved provider is non-compliant with this requirement.

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