Performance

Report

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| Name of service: | Bupa Tamworth |
| Service address: | 68-74 Bligh Street TAMWORTH NSW 2340 |
| Commission ID: | 0513 |
| Approved provider: | Bupa Aged Care Australia Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 23 August 2022 to 25 August 2022 |
| Performance report date: | 26 September 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 Tamworth (**the service**) has been prepared by Melissa 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 23 September 2022.
* the following information given to the Commission, or to the Assessment Team for the Site Audit of the service: Ten consumers and 10 representatives were interviewed by the Assessment Team.
* the following information received from the Secretary of the Department of Health and Aged Care (**the Secretary**): Exceptional Circumstances determination dated; 25 May 2021, 23 November 2021, 24 May 2022.

# Assessment summary

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

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

# Areas for improvement

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

* Requirement 1(3)(a) The approved provider must demonstrate all staff undertake education on dignity and respect and demonstrate this in practice.
* Requirement 1(3)(b) The approved provider must demonstrate that assessments record adequate details on consumers’ identity, culture and diversity to direct safe and quality care. Care planning documents should detail how to provide culturally safe care.
* Requirement 1(3)(c) The approved provider must demonstrate that decisions about consumers care and maintaining relationships of choice are supported. The service must demonstrate the consumer’s partner in care.
* Requirement 1(3)(d) The approved provider must demonstrate that consumers are supported to undertake risks and that risk assessments and strategies are in place for consumers.
* Requirement 1(3)(e) The approved provider must demonstrate that consumers and representatives receive current, accurate and timely information and that communication about consumers’ care within the service is also current and accurate.
* Requirement 2(3)(a) The approved provider must demonstrate that assessment and planning consider risks to consumer’s health and well-being to facilitate the safe delivery of effective care, this was found to be lacking in care areas such as medication administration and management, diabetes management, unintended weight loss, and skin integrity and pressure injuries.
* Requirement 2(3)(e) The approved provider must demonstrate that incident reports are routinely completed when incidents occur, and that care and services are reviewed regularly for effectiveness, including when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.
* Requirement 3(3)(a) The approved provider must demonstrate that safe and effective care is provided to consumers and risks to their health are identified. Gaps in relation to medication management are remediated and the Plan for Continuous Improvement initiatives are in place to prevent these issues from reoccurring.
* Requirement 3(3)(b) The approved provider must demonstrate that high impact and high prevalence risks are identified and managed. Incident reports must be completed with documented risks and strategies and evaluated for effectiveness.
* Requirement 3(3)(e) The approved provider must demonstrate that the consumers’ information is accurate and current and monitoring charts are updated in care plans. Consumers’ condition, needs and preferences are completed, and Behaviour Support Plans are individualised. Communication of consumers condition is effective between staff and representatives.
* Requirement 4(3)(a) The approved provider must demonstrate that consumers receive services and supports that are important to their health and well-being and that activities are developed to provide meaningful engagement with consumers.
* Requirement 4(3)(b) The approved provider must demonstrate consumers receive emotional and psychological support and partners in care are permitted to provide essential care to consumers.
* Requirement 4(3)(c) The approved provider must demonstrate that the consumer receives services and supports to participate in their community within and outside the service, have social and personal relationships and do things of interest to them. The service should ensure that activities are tailored to the consumers.
* Requirement 4(3)(d) The approved provider must demonstrate that staff refer to updated and current care plans to understand the consumer’s condition, needs and preferences and that the consumers condition, needs and preferences are known and communicated effectively within the service.
* Requirement 4(3)(f) The approved provider must demonstrate that consumers food preferences are provided, and that food is varied and of suitable quality and quantity.
* Requirement 4(3)(g) The approved provider must demonstrate that a system for reactive maintenance is in place and is risk managed to ensure that equipment is fixed effectively. The service must demonstrate that there is proactive cleaning and maintenance.
* Requirement 5(3)(a) The approved provider must demonstrate that a review of wayfinding is considered to optimise the consumer’s ability to find their way throughout the service and that consumer’s feedback is considered to feel a greater sense of belonging.
* Requirement 5(3)(b) The approved provider must demonstrate that consumers are able to move freely throughout the service and that the service’s environment is clean and safe.
* Requirement 5(3)(c) The approved provider must demonstrate that the identified issues relating to furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.
* Requirement 6(3)(c) The approved provider must demonstrate that appropriate action is taken in response to complaints and feedback of actions is provided to consumer or representative.
* Requirement 6(3)(d) The approved provider must demonstrate that the feedback and complaints that have been provided to the service in relation to the lack of staffing, food quality, and the quality of care at the service, are reviewed and improvements are in place to address these complaints.
* Requirement 7(3)(a) The approved provider must demonstrate there are enough staff rostered to prevent staff from rushing consumer care and services and that consumers are not left waiting unreasonable periods of time after using call bell.
* Requirement 7(3)(b) The approved provider must demonstrate that staff interaction with consumers and representatives is respectful, kind and caring and their interactions with the consumers is not rushed enabling staff to provide care that is kind, caring and respectful.
* Requirement 7(3)(c) The approved provider must demonstrate that staff are competent at delivering safe, quality care to consumers. Staff consistently demonstrate a comprehensive knowledge of what is important to the consumers in relation to how their personal and clinical care is delivered.
* Requirement 7(3)(d) The approved provider must demonstrate that staff complete mandatory training and have ongoing training to ensure they can demonstrate their competence.
* Requirement 8(3)(b) The approved provider must demonstrate that non-compliance with the Quality Standards is reported, escalated and addressed by the governing body to ensure a culture of safe, inclusive and quality care and services.
* Requirement 8(3)(c) The approved provider must demonstrate that there are effective organisation wide governance systems relating to systems for information management, regulatory compliance and workforce governance to ensure staff are able to provide safe and effective care and services for consumers.
* Requirement 8(3)(d) The approved provider must demonstrate that effective risk management systems and practices, are in place to identify, assess, respond and monitor high-impact and high-prevalence risks, as well as other risks at the service. Incident forms must consistently be completed for all incidents. Risks associated with unsafe practices must be identified and strategies and interventions implemented to minimise risk to the consumer.
* Requirement 8(3)(e) The approved provider must demonstrate that there in an effective clinical governance framework, and that these policies are discussed and understood by staff.

# 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. | Non-compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Non-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. | Non-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. | Non-compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

I have assessed this Quality Standard as Non-compliant as I am satisfied that the following five of the six specific requirements have been assessed as Non-compliant.

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

* Requirement 1(3)(a) Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.
* Requirement 1(3)(b) Care and services are culturally safe.
* Requirement 1(3)(c) Each consumer is supported to exercise choice and independence, including to:

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

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

The Assessment Team found that the service did not demonstrate that consumers are treated with dignity and respect or that care services are culturally safe, this was also observed in practice. There was limited evidence that each consumer is supported to exercise choice and independence.

The Assessment Team interviewed consumers and representatives and found three consumers and four representatives said consumers were not always treated with dignity and respect. Two staff members said that most of the time there were not enough staff and they could not always treat each consumer with dignity and respect. Care planning documents did not include what staff needed to do to deliver care in a way that valued consumers’ identity, culture and diversity.

Two consumers and representatives said that decisions about consumers’ care are often not adhered to by staff and maintaining relationships of choice is not supported. Two representatives who are partners providing essential care to their consumers were not permitted to enter during Covid-19 outbreaks, this resulted in the consumers not receiving assistance with meals, socialisation and emotional support. Another consumer said they are not supported to visit family living locally. One consumer said there has been no discussions about risk mitigation strategies for the electrical equipment in their room such as an electric testing and tagging schedule or how to keep other consumers with cognitive decline safe when they wander into the consumers room.

The Assessment Team found that the service did not demonstrate that each consumer is supported to take risks to enable them to live the best life they can. The Assessment Team interviewed consumers who said that there are never enough staff to assist or support with taking risks. One consumer said that they must rely on family to help them do the things they want to do.

The Assessment Team identified that staff responsible for recording initial assessments and reassessments were not recording adequate details of consumers’ identity, cultural and diversity needs to direct safe and quality care. Staff did not know about, or how to identify, consumers who may be from special needs groups and special considerations for inclusion in assessment and care planning. They did not know about how to record culturally safe care instructions or special considerations for consumers from other backgrounds, culturally and linguistically diverse consumers, consumers from rural and remote areas, financially and socially disadvantaged consumers or consumers from other special needs groups.

The Assessment Team interviewed representatives and received feedback that they did not receive clear or accurate information about COVID-19 restrictions and were not permitted to enter the service to provide essential services to their respective consumers. Another consumer and representative said that they do not receive accurate information about meal and food options and often receives food or meals she has not chosen.

The approved provider responded to the Assessment Team’s report and agreed with the team’s findings. The approved provider has furnished their Plan for Continuous Improvement and a training schedule for staff and has initiated a number of actions to achieve and sustain compliance for all Bupa Tamworth. Assessments and care plans are currently being reviewed and specialist consultation carried out to ensure that assessments and care plans are comprehensive, with education being provided to staff to ensure that they have the knowledge and skills to care for the consumers in the service. The service has reviewed all identified consumers from the team’s report to identify and remediate gaps impacting on the health, safety and wellbeing of the consumers and has taken a targeted approach to address the gaps identified. These actions have included a comprehensive assessment of each consumer’s current clinical condition, actions to address the issues and concerns, including emergent issues and further planned actions to ensure their care needs continue to be met.

I acknowledge the immediate actions and ongoing actions that the provider has initiated, however accept it will take some time for these initiatives to be reflected.

I find that the approved provider is Non-compliant with these requirements.

I am satisfied that the following requirement is Compliant.

* Requirement 1(3)(f) Each consumer’s privacy is respected and personal information is kept confidential.

The Assessment Team found that the service demonstrated consumers’ privacy is respected and personal information is kept confidential. Three consumers and two representatives said consumers’ privacy is respected and personal information is kept confidential. The Assessment Team observed staff consistently knocking on consumers’ doors, announcing themselves and asking permission to enter consumers’ rooms. Computers were password protected.

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

I have assessed this Quality Standard as Non-compliant as I am satisfied that the following two of the five requirements have been assessed as Non-compliant.

* Requirement 2(3)(a) Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.
* Requirement 2(3)(e) Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

The Assessment Team found that the service did not demonstrate assessment and planning considered risks to consumer’s health and well-being to facilitate the safe delivery of effective care in care areas. Incident forms are not routinely completed when incidents occur such as medication administration and management, diabetes management, unintended weight loss, and skin integrity and pressure injuries. Therefore, the monthly clinical indicators and the data collection for quality improvements is not an accurate reflection of the consumer incidents occurring at the service.

The Assessment Team reviewed care planning documentation and noted for one consumer that high blood glucose levels have not been assessed with strategies to prevent this from happening. An increase in weight monitoring had not been considered for a consumer who had unexpected weight loss and medication incidents had occurred for two sampled consumers who did not receive their medication in a timely manner to manage their conditions. One consumer advised the Assessment Team that staff had missed the consumer’s medication for over a week and the Assessment Team noted that there were no medication charts in place for over 2 months. Documentation reviewed does not support staff monitoring the consumer’s condition for potential issues associated with not receiving medication over this period of time. There was no medication incident reporting completed to indicate a lack of stock and ensure timely review of the consumer. Quality indicator data reviewed does not reflect issues relating to stock control therefore there are no mitigating strategies in place to address the issue at a service and governance level.

The Assessment Team identified through clinical indicator data for May 2022 that 8 of 27 consumers in one wing had grade 1 pressure injuries and documentation does not support root cause analyses regarding why there was a cluster of pressure injuries in this community. The clinical care managers were unable to provide further details such as root cause analysis, staff practice review, equipment review and/or staffing sufficiency review.

Care planning documentation indicated the effectiveness of the care plan is not consistently reviewed when consumer care needs change or when consumers have incidents that can impact on their care needs. The Assessment Team provided this feedback to the clinical care managers and management.

The approved provider responded to the Assessment Team’s report and agreed with the team’s findings. The approved provider has furnished their Plan for Continuous Improvement and a training schedule for staff and has initiated a number of actions to achieve and sustain compliance for all Bupa Tamworth. The service has reviewed all consumers to ensure that they have an up to date assessment to guide staff with medication administration. Consumers deemed competent to self-administer their medication have undertaken assessments and this has been deemed appropriate by their medical officer. Education has been provided to staff, weekly clinical review meetings will be held to minimise and assess risk with the Nurse Advisor that the approved provider has engaged to lead these meetings. A review of all complex wounds has been conducted and recommendations have been added to consumers care plans.

I acknowledge the immediate initiatives that the provider has initiated to return to compliance, however accept it will take some time to reflect these improvements.

I find that the approved provider is Non-compliant with these requirements.

I am satisfied that the following requirements are 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.
* Requirement 2(3)(c) The organisation demonstrates that assessment and planning:

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

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

The Assessment Team reviewed consumers’ care planning documentation which reflects consumers’ goals and preferences. Advance care directives and/or end of life discussion outcomes are in place for several consumers. The clinical care managers indicated that end of life and advance care planning is discussed with consumers and /or representatives at care conferences.

The Assessment Team found that overall the service demonstrated they have a partnership with consumers and/or representatives to involve the consumer and/or representative in the care assessment and planning of the consumer. Assessment and planning included other organisations, individuals and providers of care and services that are involved in the care of the consumer.

Consumer files evidence appropriate referral and involvement with other practitioners and consumers and representatives indicated satisfaction with the ongoing partnerships with others involved in the consumers’ care. There was evidence identified where consumers had been referred to specialist services and the outcomes had been communicated to the consumers and representatives.

The Assessment Team interviewed clinical care managers who advised that case conferences occur with consumers and/or representatives and the care and services for consumers are discussed. Some consumers and representatives said they had been offered a copy of their care plan, however not all recalled attending a case conference. Four representatives indicated that the communication of care changes is not consistently and effectively communicated, however did not provide examples of when this occurred. Documentation indicated each consumer had a care plan which was available to consumers and/or nominated representatives.

# 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. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | 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. | Compliant |

Findings

I have assessed this Quality Standard as Non-compliant as I am satisfied that the following three of the seven requirements have been assessed as Non-compliant.

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

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

* Requirement 3(3)(b) Effective management of high impact or high prevalence risks associated with the care of each consumer.
* Requirement 3(3)(e) Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.

The Assessment Team identified consumers were not receiving best practice care that is being tailored to their needs and is not optimising their health and well-being. This includes medication management, weight management, behaviour management and restrictive practices.

The Assessment Team reviewed a medication report (1 March 2022 to 22 August 2022) that indicated incidents where there has been no stock of medication for consumers on approximately 168 occasions. This included such medications as; nutritional support supplements, antibiotics, blood pressure/heart medication and pain medication including schedule eight medication. The incidents pose significant high impact and high prevalence risks to the consumers demonstrating a lack of clinical governance was evident when reviewing consumers with high impact or high prevalence risks. It was also identified that weight monitoring for unintended weight loss and the oversight of consumers weight is not in place and does not align to the protocol of the service/organisation.

The Assessment Team identified that there have been no risk mitigation strategies to address the stock of medication or risk to consumer. The clinical manager indicated a medication incident form should be completed when then is no stock of medication, however this has not been the practice. The Assessment Team enquired as to how the service is aware of pharmacy issues if they are not using medication incident forms to report issues such as medication supply and no stock. The clinical manager indicated they do not and would not have a tracking process. There was also a lack of monitoring of falls, drowsiness and mobility changes following a medication increase.

The Assessment Team spoke with consumers and representatives who provided feedback that their personal needs are not being met. One consumer provided feedback that they can wait a long time for staff to respond to the call bell which is normally used to go to the bathroom. The consumer added that they like to go to the bathroom before getting dressed each morning, however this does not always occur and indicated that staff will dress the consumer and inform them they will come back after breakfast. Another representative said this is a common occurrence.

One representative indicated care could improve and that staff need to be aware of the consumer’s needs and that consistency of practice is needed. The representative advised that staff skills in dementia care are insufficient and they need to be able to identify the consumer’s unmet needs such as not drinking as fluids are left untouched. The representative also advised that staff are not identifying nonverbal signs of pain consistently and are not repositioning the consumer.

The Assessment Team identified that there was a lack of communication throughout the service with representatives providing feedback that follow up does not consistently occur, handover is poor between shifts and information is not passed on to other staff. Three consumers’ representatives said they have not been consistently updated with regards to the consumers condition, needs and preferences. Consumers’ condition, needs and preferences are not accurately documented in consumers’ care plans, monitoring charts are inconsistently completed, Behaviour Support Plans do not consistently reflect individualised care interventions.

Staff said they are provided information about consumers at handovers, however the information is brief and not clearly reflecting the consumers’ care needs. They indicated information is available in the electronic care plans, however they do not have time to read the care plans. Staff indicated communication of consumer information between shifts is not effective to ensure continuity of care, especially when you are new to a community.

The approved provider responded to the Assessment Team’s report and agreed with the team’s findings. The approved provider has furnished their Plan for Continuous Improvement and a training schedule for staff and has initiated a number of actions to achieve and sustain compliance for all Bupa Tamworth. The provider has commenced education for all staff for the identified gaps in the report, this has included, medication management, weight monitoring and clinical assessment. Formal handover is occurring at each shift. The General Manager or Care Manager attend handover to ensure that key information is communicated, and key issues and concerns are followed up. Further refinement through feedback with the Registered Nurses will occur to ensure that the handover between each shift is comprehensive.

I acknowledge the immediate and comprehensive actions that the provider has implemented, however accept it will take some time to reflect compliance with these requirements.

I find that the approved provider is Non-compliant with these requirements.

I am satisfied that the following requirements are 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.
* 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.
* Requirement 3(3)(f) Timely and appropriate referrals to individuals, other organisations and providers of other care and services.
* Requirement 3(3)(g) Minimisation of infection related risks through implementing:

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

The Assessment Team identified that for the consumers sampled who are nearing the end of their lives, documentation indicated the consumers’ care needs and preferences had been identified by staff. Their wishes and directives (advance care/end of life/case conference) had been incorporated into the consumer’s care file and associated documents. The service ensures a substitute decision-maker is identified and documented. Consultation occurs with consumers and representatives when referral to palliative care is required or when a consumer commences the palliative pathway and or nearing end stage/end of life care. The clinical care manager advised that there were no consumers receiving palliative and/or end of life care during the Site Audit, however, indicated some consumers are receiving comfort care.

The service demonstrated consumers who have experienced a deterioration or change in their cognition and/or mental health have their needs recognised and responded to in a timely manner. For consumers sampled, their care planning documents and/or progress notes reflect the identification of, and response to deterioration or changes in function/capacity/condition.

The Assessment Team reviewed care planning documents which evidenced the input of others such as allied health professionals and specialists. Referrals were made when required. For example, there was evidence of referrals to a speech pathologist, dietician, wound specialist and geriatrician. The input from the specialist and allied health professional is generally documented in the consumers’ clinical file.

Registered nurses demonstrated a general understanding of antimicrobial stewardship and the principles for outbreaks as well as standard precautions. The service had an outbreak preparedness plan and associated documents in place to guide their practice in the event of an outbreak. A clinical care manager is the infection prevention control lead (IPC lead) for the service.

There is a surveillance system in place to record when infection incidents occur, although there is no consistent review of pathology results to identify and trends, cross infections and/or risks for consumers. The infection prevention control lead indicated at recording the outcomes of pathology results was each community’s responsibility, however acknowledged this was not effective after the Assessment Team raised the gaps in the surveillance program.

The clinical care managers indicated the staff request the medical officer to order pathology prior to commencing antibiotics.

Staff were observed wearing face masks and shields, however some were observed with masks not worn correctly.

# 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. | Non-compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Non-compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | 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. | Non-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. | Non-compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Non-compliant |

Findings

I have assessed this Quality Standard as Non-compliant as I am satisfied that the following six of the seven requirements have been assessed as Non-compliant.

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

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

* Requirement 4(3)(d) Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.
* Requirement 4(3)(f) Where meals are provided, they are varied and of suitable quality and quantity.
* Requirement 4(3)(g) Where equipment is provided, it is safe, suitable, clean and well maintained.

The Assessment Team found that each consumer does not get safe and effective services and supports for daily living. Two consumers and three representatives said consumers did not receive services and supports that were important to their health and well-being and that enabled them to do the things they wanted to do. Care planning documents did not include detail of how to meet consumers’ needs in relation to activities which optimise their health, wellbeing and quality of life. Activities charts demonstrated consumers with cognitive or mobility limitations did not receive enough staff engagement to meet their recreational and social needs. The Assessment Team observed that group activities did not take place as scheduled.

The Assessment Team found that the service did not demonstrate services and supports for daily living promote each consumer’s emotional, spiritual and psychological wellbeing. Two representatives said their respective consumers did not receive emotional and psychological support during July 2022 to August 2022 during COVID-19 lockdowns. Care planning does not provide instruction or detail how care and services are to be delivered to promote consumers’ emotional, spiritual and psychological wellbeing.

The Assessment Team interviewed consumers and representatives who provided feedback that there are never enough staff to check in or provide meaningful activities. One consumer was left in the dining room alone and was alarmed as they did not know where they were. The Assessment Team escorted the consumer to the lounge room where other consumers were.

The service did not demonstrate services and supports assist each consumer to participate in their community within and outside the service, have social and personal relationships and do things of interest to them. Two consumers said they are not supported to have social and personal relationships and not supported do things of interest to them. Two representatives said their relatives are not supported to do things of interest to them.

The Assessment Team observed that some group activities did not take place as scheduled, one consumer said that their family live locally but has not been supported by staff to visit them and they have not been able to visit during the COVID-19 lockdown. The consumer said that there are no group activities of interest and finds ‘throwing a ball around’ to be undignifying. Feedback was received that there is never enough staff to support the consumer in any activities and the consumer has to look after them self and rely on family to help to do the other things. The consumer said the service do not provide any group activities in the community of interest and stays in the room or walks to the reception area and sits there for a while each day. The consumer mentioned the family had to organise an electronic device themselves to communicate with family members on ‘direct connection’ to talk to them face to face.

Representatives said they were not permitted to enter the service during June and August COVID-19 lockdown even though they provided regular essential services to their respective consumers. This also prevented them from maintaining their personal relationship with them and denied them from important socialisation.

The Assessment Team observed that the afternoon craft sessions for three communities did not place on 23 August 2022 and one exercise session did not take place on 25 August 2022 because of lack of staff.

The Assessment Team identified that information about consumers’ condition, needs and preferences is not effectively communicated within the organisation. One consumer and one representative said that the consumer’s dietary information has been miscommunicated for years. Staff said they did not refer to care plans for information about consumers. Two care plans reviewed by the Assessment Team did not contain accurate and current information.

The Assessment Team found that the service did not demonstrate meals provided are varied and of suitable quality and quantity. Three consumers and three representatives said food was of a poor quality and have been served food that is not on the menu or not the meal chosen by the consumer. Catering staff said they were short staff most of the time and meals were often being served cold. There has been no chef manager since the beginning of August 2022. There have been unqualified staff cooking food when qualified cooks are not rostered. The kitchen staff said that staff shortages has had a negative impact on the consumers as they are getting their lunch late, the meals are being presented poorly and they are not always getting what they have asked for.

The Assessment Team found that the service did not demonstrate equipment provided is safe, suitable, clean and well maintained. There was not a system for reactive maintenance to be risk managed and to ensure that equipment is fixed effectively. Several items of equipment were identified by the Assessment Team to be unsafe and unclean.

The service does not have an audit system where all equipment (excluding those on the preventative maintenance schedule) are regularly checked to be safe suitable, clean and well maintained. This was evidenced by many items of equipment being identified by the Assessment Team requiring maintenance or removal which were not on the reactive maintenance logs. Management said weekly environmental audits will be conducted but did not know if staff conducting the audits would be qualified or experienced in risk management and conducting work, health and safety inspections.

The Assessment Team identified an old fridge in the Peel community dining area had mouldy food items in it and a significant amount of mould on the fridge’s inner surfaces. Six tea trolleys (some new) were dirty and some upside down in a covered outdoor area outside the main kitchen. Staff said that the wheels in some of the trolleys had not been attached properly and the trolleys were collapsing during use. The Assessment Team noted that these trolleys were being used for moving items for storage or for discarding items and these trolleys are not fit for this purpose.

A water pipe underneath the dishwasher in the main kitchen had not been fixed properly several times and would spurt out boiling water. This was a recurring problem which was evident on 23 August 2022 to the Assessment Team but was not on the reactive maintenance log.

A bain-marie in the Bligh community was observed by the Assessment Team to be not working on 23 August 2022 and meals served to consumers were cold. This bain-marie was fixed and working by 24 August 2022.

A toasted sandwich maker, the bain-marie and a trolley in the Carthage community were not fit for purpose as they were very unclean. The Assessment Team advised management about the unclean toasted sandwich maker and management instructed the staff member to ensure it was clean before using it. However, did not advise what system would be in place to ensure all kitchen equipment is clean and fit for use.

The approved provider responded to the Assessment Team’s report and agreed with the team’s findings. The approved provider has furnished their Plan for Continuous Improvement and a training schedule for staff and has initiated a number of actions to achieve and sustain compliance for all Bupa Tamworth. In response to the care plans having limited activities designed for consumers with cognitive or mobility limitations, the provider has initiated referrals and held discussion with the local Dementia Support Australia Support team who will come to the service, assess any consumers requiring review for identification of strategies to enhance engagement and will continue to provide support through education and carer support programs. Lifestyle activities have been reviewed and changes have been made. A review of the outings outside of the service has been conducted and engagement and support for outings will be provided by the Clinical Team. The service has also initiated improvements to the meals and dining experience for consumers. An audit of all consumer equipment was undertaken at the service and the Regional Property Manager attended the service to oversee improvements required. The plans in place for refurbishment which were put on hold due to Covid-19 have now recommenced to ensure improvements across the home.

I acknowledge the immediate and comprehensive actions that the provider has initiated, however accept that it will take some time for these actions to reflect compliance.

I find that the approved provider is Non-compliant with these requirements.

I am satisfied that the following requirement is Compliant.

* Requirement 4(3)(e) Timely and appropriate referrals to individuals, other organisations and providers of other care and services.

The Assessment Team found that the service and support referrals occur for individuals and other external service providers when required. Lifestyle staff confirmed they have a list of preferred providers for services and supports and advise the registered nurse if they identify any other needs consumers require to be me. Lifestyle staff advise registered nurses if consumers need to be referred to dementia services for clinical and lifestyle purposes.

# Standard 5

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

Findings

I have assessed this Quality Standard as Non-compliant as I am satisfied that the following three of the three requirements have been assessed as Non-compliant.

The Assessment Team found that the service did not demonstrate that the environment is welcoming and easy to understand. Three consumers said the service is not welcoming and two representatives said the layout of the building made it difficult to navigate. Two consumers said their rooms and their community environment do not optimise their sense of belonging, independence and function. There were no way finding or other features in the environment to benefit consumers with memory loss.

The Assessment Team interviewed consumers who said they do not use the common areas in their community because they do not optimise their sense of belonging and would prefer to stay in their rooms. The Assessment Team observed one consumer alone in the dining room and not knowing where staff or others were, another consumer was seen to be visibly upset after being lost in the staff only area by the staff room and kitchen.

The Assessment Team found that the service did not demonstrate the environment is safe, clean, well maintained and enabled consumers to move freely indoors and outdoors.

The Assessment Team observed that many consumers in the Bligh and Burnside communities require assistance to access external garden areas because of cognitive or mobility limitations. The Assessment Team observed that there were not enough staff to assist consumers to access external garden areas. Most outdoor areas were not fit for purpose as they were not clean. Cleaning staff and care staff said they were not responsible for cleaning outdoor areas and management confirmed outdoor areas are not cleaned everyday but on a weekly basis by an external contractor. One cleaning staff member said there were supposed to be three cleaners working and indicated it was not possible to complete all cleaning duties such as weekly room cleans.

The Assessment Team observed three consumers who struggled to access the Carthage patio area because they had to open the door and manoeuvre themselves and their four-wheel walkers through the door presenting a fall risk. Two of these consumers tried to re-enter the service but couldn’t because doors were locked behind them however used another door to re-enter.

The Assessment Team observed that the service did not demonstrate furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. There was not a system for reactive maintenance to be risk managed and to ensure that furniture and fittings were fixed effectively. Several issues with furniture and fittings were identified by the Assessment Team to be unsafe and unclean.

Two consumer rooms had significant damage to window sills and one had exposed nails. Three large cupboards did not have doors and 4 oxygen cylinders (3 were not secured to a trolley or a wall) and a cleaning trolley were in plain sight and accessible to anyone walking by. These doors were part of refurbishment activities however were not on the reactive maintenance log. A window on a connecting door between the Bligh and Burnside communities was smashed with several cracks to all four edges. This was not on the reactive maintenance log. Several outdoor furniture items in the Burnside memory support outdoor area were identified as unclean and unsafe. Management were notified and attended to all items immediately including discarding two three-seater wooden benches that were unsafe, removing garden ornaments stacked in a corner, removing a plastic cup filled with water and stones and cleaning all other furniture.

The approved provider responded to the Assessment Team’s report and agreed with the team’s findings. The approved provider has furnished their Plan for Continuous Improvement and a training schedule for staff and has initiated a number of actions to achieve and sustain compliance for all Bupa Tamworth. The provider has initiated environmental audits to occur each Monday to ensure all issues identified are actioned in a timely manner. The service will introduce personalised door designs for the consumer to easily identify their room with paint finishes designed for wayfinding, consultation is currently taking place with consumers for selection of artwork to be installed and all doors will be unlocked each morning to allow consumers access to gardens and courtyards. Quotes have been obtained for automatic swing arms to be installed for doors for Carthage veranda and Burnside courtyard doors for ease of use for consumers. The service has also initiated staff education sessions through regular staff meetings to ensure all staff are aware of the reactive maintenance process with maintenance requests being entered in maintenance logs to allow Maintenance Officer the opportunity to risk assess, and complete reactive maintenance in a timely manner.

I acknowledge the comprehensive list of actions that the provider has and is undertaking to improve the environment for the consumers. I accept this may take some time to reflect the compliance with these requirements.

I find that approved provider is Non-compliant with these requirements.

# Standard 6

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

Findings

I have assessed this Quality Standard as Non-compliant as I am satisfied that the following two of the four requirements have been assessed as Non-compliant.

* Requirement 6(3)(c) Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.
* Requirement 6(3)(d) Feedback and complaints are reviewed and used to improve the quality of care and services.

The Assessment Team found that the service was not able to demonstrate that appropriate action is taken in response to complaints and an open disclosure process is followed. Staff were aware of the term open disclosure, the importance of resolving issues and apologising to consumers when things go wrong. However, five consumers provided negative feedback in relation to appropriate action being taken in response to complaints they have made.

The Assessment Team interviewed consumers and representatives and received feedback from one representative about a consumer’s missing personal items, the representative advised that staff had not followed up about the missing items or what processes would be put in place to ensure it didn’t happen again. Another representative advised that they have made many complaints over years and appropriate action has not always been taken and open disclosure processes have not been applied to ensure things that have gone wrong do not go wrong again. This includes a case conference in May 2022 and on 24 August 2022 where complaints were reiterated but issues continued to occur on 25 August 2022.

The Assessment Team found that the service was not able to demonstrate that feedback and complaints are reviewed and used to improve the quality of care and services. There are examples of improvements made to the care and services resulting from complaints and these have been included in the service’s continuous improvement plan. Management could describe processes in place to escalate complaints. However, seven consumers and representatives interviewed said they have raised issues with the lack of staffing, food quality, and the quality of care at the service, but these have not resulted in improvements to the care and services they receive.

The Assessment Team interviewed consumers and representatives. One representative advised the Assessment Team that complaints had been raised in relation to food and care issues with the service. The representative advised that if the consumer was asleep staff did not wake her or hold a meal for the consumer. Another representative advised the team that there are insufficient staff to assist the consumer with her eating and it has been raised on numerous occasions, however felt the issue was ignored, this complaint was also raised by another representative.

One consumer advised that they are often provided meals that have not been chosen. The consumer has repeatedly complained about not wanting to receive a certain food, but it is still occurring.

The approved provider responded to the Assessment Team’s report and agreed with the team’s findings. The approved provider has furnished their Plan for Continuous Improvement and a training schedule for staff and has initiated a number of actions to achieve and sustain compliance for all Bupa Tamworth. The provider has initiated actions to ensure complaints are actioned in a timely manner using open disclosure, and resolved to consumer and representative satisfaction, whilst informing continuous improvement. These actions include open disclosure education for staff and information displayed in each care station, discussion occurring at the Resident and Relatives meeting with an apology and open disclosure in relation to feedback not being actioned with reinforcement of feedback processes discussed at the Resident and Relatives meeting and reinforcement of processes at general staff meetings. A review of all feedback is currently being undertaken and open disclosure and apologies are being provided when deemed appropriate.

I acknowledge the immediate actions that the provider has initiated and the importance the provider has placed on the non-compliance. I accept that it will take some time to reflect compliance in these requirements.

I find that the approved provider is Non-compliant with these requirements.

I am satisfied that the following requirements are Compliant.

* Requirement 6(3)(a) Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.
* Requirement 6(3)(b) Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.

The Assessment Team found that the service demonstrated that consumers and representatives are supported to provide feedback and make complaints. Six consumers and representatives indicated that they feel comfortable and safe to provide feedback or make complaints. One consumer said that they are aware of how to make a complaint and has made internal and external complaints. Staff were able to describe complaints processes and how they can assist consumers to provide feedback.

The Assessment Team observed information and printed signs were located throughout the service encouraging feedback and complaints internally and externally including ‘do you have a concern’ pamphlet, and Older Persons Advocacy Network (OPAN) advocacy services. Feedback forms and locked mail boxes for consumers and representatives to place the feedback forms were accessible throughout the service.

The service demonstrated that consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. Management reported that they did not currently have any consumers who required any advocacy or interpreter services. The service promotes complaints and advocacy services for consumers through posters displayed throughout the service, and in the consumer handbook.

The Assessment Team interviewed consumers and representatives who provided feedback including that they can talk to the nurses or care managers if there are concerns and confirmed there was no need for a translator or interpreter. Another consumer confirmed awareness of external complaint mechanism, including advocacy services and knows how to access them if required.

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

Findings

I have assessed this Quality Standard as Non-compliant as I am satisfied that the following four of the five requirements have been assessed as Non-compliant.

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

The Assessment Team interviewed consumers and representatives who considered there are not enough staff at the service to provide the care consumers require and they spoke of impacts of this on the care and services they receive. Care staff confirmed with the Assessment Team that there is not enough staff rostered and they are always rushing and described how this negatively impacts on the consumers care and services.

One consumer advised that they use the call bell to go to the bathroom and that sometimes they have to wait a long time for staff to attend. On one occasion this was one hour and 15 minutes for a staff member to assist and this caused distress.

The Assessment Team interviewed staff who said that there are not enough staff and they often work short staffed. They provided examples of how this has impacted their ability to provide quality care to the consumers. Two staff said that they can only provide basic care and are not able to spend any one-to-one time with the consumers. Three staff said when they are attending to a consumer that requires two staff to assist it leaves no other staff on the floor to care for the other consumers as there is only two staff rostered between 10:30 AM and 02:30 PM.

The kitchen staff said that staff shortages are getting worse and staff are having to work many days in a row, in one case they said someone has worked 10 days in a row. The kitchen staff said this has had a negative impact on the consumers as they are getting their lunch late, the meals are being presented poorly and they are not always getting what they have asked for.

Management said that a call bell report is sent to the regional manager, general manager and care managers. The general manager said that call bell response time is part of the services Key Performance Indicators (KPIs) and call bell response times over 12 minutes are reviewed. A review of call bell data identified that for the period of 11 August 2022 to 24 August 2022 the service had 274 call bells that exceeded 12 minutes. Of these, response times of over an hour were reported on six of the 14 days reviewed. The Assessment Team asked for investigation documentation for high call bells response times however the general manager said that a review had not occurred.

The Assessment Team found that the service did not demonstrate workforce interactions with consumers are consistently kind, caring and respectful of each consumer’s identity. The organisation provides customer service training as part of their orientation process. Staff said that includes the organisations expectations that they are always expected to interact with consumers in a kind and caring way and show respect to the consumer. However, the Assessment Team observed and overheard staff interaction with a consumer that was not respectful, kind or caring. Some consumer and representative feedback indicated that not all staff are kind and caring and their interactions with the consumers are rushed which does not enable them to provide care that is kind, caring or respectful.

The Assessment Team identified that members of the workforce have appropriate qualifications in relation to their roles. However, the service was unable to demonstrate that staff are competent at delivering safe, quality care to consumers. Care staff did not consistently demonstrate a comprehensive knowledge of what was important to the consumers sampled in relation to how their personal and clinical care is delivered as most staff interviewed were new to the communities. The Assessment Team reviewed a medication competency register which showed 15 out of the 22 staff on the register have not completed a medication administration competency within the previous 12 months. Management confirmed the competencies are not up to date and they identified this in the Plan for Continuous Improvement on 8 August 2022. The general manager said they have completed 5 medication competencies in August 2022 and plan to have the remainder completed by the end of August 2022.

The Assessment Team found that the service has processes for the recruitment, induction and initial training and support of staff. The service also provides ongoing online and face-to-face education for staff. However, review of the mandatory training identified some staff have not completed all required mandatory training either through the onboarding processes or through annual training. While education about some of mandatory topics has commenced, not all staff have completed the education. Four staff interviewed could not recall being informed of the most recent legislative changes and were not able to explain their role in minimising restrictive practices, antimicrobial stewardship or the Serious Incident Response Scheme (SIRS). Review of the service training register identified that 58 staff had not completed mandatory fire training or manual handling training within the previous 12 months. Only one training session was held on SIRS and antimicrobial stewardship, with not all staff attending. Only the clinical team, including nursing staff, had received training on restrictive practices.

Management said that they send out education material, fact sheets from the Commission, policies and procedure to all staff regularly but they do not record which staff have read the material and do not know if the staff have read and understood the material provided. Staff told the Assessment Team that they do not have time to read the emails that management send out in relation to training materials.

The approved provider responded to the Assessment Team’s report and agreed with the team’s findings. The approved provider has furnished their Plan for Continuous Improvement and a training schedule for staff and has initiated a number of actions to achieve and sustain compliance for all Bupa Tamworth. The provider has delivered training to staff on consumer dignity and choice and neglect, feedback is being sought from the Resident and Relatives meeting to identify issues and concerns surrounding the behaviours of staff. A recruitment round has sourced new staff for the service and recruitment will be ongoing to address staffing needs. Call bells not answered within 6 minutes are being escalated to care manager. The general manager is following up on any call bells not responded to within 12 minutes. The service has also reviewed the mandatory training tracker and is targeting training for anyone who has not undertaken the training, with new staff not commencing until they undertake manual handling training.

I acknowledge the comprehensive plans for training and recruitment, that the provider has initiated, however accept that this will take some time to reflect compliance in these requirements.

I find that the approved provider is Non-compliant with these requirements.

I am satisfied that the following requirement is Compliant.

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

The Assessment Team found that the service demonstrated regular assessment, monitoring and review of each staff members’ performance is undertaken. Staff roles include monitoring and performance review. There is a system to ensure all formal performance appraisals are conducted in a timely manner. Staff confirmed their performance is being monitored.

The human resource manager said they meet with new staff after they complete their first “buddy” shift during orientation to see if there are any issue or concern that need to be addressed and then again after their last buddy shift to see if they are ready to commence working as a rostered member of the staff.

The general manager said they monitor staff during the shift and any gaps in quality delivery of care and service is addressed with the staff promptly. If the inefficiency is consistent amongst a number of staff, they address the issue during handover or organise formal training. They also said the same process is implemented when a concern is raised by a consumer.

# Standard 8

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

Findings

I have assessed this Quality Standard as Non-compliant as I am satisfied that the following four of the five requirements have been assessed as Non-compliant.

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

* 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.

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

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

The Assessment Team found that although the organisation has documented values that state they promote a culture of person centred, safe, quality care and systems exist for the reporting of complaints, clinical indicators and incidents to the board, the service was not able to demonstrate that it promotes a culture of safe, inclusive and quality care for the consumers.

The general manager stated they are not meeting the Quality Standards and while issues are reported and escalated to corporate, they are not being addressed. Management advised as a result of the feedback the service received from the Assessment Team they have engaged the services of an internal nurse advisor for a period of 6 months and are not taking any new admissions to the service.

The Assessment Team’s observations, documentation and consumer feedback showed that the organisation does not promotes a culture of safe, inclusive and quality care and services. The Assessment Team observed staff treating consumers disrespectfully demonstrating the organisation is failing to be accountable for delivery of safe quality care.

The service has organisation wide systems which they can access and adopt to ensure, continuous improvement, financial governance and feedback systems are in place.

The Assessment Team identified that areas for improvements that are identified by consumers, staff, surveys, meetings, incidents, complaints and audits which are logged onto the service’s plan for continuous improvement. The plan identifies the source for each action item logged and tracks the progress of the item and each item’s outcome is evaluated for effectiveness before being closed. The service has a system for the procurement of services and equipment that is central to the organisation. The regional manager said the requests to meet the identified needs of consumers are at the forefront of the service’s delivery of care and services. Budget allocation and capital expenditure levels are allocated according to the roles of management and any expenditure outside of the allocation is escalated to the board for consideration.

However, systems for information management, regulatory compliance or workforce governance were not effective to ensure staff are able to provide safe and effective care and services for consumers. Although the information management system includes an electronic care planning system, risk management system with automated reporting capabilities and policies and procedures via an online portal it was not demonstrated to be an effective system. Deficits were identified in relation to information guiding staff practices in providing clinical care to consumers.

The Assessment Team noted that deficits in regulatory compliance were identified with a number of staff not having completed their mandatory annual fire safety training and medication administration competency within the previous 12 months.

The general manager said that information on legislative changes are distributed to staff from the organisation via emails and placed on the organisations intranet site for staff to access. However, four out of six staff interviewed were not aware of legislative changes such as, SIRS, AMS and restrictive practices.

The organisation has recently reviewed the nursing roster and decreased the number of night shift staff from five to four. The length of the two of the morning shifts in each community except Burnside has been reduced from a 6 and a ½ hour to a four-hour shift. Management said that a review was undertaken to reflect the number of consumers in the service. Management said consultation occurred with the staff and consumers before the changes came into effect. Consumers their representatives and staff all have said that the change in the roster has had negative impacts on the care and services the consumers receive.

The Assessment Team found that the service was unable to demonstrate they have an adequate risk management system in place to identify, assess, respond and monitor high-impact and high-prevalence risks, as well as other risks at the service. Incident forms have not consistently been completed for all incidents. Risks associated with unsafe practices have not been identified and therefore strategies and interventions to minimise risk have not been appropriately, implemented and monitored. Management confirmed that they do not record lack of medication supply as an incident and not all medication incidents have been recorded.

The Assessment Team reviewed the clinical indicator reports which are used to inform the monthly clinical governance which is sent to the board for review. However, without all incidents being identified, reviewed and reported this information would be inaccurate.

The approved provider responded to the Assessment Team’s report and agreed with the team’s findings. The approved provider has furnished their Plan for Continuous Improvement and a training schedule for staff and has initiated a number of actions to achieve and sustain compliance for all Bupa Tamworth. The provider is currently reviewing all issues and concerns regarding compliance to ensure that the service is meeting the requirements. The facility has engaged a new general manager and nurse advisor to ensure that the Bupa systems, work instructions and compliance with Legislative directives are embedded. An education and training plan have been developed including Antimicrobial Stewardship, restrictive practices, and SIRS.

I acknowledge the immediate response and actions that the provider has taken, however accept that this will take some time to reflect compliance with these requirements.

I find that the approved provider is Non-compliant with these requirements.

I am satisfied that the following requirement is Compliant.

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

The Assessment Team were provided information that shows the service engages with consumers in the development, delivery and evaluation of care and services. Consumers interviewed confirmed they are involved in the evaluation and development of care and services.

The Assessment Team interviewed consumers who said that they are involved in a consumer-focused meeting which is held with the general manager and provides them an opportunity to be a voice for the consumers and raise any issues or concerns the consumers may have. The consumers said the issues raised at the meetings are generally attended to by the service. The general manager said that information discussed at the meetings and outcomes are disseminated to the other consumers and representatives through the organisation’s newsletters. The Assessment Team reviewed the organisational newsletter and observed information explaining the purpose of the consumer focus meetings.

One of these consumers is involved in the recruitment process for new staff and sits on the interview panel. The consumer said it provides an opportunity to ask the potential new staff a question and determine if they will be suitable to provide care and services to the consumers.

Management said that consultation was held with consumers and representatives in relation to the revised nursing roster. Resident meeting minutes 28 June 2022 confirm the consumers were informed of the proposed new roster, what was changing and when it was to commence. Consumers and representatives were given the opportunity to provide feedback and suggestions on the new roster. The feedback provided by consumers was that staff turnover was a concern for them and the time they have to wait for staff to answer their call bells.

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