Performance

Report

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| Name of service: | Bupa Woodville |
| Service address: | 104 Woodville Road WOODVILLE SA 5011 |
| Commission ID: | 6940 |
| Approved provider: | Bupa Aged Care Australia Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 24 October 2022 to 26 October 2022 |
| Performance report date: | 15 December 2022 |

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

**This performance report**

This performance report for Bupa Woodville (**the service**) has been prepared by M Glenn, 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 assessment, observations at the service, review of documents and interviews with consumers, representatives, staff and management;
* the provider’s response to the Assessment Team’s report received 17 November 2022; and
* the Performance Report dated 16 August 2022 for the Assessment Contact – Site undertaken from 12 July 2022 to 13 July 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 | **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.

**Standard 1 Requirement (3)(a)**

* Ensure staff have the skills and knowledge to provide care and services to consumers in a way which ensures they are treated with dignity and respect and values their culture and diversity.
* Ensure staff interactions with consumers are monitored to ensure kind, caring and respectful interactions are maintained at all times.

**Standard 2 Requirements (3)(a), (3)(b) and (3)(e)**

* Ensure staff have the skills and knowledge to initiate assessments and develop and/or update care plans in response to consumers’ changing condition, including end of life care and clinical incidents.
* Ensure care plans are reflective of consumers’ current and assessed needs and preferences to enable staff to provide quality care and services.
* Ensure policies and procedures in relation to assessment, care planning and review are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to assessment, care planning and review.

**Standard 3 Requirements (3)(a), (3)(b), (3)(c), (3)(e) and (3)(g)**

* Ensure staff have the skills and knowledge to:
  + provide appropriate care relating to skin integrity, wound management, end of life care and pain; and
  + initiate appropriate assessments, develop management plans and monitor effectiveness of management plans, including in relation to wounds, pain and end of life care.
* Review information exchange processes to ensure sufficient, relevant and up-to-date information is provided to staff to enable appropriate delivery of care and services to consumers.
* Review monitoring processes relating to outbreak management equipment and consumer infections.
* Review the Outbreak management plan to ensure it provides staff sufficient information and guidance relating to site specific processes.
* Ensure policies, procedures and guidelines in relation to management high impact or high prevalence clinical risks, wounds, pain, skin integrity, end of life care and infection control are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to management high impact or high prevalence clinical risks, wounds, pain, skin integrity, end of life care and infection control.

**Standard 4 Requirement (3)(c)**

* Ensure staff have the skills and knowledge to identify things of interest to each consumer, implement activity programs in line with consumers’ preferences and engage them in activities of interest both within and outside of the service environment.

**Standard 5 Requirement (3)(b)**

* Review monitoring processes to ensure they are effectively identifying issues relating to the service environment and actions are taken in response to assist in maintaining a safe, comfortable and well-maintained environment for consumers.

**Standard 7 Requirements (3)(a) and (3)(c)**

* Ensure appropriate and adequate staffing levels and skill mix are maintained to deliver care and services in line with consumers’ needs and preferences.
* Ensure staff skills and knowledge are monitored and tested to ensure staff are competent to undertake their roles.
* Ensure staff are provided appropriate training, including training to address the deficiencies identified in seven of the eight Quality Standards.

**Standard 8 Requirements (3)(d) and (3)(e)**

* Review the organisation’s risk management processes in relation to managing high impact or high prevalence risks, identifying abuse and neglect and managing and preventing incidents.
* Review the organisation’s clinical governance framework in relation to non-compliance identified in Standard 2 Ongoing assessment and planning with consumers and Standard 3 Personal care and clinical care, as well as systems relating to antimicrobial stewardship and monitoring of consumer infections.

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

Findings

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

The Assessment Team recommended Requirement (3)(a) in Standard 1 Consumer dignity and choice not met as they were not satisfied the service demonstrated each consumer was treated with dignity and respect, with their identity, culture and diversity valued. Over the three days of the Site Audit, some staff interactions with consumers were observed to be disrespectful and undignified. The Assessment Team’s report provided the following evidence relevant to my finding:

* Staff were observed not knocking before entering consumers’ rooms and yelling out their names loudly as they entered.
* Three staff were observed not talking to consumers in a respectful manner, and were described as yelling, talking to consumers in a loud voice, not engaging with them or providing redirection or reassurance.
* One consumer was observed asleep and face down in a plate of food. Three staff were observed to walk past the consumer and did not check on the consumer or reposition them.
* One representative said their family member is treated in an undignified manner and three representatives provided examples of conversations staff have had with them which were disrespectful towards consumers.

The provider’s response did not dispute the evidence outlined in the Assessment Team’s report. The response included actions taken in response to the Assessment Team’s report, a Training action plan and a Plan for continuous improvement outlining required improvements, actions and progress to address the deficits identified. The provider’s response included, but was not limited to:

* Undertaken huddles/toolbox sessions for staff relating to consumer dignity.
* Fifteen staff, including those who work in the memory support unit, attended a three day Dementia essentials program. Training has also been provided to staff on Montessori based activities.
* Staff interactions with consumers are being monitored and ongoing consultation with consumers and representatives is occurring through monthly meetings to ensure dignity and respect are being upheld.

I acknowledge the provider’s response. However, I find at the time of the Site Audit, the service did not ensure each consumer was treated with dignity and respect, with their identity, culture and diversity valued.

In coming to my finding, I have placed weight on the Assessment Team’s observations of staff and consumer interactions and feedback provided by representatives indicating staff do not consistently refer to or treat consumers in a kind, dignified and respectful manner. I have also considered that the service’s monitoring processes have not been effective in identifying the staff practices observed. The service should seek to implement processes to ensure they work with consumers and/or representatives in an inclusive and respectful way and listen to and understand each consumer’s personal experience as it relates to the way care and services are being provided to them.

For the reasons detailed above, I find Requirement (3)(a) in Standard 1 Consumer dignity and choice non-compliant.

In relation to all other Requirements in this Standard, initial and ongoing assessment processes, including consultation with consumers and/or representatives, consider how the service can support consumers’ cultural needs, preferences and goals which are outlined in care files to guide staff in delivery of care and services. Staff described how they ensure care is delivered in line with consumers’ cultural preferences, including gender specific personal care delivery. Consumers and representatives were satisfied consumers felt comfortable and safe to express themselves. Additionally, consumers felt supported to exercise choice regarding their own care and the way care and services are delivered, to involve family and others in their care, communicate their decisions and make and maintain connections and relationships with others to the extent they wish.

Consumers felt supported to do things they wish to do, even where risks are involved. Where a consumer chooses to engage in an activity which involves an element of risk, consultation with consumers and/or representatives occurs, risk assessments are completed and management strategies are developed. Risks assessments are reviewed monthly, with changes in circumstances that may impact a consumer's risk level, strategies to mitigate the risks and evidence of discussion with consumers and their representative documented, where required.

Information provided to consumers is current, accurate and timely and communicated in a way to enable them to make choices about the care and services they receive. Information is provided through a range of avenues, including meeting forums, newsletters and noticeboards and staff described how they assist consumers to understand the information. There are processes to ensure each consumer’s privacy is respected and personal information is kept confidential.

For the reasons detailed above, I find Requirements (3)(b), (3)(c), (3)(d), (3)(e) and (3)(f) in Standard 1 Consumer dignity and choice compliant.

# Standard 2

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

Findings

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

The Assessment Team recommended Requirements (3)(a), (3)(b) and (3)(e) in Standard 2 Ongoing assessment and planning with consumers not met. The Assessment Team were not satisfied:

* all assessments and planning were completed for consumers on entry;
* advance care planning and end of life planning was completed for consumers when entering this phase of life; and
* care and services were regularly reviewed for effectiveness, and when circumstances changed or when incidents impacted on the needs, goals or preferences consumers.

**Requirement (3)(a)**

The Assessment Team were not satisfied all assessments and planning were completed for consumers on entry. The Assessment Team’s report provided the following evidence relevant to my finding:

* A 72-hour checklist and 30-day assessment tool is to be completed when a consumer enters the service. Admission checklists sampled for four consumers were incomplete.
* The Continuous improvement plan identified in May 2022 that care plans contained incorrect or out-of-date information. The improvement was completed 30 August 2022, however, assessments and/or care plans sampled still contained incorrect information. For example:
  + A Medication assessment dated August 2022 indicated Consumer A takes medications whole, however, a progress note entry in September 2022 indicated medications are crushed.

Diabetes management directives dated August 2022 indicated Consumer A did not require blood glucose levels to be monitored, however, the medication system indicates weekly blood glucose levels to be taken, with the last reading obtained in October 2022. Clinical staff stated the Medical officer ceased blood glucose level readings on the day the last reading was taken, however, this was not documented in progress notes or on the Medication chart.

The pain care plan shows Consumer A experiences chronic pain to the hip and lower back, however, does not include any interventions to assist in pain management nor does it include wound 1 or 2. Clinical staff confirmed the pain assessment and care plan does not include any pain interventions

* The pain assessment and care plan shows Consumer B experiences pain to the shoulders, knee and back, however, does not include pain associated with wounds, with the last pain chart entry dated May 2022
  + Pain monitoring charting was not evidenced when Consumer B sustained a pressure injury or when a narcotic analgesic was commenced on an as required basis in August 2022.
* Pain assessment and charting was not reviewed following identification of Consumer D’s medical condition and skin excoriation in February 2022. A pain assessment completed in October 2022 did not reference pain from the medical condition.
  + Consumer D’s care plan does not reference the medical condition or include care and management strategies or associated pain. The care plan does, however, include a general notation for staff to dry skin folds well.

The provider’s response included commentary relating to evidence presented for Consumer B, actions taken in response to the Assessment Team’s report, a Training action plan and a Plan for continuous improvement outlining required improvements, actions and progress to address the deficits identified. The provider’s response included, but was not limited to, planned training for staff relating to admission processes; undertaking a complete review of assessments for accuracy; and undertaking a full assessment review of all named consumers. In relation to Consumer B, 10 progress notes entries dated between August and November 2022 demonstrating pain was monitored.

I acknowledge the provider’s response, including the improvement actions initiated since the Site Audit. However, I have considered that these improvement actions were initiated in response to the Assessment Team’s report and not as a result of the service’s own monitoring processes. As such, I find at the time of the Site Audit, the service’s assessment and planning processes did not effectively inform the delivery of safe and effective care and services.

Entry assessments and checklists had not been consistently completed to enable relevant risks to consumers’ health and well-being to be identified and inform how care and services are delivered. I have also considered that while the service identified that care plans contained incorrect or out-of-date information in May 2022, assessment and care planning documents sampled for Consumer A were found to include inconsistent information relation to care needs. Additionally, while Consumers A and B had been identified as experiencing pain associated with wounds, specific management strategies to maintain consumers’ comfort were not evident in care plan documents used by staff to guide delivery of care.

In relation to Consumer D, pain assessment and charting was not reviewed following a change in medical condition in February 2022 and the care plan was not reflective of the consumer’s current condition to ensure appropriate care was delivered and the consumer’s health and well-being not compromised.

As such, I find that the inconsistencies in assessment and planning have the potential to impact on the effective delivery of care and services, particularly where staff delivering care are not familiar with consumers’ care and service needs.

For the reasons detailed above, I find Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

**Requirement (3)(b)**

The Assessment Team were not satisfied advance care planning and end of life planning was completed for consumers when entering this phase of life. The Assessment Team’s report provided the following evidence relevant to my finding:

* Staff described personal and clinical care needs and preferences they would provide to consumers during the end of life phase, however, this was not demonstrated through completion of assessments and care plans.
* Clinical staff stated end of life care plans are completed when consumers enter this phase, however, this was not demonstrated for two consumers who had passed. For one consumer identified as palliating, an end of life pathway had not been commenced or an end of life care plan completed when they entered the service. For another consumer, an end of life pathway had not been commenced or end of life care plan completed when they transitioned to comfort care.

The provider’s response did not dispute the evidence outlined in the Assessment Team’s report. The response included actions taken in response to the Assessment Team’s report, a Training action plan and a Plan for continuous improvement outlining required improvements, actions and progress to address the deficits identified. The provider’s response included, but was not limited to, adding palliative care education to the training plan and undertaking a full review of all consumers’ assessments, including advance care directives.

I acknowledge the provider’s response. However, I find at the time of the Site Audit, assessment and planning did not identify and address consumers’ current needs, goals and preferences, specifically in relation to end of life.

In coming to my finding, I have considered that while the two consumers highlighted were identified as either palliating or had entered comfort care, end of life pathways and care plans were not completed, in line with the service’s processes, to ensure end of life planning was in line with consumers’ preferences. As such, I find the evidence demonstrates care plans are not individualised and tailored to guide staff to provide care and services which are in line with each consumer’s needs and preferences and planned around what is important to them which has the potential for consumers to not have the end of life experience they would have wanted.

For the reasons detailed above, I find Requirement (3)(b) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

**Requirement (3)(e)**

The Assessment Team were not satisfied care and services were regularly reviewed for effectiveness, and when circumstances changed or when incidents impacted on the needs, goals or preferences consumers. The Assessment Team’s report provided the following evidence relevant to my finding:

* While Consumer D complained of increasing pain on three days in October 2022 requiring as required narcotic pain relief, no assessment was completed or monitoring undertaken to ensure effectiveness.
* Consumer C’s nutrition assessment was not completed, or care plan and kitchen documentation updated to reflect diet changes made following a Speech pathologist review.
* Meeting minutes for October 2022 indicate management of falls, skin and behaviour are not completed in line with the service’s policies and procedures. However, actions taken to ensure staff are completing all assessments and documentation in line with the procedures were not evident.
* Records show not all consumers have had a monthly review completed, in line with the service’s processes, and 29 are currently overdue. Staff said many care plans have not been reviewed in the last two to three months as there has not been time due to workforce constraints.
* While three consumers said staff discussed their needs on entry, further discussions with clinical staff in relation to their care have not occurred.

The provider’s response did not dispute the evidence outlined in the Assessment Team’s report. The response included actions taken in response to the Assessment Team’s report, a Training action plan and a Plan for continuous improvement outlining required improvements, actions and progress to address the deficits identified. The provider’s response included, but was not limited to, planning training for staff; completed assessments, including in relation to pain and skin and reflected outcomes in care plans for named consumers; undertaking review of pain assessment report/charts weekly for evaluation and outcomes; reviewed consumers’ wounds and documentation; and undertaken an audit of all pressure injuries and wounds. Additionally, monthly care reviews have been undertaken in consultation with three named consumers.

I acknowledge the provider’s response. However, I find at the time of the Site Audit, the service did not ensure care and services were regularly reviewed for effectiveness in response to changes in consumers’ care and service needs.

In relation to Consumer D, while narcotic pain relief was required on three consecutive days for increased pain, assessment processes were not initiated to determine effectiveness of current pain management strategies or assist in the development of new management strategies to ensure the consumer’s pain was effectively managed and monitored.

In relation to Consumer C, appropriate assessments were not undertaken or care plan updated to reflect a change in diet consistency following an Allied health review. Care staff sampled were unaware of the changes and the consumer was observed receiving the incorrect meal consistency.

I have also considered that care plans have not been regularly reviewed in line with the service’s process, with records sampled indicating not all consumers have had a monthly review completed and 29 were noted to be overdue. As such, I find that this has not ensured care plans are up-to-date or that care and services are being delivered in line with consumers’ current needs and preferences or that risks to consumers’ are minimised.

In relation to data reflected in meeting minutes, I have considered this evidence is more aligned to the clinical governance framework and the organisation’s and service’s assessment and planning monitoring processes. As such, I have considered this evidence in my finding for Requirement (3)(e) in Standard 8 Organisational governance.

For the reasons detailed above, I find Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

In relation to Requirements (3)(c) and (3)(d) in this Standard, care files sampled demonstrated consumers and/or representatives, Medical officers and Allied health professionals are involved in assessment and planning of consumers’ care and services. Consumers and representatives described occasions where they have been consulted in relation to assessments, reviews and changes to consumers’ care and service needs, including following Medical officer and Allied health visits. However, some representatives felt there was a lack of communication from the service in relation to the care and well-being of their loved ones. Consumers and representatives were also aware of care plan documents, indicating staff have discussed care plans with them and they are able to view care plans if they wish.

For the reasons detailed above, I find Requirements (3)(c) and (3)(d) in Standard 2 Ongoing assessment and planning with consumers compliant.

# 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. | Non-compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | 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 five of the seven specific Requirements have been assessed as non-compliant.

Requirement (3)(a) was found non-compliant following an Assessment Contact undertaken on 12 July 2022 to 13 July 2022, where it was found each consumer was not receiving safe and effective personal care and/or clinical care, that was best practice, tailored to their needs; and optimised their health and well-being. Specifically in relation to managing weight loss, documenting alternatives trialled prior to administering as required medications and effectiveness and managing consumers’ risk of falls. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, providing training to staff and ensuring consumers prescribed psychotropic medications have consent and a Behaviour support plan in place. Documentation sampled demonstrated consumers’ weights have remained stable with some gaining weight since the Assessment Contact in July 2022.

At the Site Audit, the Assessment Team found improvements implemented to address the deficiencies had not been effective in ensuring consumers received safe and effective personal and clinical care, recommending Requirement (3)(a) not met. Additionally, the Assessment Team recommended Requirements (3)(b), (3)(c), (3)(e) and (3)(g) not met. The Assessment Team were not satisfied the service demonstrated:

* consumers are receiving appropriate personal and/or clinical care;
* effective management of high impact or high prevalence risks, specifically wounds, pain and skin integrity;
* the needs, goals and preferences of consumers entering the end stages of life are recognised and addressed, their comfort maximised, and their dignity preserved;
* how consumers’ needs, preferences, and changes to care are communicated within the service; and
* minimisation of infection related risks through implementing standard and transmission-based precautions to prevent and control infections.

**Requirement (3)(a)**

The Assessment Team were not satisfied consumers are receiving appropriate personal and/or clinical care. The Assessment Team’s report provided the following evidence relevant to my finding:

* Three representatives stated consumers are not receiving appropriate care needs, including being assisted with meals and activities of daily living, such as oral care and changing consumers into nightwear prior to bed.
* Staff stated they do not have time to assist consumers with repositioning, assisting with meals or showering, as per their wishes

Consumer D

* Consumer D stated they were identified with a medical condition in February 2022 and as a result, experiences pain and skin excoriation. The consumer said they have pain relief, but it is not working and the excoriation and medical condition have not been assessed. The consumer described how they manage skin excoriation; staff were not aware this was occurring. The consumer said the medical condition is getting worse and with the excoriation it makes it hard for them to walk. The consumer said pain has increased in the past two weeks, and while they tell nursing staff, they say they can do nothing and say the consumer should speak with the doctor. The consumer was observed to be shuffling while ambulating and appeared to have trouble mobilising. Three clinical and/or care staff were not aware of the consumer’s shuffling gait or that they were having more difficulty ambulating.
* A clinical report created on day one of the Site Audit references the medical condition and directs staff to place combine to reduce excoriation, however, Consumer D confirmed this does not occur and three care staff said they had not been informed of this requirement.

The provider’s response did not dispute the evidence outlined in the Assessment Team’s report. The response included actions taken in response to the Assessment Team’s report, a Training action plan and a Plan for continuous improvement outlining required improvements, actions and progress to address the deficits identified. Actions implemented/planned included, but were not limited to, updating all consumers’ assessments and care plans to ensure alignment with

consumer preferences; monitoring completion of charting through spot checks; and increased leadership presence. In relation to Consumer D, completed a Dignity of risk discussion regarding the medical condition and risks; completed a detailed pain assessment; scheduled a specialist appointment; and completed a skin assessment and implemented a wound management plan.

I acknowledge the provider’s response, including the improvement actions initiated since the Site Audit. However, I have considered that these improvement actions were initiated in response to the Assessment Team’s report and not as a result of the service’s own monitoring processes. As such, I find at the time of the Site Audit, safe and effective personal and/or clinical care that was tailored to consumers’ needs and optimised their health and well-being was not being consistently provided. This was supported through feedback from representatives who described impacts to consumers’ care delivery and from staff who indicated they do not have time to attend consumers’ care needs.

In coming to my finding, I have placed weight on evidence presented relating to Consumer D. I have considered that the service has not ensured Consumer D is receiving care that reflects their individual needs and current situation. I have placed weight on feedback from Consumer D indicating their medical condition, first identified in February 2022, is causing them pain and has worsened over the past two weeks. Feedback from Consumer D and observations made by the Assessment Team indicate the medical condition is impacting the consumer’s mobility and skin integrity, however, assessments to identify appropriate management strategies and ensure tailored care management strategies, in line with the consumer’s current needs and preferences has not been undertaken. Staff were not aware of strategies the consumer was implementing to manage skin excoriation or that the consumer was having increased difficulty mobilising as a result of their medical condition. Additionally, staff indicated they had not been informed of strategies to manage excoriation and Consumer D stated this strategy is not implemented. As such, I find the service has not ensured care provided to Consumer D is tailored to their needs and optimises their health and well-being.

I acknowledge the improvements implemented in response to the non-compliance identified in Requirement (3)(a) following the Assessment Contact undertaken in July 2022. However, I find these improvements have not been sufficiently embedded to ensure consumers consistently receive personal and/or clinical care, which is best practice, tailored to their needs and optimises their health and well-being.

For the reasons detailed, I find Requirement (3)(a) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(b)**

The Assessment Team were not satisfied the service demonstrated effective management of high impact or high prevalence risks, specifically wounds, pain and skin integrity. The Assessment Team’s report provided the following evidence relevant to my finding:

Consumer A

* A progress note dated February 2022 queried if the consumer had an injury indicating the area was purple in colour. A Medical officer review the following day indicated gangrene. Further investigation noted the wound (wound 1) was medically untreatable with wound treatment and pain management to continue for comfort measures. The service was not able to provide evidence wound care was attended from identification in February to August 2022, prior to implementation of the electronic care system.
* A pressure injury (wound 2) was first noted in September 2022, as a stage 1 pressure wound, however, photographs taken show the wound to have broken skin in two areas. Latest photographs of the wound showed it to be red and swollen, however, a swab of the wound was not completed until the Assessment Team spoke to management.
* Wound management plans direct all wounds to be attended every third day, however, documentation reviewed for a 74 day period between August to October 2022 indicated wounds were not attended at this frequency. Wound 1 was attended on three of 24 occasions, wound 2 on three of 16 occasions and wound 3 on four of 24 occasions.
* Progress notes showed the consumer is experiencing ongoing pain relating to wound 2. The last pain charting was completed in May 2022. Pain charting was not commenced following a Medical officer directive to use a narcotic analgesic prior to wound dressings.
* The skin care plan directs staff to reposition Consumer A one to two hourly which staff confirmed. A Wound specialist report dated August 2022 indicated while wound 3 was healing, the area remained fragile and recommended regular, two-hourly, repositioning. Daily repositioning charting demonstrated pressure area care is not being undertaken at the frequency directed with Consumer A being left up to 14 hours in one position. Over a three-day sampled period in October 2022, the consumer was repositioned on only 10 of 36 occasions.
* Pressure relieving equipment, in line with the consumer’s skin integrity assessment, was noted to not be in place on two of three days of the Site Audit,.
* One clinical staff member stated they do not have the time to attend to consumers’ wounds when they are required. One care staff stated sometimes they are understaffed which resulted in the consumer’s pressure area care not being undertaken in line with the two hour frequency.

Consumer B

* Consumer B has two wounds. Wound documentation sampled for a 50 day period between September to October 2022 indicated wounds were not attended in line with the frequency directed by a Wound specialist or the wound treatment plan. Wound 1 was attended on eight occasions and should have been attended on 25 per specialist recommendations and 16 per the wound treatment plan and wound 2 on 11 occasions as opposed to 25 per specialist’s recommendations and 50 per the wound treatment plan.
* Progress notes indicate the consumer has ongoing pain and Wound specialist reviews indicate increased pain during wound dressing changes. There is no evidence of pain monitoring charting when the consumer first sustained the pressure injuries or in response to increased pain due to the pressure wounds as stated by the specialist.
* The skin care plan directs staff to reposition Consumer B one to two hourly which staff confirmed. A Wound specialist report dated September 2022 recommended regular, two-hourly, repositioning and, if possible not to position on the existing wound site. Daily repositioning charting demonstrated pressure area care is not being undertaken at the frequency directed with Consumer B being left up to 17 hours in one position. Over a four-day sampled period in October 2022, the consumer was repositioned on only 10 of 60 occasions
* Care staff stated they do not have time to reposition consumers as they are always busy doing other things. A clinical staff stated all wounds are due for weekly Registered nurse reviews, however, they have not been reviewed in the last two weeks as they have not had time to attend to them.

The provider’s response included commentary and supporting information in relation to Consumers A and B. The response also included actions taken in response to the Assessment Team’s report, a Training action plan and a Plan for continuous improvement outlining required improvements, actions and progress to address the deficits identified. The provider’s response included, but was not limited to:

* Wound management plans for all Consumer A and B’s wounds to demonstrate wound dressing regimes were attended to in line with plans and at a frequency more than that described by the Assessment Team.

In relation to Consumer A

* Acknowledged feedback and inconsistencies in recording repositioning. Wound 3 has since resolved, indicating pressure area strategies to reach the goal of wound healing were successful.
* Documentation demonstrating pain has been monitored through monthly reviews and by the Medical officer and that staff have acted appropriately when pain has been identified.
* Documentation demonstrating a Medical officer review occurred post the Site Audit concluding the consumer is not in pain except when being moved and when wound care is attended. A regular opioid analgesic has been prescribed with mild pain associated with wound management since commencement.

In relation to Consumer B

* Progress notes to demonstrate pain levels have been monitored and actions taken where pain had been identified.
* Undertaken pain charting and updated a Dignity and choice plan in relation to repositioning.

I acknowledge the provider’s response, including the improvement actions initiated since the Site Audit. However, I have considered that these improvement actions were initiated in response to the Assessment Team’s report and not as a result of the service’s own monitoring processes. As such, I find at the time of the Site Audit, for the consumers highlighted, effective management of high impact or high prevalence risks, specifically in relation to wounds and pain, was not demonstrated.

In relation to Consumer A, while documentation included in the provider’s response did not align with the date range highlighted by the Assessment Team, the provider’s response asserts wound treatments for all three of Consumer A’s wounds were conducted in line with recommendations, however, I find this is not supported by the wound management plans provided. If it is the provider’s assertion that wound treatments, highlighted in pink on wound management plans provided, have been undertaken in line with directives, these entries do not provide sufficient detail to determine what type of treatment, if any, was undertaken. The majority of entries do not include any commentary relating to whether observation to establish if the dressing was intact or if the wound dressing and treatment was undertaken as there is no description of the wound appearance or measurements documented. And while a photograph of the wound had been taken on one occasion in September 2022, the corresponding wound plan entry also did not include any commentary relating to the wound description or appearance. I also find staff failed to identify changes in the consumer’s skin integrity, with wound 1 not being identified until it had to deteriorated to a point at which it was described by the Medical officer as gangrenous. And while photographs of wound 2 indicated the area to be swollen and red, further actions were only taken in response to feedback by the Assessment Team.

In relation to Consumer B, the provider’s response asserts wound treatments for both of Consumer B’s wounds were conducted in line with recommendations, however, I find this is not supported by the wound management plans provided. If it is the provider’s assertion that wound treatments, highlighted in pink on wound management plans provided, have been undertaken in line with directives, these entries do not provide sufficient detail to determine what type of treatment, if any was undertaken. The majority of entries do not include any commentary relating to whether observation to establish if the dressing was intact or if the wound dressing and treatment was undertaken as there is no description of the wound appearance or measurements documented. And while photographs of the wounds had been taken on six occasions during the highlighted timeframe, the corresponding wound plan entries did not include any commentary relating to the wound description or appearance.

Feedback from clinical staff indicated wound treatments are not undertaken in line with the required timeframes with staff citing time pressures. Considering the nature of the wounds described for both Consumers A and B, consumers should expect wounds to be attended in line with treatment plans and specialist’s recommendations and for wounds to be monitored at each treatment/change in wound dressing and a description of the wound documented, including consideration of wound appearance and measurements. Such practices would ensure wound progression is monitored, wound deterioration is identified in a timely manner and actions taken accordingly.

I have also considered staff practices have not supported effective pain or skin integrity management. While Consumers A and B have been identified as experiencing pain associated with wounds, including during dressing changes, progress note documentation included in the provider’s response indicate analgesic medication to maintain consumers’ comfort during dressing changes is not consistently being administered. Additionally, I find formal pain monitoring processes, such as charting, were not initiated in response to identification of wounds and/or the addition of a narcotic analgesic. This has not ensured appropriate management strategies have been implemented and are consistently applied to ensure consumers’ comfort is maintained.

Repositioning had not been undertaken for both Consumers in line with recommendations to assist in minimising risk of further pressure injuries. Additionally, pressure relieving equipment to enhance Consumer A’s comfort was observed not to be in place over two days of the Site Audit. Feedback from care staff confirmed consumers are not repositioned in line with required timeframes, citing staffing shortfalls and being busy doing other things. I find such practices do not demonstrate appropriate implementation of management strategies to ensure risks to consumers’ skin integrity are minimised and changes to skin integrity to be identified and escalated in a timely manner.

For the reasons detailed, I find Requirement (3)(b) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(c)**

The Assessment Team were not satisfied the needs, goals and preferences of consumers entering the end stages of life are recognised and addressed, their comfort maximised, and their dignity preserved. The Assessment Team’s report provided the following evidence relevant to my finding:

* Two consumers identified as palliating and entering comfort care, did not have an end of life pathway or care plan completed. Care files for both consumers did not contain documentation for end of life care.
* Progress notes for a seven day period in September 2022 did not identify the consumer was actively palliating. While progress notes indicate pain management was provided when the consumer was experiencing pain, progress notes do not identify care provided during this stage, such as repositioning, mouth care or activities of daily living. The consumer was identified as palliating on entry in September 2022. There were no progress notes documented for a 40 hour period over three days in September 2022.

The provider’s response did not dispute the evidence outlined in the Assessment Team’s report. The response included actions taken in response to the Assessment Team’s report, a Training action plan and a Plan for continuous improvement outlining required improvements, actions and progress to address the deficits identified. Actions implemented/planned included, but were not limited to, adding palliative care education to the training plan and undertaking a full review of all consumers’ assessments, including advance care directives.

I acknowledge the provider’s response. However, I find at the time of the Site Audit, the needs goals and preferences of consumers nearing the end of life had not been recognised and addressed. I have considered the needs, goals and preferences of consumers nearing the end of life had not been recognised or addressed to ensure their comfort was maximised and dignity preserved. Care plans, inclusive of end of life care needs, had not been developed or end of life pathways completed to ensure the personal and clinical care delivered to consumers was appropriate, and in line with their needs and preferences.

For the reasons detailed, I find Requirement (3)(c) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(e)**

The Assessment Team were not satisfied the service demonstrated how consumers’ needs, preferences, and changes to care are communicated within the service. The Assessment Team’s report provided the following evidence relevant to my finding:

* Staff did not feel informed of daily changes to consumers’ condition, needs and preferences through the handover process due to the new handover system. Staff stated since implementation of the new system, handover consists of reading the vital information in consumers’ files on the computer. Staff stated this process is hard to follow and does not include day-to-day changes of consumers.
* Three care staff stated they do not always get handover as they are short staffed.

The provider’s response did not dispute the evidence outlined in the Assessment Team’s report. The response included actions taken in response to the Assessment Team’s report, a Training action plan and a Plan for continuous improvement outlining required improvements, actions and progress to address the deficits identified. Actions implemented/planned included, but were not limited to, implementing a verbal handover; reintroduced a handover sheet in the interim; and scheduled further training for staff on the electronic system.

I acknowledge the provider’s response. However, I find at the time of the Site Audit, information about consumers’ condition, needs and preferences was not effectively communicated. In coming to my finding, I have considered that new handover processes are not effective in ensuring staff receive key information required to deliver care and services to consumers. The ineffectiveness of these processes was supported through feedback from staff who did not feel informed of daily changes to consumers’ condition, needs and preferences. Additionally, some staff indicated that they do not consistently receive a handover due to workforce issues. As such, I have considered that these practices do not ensure the workforce has sufficient information to enable coordination and delivery of safe and effective clinical care or have sufficient understanding of consumers’ conditions to provide and coordinate care.

For the reasons detailed, I find Requirement (3)(e) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(g)**

The Assessment Team were not satisfied the service demonstrated minimisation of infection related risks through implementing standard and transmission-based precautions to prevent and control infections. The Assessment Team’s report provided the following evidence relevant to my finding:

* A log of all infections and treatment provided is maintained, however, there is no evidence infection rates are analysed and trends identified each month.
* The Infection prevention control lead could not provide information on the COVID-19 Outbreak management plan, differing infection control practices, personal protective equipment requirements for dealing with other outbreaks or examples of what signage should be used in each outbreak.
* Management stated there were no lessons learnt post a significant COVID-19 outbreak in June 2022, despite this being part of the Outbreak management plan.
* Staff were unaware of where they would find additional personal protective equipment supplies in the event of an outbreak when management is not present.
* An Influenza outbreak kit was not adequately stocked and had not been checked since October 2019.
* An organisational outbreak management plan was provided, however, plans specific to the service or procedures relating to an outbreak was not provided.

The provider’s response did not dispute the evidence outlined in the Assessment Team’s report. The response included actions taken in response to the Assessment Team’s report, a Training action plan and a Plan for continuous improvement outlining required improvements, actions and progress to address the deficits identified. Actions implemented/planned include, but are not limited to, appointed two Infection prevention control leads; monitoring staff practice; and implemented monitoring processes for outbreak management kits.

I acknowledge the provider’s response, including the improvement actions initiated since the Site Audit. However, I have considered that these improvement actions were initiated in response to the Assessment Team’s report and not as a result of the service’s own monitoring processes. As such, I find at the time of the Site Audit, the service did not demonstrate effective systems and processes to ensure infection related risks are minimised.

In coming to my finding, I have considered staff were unaware of where to locate additional supplies of personal protective equipment in the event of an outbreak, a plan outlining site specific processes for outbreak management was not provided and an outbreak management kit was insufficiently stocked and had not been monitored for three years. Additionally, the Infection prevention control lead, who has the responsibility of ensuring the service is prepared to prevent and respond to infectious diseases, did not demonstrate sound knowledge of the service’s outbreak management processes, including those relating to COVID-19.

I have also considered that the service did not demonstrate that data is used to monitor infections and resolution rates and the effectiveness of the infection control and prevention program. While infections are logged, there was no evidence to demonstrate infections rates are monitored, analysed and used to identify trends and opportunities to minimise infection related risks. Additionally, despite the deficits identified by the Assessment Team, opportunities to identify learnings and improvement initiatives following a significant COVID-19 outbreak had not been identified.

For the reasons detailed, I find Requirement (3)(g) in Standard 3 Personal care and clinical care non-compliant.

In relation to Requirements (3)(d) and (3)(f) in this Standard, care files demonstrated changes in a consumer’s mental health, cognitive or physical function or condition capacity are recognised and responded to in a timely manner, and timely and appropriate referrals to Medical officers or specialist services are initiated, where required. Care staff said where changes to consumers’ condition or needs are identified, they escalate concerns to clinical staff and where required, referrals are escalated by clinical staff to Medical officers or specialist services. Recommendations from external specialists or following review by Allied health reviews are included in care files for staff access. Consumers and representatives confirmed appropriate and prompt action had been taken in response to deterioration in consumers’ health, and recalled assessments, observations and medical reviews following falls, weight loss and escalation of behaviours.

For the reasons detailed, I find Requirements (3)(d) and (3)(f) in Standard 3 Personal care and clinical care compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(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 recommended Requirement (3)(c) in Standard 4 Services and supports for daily living not met as they were not satisfied consumers are assisted to participate in their community within and outside the organisation’s service environment or that lifestyle activities are provided in line with the activities program. The Assessment Team’s report provided the following evidence relevant to my finding:

* Two consumers said they miss talking to friends and people from their culture and would like to go to regional social clubs to catch up on old times and eat regional foods. One consumer said they would like to go shopping but cannot go alone and while they have told staff, nothing has happened. Staff said no consumers attend external activities.
* Two consumers said they attend exercise activities and bingo only as no other activities are provided. Two consumers and two representatives said consumers are bored as activities are not provided. One consumer said bingo did not occur on Tuesday due to ‘no staff’
* No activities were observed to be occurring, specifically in the memory support unit, during the three days of the Site Audit. Three representatives confirmed activities are not provided and stated consumers are bored, restless and wander about without a purpose.
* During the Site Audit, only three of the six activities were observed to occur as scheduled, in one level of the service. No one-to-one activity was provided for consumers in their rooms or for those unable to attend activities.
* Consumers were observed in communal areas watching television or sleeping without stimulation or lifestyle staff present.

The provider’s response did not dispute the evidence outlined in the Assessment Team’s report. The response included actions taken in response to the Assessment Team’s report, a Training action plan and a Plan for continuous improvement outlining required improvements, actions and progress to address the deficits identified. The provider’s response included, but was not limited to engaging local communities to build relationships and enable participation within the service; developing an approach with local cultural communities for inclusion in planned events; seeking feedback from consumers in relation to community activities they would like to participate in; and reviewed the activities calendar with consultation with consumers to occur and adjustments made to reflect consumers’ wishes. Additionally, Spotlight consultation and/or case conferences have been held with three named consumers’ representatives.

I acknowledge the provider’s response. However, I find at the time of the Site Audit, services and supports for daily living did not assist each consumer to participate in activities of interest to them. In coming to my finding, I have placed weight on feedback provided by consumers and representatives indicating consumers are not able to take part in their community and social activities, external to the service, the way that they want or provided activities in line with the documented activity program. While a monthly activity program is in place, activities were not occurring in line with the program, with no activities observed to take place in the memory support unit at all for the duration of the Site Audit. As a result, consumers were described as being bored and restless. As such, I find that the service has not ensured services and supports, specifically the lifestyle program, have been tailored to meet the unique needs of the consumers or ensures their well-being and quality of life are enhanced through community and/or social interaction through doing things they enjoy and are of interest to them.

For the reasons detailed above, I find Requirement (3)(c) in Standard 4 Services and supports for daily living non-compliant.

In relation to all other Requirements in this Standard, each consumer receives safe and effective services and supports for daily living that meet their needs, goals and preferences and optimises their independence, health, well-being and quality of life. Care files demonstrated consumers generally engage in the lifestyle program and there are activities available to meet their individual spiritual needs. Consumers and representatives confirmed the services and supports provided promote consumers’ emotional, spiritual, and psychological well-being and consumers described ways they are supported emotionally when they are feeling low or need extra support.

Consumer files demonstrated information about consumers’ conditions, needs and preferences is documented and communicated within the service and with others where responsibility is shared and, where required, appropriate and timely are referrals are initiated. Consumers and representatives indicated they do not have to repeat information about consumers’ needs and preferences with different staff who deliver those services.

Meals are prepared in line with a seasonal six-week rotational menu which has been reviewed by a Dietitian. Feedback from consumers through food focus groups, surveys and meeting forums are considered in menu planning. During meal service, staff were observed to be engaging and supporting consumers with their meals. Most consumers expressed satisfaction with the quality, quantity and variety of meals provided and stated meals provided are good, there is plenty to eat and alternative options are available. Some consumers said since the arrival of a new Chef, the quality, choice and temperature of the meals served in the last two weeks prior to the Site Audit has improved.

There are processes to ensure equipment, required to support delivery of services, is clean, safe and suitable for consumer use. Preventative and reactive maintenance processes ensure equipment provided is maintained. Consumers indicated they felt safe when using equipment and equipment they use is always clean and well maintained.

For the reasons detailed above, I find Requirements (3)(a), (3)(b), (3)(d), (3)(e), (3)(f) and (3)(g) in Standard 4 Services and supports for daily living compliant.

# Standard 5

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

Findings

The Quality Standard is assessed as non-compliant as one of the three specific Requirements have been assessed as non-compliant.

Requirement (3)(b) was found non-compliant following an Assessment Contact undertaken on 12 July 2022 to 13 July 2022, where deficits relating to consumers’ ability to move freely, security of medications and the heating system were identified. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including opening automatic doors within the memory support units to allow consumers free access to large outdoor courtyard areas.

However, at the Site Audit, the Assessment Team was not satisfied the service demonstrated a safe, clean and well maintained environment and recommended Requirement (3)(b) not met. The Assessment Team’s report provided the following evidence relevant to my finding:

* A significant smell of smoke was noted in one level, adjacent to the smoking area, throughout the duration of the Site Audit and ash trays were observed to be overflowing. Two representatives stated the smell was very noticeable.
* The lounge room floor was dirty and wet, and floors in consumers’ rooms were wet and did not have signage to indicate a hazard was present
* Between August and October 2022, there were four reported incidents of consumers trying to abscond over the fence by climbing on garden furniture. However:
  + The furniture was not removed until day two of the Site Audit, despite the most recent incident occurring 10 days prior.
  + A risk assessment was not undertaken in line with the organisation’s incident management process. Assessments were undertaken on day two of the Site Audit following feedback from the Assessment Team.
  + Management said they perform daily walk arounds with maintenance to ensure a safe environment, however, these monitoring measures failed to identify the environment was unsafe
* An audit conducted in August 2022 identified a 25.4% compliance. Twenty-five action items were flagged, however, only six were completed. Non-completed actions included under-reporting of incidents and near misses and staff being unaware of how to report hazards. There was no evidence to demonstrate that actions had been taken in response to the audit provided. Several sections of the audit had not been completed and the audit for September 2022 did not occur due to staff being on leave.

The provider’s response did not dispute the evidence outlined in the Assessment Team’s report. The response included actions taken in response to the Assessment Team’s report, a Training action plan and a Plan for continuous improvement outlining required improvements, actions and progress to address the deficits identified. The provider’s response included, but was not limited to, conducting random spot checks on all consumer rooms’ throughout the week to monitor cleaning standards; conducting daily safety checks of the wall/fence, with a planned increase in fence height expected in late November 2022; and providing information to staff in relation to the smoking area.

I acknowledge the provider’s response. However, I find at the time of the Site Audit, monitoring processes were not effective to ensure a safe environment for consumers was maintained. In coming to my finding, I have placed weight on evidence indicating risks to consumers’ safety were not promptly or effectively managed. Despite four incidents in a three month period involving consumers attempting to abscond from the service by climbing over furniture in a courtyard, measures to mitigate the risk were not implemented, placing consumers at considerable risk. Actions were only taken subsequent to feedback being provided by the Assessment Team.

I have also considered the service’s monitoring processes failed to ensure a safe and comfortable environment was maintained. While daily walk arounds by management are undertaken, these measures failed to identify issues identified by the Assessment Team, including the smoking area and smell of smoke throughout one area of the service, lack of signage being used to identify hazards, such as wet floors and furniture located in the courtyard area. Additionally, while issues had been identified through audit processes undertaken in August 2022, actions to address most of these issues had not been implemented. As such, I find the service has not ensured environmental risks are effectively identified to ensure consumers are kept safe and impacts to their health and well-being minimised.

I acknowledge the improvements implemented in response to the non-compliance identified in Requirement (3)(b) following the Assessment Contact undertaken in July 2022. However, I find these improvements have not been sufficiently embedded to ensure safe, clean, well-maintained and comfortable service environment is maintained.

For the reasons detailed above, I find Requirement (3)(b) in Standard 5 Organisation’s service environment non-compliant.

In relation to Requirements (3)(a) and (3)(c) in this Standard, the service environment was observed to be large and easy to understand and navigate. Various communal seating areas and courtyard areas are available where consumers were observed to be engaging with visitors and other consumers. Consumers were observed using the lifts and interacting with consumers on other floors. Consumers within the memory support unit have access to external areas which were well maintained and consumer rooms were clearly marked and observed to be spacious and personalised.

Furniture, fittings and equipment were observed to be generally safe, clean, well maintained and suitable for the consumer. Lounge areas and outdoor areas appeared suitably furnished and furniture in consumers’ rooms was generally well maintained. Staff described how they ensure furniture, fittings and equipment is safe, cleaned and maintained, including through preventative and reactive maintenance processes.

For the reasons detailed above, I find Requirements (3)(a) and (3)(c) in Standard 5 Organisation’s service environment compliant.

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

Findings

Consumers and representatives sampled were aware of the methods available to make complaints and provide feedback, and felt comfortable to use these methods. Staff described how they support consumers who want to provide feedback or make complaints, including by completing feedback forms on the consumer’s behalf. Prominent displays and hand out materials encouraging and supporting consumers and their family and friends to provide feedback and make complaints were observed.

Consumers and representatives have access to information relating to internal and external feedback and complaints mechanisms, advocacy and language services, where required, on entry and on an ongoing basis. Feedback forms and external complaints, language services and advocacy information was also observed on display and complaints information in languages other than English were available.

A system to capture feedback and complaints is maintained and an open disclosure process is applied where things go wrong. Management and staff are supported in the complaints process through various policies and procedures. A feedback and complaints register is maintained and demonstrated response to complaints are timely and effective. However, while one complaint was noted to have been resolved, the issues were observed by the Assessment Team to be ongoing; this was rectified by management during the Site Audit. Feedback and complaints are reviewed and used to improve the quality of care and services. However, not all verbal feedback and complaints information is being captured on the complaints register, which has potential for opportunities for improvement to be missed. As such, I would encourage the service to review processes relating to how verbal feedback is captured, actioned and monitored. Most consumers and representatives confirmed appropriate action is taken to address feedback and feedback and complaints are used to improve care and services.

Based on the Assessment Team’s report, I find Standard 6 Feedback and complaints compliant.

# 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. | 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 is assessed as non-compliant as two of the five specific Requirements have been assessed as non-compliant.

Requirement (3)(a) was found non-compliant following an Assessment Contact undertaken on 12 July 2022 to 13 July 2022, where it was found the service did not demonstrate sufficient staffing numbers to deliver and manage safe and quality care and services. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, increasing direct care hours and redirecting staffing levels to higher workload areas and consumer care acuity levels; introduced a late notice shift replacement process to decrease reliance on agency staff; implemented an advanced planning procedure to mitigate late notice and unplanned staff leave; and increased managerial oversight of meal services.

At the Site Audit, the Assessment Team found improvements implemented to address the deficiencies had not been effective to ensure sufficient staff to deliver and manage safe and quality care and services and recommended Requirement (3)(a) not met. Additionally, the Assessment Team were not satisfied the workforce was competent or had the qualifications and knowledge to effectively perform their roles and recommended Requirement (3)(c) not met.

**Requirement (3)(a)**

The Assessment Team were not satisfied the service demonstrated there are sufficient staff to deliver and manage safe and quality care and services. The Assessment Team’s report provided the following evidence relevant to my finding:

* Consumers and representatives felt the service did not have enough staff. Impacts to consumers described included delays in meal delivery and not enough staff to assist consumers with meal time activities; not feeling safe at night as there are not enough staff; other consumers’ behaviours making them feel unsafe due to insufficient staff to monitor them; and not enough staff to attend to consumers’ needs.
* Staff said the service does not have an adequately staffed workforce for them to deliver and manage safe, quality care and services. Staff described impacts, including not being able to reposition consumers with wounds at the frequency in line with their assessed needs; being unable to review wounds weekly, with a clinical staff member indicating consumers' wounds have not been reviewed in the two weeks prior to the Site Audit; inability to respond to call bells and manage incontinence; activities often being interrupted or suspended due to staff being redirected to assist staff attend to individual consumer’s care needs; and not receiving handover.
* Staff allocations and rosters shift vacancies form unplanned leave were often filled by staff performing double shifts.

The provider’s response did not dispute the evidence outlined in the Assessment Team’s report. The response included actions taken prior to the Site Audit, a Training action plan and a Plan for continuous improvement outlining required improvements, actions and progress to address the deficits identified. The provider’s response included, but was not limited, commencement of recruitment for a personal care traineeship program; daily review of the roster; and actively monitoring staffing levels in line with consumer needs and feedback.

I acknowledge the provider’s response. However, I find at the time of the Site Audit, the service did not effectively demonstrate there were adequate numbers and mix of staff to deliver safe and quality care and services. In coming to my finding, I have placed weight on feedback provided by consumers and representatives indicating insufficient staffing numbers to provide quality care and services which has resulted in impacts for consumers. Additionally, I have also considered feedback provided by clinical and care staff indicating staffing levels are not sufficient to support the effective delivery of care and services to consumers and the resulting impacts to consumers described by staff.

I acknowledge the improvements implemented in response to the non-compliance identified in Requirement (3)(a) following the Assessment Contact undertaken in July 2022. However, I find these improvements have not been sufficiently embedded to ensure the workforce is sufficient to enable the delivery and management of safe and quality care and services.

For the reasons detailed above, I find Requirement (3)(a) in Standard 7 Human resources non-compliant.

**Requirement (3)(c)**

The Assessment Team were not satisfied the workforce was competent or had the qualifications and knowledge to effectively perform their roles. The Assessment Team’s report provided the following evidence relevant to my finding:

* Progress notes showed staff were not competent in identifying Consumer A’s wounds in a timely manner.
  + Wound management training was conducted in October 2022, however, the service was unable to produce a staff attendance record for this.
* Staff were not competent in identifying and responding to two consumers’ pain associated with wounds.
* Staff were not competent in understanding and applying the organisation’s incident management policies and procedures or regulatory obligations under the Serious Incident Response Scheme, as Consumer A and B’s wounds have not been reported.
* The Infection prevention control lead did not demonstrate they have the knowledge or skills to undertake their role.
* The service does not maintain a formal process for monitoring staff competency

The provider’s response did not dispute the evidence outlined in the Assessment Team’s report. The response included actions taken in response to the Assessment Team’s report, a Training action plan and a Plan for continuous improvement outlining required improvements, actions and progress to address the deficits identified. The provider’s response included, but was not limited, continuing to update knowledge for registered and care staff through a robust training plan targeting key deficiencies identified; recruited a Quality education manager; and engaged an Advisory nurse consultant to assist with provision of best practice, advice and education regarding clinical care.

I acknowledge the provider’s response, including the improvement actions initiated since the Site Audit. However, I have considered that these improvement actions were initiated in response to the Assessment Team’s report and not as a result of the service’s own monitoring processes. As such, I find at the time of the Site Audit, the workforce was not sufficiently competent or had the qualifications and knowledge to effectively perform their roles. In coming to my finding, I have considered outcomes for consumers highlighted in Standard 3 Personal care and clinical care which indicate staff skills and knowledge are not adequate to support the delivery of safe and effective personal and clinical care. Evidence presented in Standard 3 Requirements (3)(a), (3)(b) and (3)(c), which have been found non-compliant, demonstrate consumers have not been provided care that is best practice, tailored to their needs or optimised their health and well-being or that high impact or high prevalence risks have been effectively managed. Deficits have been identified in management of skin integrity, wounds, pain and end of life care. Additionally, as evidenced in Requirement (3)(g), the Infection prevention control lead, who has the responsibility of ensuring the service is prepared to prevent and respond to infectious diseases, including overseeing staff practices relating to infection control, did not demonstrate sound knowledge of the service’s outbreak management processes.

I have also considered the outcomes highlighted in Standard 2 Ongoing assessment and planning with consumers indicate staff skills and knowledge are not adequate to ensure consumers’ goals, needs and preferences for personal and clinical aspects of care are effectively identified through assessment or planned and reviewed for effectiveness.

For the reasons detailed above, I find Requirement (3)(c) in Standard 7 Human resources non-compliant.

In relation to Requirements (3)(b), (3)(d) and (3)(e) in this Standard, overall, staff were observed to treat consumers with kindness and care, respecting their identity, culture and diversity and most consumers said staff treat them well. The organisation’s code of conduct includes workplace behaviour standards and expectations for staff interactions with consumers and staff were aware of the organisation’s workplace behavioural expectations. Management regularly conduct floor walks to be seen by consumers and to monitor staff performance and documentation showed findings of observations being brought to the attention of staff through memoranda. However, as evidenced in Standard 1 Consumer dignity and choice Requirement (3)(a) which has been found non-compliant, the Assessment Team’s observations of staff and consumer interactions and feedback provided by representatives during the Site Audit indicated staff do not consistently refer to or treat consumers in a kind, dignified and respectful manner.

The service recruits suitable staff for specific roles and ongoing training and development is provided to ensure the workforce is equipped to perform their expected duties. Staff said they receive ongoing mandatory training, as well as supplementary training to assist them to expand their knowledge in caring for the consumers. Overall, consumers and representatives were satisfied with the skills and knowledge of staff and have confidence in them to deliver care and services.

A staff performance framework ensures staff performance is regularly assessed, monitored and reviewed. Staff undertake a probation period of six months then annual performance appraisals are conducted thereafter, or as required. Management described performance expectations against the differing roles of staff and provided an example describing how poor staff performance was managed. While many staff appraisals were found to be overdue, this had been identified by management and is currently being rectified.

For the reasons detailed above, I find Requirements (3)(b), (3)(d) and (3)(e) in Standard 7 Human resources compliant.

# Standard 8

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

Findings

The Quality Standard is assessed as non-compliant as two of the five specific Requirements have been assessed as non-compliant.

Requirement (3)(d) was found non-compliant following an Assessment Contact undertaken on 12 July 2022 to 13 July 2022, where effective risk management systems and practices in relation to managing high impact or high prevalence risks and managing and preventing incidents, including use of an incident management system were not demonstrated. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, provided training in relation to restrictive practices, documentation review, consumer feedback, incident review and the Serious Incident Response Scheme; and undertaking daily review of the electronic risk management system to analyse and close off incidents.

At the Site Audit, the Assessment Team found improvements implemented to address the deficiencies had not been effective, identifying deficits relating managing and escalating high impact or high prevalence risks, responding to the potential neglect of consumers, and ensuring appropriate protections and safeguards were in place to mitigate identified risk. The Assessment Team recommended Requirement (3)(d) not met. Additionally, the Assessment Team were not satisfied the service demonstrated an effective clinical governance framework for minimising and monitoring infection related and clinical risks and recommended Requirement (3)(e) not met.

**Requirement (3)(d)**

The Assessment Team were not satisfied the service demonstrated effective risk management systems and practices for managing and escalating high impact or high prevalence risks, responding to the potential neglect of consumers, and ensuring appropriate protections and safeguards to mitigate identified risk. The Assessment Team’s report provided the following evidence relevant to my finding:

* In relation to managing high impact or high prevalence risks, the Clinical Risk Register is discussed at weekly Clinical review meetings. At the conclusion of the meeting, service management are advised of the risk profile of the service and informed to communicate and escalate concerns or issues to leadership and their team members. Consumers A, B and Ds wound and pain management were not noted on any of the minutes sampled in relation to risks, concerns and monitoring.
* Clinical staff did not identify and/or report on the Clinical risk profile register, incident management system or progress notes, wound stages, pressure area care, pain, incidents of deterioration, skin care and behaviours.
* Monthly Spotlight reviews have not yet been completed for Consumers A, B and D, who have significant wounds, pain and pressure injures.
* The service has recently transitioned over to an electronic care system, however, historical data relating to consumers’ condition and care and service needs has not been maintained during the transition resulting in the service not being able to efficiently obtain data, to analyse incidents, trend clinical data and care deficits, and monitor consumers for deterioration.
* Four incidents of consumers attempting to abscond over a courtyard fence occurred between August and October 2022, however, actions were not taken in line with the service’s risk management processes to prevent the occurrences. While management said they use daily walk arounds as an overarching risk management practice to identify and manage risk, these failed to identify the environment was unsafe.
* In relation to identifying and responding to abuse and neglect, the service failed to identify Consumer A’s wound in a timely manner in February 2022 and there was no evidence wound monitoring occurred until August 2022. Another wound was not identified until it had deteriorated to a stage 2 pressure injury. Additionally, reportable incidents were not consistently reported in line with regulatory responsibilities.
* In relation to managing and preventing incidents, Consumers A, B and D’s wounds were not reported in line with the service’s incident reporting policies and governance systems failed to identify this was occurring.
* All behaviour incidents are still not being reported/entered onto the incident management system. Only two of 11 behaviour incidents identified through progress notes were recorded as incidents.

The provider’s response did not dispute the evidence outlined in the Assessment Team’s report. The response included actions taken in response to the Assessment Team’s report, a Training action plan and a Plan for continuous improvement outlining required improvements, actions and progress to address the deficits identified. The provider’s response included, but was not limited to, recruited a full-time Quality education manager; recruiting Champions in the areas of wounds and pain; completed skin assessments for all consumers; auditing wound care and pressure injuries and observing staff practice; and scheduled all consumers for a full care plan review – 50 consumers have had risks and care reassessed and documented.

I acknowledge the provider’s response. However, I find at the time of the Site Audit, the organisation did not demonstrate effective risk management systems and practices in relation to managing high impact or high prevalence risks, identifying abuse and neglect or managing and preventing incidents.

In coming to my finding, I have considered the service has not demonstrated effective risk management systems and practices to support management of consumers’ high impact or high prevalence risks, specifically in relation to skin integrity, wounds and pain as highlighted in Standard 3 Personal care and clinical care Requirements (3)(a) and (3)(b). While three consumers highlighted have been identified with high impact or high prevalence risks, these have not been effectively identified and/or monitored, including through monthly care review processes and weekly clinical review meetings, to ensure timely identification, assessment and monitoring of risks to consumers’ health, safety and well-being. I have also considered that the organisation’s own monitoring processes have not identified deficits identified by the Assessment Team relating to management of high impact or high prevalence risks to consumers’ care.

In relation to identifying and responding to abuse and neglect, I have considered in relation to Consumer A’s wounds, appropriate safeguards were not initiated following identification. There was no evidence to demonstrate an investigation process was initiated to identify how the incidents occurred or strategies implemented to ensure the incidents do not reoccur. Additionally, in relation to Consumer A and B’s wounds, there was no evidence that the service had reported these in line with legislative requirements.

I have also considered staff have not demonstrated an understanding and application of incident reporting and escalation processes. Not all consumer incidents had been documented, escalated or reported. I find this has not ensured that all incidents are identified or analysed to assist to identify trends and opportunities for improvement or risks to consumers’ health and well-being are minimised and/or eliminated.

I acknowledge the improvements implemented in response to the non-compliance identified in Requirement (3)(d) following the Assessment Contact undertaken in July 2022. However, I find these improvements have not been sufficiently embedded to ensure risk management systems and practices are effective in assisting the service to identify and assess risks to the health, safety and well-being of consumers.

For the reasons detailed above, I find Requirement (3)(d) in Standard 8 Organisational governance non-compliant.

**Requirement (3)(e)**

The Assessment Team were not satisfied the service demonstrated an effective clinical governance framework for minimising and monitoring infection related and clinical risks. The Assessment Team’s report provided the following evidence relevant to my finding:

* The clinical governance framework was not effective in recognising delayed identification of and ineffective management of wounds and associated pain
* A monthly clinical indicator report is used to identify risks and drive continuous improvement initiatives, however, these reports failed to identify significant risk, concerns and trends, and alert leadership in relation to wounds, pain, pressure area care, skin integrity and infections.
* A Skin and integrity and Wound management clinical audit undertaken in August 2022 resulted in 100% compliance. The audit was deficient in identifying which consumers were sampled and the criteria sampled. The audit did not identify that Consumer A’s pain had not been assessed or that Consumer B’s pain assessment did not capture pain levels, despite the audit determining that all consumers with pressure injuries had been assessed and evaluated for pain.
* The service was unable to provide the Assessment Team with information relating to Consumer A and B’s wounds prior to implementation of the electronic management system during August 2022.
* A log of all infections and treatment utilised for consumers is maintained, however, there is no evidence the service trends and analyses infection rates each month and identifies opportunities for improvement. Clinical Review meeting minutes for October 2022 did not include discussions relating to consumer infections.

I have also considered evidence highlighted in Standard 2 Requirement (3)(e) demonstrating meeting minutes for October 2022 indicate management of falls, skin and behaviour are not completed in line with the service’s policies and procedures. However, actions taken to ensure staff are completing all assessments and documentation in line with the procedures were not evident.

The provider’s response did not dispute the evidence outlined in the Assessment Team’s report. The response included actions taken in response to the Assessment Team’s report, a Training action plan and a Plan for continuous improvement outlining required improvements, actions and progress to address the deficits identified. The provider’s response included, but was not limited to, appointed two Infection prevention control leads who have responsibility for undertaking antibiotic stewardship reports; completed skin assessments for all consumers and ensuring all wounds are documented and management plans in place; auditing wound care and pressure injuries and observing staff practice; and conducting daily audits of pain charting.

I acknowledge the provider’s response. However, I find at the time of the Site Audit, the organisation’s clinical governance framework was not effective. In coming to my finding, I have considered that while a clinical leadership structure is in place this has not effectively ensured the performance of the workforce is monitored and quality care and service delivery to consumers is maintained, good clinical results achieved and improvement opportunities identified. I have also considered the findings of non-compliance in three of the five Requirements in Standard 2 Ongoing assessment and planning with consumers and five of seven Requirements in Standard 3 Personal care and clinical care, including Requirement (3)(a) which has been non-compliant since an Assessment Contact undertaken in July 2022. The findings in these Standards and the evidence presented in this Requirement indicates the organisation’s clinical governance framework is not effective with deficits highlighted not being identified by the service’s or organisation’s own monitoring processes.

In relation to antimicrobial stewardship, I have considered that while an infection log, including treatments initiated, is maintained, there was no evidence to demonstrate how this information is used to monitor infection rates and antimicrobial use. I find this has not ensured an effective system to prevent, manage and control infections and antimicrobial resistance is maintained to assist to identify trends and opportunities to improve the care and services delivered.

For the reasons detailed above, I find Requirement (3)(e) in Standard 8 Organisational governance non-compliant.

In relation to Requirements (3)(a), (3)(b) and (3)(c) in this Standard, consumers considered the service to be well run and indicated they are actively involved in the development and delivery of care and services through surveys, feedback processes, meeting forums and care reviews. A Resident experience and community engagement committee has recently commenced to discuss ways on helping consumers to live their best lives, improve communication between staff and consumers and how care and services are delivered to consumers.

The governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. The Board regularly visit the service to engage with consumers and their families, and the Regional general manager will often chair consumer meeting forums to ensure they are kept abreast of consumers’ issues and concerns. Communication from Board meetings is provided to consumers and staff through meeting forums and newsletters. The organisation has reporting mechanisms to ensure the Board is aware and accountable for the delivery of services.

The organisation has a governance structure to support all aspects of the organisation, including information management, continuous improvement, financial governance, workforce and clinical governance, regulatory compliance and feedback and complaints. There are processes to ensure these areas are monitored and the Board is aware and accountable for the delivery of services.

For the reasons detailed above, I find Requirements (3)(a), (3)(b) and (3)(c) in Standard 8 Organisational governance compliant.

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