Performance

Report

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| Name: | Bupa Woodville |
| Commission ID: | 6940 |
| Address: | 104 Woodville Road, WOODVILLE, South Australia, 5011 |
| Activity type: | Site Audit |
| Activity date: | 28 February 2024 to 4 March 2024 |
| Performance report date: | 3 May 2024 |
| Service included in this assessment: | Provider: 1297 Bupa Aged Care Australia Pty Ltd  Service: 4349 Bupa Woodville |

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 A. Kasyan, 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 report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others;
* the provider’s response to the assessment team’s report received 4 April 2024; and
* performance report for the assessment contact undertaken on 28 November 2023.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not 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 each consumer is treated with dignity and respect, with their identity, culture and

diversity valued.

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

* Ensure consumer care plans are reflective of consumers’ current and assessed needs and preferences and risks to consumers’ health and well-being are identified and management strategies developed to enable staff to provide quality care and services.
* Ensure effective and timely reviews of care plans, particularly when circumstances change and incidents occur.

**Standard 3 Requirements (3)(a), (3)(b) and (3)(d)**

* Ensure consumers are provided personal and clinical care which is tailored to their needs, best practice and optimises consumer health and well-being.
* Ensure consumers’ high impact or high prevalence risks are effectively managed, including risks associated with pain, falls, pressure injuries and changed behaviours.
* Ensure consumers’ changes in health or condition are recognised, responded to and escalated in a timely manner.

**Standard 6 Requirements (3)(c)**

* Ensure appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. Ensure effectiveness of measures the service take to address consumers’ concerns is evaluated.

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

* Ensure 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.
* Ensure staff competency, skills and knowledge are monitored and tested to ensure staff are competent to undertake their roles.
* Ensure regular assessment, monitoring and review of the performance of each staff member is undertaken.

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

* Ensure organisation wide governance systems, specifically workforce governance systems are effective.
* Ensure effective risk management systems and practices associated with managing consumers’ high impact or high prevalence risks associated with their care, including using incident data to identify trends and deficiencies.
* Ensure the clinical governance framework is effectively implemented and is addressing minimisation of restrictive practices. Ensure the framework is reviewed for effectiveness.

# 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. | Not 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

I have assessed this Quality Standard as non-compliant as I am satisfied requirement (3)(a) is non-compliant.

**Requirement (3)(a)**

The assessment team recommended this requirement not met as each consumer is not treated with dignity and respect, with their identity, culture and diversity valued.

Whilst some consumers and representatives confirmed staff treat consumers with dignity and respect, five consumers and two representatives provided examples of where they felt consumers were not treated in this way. Examples provided include feeling ignored and unheard by staff, feeling their voices are not valued or not listened to by staff, being left to sit on the toilet for an extended period, and not receiving an apology for the delay in getting an assistance with a simple request. The assessment team observed a situation where a consumer’s dignity was not upheld. The consumer was found lying in a urine-soaked bed without receiving assistance for their hygiene needs.

The provider responded to the assessment team’s report by stating whilst they value the feedback of the individual consumers and have followed up with them personally, they consider the service is treating consumers with dignity and respect. The provider states they regret the consumers felt the way it is described in the assessment team’s report, however, they assert the consumers and representatives named in the report did not express ongoing concerns when the service consulted with them following the site audit.

The provider’s response included outcomes of consumer experience interviews for consumers named in the assessment team’s report undertaken prior to or after the site audit. It showed the consumers expressed satisfaction with care. Other evidence and information was related to clinical and personal aspects of the consumers’ care discussed in the assessment team’s report, including, but not limited to, abstracts from care plans, assessments, progress notes, referrals and hygiene charts. The provider’s response also included a range of actions taken in response to the situation where a consumer did not receive an assistance with their hygiene needs, including open disclosure with the representative, submission of the incident through Serious Incident Response Scheme, referrals, assessments and review of the care plan.

I acknowledge the provider’s response and that the service consulted/met with all mentioned consumers and/or representatives and received positive feedback in recent surveys. However, whilst I acknowledge the absence of ongoing concerns voiced during these consultations/meetings, I have placed weight on the feedback provided by consumers and representatives and their feelings of not being listened to, ignored and not being heard by staff, and observations of the assessment team showing a consumer’s dignity was not upheld.

Based on the reasons summarised above, I find requirement (3)(a) non-compliant.

**Requirement (3)(c)**

The assessment team recommended this requirement not met. They found whilst the service supports consumers to maintain relationships of choice and make decisions about when family, friends, carers or others should be involved in their care, it does not support each consumer to make decisions about their own care and the way care and services are delivered. The assessment team’s findings were based on consumers’, representatives’ and staff feedback.

Five consumers advised sometimes their needs and preferences in relation to personal hygiene, and time and place for having their meals are not met. Care staff confirmed this sometimes occurs when they are short staffed.

The provider responded to the assessment team’s report by stating whilst they value the feedback of the consumers named in the report and have followed up with them personally to determine there are no outstanding concerns, they believe the service supports consumers to exercise choice and independence. The provider’s response included abstracts from consumers’ care plans, progress notes and outcomes of consumer satisfaction survey showing the named consumers’ satisfaction with supports to exercise choice and make decisions.

I have come to a different finding to the assessment team’s recommendation for not met and find requirement (3)(c) compliant. I base my finding on the reasons summarised below.

Whilst multiple consumers reported they do not aways receive the care they need or in line with their preferences, the provider’s response and supporting evidence shows the named consumers were consulted and participated in decision making process regarding care.

This requirement consists of multiple elements related to supporting consumer dignity and choice, and the provider demonstrated they have effective systems and processes to support consumer choice. The assessment team found the service supports consumers to make decisions about when family, friends, carers or others should be involved in their care; to communicate their decisions; and to make connections with others and maintain relationships of choice.

Whilst care staff acknowledged they are not always able to meet some consumer needs and preferences, I have considered this is impacted by staffing issues which I have considered in coming to my finding in relation to Standard 7.

**In relation to all other requirements,** care and services were found to be culturally safe with consideration and supports for cultural needs when planning and providing care. Consumers and representatives said staff were supportive of consumers’ backgrounds and cultural preferences. Staff were knowledgeable of each individual consumer’s cultural preferences and needs.

Consumers said they are supported to take risks which enable them to live their best life, with risks and risk mitigation strategies discussed with them to enable them to make informed choices. They said information relating to care and services is provided in a format which is clear and easy to understand and allows them to make informed choices. Staff described how they adapt their communication style when interacting with consumers living with hearing and cognitive impairment and who communicate in different languages.

Consumers’ privacy is respected, with personal information kept confidential and secured via an electronic care system. Staff showed respect for consumers’ privacy and said they did not discuss consumers’ personal information in public spaces. Staff were observed knocking and seeking permission before entering rooms and closing doors when undertaking clinical or care tasks.

Based on the assessment team’s report, I find requirements (3)(b), (3)(d), (3)(e) and (3)(f) 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. | Not Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Not Compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied requirements (3)(a) and (3)(e) are non-compliant.

**Requirement (3)(a)**

The assessment team found assessment and planning, including consideration of risks to the consumer’s health and well-being, does not inform the delivery of safe and effective care and services. Not all assessments, including communication, sensory, vision, sleep and advance care planning were completed for sampled consumers, consistent with the 30-day planner when the consumer first enters the service. One consumer file showed no risk assessment was undertaken in relation to their choice to consume alcohol despite the consumer being prescribed medications that can interfere with alcohol.

The provider responded to the assessment team’s findings by acknowledging that some assessments, such as communication, sensory, and sleep were not completed in a required timeframe and demonstrated the completion of these since the site audit. However, the provider demonstrated through progress notes and other documentation related to assessment and planning that discussions and planning around advance care and vision have taken place.

The provider acknowledges some assessments were not completed in line with and procedures. However, other evidence demonstrates assessment and planning did occur through other ways. The provider states to ensure timely and accurate completion of documentation during the admission process, oversight for completion is now embedded into the care manager workplan. In relation to the named consumer’s choice to consume alcohol, the provider states the consumer enjoys an occasional alcoholic drink and is supported to do so in line with the organisation’s policies and procedures.

I acknowledge the provider rectified the incomplete assessments for the named consumers and is taking steps to ensure ongoing monitoring of the completion of documentation following a consumer’s entry into the service. However, the provider does not supply evidence in its response showing how they assessed and planned management of risks for a consumer drinking alcohol who is prescribed medications that “can interact badly with alcohol” as described in the service’s work instruction. Staff did not follow this instruction that states clinical staff responsible for undertaking assessments are required, in consultation with the general practitioner, to consider and take into account the consumer’s diagnoses and medication regime to ascertain the number of standard drinks the consumer can safely handle within a week or over any one day. Whilst the service has policies and procedures in relation to assessment and planning, including how risks associated with alcohol consumption and its interaction with medications the consumer is taking, are identified, assessed and managed, staff do not follow these processes to ensure safe and effective care. The provider’s response does not include information and evidence to demonstrate improvements planned or underway in relation to this.

Based on the reasons summarised above, I find requirement (3)(a) is non-compliant.

**Requirement (3)(b)**

The assessment team recommended requirement (3)(b) not met as care planning documentation for three consumers showed some assessments were not completed and goals in relation to all care plan domains were generic. In addition, goals in relation to taste, touch, smell and continence care were not recorded. A care file for a consumer who was commenced on end-of-life care showed medications for comfort/palliative care were administered almost two weeks prior to this.

In response to the assessment team’s report and findings, the provider acknowledged some goals were generic and has undertaken a range of actions documented in the continuous improvement plan which included review and update of all consumers’ files to ensure goals are personalised. In relation to assessment and planning of end of life care, the provider states end of life care is different to palliative/comfort care in that it is specialised care in the last few days or weeks of someone’s life. The consumer named in the report was receiving medications for comfort care in consultation with the consumer and their representative and was commenced on an end of life pathway when the care needs passed from the goal of improving quality of life to recognising dying.

I have come to a different finding to the assessment team’s recommendation of not met and find this requirement compliant. Whilst some assessments were not completed, the provider has acknowledged this deficiency and rectified it which I have considered in coming to my finding in relation to requirement (3)(a) of this Standard. Whilst the assessment team found goals were not recorded for all care domains in care files sampled, this requirement does not specify a minimum number of goals that must be established. The intent of this requirement is to ensure care planning is person-centred and tailored to meet the needs and preferences of each consumer. Whilst it is not clear whether assessment and planning was person centred for the three named consumers, as the evidence in the assessment team report was limited to description of missing assessments, I have considered other evidence and information in the assessment team’s report relevant to this requirement that shows consumers’ goals, needs and preferences are assessed and planned.

The assessment team found staff had a detailed knowledge of consumers’ preferences, needs and goals and individual strategies to support and encourage consumer independence, well-being, cultural, emotional, and spiritual needs. Dietary needs and preferences were recorded and personalised. Five consumers advised staff are aware of their needs and preferences and support them to achieve their goals. Based on the evidence summarised above, I find the provider has established systems and processes to identify consumer needs, goals and preferences. The supporting evidence in the provider’s response shows this process includes end of life and advance care planning if the consumer wishes.

Based on the reasons summarised above, I find requirement (3)(b) compliant.

**Requirement (3)(e)**

The assessment team recommended this requirement not met as care files for four consumers who had experienced a change in circumstance or incidents showed care and services were not reviewed for effectiveness.

Documentation showed following incidents, such as recurrent falls resulting in major injury and pressure injuries, consumers’ needs, goals and preferences were not assessed to identify if any adjustments to care plans were necessary. Care plans remained unchanged, even when these incidents occurred, post hospitalisation and where there was a change in circumstances, such as when a named consumer required isolation in their room due to infectious disease.

The provider responded to the assessment team’s report acknowledging a skin assessment was not completed after the named consumer developed pressure injury, however, staff undertook wound assessment, created a wound management plan, updated the handover sheet to include information on changes to care, and completed an incident report. The provider acknowledges the assessment team’s finding in relation to the named consumer who sustained major injury following one of the multiple falls and that falls prevention interventions remained unchanged even after the consumer sustained the injury which significantly affected the consumer’s mobility.

In relation to the consumer who was in isolation during a short period of time, the provider acknowledges the activity attendance sheet reflected the consumer continued attending a group activity. However, asserts this was an error in documentation and the consumer remained in their room in line with infection control procedures. The provider asserts that prevention strategies were in place for the named consumers and on the whole, effective at preventing recurrence whilst acknowledging care planning documentation did not reflect care and services provided.

I acknowledge the provider’s response and additional information provided in relation to the named consumers. However, I find that the provider does not have effective systems and processes to ensure care and services provided to consumers are continually assessed and adjusted to meet the changed needs of consumers. Whilst the provider states that following incidents, prevention strategies have been implemented and were effective at preventing recurrence of the incidents, consumers’ care and services were not holistically reviewed and updated, and preventative strategies remained the same even after the significant change in consumer mobility status. Care plans were not adjusted based on changes in consumer condition and response to interventions.

Based on the reasons summarised above, I find requirement (3)(e) non-compliant.

**In relation to requirements (3)(c) and (3)(d),** assessment and planning was found to be based on ongoing partnership with the consumer and others the consumer wishes to involve and includes other organisations. Documentation demonstrated consumers and representatives are involved in the assessment and care planning process on entry and on an ongoing basis. Representatives said they are informed of all changes to consumers' needs, including incidents, medication changes or decline in consumers’ health and care needs. Staff described how referrals are made and how members of multidisciplinary team are involved in the assessment of consumers’ care and service needs.

Consumers and representatives said they are informed of the outcomes of assessment and planning, and management advised they provide representatives with copies of care plans if requested. Representatives said they are informed when there are changes to the consumer's needs, or where an incident has occurred.

Based on the assessment team’s report, I find requirements (3)(c) and (3)(d) 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. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Not 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. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied requirements (3)(a), (3)(b) and (3)(d) are non-compliant.

**Requirement (3)(a)**

The assessment team recommended this requirement not met. The service was found non-compliant in this requirement following an assessment contact undertaken in November 2023 as clinical care in diabetes, skin and behaviour management was not best practice resulting in ineffective care. While the service has implemented improvements to address non-compliance, the assessment team found consumers did not receive safe and effective personal and/or clinical care that is tailored to their needs and optimises their health and well-being.

Five consumers and representatives provided various examples of how consumers’ needs in relation to personal or clinical care are not met. They said personal care is not tailored to the consumer’s needs and preferences in relation to when and how they receive assistance with personal hygiene and dressing. They reported their concerns about the quality of care, such as inadequate monitoring of consumers’ health condition and lack of follow up leading to a family member taking actions after no actions had been taken by staff. Feedback included concerns about the competency of staff to use lifting equipment resulting in a consumer feeling unsafe. One consumer reported feeling embarrassed when situations occurred due staff not managing their bladder drainage device safely and effectively resulting in urine spillage.

Best practice was not demonstrated in how consumers’ changed behaviours are managed. Documentation for three named consumers showed interventions for managing behaviours of physical, verbal aggression towards other consumers and/or staff and refusal of care are not tailored to the consumer’s needs or effective. Behaviour management plans are not comprehensive and do not provide tailored strategies and interventions to address the behaviours requiring support.

Three staff members reported they are unable to provide individualised care when they are short staffed.

In response to the assessment team’s report, the provider responded by stating they consider consumers receive safe and effective clinical and personal care. The provider states they regret the consumers felt the way it is described in the assessment team’s report, however, they assert the consumers and representatives named in the report did not express ongoing concerns when the service consulted with them after the site audit. The provider’s response included outcomes of consumer experience interviews for some consumers named in the assessment team’s report undertaken prior and/or after the site audit which showed satisfaction with care.

The provider states all staff are competent in using lifting equipment and bladder drainage devices and found no documented evidence of any incidents related to staff not competently providing care. The provider states they found no documented evidence with reference to any requests for a follow up or any issue relating to one of the named consumer’s concerns around lack of follow up. The provider expressed they are taking the opportunity to further ensure the team’s capability in bladder drainage system management by adding training session for all staff.

I acknowledge the provider’s response. However, it is expected under this requirement that personal and clinical care is tailored to consumers’ needs and is safe and effective. Fifty per cent of all consumers/representatives interviewed stated it is not tailored consumers’ needs and not always effective and compromises their health and well-being. Consumers requiring behaviour support do not receive effective care as their care plans do not contain tailored interventions.

Based on the reasons summarised above, I find this requirement non-compliant.

**Requirement (3)(b)**

The assessment team found high impact high prevalence risks associated with pain, falls and pressure injuries are not effectively managed.

Care files for three consumers who sustained multiple falls within a relatively short period of time, and where for one consumer a fall resulted in a major injury showed falls preventative strategies for all three consumers were generic and not individualised. Falls preventative strategies tailored to the consumer’s needs were not implemented, including when one of the consumers sustained a major injury resulting in a new non-weight bearing status. Staff did not implement timely falls preventative strategies and did not monitor consumers post falls in line with the policies and procedures.

Staff did not administer pain relieving medication as prescribed prior to activities of daily living resulting in ineffective management of one consumer’s pain associated with a major injury. Effectiveness of interventions was either not evaluated or evaluated with a delay. The pain management plan was not completed until after six days post the consumer’s return from hospital where they underwent a surgical procedure. The representative advised the first couple of weeks after the consumer returned to the service following surgery, they were in pain and uncomfortable.

Two consumers developed pressure injuries that progressed to severe stages before staff identified them. Documentation showed repositioning was not recorded as being implemented in line with care plans.

In response to the assessment team’s findings, the provider acknowledged incomplete documentation, however, considers the service effectively manages high impact or high prevalence risks. The provider states they addressed poor documentation practices through providing education to all registered and enrolled nurses on falls management process. Care managers are reviewing all incidents daily to ensure observations and assessments are completed as required. Effectiveness of these strategies will be measured by the completion of falls focus audits. The provider disagrees pain was not managed effectively for the named consumer as whilst pain assessment was guiding staff to administer opioid analgesia prior to activities of daily living, the medical chart did not include a directive to administer pain relief prior to activities of daily living. Medication administration records show as required analgesia was administered multiple times in the two weeks since the consumer’s return from hospital

The provider disagrees with the finding that there was a delay with implementing falls preventative measures and provided documented evidence that one of the interventions mentioned in the assessment team’s report was implemented without a delay. Whilst the provider acknowledges one consumer’s pressure injury was not identified until it progressed to a severe stage, the consumer has been regularly monitored by the wound consultant and on their most recent review in March 2024, noted that the wound is now a dry scab. In relation to the second consumer’s pressure injury, the provider disagrees with the staging recorded in the assessment team’s report and advised the wound is healing and was being dressed in line with the wound consultant recommendations.

I acknowledge the provider’s response and additional information in relation to the named consumers. However, I find the service does not effectively manage risks relating to falls, pain and pressure injuries. The high incidents of falls, the severity of resulting injuries and lack of tailored falls preventative strategies shows a system deficiency in addressing and mitigating falls risks effectively. Whilst the provider states as required opioid analgesia did not have to be administered prior to activities of daily living, I have placed weight on the representative’s feedback who advised in the first two weeks after the consumer returned to the service following surgery, pain was not managed effectively. I have also considered the assessment team’s finding that staff did not monitor and record pain relief effectiveness following administration to enable implementation of appropriate interventions to manage risks. I also find the service does not manage risks of developing pressure injuries effectively. The provider states the wound consultant has completed a review of all the wounds remotely and no concerns were identified. Whilst acknowledging this review showing effectiveness of wound management, I find the service does not have effective systems and practices enabling staff to identify and assess pressure injuries in a timely manner as evidenced by two consumers developing pressure injuries that progressed to a severe stage before they were identified.

Based on the evidence summarised above, I find requirement (3)(b) non-compliant.

**Requirement (3)(d)**

The assessment team found whilst the provider has systems and processes to enable staff to recognise consumer deterioration or change of their mental health, cognitive or physical function, capacity or condition and to respond to in a timely manner, staff do not always apply these systems. Where a named consumer’s condition changed, staff did not recognise and respond to deterioration in fluid intake and output. The representative expressed dissatisfaction with the service’s actions in response to the consumer’s deterioration because they had to request a hospital transfer after visiting the consumer who was showing signs of deterioration. The consumer was discharged from hospital with a diagnosis of sepsis.

The provider responded to the assessment team’s report by stating they consider deterioration is identified and actioned in a timely manner and provided progress notes entered by clinical staff several days prior to hospital transfer and hospital discharge summary. The provider’s response included supporting evidence demonstrating staff monitored urine output, and that an enrolled nurse assessed the consumer following escalation of their deterioration from care staff.

I have considered the assessment team report and the provider’s response and I find this requirement is non-compliant. Whilst progress notes in the provider’s response show an enrolled nurse observed a change in the consumer’s condition and signs of deterioration, such as excessive sweating and increased confusion, there is no evidence of timely escalation to a registered nurse or other appropriate health professional. Whilst the consumer was transferred to hospital where they were diagnosed with sepsis, this transfer was offered to the representative in response to their concerns about the consumer’s decline. The representative’s dissatisfaction with how this was managed, specifically that they had to request escalation to hospital demonstrates staff did not recognise the seriousness of the change in the consumer’s condition.

Whilst both enrolled and registered nurses are trained to use their clinical judgment to determine the appropriate course of action based on the consumer’s condition, an enrolled nurse provides care under the supervision of a registered nurse and, as such, should communicate information about a change in a consumer’s condition to a registered nurse in a timely manner which the provider did not demonstrate has occurred.

Based on the evidence summarised above, I find requirement (3)(d) non-compliant.

**Requirement (3)(e)**

The assessment team found information about the consumer’s condition, needs and preferences is not documented and communicated within the organisation. Clinical handover records used to capture vital information showed where a consumer’s condition changes, this information is not always recorded to enable effective communication of information. Examples included not recording a named consumer’s denial to receive assistance with activities of daily living and not recording information about another consumer’s fracture, falls risk status and a requirement for close monitoring. Two staff members advised they do not read consumer care plans.

The provider disagrees with the assessment team’s findings and states they consider that information about consumers’ condition, needs and preferences is documented and communicated within the organisation and with others where needed. The provider advises the purpose of the vital information on a handover sheet is to highlight any new relevant information for the consumer. In relation to the consumer’s denial of assistance, this is additional information relating to care needs that would be included in the consumer’s care plan which is accessible at the point of care delivery through handheld devices. The provider acknowledges this information was not included in the care plan and has updated it since the site audit. The provider acknowledges that the detail of the fall and injury sustained was not documented in the handover of the vital information, however, the consumer was identified as a high falls risk and it was referenced there was a surgical wound.

I have come to a different finding to the assessment team’s recommendation of not met and find this requirement compliant. In coming to my finding, I have considered information across Standards 2 and 3. The service documents information about consumers’ condition, needs and preferences in care plans, progress notes and handover sheets and staff have access to this information through handheld devices. The service’s medical officer has access to the documentation system and can access consumers’ files, including charting, forms, and progress notes. Recommendations from external health care providers are included in consumers’ care plans.

In relation to the service not recording in the handover sheet vital information about one of the named consumer’s fracture, I find, whilst this indicates a breakdown in communication between staff members, overall, this incident alone does not indicate systemic deficits in how information is communicated within the service and with others where responsibility for care is shared.

Based on the reasons summarised above, I find requirement (3) (e) is compliant.

**In relation to requirements (3)(c), (3)(f) and (3)(g),** the needs and preferences of consumers nearing end of life are recognised and addressed, their comfort maximised, and their dignity preserved. Clinical and care staff were knowledgeable of the end of life process and how to monitor and record the consumer's condition.

Consumers and representatives said referrals are initiated when consumers need them and are satisfied with the process in place. Clinical staff were knowledgeable of the referral process, including when and how to refer consumers to other providers of care and services. The organisation has policies and procedures in place to guide and support staff in relation to timely and appropriate referrals.

Staff confirmed they have received training, including in relation to infection control, COVID-19 and hand washing, and were knowledgeable in relation to reducing the use of antibiotics. They demonstrated and confirmed infection control practices in line with current infection control guidelines.

Based on the assessment team’s report, I find requirements (3)(c), (3)(f) and (3)(g) 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. | 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

I have assessed this Quality Standard as compliant as I am satisfied all requirements within this Standard are compliant.

Consumers interviewed confirmed they are supported to do the things they want to do, including accessing the community and maintaining relationships with people important to them. Consumers provided examples of individual and group activities they are supported to engage in, including spiritual, cultural and social activities in line with their preferences. Consumers confirmed they are able to talk to staff or access other supports when they are feeling down and need emotional support. Consumers confirmed they receive meals which are of good quality and suitable to their dietary preferences.

The service demonstrated effective processes to ensure consumers receive safe and effective services and supports for daily living. Assessments are completed and recorded to identify and communicate consumers’ needs, preferences and goals which optimise their independence, well-being and quality of life. Care plans include strategies for staff on how to provide support, including equipment required and activities the consumer wishes to attend.

The service has an activity program and consumers are supported to participate in activities of their choice both within and outside of the service and maintain social and personal relationships that are meaningful to them. Consumers were observed participating in activities of choice, such as group exercises, mobile library and leaving and returning to the service.

Staff described ways in which they share information and are kept informed of consumer changes and preferences. Care documentation showed adequate information where the responsibility for care is shared as it relates to services and supports for daily living. The service showed sufficient and timely referrals to providers of other care and services, or other organisations when required. The service has established links with various groups and providers, such as cultural community associations, volunteers, library, and churches.

Consumers’ dietary needs and preferences are recorded and available where food and drinks are prepared and delivered to consumers. Equipment utilised for lifestyle activities, such as games, activities and books appeared clean and in good condition. Mobility aids, such as four-wheeled walkers and wheelchairs were used throughout the service and were clean and functional. There are systems and processes to ensure equipment is clean and safe.

# Standard 5

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

Findings

I have assessed this Quality Standard as compliant as I am satisfied all requirements within this Standard are compliant.

**In relation to requirements (3)(a) and (3)(c),** the service was found to have a welcoming environment spread across three levels with access facilitated by stairs and lifts. Both indoor and outdoor areas allow consumers with varying degrees of mobility to maximise their independence. Communal areas provided a range of seating options and places to rest, as well as shaded areas and patios with well-maintained gardens. Consumers’ rooms were personalised with various photos, mementos, artworks, books and furniture items.

Furniture, fittings and equipment were clean, safe and well maintained and suitable for the consumers. There are systems to ensure preventative maintenance is completed and reactive maintenance is notified and promptly addressed via an electronic software system which external contractors can access. Consumers and representatives said furnishings and equipment are kept clean and in working order.

**Requirement (3)(b)**

The assessment team recommended this requirement not met. The assessment team found the service environment was safe, clean and well maintained and consumers were able to move freely, both indoors and outdoors. However, the smoking area was untidy with cigarette butts and ash on the ground. Multiple evacuation slides located on consumers’ beds had straps hanging down which posed tripping hazards and staff were not aware of their purpose. Fire certification was not renewed as required in 2022. The service cleaned the smoking area by the end of the site audit and commenced an action plan to address the issues identified by the assessment team.

The provider responded to the assessment team’s report and findings by stating that improvement actions in relation to the above deficits commenced during the site audit and have all been addressed. In order to ensure the cleanliness of the smoking area is maintained at all times, the cleaning schedule has been updated to include daily attendance by the cleaning staff member and management has been completing visual checks of the area and it has remained tidy. The provider eliminated the tripping risk by completely removing the evacuation slides from under the mattress and placing them in consumers’ bedside drawers, have educated all staff on the use of evacuation slides and will continue to orientate staff to evacuation slides during mandatory fire training. The provider attached the fire certification dated 2022 confirming that an appropriate level of fire safety exists and emergency procedures are in place.

I have come to a different finding to the assessment team’s recommendation of not met and find this requirement compliant. Whist the smoking area was untidy and the evacuation slide straps were posing a tripping hazard, these issues were promptly addressed. I find based on the assessment team’s report and their findings of service environment being safe, clean, well maintained and comfortable and enabling free movement of consumers which was confirmed through documentation, consumer and staff interviews, requirement (3)(b) is 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. | Not Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

I have assessed this Quality Standard as non-compliant as I am satisfied requirement (3)(c) is non-compliant.

**Requirement (3)(c)**

The assessment team found whilst the organisation has established complaint handling procedures and has implemented open disclosure policy, the processes are not effective because consumers reported unresolved complaints and recurring issues. Whilst the service generally maintains records of all complaints received, including the nature of the complaint and actions taken, the use of open disclosure was not always documented. Five consumers and representatives provided feedback describing in different ways how their complaints are not resolved to their dissatisfaction. Examples provided include unresolved issues despite raising them multiple times, not getting feedback or updates on what was being done to address the issue, being frustrated and disillusioned due to seeing the same problems happening and stopping to complain due to not believing anything will change.

The provider responded to the assessment team’s report and findings by acknowledging consumers’ feedback and providing detail of the follow up that has been undertaken to ensure the named consumers’ satisfaction with resolution of their concerns. The provider submitted information to demonstrate the complaints handling process is effective as evident through healthy reporting culture, closing complaints in a timely manner, a reduction in the instances where complainants chose to raise their complaints with the Commission over the last 15 months, and 96% of respondents to the experience survey reporting their complaint was followed up. The provider’s response included supporting evidence in relation to the named consumers/representatives showing management met with them and they generally expressed satisfaction with the care consumers receive and did not raise any concerns.

I acknowledge the provider’s response and additional information and evidence. However, whilst the provider’s response shows that 96% of respondents to the experience survey reported their complaint was followed up, this indicates the service has a process in place for addressing concerns, however, it does not necessarily mean that the respondents were satisfied with the resolution or outcome of their complaints. Whilst the service demonstrates they take actions in response to complaints, 30% of consumers and representatives interviewed during the site audit expressed their dissatisfaction with the resolution and reported things do not change which shows systemic issues with effectiveness of measures the service take to address consumers’ concerns.

Based on the reasons summarised above, I find requirement (3)(c) non-compliant.

**Requirement (3)(d)**

The assessment team recommended this requirement non met because whilst they found feedback and complaints are reviewed, this has not led to improvements in the quality of care and services provided. Although consumers and representatives said feedback has been provided in relation to staffing and management described actions taken to improve staffing, multiple consumers and representatives expressed continued dissatisfaction with staffing levels and mix. Not all verbal feedback was captured in the feedback management system to enable accurate trending and analysis. Documentation showed the service identified trends in relation to consumer feedback about staffing resulting in a review of staffing levels in one area of the service. However, no analysis was undertaken in relation to call bells activations.

The provider responded to the assessment team’s finding in relation to ongoing consumer dissatisfaction with staffing levels by providing an outcome of survey undertaken in March 2024 with 115 consumers with high level of satisfaction across multiple areas, including in relation to quality of life, safety, competency of staff, governance of the service and food. The provider acknowledged there is an area for improvement to ensure all feedback is captured and has added several actions to continuous improvement plan, including providing education to staff and reinforcing the process at staff meetings.

The provider disagrees that complaints and feedback are not used to improve quality of care and services and provided examples of how improvements have been made based on consumer feedback which was captured in the continuous improvement plan. The provider described systems and process for effective trending and analysis of data through monthly evaluation of actions from the prior month, summary of results/trends for the reporting period and actions for the current month and submitted monthly indicator analysis for February 2024 to demonstrate this.

I have come to a different finding to that of the assessment team and find this requirement compliant. The evidence in the assessment team’s report and the provider’s response demonstrates the service reviews feedback and complaints systematically and are using them to identify areas for improvement in the quality of care and services. The assessment team found complaints data was analysed and trends in relation to quality of care, staffing and communication were identified and recorded. The provider’s response showed how this drives continuous improvement through implementation of actions addressing trends. Whilst not all verbal feedback was recorded, the provider demonstrates it reviews and analyses most of the feedback received and takes steps to address it.

Based on the reasons summarised above, I find requirement (3)(d) compliant.

**In relation to requirements (3)(a) and (3)(b)**, consumers and representatives were knowledgeable about methods for providing feedback and making complaints including providing feedback verbally to staff, raising issues at staff meetings, or in writing via email and feedback forms. Although they were aware of mechanisms, some consumers and representatives expressed reluctance to raise issues for fear of getting staff in trouble or potential reprisals. Staff described how consumers and representatives are encouraged to provide feedback and make complaints and provided examples of when this occurred. There are formal processes to collect and encourage feedback, including but not limited to feedback forms, surveys and consumer meetings.

Consumers and representatives confirmed other methods of how to raise complaints were explained to them and they have access to advocacy and language services if required. Staff and management described how they support consumers with access to advocates, language services and other methods for raising and resolving complaints.

Based on the assessment team’s report, I find requirements (3)(a) and (3)(b) 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. | Not 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. | Not 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. | Not Compliant |

Findings

I have assessed this Quality Standard as non-compliant as I find requirements (3)(a), (3)(c) and (3)(e) are non-compliant.

**Requirement 7(3)(a)**

The assessment team found the service did not demonstrate sufficient numbers and skill mix of staff are provided to ensure the delivery of safe and quality care for consumers. Fifty per cent of all consumers and representatives interviewed were not satisfied with the number and mix of staff to deliver safe and effective care and services. Consumers and representatives described how this negatively impacted the quality of care consumers receive and their well-being. Examples provided include not receiving assistance with personal hygiene and dressing in line with the consumer’s needs and preferences when agency staff are used to fill vacant shifts, not being taken outside due to low level of staffing on some days, being left to sit on the toilet for an extended period causing back pain, being rushed by staff to get ready for appointments causing the consumer to feel stressed and expressing concerns with the number of junior staff rostered on in the memory support area without a senior staff member to support them.

The assessment team observed a situation where a consumer did not receive timely assistance with personal hygiene and was found lying in a urine-soaked bed.

Six staff from various disciplines confirmed staff do not always have sufficient time to provide care and supervision and there are often delays in backfilling shifts with agency staff which leads to delays in care which magnify throughout the day. Management said there are processes to pair experienced staff with less experienced and agency staff, however, this does not always occur. The service does not have a process to investigate multiple call bell activations in short time frames and they are not aware of dissatisfaction with staffing levels and feedback from consumers and representatives during the site audit had come as a surprise.

The provider disagreed with the assessment team’s findings and that staffing have impacted the named consumers’ care and submitted hygiene charts, call bell response data analysis and activity charts. The service continues to actively manage sector wide workforce challenges through direct care roster management, ongoing recruitment and managing unplanned leave by using agency staff.

I acknowledge the provider’s response and additional information. The service is supported by the wider organisation’s systems of rostering, access to agency staff and review and monitoring processes used to plan numbers and skill mix of staff. However, the systems have not been effective and the service did not identify through feedback, monitoring or outcomes in consumers’ care the deficits in staff numbers and skill mix as identified by the assessment team. Fifty percent of all consumers and representatives interviewed were not satisfied with the number and mix of staff to deliver safe and effective care and services, with nearly 40% of staff from various disciplines confirming staffing mix and level does not enable them to provide quality care and services. Observations by the assessment team confirm consumer care and dignity has been impacted due to insufficient staff available to provide timely and appropriate care.

Based on the reasons summarised above, I find requirement (3)(a) non-compliant.

**Requirement (3)(b)**

The assessment team recommended this requirement not met. The assessment team found staff are provided with a handbook which outlines expected behaviour and professional etiquette, and the organisation has a code of conduct and values statements. Whilst some consumers and representatives said staff are kind, caring, and respectful, some said consumers do not always feel listened to and their preferences in relation to care are not always met as described in Standard1.

The provider responded by stating they responded to these findings in Standard 1. The provider states their most recent consumer experience survey does not reflect the findings with 99% of respondents confirming staff are kind and caring always or most of the time.

I have come to a different finding to that of the assessment team and find this requirement compliant. I find, whilst some consumers provided examples of how they felt they were not listened to about how they would like care and services delivered, such as when they would like to get up and go to bed and being dressed for breakfast, the evidence in the assessment team’s report does not show these feelings were caused by staff not interacting with consumers in a kind and caring manner or by not supporting each consumer’s identity, culture and diversity in their interactions.

Based on these reasons, I find requirement (3)(b) compliant.

**Requirement (3)(c)**

The assessment team found the workforce is not competent and do not have sufficient knowledge to undertake their roles effectively. Four consumers and representatives provided examples indicating their dissatisfaction with some staff competency in relation to identification of clinical deterioration, managing bladder draining devices, administering medications and having no knowledge of consumer current condition and needs. Multiple consumers’ health and well-being were negatively impacted due to staffs’ lack of knowledge or competency in identifying and managing deterioration, managing risks of falls, pain and pressure injuries. The service did not have effective processes to identify deficits in care and clinical staff knowledge or competency in performing their roles.

In response to the assessment team report and findings, the provider described a range of actions they started implementing prior to the site to address deficits in staff skills and knowledge. Improvements include, but are not limited to, providing staff training, enhancing agency staff induction and increasing support to staff during onboarding process.

I acknowledge the actions identified by the provider to address clinical and care staff lack of knowledge they are required to have to effectively perform their roles. However, these actions will take some time to be fully imbedded in staff practice and result in changes to consumer care and services. The provider did not demonstrate in its response the evaluation of the effectiveness of these actions.

Based on the reasons summarised above, I find requirement (3)(c) non-compliant.

**Requirement (3)(d)**

The assessment team found staff reported satisfaction with a range of training provided, however, not all staff have completed mandatory training in the previous 12-months in line with organisational policy. Although deficits in knowledge and skill have been identified as part of audits and incidents, training to rectify these deficits has not been provided in a timely manner. Whilst the service provides training to improve staff knowledge in managing skin integrity and pressure area care, records show only five care staff attended training in May 2023 and this was not effective as evidenced by two consumers developing pressure injuries that were not identified until they reached advanced stages.

In response to the assessment team report and findings, the provider stated they have identified deficits in staff completion of mandatory training with improvement actions commenced prior to the site audit. Since the site audit, the service has escalated the follow up with staff who have incomplete modules. The service continues to focus on completing 100% of all mandatory training modules and is on track to achieve this by end of May 2024.

I have come to a different finding to that of the assessment team and find this requirement compliant. I acknowledge at the time of the site audit not all staff completed mandatory training. However, the assessment team’s report and the provider’s response show the service has systems to enable the workforce to perform effectively in their roles. Staff interviewed during the site audit expressed satisfaction with the training and support provided by senior staff members and management. They said they are supported by a range of processes, such as induction, orientation and buddy shifts and said competencies in relation to manual handling, insulin management, wounds, hand hygiene and donning had been completed. A training calendar for 2024 has been established and management said training completion records will be monitored, and compliance action taken for non-conformance.

Based on the reasons and evidence summarised above, I find this requirement compliant.

**Requirement (3)(e)**

The vast majority of staff had not completed annual appraisals. Staff confirmed annual appraisals were not up to date and competency assessments were not regularly assessed. Management acknowledged deficits in completion of staff performance appraisals and competency assessments. Two sampled staff files showed performance assessments were not completed.

The provider responded by acknowledging, prior to the site audit the service had identified that with the changes in the leadership team appraisals had not been completed as needed. This was identified as a continuous improvement opportunity in January 2024. A risk-based approach to catch up overdue appraisals was initiated with a focus on critical roles, such as clinical staff.

I acknowledge the provider has commenced an action plan to address low compliance rate with completing staff regular appraisals. However, 75% of staff did not complete their annual appraisal or pre-probationary review in the past 12 months, and the provider’s response does not demonstrate how they ensure appraisals are comprehensive, address performance, training needs, professional development goals and any issues identified during appraisal process are addressed.

Based on these reasons, I find this requirement non-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. | Not 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. | Not 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. | Not Compliant |

Findings

I have assessed this Quality Standard as non-compliant as I find requirements (3)(c), (3)(d) and (3)(e) are non-compliant. The assessment team recommended all requirements in this Standard not met.

**Requirement (3)(a)**

The assessment team found whilst the service demonstrated a range of ways they support consumer involvement in the development, delivery and evaluation of care and services, some consumers and representatives feel they are not listened to and things do not change.

In response to the assessment team’s finding, the provider acknowledged feedback channels had not been effective in engaging some consumers and representative in the process. However, they do not consider this to be systemic in nature.

I have come to a different finding to that of the assessment team and find this requirement compliant. I consider whilst the assessment team’s report states some consumers and representatives expressed they feel they are not listened to, there were no specific examples provided in this requirement of where their input and feedback in relation to the development, delivery and evaluation of care and services have not been valued by the service.

The assessment team’s report shows consumers are given opportunities to participate in care planning meetings, provide feedback on services and be involved in quality improvement initiatives. Consumer meeting minutes showed consumers are provided updates and information in relation to survey results and improvements being made. Consumers are consulted when new menus are proposed and this involves a tasting process, and consumers can select from a range of alternatives which are displayed weekly. Executive leadership said they provide information from the Board to consumers and representatives which is tabled at consumer meetings. The consumer experience committee has become the Consumer Advisory Body, and an expression of interest goes out to all consumers to provide an opportunity to participate.

Based on the evidence and reasons summarised above, I find requirement (3)(a) is compliant.

**Requirement (3)(b)**

Whilst the governing body promote a culture of safe, inclusive, and quality care and services and has an operational governance framework that encompasses various committees which govern the business activities, the assessment team found this requirement not met because these systems have not been effective to identify deficiencies in delivery of clinical and personal care, completion of mandatory training, skills assessment, and performance appraisals in line with organisational policies.

The provider responded by stating the service had been identified as the service at risk in late 2023 and was supported through daily clinical governance led by the Quality Improvement Management. In January 2024, following the improved clinical indicators, the risk at the service was assessed as reduced which resulted in the service being transitioned from daily clinical governance to weekly remediation. Led by the Quality Improvement Manager, weekly remediation meetings support the home’s leadership team to track and evaluate improvements.

The provider disagrees the governance processes did not identify clinical risks and provided supporting evidence to demonstrate trending of the incidents and states that continuous improvement activity were commenced where there was an increase. The provider also disagrees that the governing processes did not identify deficits in staff completion of mandatory training, skills assessment, and performance appraisals and states the service had self-identified deficits before the site audit and commenced an action plan to address this.

I have come to a different finding to that of the assessment team and find this requirement compliant. Based on the assessment team’s report and the provider’s response and additional information, I find the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. Regular audits and assessments are conducted to evaluate the performance of the service and this covers clinical outcomes, patient satisfaction and compliance with the Quality Standards. Whilst not always effective, actions are taken to address identified areas for improvement. There are regular reporting mechanisms to keep the governing body informed about key performance indicators.

Based on the evidence and reasons summarised above, I find requirement (3)(b) is compliant.

**Requirement (3)(c)**

The assessment team found the service did not have effective governance systems in relation to information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints. Staff do not have access to accurate and up to date information through care plans that often are not personalised. Not all staff could describe how and where to access information such as policies, procedures, and work instructions relevant to their roles. Whilst the service has a continuous improvement plan which draws information from surveys, incidents, feedback mechanism and clinical indicators, progress in addressing deficits cannot be easily monitored, such as with performance appraisals.

Workforce governance systems and processes are not effective as evidenced in low compliance rate with staff formal performance evaluation the service has not addressed for a prolonged period of time; inadequate staffing levels and ineffective processes to ensure staff have the necessary skills and competencies to meet the needs of consumers. The service is informed of changes to legislation through various bodies and subscriptions with governance team revising legislative change and informing the board, however, it did not result in effective implementation of processes to recognise where chemical restraint is used. Although the organisation has systems and processes to encourage feedback and complaints, these were not effective. Consumers and representatives expressed disengagement from processes, said they often felt unheard, and issues were not always resolved to their satisfaction.

In response to the assessment team’s report, the provider acknowledged some findings, however, states these have been addressed in other requirements and continuous improvement activities commenced prior to the site audit. The provider disagrees with most of the findings in relation to this requirement and states they have responded to them in Standards 2, 3, 6 and 7.

I find this requirement is non-compliant. In coming to my finding, I considered the assessment team’s report, the provider’s response and my findings and information in the assessment team’s report across all Quality Standards.

Whilst I find there are no system wide deficiencies in relation to information management, feedback and complaints and regulatory compliance, organisation wide workforce governance systems are not effective. These systems do not ensure the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. They do not identify and address in timely manner the workforce lack of competency, skills or knowledge. There are systematic issues with undertaking regular assessment, monitoring, and review of the performance of each member of the workforce.

As described in Standard 7, nearly 40% of all staff from various discipline said staff do not always have sufficient time to provide care and supervision and there are often delays in backfilling shifts with agency staff which leads to delays in care and impact its quality.

Fifty per cent of all consumers and representatives interviewed were not satisfied with the number and mix of staff to deliver safe and effective care and services and described not receiving assistance with personal hygiene and dressing in line with the consumer’s needs and preferences, not being taken outside, being left to sit on the toilet for an extended period causing back pain and being rushed by staff. There has been an increase in falls with some consumers sustaining major injuries when consumers were not supervised. Consumers developed pressure injuries which were not identified until they deteriorated.

Based on the evidence and reasons summarised above, I find requirement (3)(c) non-compliant.

**Requirement (3)(d)**

Although the service has systems and practices to manage risk, which incorporates daily review of high risk consumers, regular high risk clinical meetings and monthly monitoring of clinical indicators, these were not effective in ensuring risks were identified during assessment processes, upon identification of deterioration in consumers, upon changes to skin integrity, post fall and upon presentation of changed behaviours, including post incident. Although the organisation has a risk management framework, which includes a Risk and Governance committee, policies, alerts, and work instructions to mitigate and manage risks, management acknowledged deficits highlighted by the assessment team during the site audit and added items to the continuous improvement plan to review all high risk consumers.

In response to the assessment team’s report, the provider’s response refers to its response to Standards 2 3 in relation to assessment of risks and its management. While the provider acknowledged some occasions of incomplete charting, they consider that high impact or high prevalence risks are identified with strategies implemented to prevent incidents, minimise incident impact and prevent recurrence.

I find the provider’s framework of risk management systems and practices is not effective. In coming to my finding in relation to this requirement I have considered information and evidence across Standards 2, 3 and 7 which shows the service did not implement robust risk management strategies to prevent, detect and respond to incidents/high impact risks, such as falls and pressure injuries. This is evidenced by lack of individualised care plans and lack of timely and accurate assessment of risk, high incidents of falls and consumers sustaining recurring falls, late identification of pressure injuries, not effective or not timely quality improvement initiatives to address trends and recurring issues.

Based on the evidence and reasons summarised above, I find requirement (3)(d) non-compliant.

**Requirement (3)(e)**

The service has implemented clinical governance framework. However, the assessment team found not all systems and processes have been implemented and imbedded. Not all scheduled audits had been completed. Quality learnings from January 2024 and February 2024 show pressure injuries identified in late stages (stage 3 onward) are the most common form of neglect across the organisation and reported as SIRS.

Documentation shows eight clinical audits were undertaken in 2023, which identified opportunities for improvement in clinical care related to wounds, however, not all staff received training. Documentation shows an organisation pressure injury safety alert was issued in November 2023 to highlight ongoing monitoring. Management reported wound innovations are scheduled to attend the service on 14 March 2024 to provide wound training for clinical staff.

Clinical data identified an increase in falls and the organisation undertook a review of call bell response times to ascertain if staff availability during shift changeover was a contributing factor to falls, however, the analysis did not consider all contributing factors. Although mechanisms are in place to monitor use of restrictive practices, the psychotropic register shows three consumers have been prescribed psychotropic medications to manage agitation and behavioural symptoms of dementia which has not been identified as restrictive practice.

The provider responded by stating clinical governance has supported the service to identify deficiencies and implement improvements. The service had self-identified deficits in completion of mandatory training and skills assessments and commenced action plan prior to the site audit. The service’s clinical governance is supported through the Knowledge Hub which includes work instructions guiding staff on Bupa’s ways of working, including for clinical care. To ensure adherence to work instructions, leadership teams have workplans that include daily, weekly, monthly and quarterly tasks that are required to monitor clinical care and its compliance to work instructions. Additionally, a registered nurse workplan is in place to support monitoring and follow up of clinical care on every shift. In addition to the workplans, the service has a local audit program that supports the Quality Education Manager to complete audits of clinical care to inform continuous improvement initiatives.

I acknowledge the provider’s response and additional information provided in relation to how clinical governance framework ensures the provision of safe and quality care through a range of processes.

In coming to my finding in relation to this requirement, I have considered information about minimisation of restrictive practices included in the assessment team’s report under requirement 3(3)(b). The evidence in the assessment team’s report and the provider’s response show there are systemic issues in how the service identified and minimise restrictive practices, specifically chemical restraint. The service did not identify for three consumers’ psychotropic medications to manage agitation and behavioural symptoms of dementia where chemical restraint and, as such, did not manage these medication in line with relevant legislation to minimise harm from its use.

The provider acknowledges the finding in relation to chemical restraint and states they have reviewed behaviour support plans for three consumers, obtained consent and engaged nurse practitioner to complete a review of all consumers on the psychotropic register to ensure accurate identification of chemical restraint. The provider states in order to strengthen their processes and ensure that this does not occur in the future it was added as an agenda item on Clinical Review meeting, and medication management audit will be completed quarterly to ensure effectiveness of the above actions.

Whilst I acknowledge the provider’s interventions, I consider they will require time to be imbedded and their effectiveness is yet to be evaluated. The organisation’s own monitoring systems did not identify deficits in staff identifying chemical restraint to enable its safe use and as a last resort.

Based on the evidence and reasons summarised above, I find requirement (3)(e) is non-compliant.

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