

**Performance Report**

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| Name: | Carinya of Bristol |
| Commission ID: | 7449 |
| Address: | 41 Bristol Avenue, BICTON, Western Australia, 6157 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 28 January 2025 to 29 January 2025 |
| Performance report date: | 12 March 2025 |
| Service included in this assessment: | Provider: 1120 Pu-Fam Pty Ltd  Service: 19374 Carinya of Bristol |

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 Carinya of Bristol (**the service**) has been prepared by R Beaman, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies any areas in which improvements must be made to ensure the Quality Standards are complied with.

# Material relied on

The following information has been considered in preparing the performance report:

* the Assessment Team’s report for the assessment contact (performance assessment) – site, which was informed by a site assessment, observations at the service, review of documents and interviews with staff, older people/representatives and others; and
* the provider’s response to the Assessment Team’s report received 21 February 2025.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |
| **Standard 3** Personal care and clinical care | **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 2 requirement (3)(e)**

The provider ensures:

* care plans are reviewed for effectiveness and updated, including in response to incidents and changes in consumers’ condition.

**Standard 3 requirement (3)(b)**

The provider ensures:

* high impact or high prevalence risks associated with consumers’ care are identified, managed, planned for, and monitored, including risks relating to falls, diabetes, and unplanned weight loss.

**Standard 7 requirement (3)(a)**

The provider ensures:

* the number and mix of staff enables the delivery and management of safe and quality care and services. Staff training, monitoring and oversight processes will be introduced to ensure sufficiency of staff numbers, knowledge, and skills to meet consumer needs.

**Standard 8 requirements (3)(b), and (3)(d)**

The provider ensures:

* there are systems and processes in place for the governing body to have oversight, is aware of deficiencies identified in the performance of the service and are accountable for the delivery of care and services; and
* the organisation’s risk management systems and practices, including in relation to managing high impact or high prevalence risks, responding to abuse and neglect, and managing and preventing incidents are reviewed to ensure effectiveness.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| 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

The Assessment Team assessed requirement 2(3)(e) and recommended it not met. The Assessment Team provided the following information and evidence captured through interviews, documentation and observations.

One named consumer has had multiple incidents between October 2024 and 10 January 2025, including falls and weight loss. While the consumer sustained a fall resulting in a fracture requiring surgical intervention in January 2025, staff did not review pain consistently or refer to the medical officer for review post fall. Assessments, including falls risk, skin integrity and pain were not reviewed following incidents or post hospitalisation. The consumer has had an almost 13kg weight loss since July 2024 and the service has not reviewed nutritional care consistently despite ongoing weight loss with the last nutritional assessment in September 2023. Information in relation to dietary needs recommended post speech pathology review have not been included in the consumer’s care plan and they do not receive their meals of choice.

In relation to wound management, one consumer with multiple skin integrity incidents, including a stage 2 pressure injury between November 2024 and December 2024 did not have skin assessments undertaken between 13 September 2024 and 30 December 2024. Additionally, the skin assessment completed on 31 December 2024 did not include a reassessment of risk of pressure injuries and did not review strategies in place for effectiveness or identify additional strategies to mitigate the consumer’s risks.

One consumer identified with multiple incidents had a falls risk assessment completed following the incidents, but for a fall which occurred on the 31 December 2024, information was identical to previous assessments. Following the fall on 31 December 2024, the consumer was not able to mobilise, and the assessment states they require 2 staff assist to mobilise and to wear proper footwear. Information in the physiotherapy assessment on 27 January 2025 after the previous falls contained the same information as the previous assessment on 16 August 2024. The consumer’s decline has required them to be cared for in bed and in a chair, but there has been no assessment for their risk of pressure injury since October 2024. The consumer has recorded 5 skin integrity incidents since 29 October 2024 with a skin assessment completed on 27 January 2025, which included the same information as the previous assessment completed on 31 May 2024.

In relation to behaviour management, 2 consumers are identified as not having personalised behaviour support plans in place and are prescribed and administered psychotropic medications to manage their behaviour. For one consumer, recommended interventions to assist with managing the consumer’s adverse behaviours were not included in their behaviour support plan to provide staff guidance. For the other consumer, their behaviour support plan did not include individualised interventions, and recommended reviews to specialised dementia services for assessment and review were not actioned.

The provider acknowledged the deficits identified in the Assessment Team’s report and included additional commentary in their response of actions they will take. Those actions they will take or have taken in relation to the named consumers in the Assessment Team’s report include, but are not limited to, undertaking reassessments of falls risk, pressure injury risks, skin integrity, pain, wound care, mobility, nutrition and hydration with timeframes for completion between 31 January 2025 and end of February 2025. I acknowledge the actions the provider has described in their response; however, I find the service does not have an effective system or process in place to regularly review care and services regularly, including when changes in condition or incidents occur. While the provider has acknowledged these deficits and included the actions taken and planned, I have considered this information but have no evidence before me of those actions, including updated consumer assessments, care plans or incident investigations. As such, I place weight on the information in relation to the deficits in care and service delivery for assessment and planning.

Based on the information above, I find requirement 2(3)(e) non-compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |

Findings

The Assessment Team assessed requirement 3(3)(b) and recommended it not met. The Assessment Team provided the following information and evidence captured through interviews, documentation and observations.

Time sensitive medications are not administered within required timeframes and processes in place for clinical oversight of medication administration do not identify late or missed medications. One consumer who is administered time sensitive medications for a significant condition that impacts their mobility had 3 occasions over a 7-day period prior to the assessment contact visit where medications were between 30 minutes and just over one hour late.

In relation to restrictive practices, the service is not recognising administration of psychotropic medications, including antipsychotic medications to manage consumer behaviour as chemical restraint. For one consumer who was prescribed antipsychotic medication as a trial by the medical officer after concerns were raised by the service’s management in December 2024, there is no evaluation of the medication post administration, or that it was initiated as last resort. Monitoring of the consumer’s behaviour was not consistent and contained 2 entries only, one in November 2024 and one in December 2024 and recorded wandering, verbal and physical aggression. Management advised bruising to another consumer was caused by the consumer but there were no incidents completed with this information. For another consumer, assessment and planning did not show chemical restraint is used as a last resort and the service was unable to provide any further information to show how they support the consumers behaviour management.

The service did not manage the risk of pressure injuries effectively and one named consumer, who was immobile, developed a pressure injury which was not identified by staff until November 2024 when it was stage 2. Staff did not deliver wound care in line with the wound management directives of daily dressing and did not attend the wound on multiple days during January 2025 and the wound has deteriorated further. The wound management plan was not reviewed after the wound had deteriorated to identify alternative strategies.

One named consumer who has had multiple incidents since October 2024, including falls, choking, a skin tear and weight loss has not had their high impact risks managed effectively. The consumer has experienced a 12kg weight loss over a 6-month period between July 2024 and January 2025. There is an ongoing food and fluid chart recorded by staff which is not consistently completed or evaluated to identify strategies to improve nutrition for the consumer. Recommendations by the speech pathologist post review mid 2024 was not followed and the consumer experienced a choking episode in October 2024, following which the service downgraded the diet to mince and moist. The consumer’s choice was to have sandwiches, and the risks discussed with speech pathologist in October 2024, however, the service did not put those measures in place. The consumer experienced 2 unwitnessed falls on 10 January 2025 and documentation shows a head to toe assessment was conducted initial vital signs completed, however, staff did not undertake neurological observations consistently in line with organisational policy. Pain and neurological observations were not monitored, the consumer was transferred to hospital 2 days later and was identified with fracture requiring surgical repair. Pain was not monitored effectively following the consumer being transferred back to the service and the consumer was not able to be safely transferred due to the service not having the appropriate mobility equipment and they were cared for in bed.

The provider acknowledged the deficits identified in the Assessment Team’s report and included additional commentary in their response of actions they will take in relation to the named consumers in the Assessment Team’s report. Those actions include, but are not limited to, undertaking reassessments of falls risk, pressure injury risks, skin integrity, pain, wound care, mobility, nutrition and hydration and conducting root cause analysis for all previous incidents identified. The provider has also included additional commentary indicating they will be implementing a pain monitoring schedule, weekly clinical case reviews, formal review of all chemical restraints for one consumer, and staff education in relation to areas where deficits have been identified. The provider’s response includes actions with most timeframes having a completion date of 31 January 2025 and various dates through February 2025.

I acknowledge the actions planned and implemented by the provider in relation to the deficits identified. However, the service did not demonstrate it effectively manages the high impact or high prevalence risks associated with consumer care. In coming to my finding, I have considered the deficits identified in relation to consumers and the negative outcomes they have had to care and services, including in relation to falls, wounds, medication, behaviour and pain management. I acknowledge the actions included in the provider’s response in relation to the named consumers. However, there is no evidence provided of the actions having been completed or implemented, including assessments, care plan reviews or incident investigation for specific consumers. I also do not have before me evidence of how the service will improve performance in relation to this requirement for the general consumer cohort. I find the actions the service has proposed and implemented will need time to be embedded in practice and evaluated for effectiveness to improve consumer outcomes.

Based on the information above, I find requirement 3(3)(b) non-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 |

Findings

The Assessment Team assessed requirement 7(3)(a) and recommended it not met. The Assessment Team provided the following information and evidence captured through interviews, documentation and observations.

The service is not meeting care minutes and has not implemented strategies to improve, and management was not aware of the deficits. Most consumers were satisfied with the staffing levels, however, one representative for a consumer who had sustained a fracture requiring repositioning every 2 hours, described a recent example of staff not attending the consumer for over 3 hours, and they frequently find the consumer has not had their continence aid changed and their bed is soaked when they visit. One consumer recalled how they have extended wait times for staff assistance when requested and described how their time sensitive medication is often administered late. Documentation showed for this consumer call bell responses are frequently extended time periods. Documentation showed for 3 sampled consumers, call bell records note multiple incidents of wait times in excess of 10 minutes and up to almost 50 minutes.

Documentation confirmed the service has a high agency workforce usage, with almost 40% of all shifts between 23 December 2024 and the assessment contact visit filled by agency staff. Management were unable to provide the processes in place to monitor the performance of agency staff, including registered staff. Agency staff interviewed could not describe training in areas, including falls, pressure injuries, wound and skin integrity.

The provider acknowledged the deficits identified in the Assessment Team’s report and included additional commentary in their response of actions they will take. Those actions included undertaking a training needs analysis across all care staff to identify areas requiring development. The provider asserts from the analysis a training schedule will be implemented to address the identified deficiencies. I acknowledge the provider’s response; however, I find the service did not demonstrate its workforce is planned to enable to delivery and management of safe, effective, and quality care and services. In coming to my finding, I have considered the information in the Assessment Team’s report in Standards 2 and 3 that show multiple deficiencies in staff practice with negative impacts in the care delivered to multiple consumers. I have also considered the provider has not indicated in their response how they plan to address the deficits identified with the mix of staff. I do acknowledge the actions the provider has planned in relation to the training of the workforce to improve skills and knowledge, however, find this will need further time to be embedded and for those actioned to be evaluated for effectiveness.

Based on the information above, I find requirement 7(3)(a) non-compliant.

# Standard 8

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

**Findings**

The Assessment Team assessed requirements 8(3)(b) and 8(3)(d) and recommended both not met. The Assessment Team provided the following information and evidence captured through interview, documentation and observations.

**Requirement 8(3)(b)** the organisation has not ensures legislative requirements are met, including complying with care minutes and restrictive practices and were not aware of those deficiencies. The governing body has not ensured the policies and procedures are sufficient to guide staff practice in the delivery of care and services, including the delivery of reliable physiotherapy services.

**Requirement 8(3)(d)** the service’s incident management system did not identify deficits in relation to the identification, management and investigation of incidents. One incident involving significant bruising to one consumer by another consumer was not adequately investigated or a root cause analysis completed to determine potential causes or consider possible abuse and prevent recurrence. Incident documentation confirmed incidents that may require reporting under the serious incident response scheme (SIRS) are not being considered or actioned in that way, including the consumer who had a fracture from an unwitnessed fall and delay in being transferred to hospital.

Data in relation to clinical incidents are collected by the service and management described the process in place to monitor and review those, including through clinical care meetings, quality meetings, care plan reviews, but those processes do not identify deficits in staff practice that contributed to the incident or strategies to manage those to prevent recurrence.

Risk assessments are not completed consistently to manage consumer risks, including restrictive practices, smoking, falls, and weight loss.

The provider acknowledged the deficits identified in the Assessment Team’s report and included additional commentary in their response of actions they will take. Those actions included but not limited to, implementing a centralised clinical care data analysis system by end of February 2025 to monitor and evaluate care delivery, implementation of a care evaluation schedule and having ongoing reviews of the psychotropic register. I acknowledge the actions the provider is planning to put in place; however, I find the service did not demonstrate the governing body is accountable for the delivery of safe care and service and the service does not have an effective risk management framework. I acknowledge the improvements that are planned and encourage the provider to continue to embed, monitor and evaluate those, however, I have no information or evidence before me that shows how improvements to the accountability of care and service delivery or the systemic deficits identified in the risk management process will be embedded to improve performance.

For the reasons above, I find requirements 8(3)(b) and 8(3)(d) non-compliant.

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