Performance

Report

**1800 951 822**

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| Name of service: | Regis Bunbury |
| Service address: | 926 Woodrow Street BUNBURY WA 6230 |
| Commission ID: | 7247 |
| Approved provider: | Regis Aged Care Pty Ltd |
| Activity type: | Site Audit |
| Activity date: | 9 May 2023 to 12 May 2023 |
| Performance report date: | 21 June 2023 |

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

**This Performance Report**

This Performance Report for Regis Bunbury (**the service**) has been prepared by Melissa Buhagiar, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

**Material relied on**

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

* the Assessment Team’s Report for the Site Audit; the Site Audit report was informed by a site assessment conducted 9 May 2023 to 12 May 2023, 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 14 June 2023
* the following information given to the Commission, or to the Assessment Team for the Site Audit of the service: Performance Report dated 28 February 2022 following Assessment Contact conducted 5 January 2022
* the following information received from the Secretary of the Department of Health and Aged Care (**the Secretary**): Exceptional Circumstances Determinations dated: 26 May 2023 and 28 November 2022

**Assessment summary**

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

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

**Areas for improvement**

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

**Requirement 1(3)(a)** The approved provider must demonstrate that staff interact with consumers in a respectful manner and provide timely care for consumers to maintain their dignity.

**Requirement 2(3)(a)** The approved provider must demonstrate that assessment and planning, identifies and documents evidence of discussion with consumer and representative of risks to the consumer’s health and well-being to informs the delivery of safe and effective care and services.

**Requirement 2(3)(e)** The approved provider must demonstrate that changes to the condition of consumers are documented, and incidents are investigated to reflect the consumer’s condition and to mitigate the risk of incidents reoccurring. That staff education can be demonstrated in a practical manner.

**Requirement 3(3)(a)** The approved provider must demonstrate that all consumers receive safe and effective personal and clinical care that is individually tailored to their needs including the provision of pain monitoring and appropriate pain management for consumers.

**Requirement 3(3)(b)** The approved provider must demonstrate that there is effective oversight for high impact and high prevalence risks and that these are managed effectively with staff following up on risks to consumers and following medical and specialist instructions.

**Requirement 3(3)(e)** The approved provider must demonstrate that there is effective handover and that computer records are accurately documented and updated and that the electronic information system is accessible to all staff, and with others where responsibility for care is shared.

**Requirement 4(3)(f)** The approved provider must demonstrate that feedback is taken into consideration in relation to meal quantity and quality and feedback initiates continuous improvement and consumer satisfaction with meals.

**Requirement 5(3)(b)** The approved provider must demonstrate that consideration is given to the cleanliness of consumer’s rooms and environment. The provider must demonstrate that consumers are provided access to the outdoor areas to move freely.

**Requirement 6(3)(c)** The approved provider must demonstrate that all complaints and feedback is recorded, and that appropriate action is taken and discussed with complainants with the use of open disclosure.

**Requirement 6(3)(d)** The approved provider must demonstrate that all complaints and feedback are reviewed and used to improve the quality of care and services and the complaints and feedback are entered into the Plan for Continuous Improvement and evaluated.

**Requirement 7(3)(a)** The approved provider must demonstrate there are sufficient staff to provide timely, safe and effective care to consumers.

**Requirement 7(3)(b)** The approved provider must demonstrate that staff interactions with consumers and representatives are always kind, caring and respectful.

**Requirement 7(3)(c)** The approved provider must demonstrate that all staff have the practical knowledge and competence to perform their roles.

**Requirement 8(3)(c)** The approved provider must demonstrate that information in relation to consumers is available to other staff and that all staff including agency staff know how to use the electronic care system. That complaints and feedback are documented and actioned and the actions from these are communicated and are evaluated to reflect the effective organisation wide governance systems relating to information management, continuous improvement, and feedback and complaints.

**Requirement 8(3)(d)** The approved provider must demonstrate that there is effective risk management systems and practices, to manage the high impact or high prevalence risks associated with the care of consumers; in relation to bowel management, weight management, falls management, behaviours, medication, nutrition, continence and deterioration and those incidents are recorded in incident management system with investigation conducted to review strategies to reduce the incident reoccurring.

**Requirement 8(3)(e)** The approved provider must demonstrate that restraint continues to be reviewed and minimised and that open disclosure training is provided to staff and demonstrated to consumers and representatives when things go wrong.

**Standard 1**

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

**Findings**

The Quality Standard has been assessed as Non-compliant as one of the six specific requirements have been found to be Non-compliant.

The Assessment Team interviewed consumers and staff and found that the service demonstrates that the care and services for consumers are culturally safe. Consumers provided feedback of the importance of their culture and special days, and it was identified that the service involved consumers to commemorate these days. It was also identified that gender specific care was recognised and provided to consumers.

Most consumers and representatives interviewed said consumers are supported to exercise choice and independence and to make decisions about their own care and how it is delivered. Consumers provided feedback that they have a say in the planning and delivery of their care and staff have spoken to consumers several times and they can tell them what they want. Representatives provided feedback that they are offered a choice of meals, and some spoke of how activity calendars are provided in their rooms. Overall, it was demonstrated that consumers are supported to exercise choice and independence.

The Assessment Team found that the service is guided by a dignity of risk policy. Information gathered from interviews, documentation and observations confirms consumers are supported to take risks to enable them to live the best life they can. The service’s emergency bed register/handover form contains risk alert information in relation to consumers who have risk assessments conducted to support them to take risks to enable them to live the best life they can. Not all risks in relation to dietary preferences information are on the service’s emergency bed register/handover form, however the Clinical Care Manager was able to show a summary of this on a separate document. Documentation review of the risk assessment forms shows the risks and controls have been communicated to consumers and representatives.

Staff interviewed indicated they help consumers to take risks and maintain independence by giving them longer time to do things. Also, if the consumer wants to get up on their own without being touched, they ask the consumer if they need help or observe closely.

The Assessment Team interviewed consumers and representatives who provided feedback that the information they receive is communicated in a way that is easy to understand and enables them to make choices. Staff interviewed were able to describe the different ways they communicate information to consumers to help them make choices. One representative advised the team that the service always keep them informed of the consumer’s condition.

Staff interviewed were able to describe how they communicate with consumers who may have difficulty in communicating. They do this by writing things down to show them, using hand gestures and providing reassurance. Also, holding plates and drinks for consumers to see so the consumers can point to what they would like to eat or drink and for consumers who have vision impairments they will explain what meal the consumer is having.

The lifestyle coordinator indicated they will print out a large format activities schedule for consumers who have visual impairments, go and see the consumers to verbally invite them and make announcements over the public announcement system.

Consumers and representatives said consumer privacy is respected and felt that consumer personal information was kept confidential. Staff described how they were able to respect consumers’ privacy and maintain confidentiality. Observations demonstrated how staff respected consumers’ privacy when providing care. Representatives provided examples such as staff knocking on doors before entering and staff respecting their privacy when they want to be left alone.

The Assessment Team observed several consumer doors had signs on them when care was being provided and staff were knocking on consumers’ room doors before entering. Also, nurses’ stations with consumers’ personal information were locked, computers password protected and there was a secure document bin for the disposal of confidential information.

The following requirement 1(3)(a) was found to be Non-compliant.

The Assessment Team interviewed consumers and representatives with some providing positive feedback about being treated with dignity and respect and care staff interviewed were able to describe how they practice this. However, some information gathered from consumer, representatives and staff interviews and documentation reviewed shows some consumers are not treated with respect and do not receive dignified care. One consumer provided feedback that some staff are grumpy and when discussing favourite meals, the consumer said that staff do not take notice and gives up. One representative provided feedback that staff do not talk to the consumer when providing care and are often heard speaking to other staff about not being happy with their jobs. The representative said this happens all the time and wants the consumer to be recognised as a person. Another representative said that staff do not respect the consumer’s decision making about what clothes the consumer would like to wear and feel staff do not see this as important and do not see this as supporting a level of independence for the consumer. A consumer representative told the Assessment Team their relative feels like they are not always listened to by the staff.

Representatives also provided feedback that the care of consumers is not dignified or respectful with consumers using the call bell to attend the bathroom, however staff not attending in a timely manner.

The Assessment Team observed the lunch service on the first day of the Site Audit commenced and three consumers requiring assistance with meals were being assisted by one staff member. One consumer started using their hands to eat, however the staff member assisting with meals told the consumer to use the spoon to eat and the consumer then used their hands to put the food on the spoon before trying to eat it on their own. Another staff member approached the table and offered to assist with meals, however the staff member said they need to encourage consumers to eat by themselves.

Then approved provider responded to the Assessment Team’s report and refuted the findings. The provider advised that when instances had been raised about staff not being respectful this had been addressed by management, putting a stop to this behaviour. The provider advised where there had been adverse outcomes for consumers, they had apologised to the consumer concerned. The provider is also monitoring meal services to gain feedback from consumer and to ensure processes are followed, with staff reminded to arrive on time to assist consumers with meals as required to maintain their dignity.

I acknowledge the response and the actions that the provider has implemented, however, I am not satisfied that the actions will have an immediate and sustaining effect and feel that it may take some time to reflect that these actions are sustainable.

I therefore find that the approved provider is Non-compliant with requirement 1(3)(a).

**Standard 2**

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

**Findings**

The Quality Standard has been assessed as Non-compliant as two of the five specific requirements have been found to be Non-compliant.

The Assessment Team reviewed assessment and care planning which shows the consumers’ care plans are reflective of their current needs, goals and preferences, including advance care planning and end of life planning. Staff could describe what is important to the consumer in terms of how their care is delivered. Management advised end of life care planning discussions are offered with consumers and representatives on entry to the service when the consumer’s condition changes and at care plan reviews.

Consumers and representatives provided feedback that discussions on advance care planning occurred when they moved into the service and are happy with the arrangements. All representatives interviewed said they have had discussions with the service about advance care planning for their relative.

Care staff interviewed were able to explain the care needs and preferences of all consumer’s the Assessment Team asked them about.

The Assessment Team found the service demonstrated that assessment and planning is based on ongoing partnership with the consumer or others that the consumer wishes to involve in their care and services and includes other organisations, individuals or providers when required. This was confirmed through interviews and documentation review which identified consumer representatives and service providers such as the physiotherapist, speech pathologist or dietician are involved in consumer care. These individuals or providers then provide input to the consumer’s care plan, write progress notes or update relevant consumer assessments as required. A review of clinical assessments and care plans demonstrates the involvement of physiotherapists, dieticians and speech pathologists.

The consumers’ care and service records show the outcomes of consumer assessment and planning are being communicated to the consumers and representatives and staff interviews confirmed this. Observations made, and staff interviews show that consumer care plans are accessible to staff and there are processes to ensure the care plan is made available to the consumer or their representative.

The following requirements 2(3)(a) and 2(3)(e) were found to be Non-compliant.

The Assessment Team reviewed assessments and care plans and found that some include information about some risks associated with their care and related management strategies for staff to follow. However, for other consumers a risk management approach was not considered, for example, a consumer who is receiving anticoagulant medication, the care plan does not provide guidance to staff on what signs or symptoms to be aware of in the case of an adverse event as a result of taking the medication. It was also identified for a consumer on fluid restriction, that the consumer chooses not to follow directions from a medical officer and maintain fluid restrictions. However, the care and services plan does not identify the risk to the consumer from not adhering to the fluid restriction and these risks have not been discussed with the consumer or the representative. A risk assessment has not been completed. It was not demonstrated for some consumers that their assessments and care plans inform the delivery of safe and effective care.

The Assessment Team also identified for some consumers that a documented bowel management plan is not in place and consideration had not been given to the risk of constipation or escalation to a medical officer in a timely manner when interventions have not proven successful.

The Assessment Team identified care and services plans are not always updated or reviewed when there is a change in a consumer’s condition or when incidents impact on the needs of the consumer. Incident forms were not always completed or only partially completed when consumers are involved in an incident. The Assessment Team noted for one consumer who required medication to be crushed, the care plan was not updated to reflect how staff should administer the medication. For consumers who had experienced falls a comprehensive review of the incidents did not occur and no preventative strategies were identified to be implemented to prevent further similar incidents from occurring or to minimise harm to the consumer.

Behavioural incidents were not recorded in behaviour monitoring charts for some consumers to allow for an accurate review of care and services.

The approved provider responded to the Assessment Team’s report and advised that they have taken appropriate action to remediate the risks identified and that a strong Plan for Continuous Improvement has been initiated to address these issues actions sustainably. Actions include undertaking 100% file review for the consumers named in the Site Audit report, to ensure a risk management approach is considered, conducting clinical care reviews and commencing staff education and training in incident management, behaviour management, choking, bowel management and open disclosure to ensure that outcomes of incident investigations are discussed with representatives or decision makers.

I acknowledge the providers response, however, understand that it will take some time to reflect that the education and incident investigations are practically conducted and address strategies to prevent the risks from reoccurring.

I find that the approved provider is Non-compliant with requirements 2(3)(a) and 2(3)(e).

**Standard 3**

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

**Findings**

The Quality Standard has been assessed as Non-compliant as three of the seven specific requirements have been found to be Non-compliant.

The Assessment Team reviewed documentation for the consumers sampled who were receiving end-of-life care or who have recently passed away showed the consumers’ goals and preferences have been identified and their wishes and directives have been incorporated into their care and services plan. Consultation occurs with consumers and representatives when a consumer commences a palliative pathway and/or is receiving end of life care. Feedback from consumers representatives was positive in relation to the care their relative received during end-of-life care.

All staff interviewed were able to describe how they maintain the comfort and dignity of consumers when they are nearing the end of their life, including providing pressure area care, pain relief and oral hygiene.

The Assessment Team found that it was demonstrated in the main, that consumers who have experienced a deterioration or change in their cognition and/or mental health have their needs recognised and responded to in a timely manner.

The Assessment Team found for one consumer experiencing deterioration, staff recognised the consumer was becoming confused and referred the consumer to the medical officer, who promptly informed the service to transfer the consumer to hospital. Another consumer was having difficult chewing due to a decline in the consumer’s physical condition and weight loss, a referral was made to a speech pathologist who changed the consumer’s diet.

The Assessment Team found that review of the care and service records for most consumers sampled shows appropriate and timely referrals and escalation to relevant health professionals is occurring.

The service has organisational policy and procedure regarding infection prevention and appropriate antibiotic use. The service has two onsite IPC leads. However, during the Site Audit both were on leave and the regional clinical manager was assuming the responsibilities of IPC lead in the interim. During the Site Audit, it was observed that overall, there is effective management of standard and transmission-based precautions to prevent and control infections. Staff interviewed were able to describe how they prevent and control infection in the service and demonstrated understanding of how they minimise the need for or use of antibiotics and ensure they are used appropriately.

The following requirements 3(3)(a), 3(3)(b) and 3(3)(e) were found to be Non-compliant.

An Assessment Contact had been conducted on 5 January 2022 and requirement 3(3)(a) had been found to be Non-compliant due to bowel management not being effectively monitored or acted upon in a timely manner for three consumers. Weight management was not being undertaken in line with the organisation’s policy and processes at the time of Assessment. The provider responded with a number of actions in the Plan for Continuous Improvement in relation to these findings.

The Assessment Team has identified at this Site Audit that consumers are not receiving best practice care that is being tailored to their needs and optimises their health and well-being. This is in the areas of pain management and weight management for some consumers sampled.

Consumers provided feedback that they are not always provided effective pain relief, with medicated creams not being provided or applied to affected areas. One representative provided feedback that their consumer often complains that staff do not pay enough attention when they are providing personal care which causes additional pain to the consumer’s existing condition.

A review of documentation identified for one consumer who sustained a fracture, that pain monitoring following return from hospital had not occurred in line with the service’s clinical policy. The pain chart was inconsistently completed and would not enable staff to adequately monitor if the consumer was experiencing any pain.

The service has processes to manage high impact and high prevalence risks associated with the care of consumers. Care planning documentation for some consumers sampled shows effective management of some high impact and high prevalence risks with evidence of effective wound management and referrals for behaviour support to Dementia Services Australia.

However, there are significant gaps in relation to effective management of risk of constipation for some consumers. The Assessment Team identified that bowel charts and progress notes state there are numerous occasions when consumers have gone for several days without opening their bowels. There is some information on some occasions, although a minority, about staff follow-up. The bowel chart does not show any interventions undertaken by the staff in relation to one consumer who had not had a bowel movement for six days, despite appearing unsettled and having a tender abdomen. Constipation as a factor potentially contributing to the consumer’s discomfort and pain was not ruled out in a timely manner.

The service did not demonstrate that the risk of nutritional deficiency was effectively managed for one consumer, following a significant weight loss. A dietician referral was not completed after weight loss was identified in March 2023, despite further weight loss and was not reviewed until late April 2023. The progress directs staff to complete weekly weights. A review of the weight chart shows that this had not occurred, and the consumer was only weighed once, whereas the consumer was due to be weighed three times.

While some high impact high prevalence risks are being managed effectively for some consumers, other risks are not being managed for others. The latter includes significant gaps in relation to the effective management of risk of constipation.

Some consumers and representatives thought information about the condition and needs of consumers was well communicated between staff at the service, however some did not.

The representatives of a consumer said the system has failed in communicating the needs of their relative. For example, there were issues with the transfer of information from the paper to electronic system and staff did not know the medication needs of their relative and were unfamiliar with the electronic system and how to find this information. The representatives spoke of an impact on their relative due to the ineffective communication.

Consumer representatives spoke about agency staff not knowing the needs of the consumers and consumers and representatives spoke about having to explain what needed to happen and to repeat themselves. One consumer representative said the agency staff do not read their relative’s notes and there is limited handover. Even if information is included in the first handover, it is lost by the time of the next handover.

The Assessment Team identified that there is information in the minutes of the clinical governance and care sub-committee meeting of the board from January 2023 about inconsistencies in clinical handover across all services. There is no information in staff meeting minutes for 2023, in the service’s Plan for Continuous Improvement or in the service’s updated self-assessment report of performance against the Quality Standards about this and related improvement activity. Some consumer assessments and care plans do not include current or comprehensive information about the condition, needs and preferences to enable effective communication.

The approved provider responded to the Assessment Team’s report with their Plan for Continuous Improvement advising that education for staff on bowel management will be conducted which will include assessment, usual patterns, contributing factors including possible associated behaviours and pain, documentation and charting, interventions, medication and escalation to GP. The provider also advised that the service would undertake 100% of review of bowel management for named consumer with ongoing daily monitoring. The provider has followed up with consumers who were experiencing pain to ensure that pain management is effective. The provider acknowledged that the referral to the dietician was delayed, however after the appointment, it was noted by the service there were minimal changes to what the service was doing to maintain weight. The provider has also advised that the agency staff have access to the electronic care system and will continue to confirm with staff the expectation for agency staff to use the available login to document care that they have provided.

I have considered the response from the provider; however, the provider has not satisfied me that they have demonstrated effective management of pain, weight management, bowel management, high impact and high prevalence risks or that information is shared effectively between staff or those that have a responsibility to know. It is also noted that bowel and weight management were not effective in January 2022, despite the Plan for Continuous Improvement, which may demonstrate that the improvements were not effective or sustained.

I find that the approved provider is Non-compliant with requirements 3(3)(a), 3(3)(b) and 3(3)(e).

**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. | Non-compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

**Findings**

The Quality Standard has been assessed as Non-compliant as one of the seven specific requirements have been found to be Non-compliant.

The Assessment Team interviewed consumers and representatives who mostly provided feedback that they get safe and effective services to support the consumer’s daily living needs, including having enough activities. Staff interviewed were knowledgeable about consumers’ daily needs and lifestyle preferences, with lifestyle attendance records detailing consumer participation and engagement, however some lifestyle preferences documented in care plans were observed to be brief or blank. Some representatives provided positive feedback in relation to the activities. They said they have the choice of their own activities of interest in their rooms if they do not feel like joining the group activities.

However, some consumers said sometimes the activities schedule is different to what is offered. One consumer said there is no one to do activities on the weekend. The lifestyle coordinator said on weekends there is only one lifestyle staff member covering both the regular areas and Memory Support Unit, however commencing 15 May 2023 they will have 2 lifestyle staff for weekends so the regular areas and Memory Support Unit will each have dedicated lifestyle staff. One consumer said there have been no bus trips because there is no driver to take them out and the service was unable to get staff. The lifestyle coordinator indicated staff members, including herself have been trained to drive the bus to allow for the bus trips to start again.

While some consumers provided negative feedback in relation to the activities, overall, the service demonstrates that consumers get safe and effective services and support for daily living meeting consumer needs and preferences in supporting their independence and quality of life.

Consumers interviewed provided positive feedback that their religious and spiritual needs are supported. Staff interviewed were able to describe how they provide emotional support to consumers. Documentation review of activity charts and attendance records reflects consumer engagement to meet their needs.

Care and lifestyle staff interviewed indicated if they notice a consumer is feeling down or not joining activities, they will sit down with them and try to give emotional support by asking what is bothering them and if they cannot help, they will tell the registered nurses.

Consumers provided feedback on the services and supports to assist them with daily living, maintain social relationships and do things of interest to them, and staff were able to describe how they support the consumers. The Assessment Team observed during the Site Audit consumers participating in exercise activities, painting, a sing-along session with the local preschool children and returning from a Mother’s Day high tea at a local café where consumers families were also invited to attend.

Consumers and representatives interviewed did not raise any concerns in relation to information sharing to support their daily living needs. Staff described how information about consumers’ condition, needs and preferences is communicated with the organisation with documentation reflecting this.

The lifestyle coordinator explained how based on inputs from the physiotherapist they split the one walking group into 2 separate walking groups as the consumers functional abilities are diverse and having 2 smaller groups would be easier to manage. The lifestyle coordinator showed the Assessment Team documents used for activity planning including a lifestyle invitation list and spiritual invitation list, that includes details of consumers interests and activity preferences, so staff know who to invite with copies available in the nurses’ stations.

Staff interviewed were able to describe the process of referring consumers to other organisations and providers of care. Recommendations where applicable have been recorded in consumer care records in a timely manner. The lifestyle coordinator and regional lifestyle and housekeeping specialist explained that the organisation has an internal emotional support program providing emotional confidential support by social workers. The lifestyle coordinator spoke of how she works together with the registered nurses to identify and refer consumers to this support program.

Interviews with care staff and observations of equipment demonstrate that equipment provided for daily services and lifestyle requirements is safe, suitable, clean and well maintained. Consumers interviewed did not raise any concerns in relation to the equipment provided when prompted by the Assessment Team. The Assessment Team observed walking aids were clean and in good working order. Lifestyle equipment, books, musical records and colouring in materials were observed to be clean.

The following requirement 4(3)(f) was found to be Non-compliant.

The Assessment Team interviewed consumers and representatives with some consumer providing positive feedback about the meals and some other information gathered supports that there are varied meals of suitable quality and quantity. Three consumers provided feedback that the meals are good, they are happy with the meals, meals are nutritious, there is more than enough to eat and so far, they have not had any meals that they did not like, and they know they can ask staff for sandwiches.

However, overall consumers and representatives interviewed said they were not satisfied with the meals. This related to the food not being hot, not receiving meals according to their dietary needs and meals being served not corresponding with the menu or what had been agreed.

Consumer and representative provided feedback including the food and meal service are terrible in every respect. The consumer advised that they have complained about this in the past. One consumer said the food is good when it is not cold.

One consumer who provided feedback at the resident meeting in relation to soup being cold said it was fixed to a degree, however sometimes they do not keep it hot in the Bain Marie. The consumer said the porridge is sometimes hot and sometimes cold. One consumer stated that although they are lactose intolerant, they are often given meals inconsistent with this.

One representative said food has been an issue for 3 years. The representative said they observe what they offer, and they promise the earth but do not deliver and now they flutter around whenever the representative visits.

The Assessment Team observed the lunch service on the first day of the Site Audit in the Jarrah/Karri dining room with the lunch menu showing creamy mustard chicken with potatoes, broccoli and baked tomatoes or sticky plum pork with Singapore vegetable noodles. Staff were observed asking consumers if they would like the choice of chicken or pork, however the sides were the same and there were no baked tomatoes or vegetable noodles served.

The Assessment Team observed the lunch service commenced at 12:00 pm and consumers requiring meal assistance were only served their meals at 12:20 pm, with one staff member seated with 3 consumers who required meal assistance and at 12:35 pm the meals of the other 2 consumers were barely touched. One consumer started using her hands to eat, however the staff member assisting with meals told the consumer to use her spoon to eat and the consumer then used her hands to put her food on the spoon and tried to eat.

In relation to meals being cold, the catering staff interviewed said there are no temperature checks for the hot boxes. The chef manager acknowledged the complaints in relation to the meals not being hot enough and indicated the current hot boxes are thermal operated and they will be trialling new electric hot boxes that allow for temperature adjustments. The regional catering manager advised they are still in the trial phase before a full rollout of the new electric hot boxes throughout the service.

While some consumers provided positive comments about the meals, most provided information about the meals not being enjoyable and not meeting the consumer’s needs and preferences. Management was aware of some of these issues and some action had been taken or was planned to bring about improvement. However, at this time there is significant consumer dissatisfaction with the quality of the meals.

The approved provider responded to the Assessment Team’s report with the Plan for Continuous Improvement with actions including that they will undertake a100% review of feedback regarding catering / meal service to gain insight into issues and create a food focus group for ongoing feedback and improvement for meal service with the Chef manager to attend. The service will actively seek feedback on meal service at resident and representative meetings with the Chef manager in attendance. The service will review the current meal service to ensure the use of dietary spreadsheets to ensure preferences are captured and followed, there is appropriate heat of meals, menu planning and changes The service will conduct education for staff on dining room service, meal presentation, understanding dietary requirements, and how to communicate meal changes to residents.

I acknowledge the actions that the provider is implementing, however I understand it will take some time to reflect compliance with this requirement.

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

**Standard 5**

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

**Findings**

The Quality Standard has been assessed as Non-compliant as one of the three specific requirements have been found to be Non-compliant.

The Assessment Team observed the service has a welcoming environment. Consumers interviewed said they feel welcome and at home at the service and they were observed to be interacting with each other, staff and visitors both indoors and outdoors providing a sense of belonging, independence and interaction. Management advised they try and accommodate consumers who are cognitively or physically impaired with wide doorways and good paths for wheelchair access in the garden areas. The Assessment Team observed this to be the case.

The Assessment Team observed consumers’ rooms to have unique mosaic signs providing staff with discreet cues as reminders for each consumer’s requirements and some consumers’ bedroom entryway features a ‘memory box’ containing personal items.

Consumers’ rooms were observed to be decorated with personal items, such as family photos, pictures, furniture and ornaments to provide a sense of belonging. Lounge areas are located throughout the service providing consumers with sitting areas for interaction. Most dining rooms were observed to bright and spacious to allow consumers with mobility aids to move comfortably.

However, there is limited wayfinding signage throughout the service to assist consumers (and others) to find their way around or find their way to their room and to other key areas. The service is all on one floor and the floor plan is complex to navigate. In some areas there was signage with the name of the area and room number ranges and arrows to send the reader in a certain direction. However, once along the path there was no further signage or limited signage (such as in small print high up above doors) to stay on track, other than emergency evacuation plans posted on the walls.

The Assessment Team interviewed consumers and representatives who did not raise any concerns in relation to consumer furniture, fittings and equipment and expressed satisfaction that maintenance requests are completed in a timely manner. Documentation review showed maintenance requests and schedules are up to date.

The Assessment Team observed some indoor furniture to be dirty and soiled and some outdoor furniture appeared to be dusty and had spiderwebs on it. Management acknowledged the feedback provided by the Assessment Team and indicated a work order had already been raised and approved for the replacement of old indoor and outdoor furniture. This included new coffee tables, armchairs, sitting chairs, dining tables and chairs and additional garden furniture. Management advised they were awaiting delivery.

One consumer representative provided negative feedback in relation to furniture being broken and observations showed some indoor and outdoor furniture was not clean and not well maintained. However, overall, it was demonstrated that in the main the furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.

The following requirement 5(3)(b) was found to be Non-compliant.

The Assessment Team interviewed consumers and representatives and received mixed feedback in relation to the service environment being safe, clean and comfortable. Some information gathered supports that the service environment is safe, clean, well maintained and comfortable. Feedback included that consumers are able to go outdoors whenever they like. One representative said their consumer’s room is always clean when she comes to visit every week.

However, there was also some negative feedback from consumers and representatives. Additionally, observations show consumers living in the Memory Support Unit are not consistently able to move freely both indoors and outdoors, and the service environment throughout is not safe, clean and well maintained. Several representatives who wish to remain anonymous said they are not satisfied with the cleaning and have needed to tell staff how to clean their relative’s room.

The Assessment Team observed in the Memory Support Unit on two separate occasions the door leading to the outdoor garden was locked preventing consumers from moving freely both indoors and outdoors and the door to the sensory activity room was locked. The team were advised that the sensory activity room lock is broken preventing them from opening the door and were advised that a workorder has been issued for the lock to be removed. One care staff member said the door to the garden is usually locked and will be unlocked after breakfast to stop consumers from getting distracted during breakfast and will stay open all day unless it is cold and windy. However, the Assessment Team observed the door was locked at around 12:15pm on day 2 of the Site Audit.

The Assessment Team observed on the fire panel digital screen there was a sprinkler pump fault highlighted with the alarm and isolated lights on. The team were advised that fire safety contractors have investigated the fault and confirmed that the fire sprinkler system is still functioning correctly, and the fire panel card is pending replacement.

The Assessment Team conducted a walkthrough of the service identifying issues with the service environment not being safe and clean, and not well-maintained. This included stained, fraying and lifting carpet, splintered handrails, walls/door frames damaged, and scuffed walls and floors throughout the service.

While some consumers and representatives expressed satisfaction with the service environment, others provided negative feedback in relation to the service being safe, clean and comfortable. Observations show consumers living in the Memory Support Unit were not enabled to consistently move freely to access the outdoors. Observations show across the service environment areas are not safe, clean and well-maintained.

The approved provider responded to the Assessment Team’s report refuting the findings of the Assessment Team, the provider provided commentary to the team’s findings in response to the cleanliness and the locked door not providing access for consumers. However, the response did not satisfy me that the consumers and representatives are satisfied that the service environment is safe, clean, well maintained and comfortable; and enables consumers to move freely, both indoors and outdoors.

I find that the approved provider is Non-compliant with requirement 5(3)(b).

**Standard 6**

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

**Findings**

The Quality Standard has been assessed as Non-compliant as two of the four specific requirements have been found to be Non-compliant.

The Assessment Team reviewed the organisational feedback policy, which includes encouraging and supporting stakeholders to give feedback and make a complaint. Notices and brochures in the service environment promote the feedback mechanism and the resident handbook includes related information. Most consumers and representatives who had given feedback or made a complaint said they had not experienced any difficulties doing so. Consumers and representatives who had not given feedback or made a complaint said they thought they would feel comfortable doing so if the need arose. Staff interviewed were aware of their role and responsibilities in supporting consumers to give feedback or to make a complaint and some gave examples of having done so.

Staff members provided detailed answers about helping a consumer to make a complaint if the need arose, and another staff member gave an example of escorting a consumer to the reception area in the past week so they could raise a concern.

The Assessment Team spoke with consumers and representatives with one consumer saying they do not have any complaints but if they did, would feel comfortable approaching management or staff. Consumers and representatives interviewed were not generally aware of advocacy or language services although none felt they had needed to use them; some were aware of an external aged care complaint handling service. The Assessment Team notes a consumer representative has accessed the external aged care complaint handling service. The Assessment Team observed in the service environment notices, brochures and a newsletter promoting advocacy, language and external complaint handling services, and notes there is information about those services in the resident handbook. A staff member interviewed was aware of these services and how to help a consumer or representative access them.

The following requirements 6(3)(c) and 6(3)(d) were found to be Non-compliant.

The Assessment Team interviewed consumers and representatives who provided feedback that they did not feel that any of their complaints or feedback made in 2023 had been actioned. Records reviewed did not show in the main that appropriate action was taken, or open disclosure had been practised in response to consumer and representative feedback and complaints. Management explained those responsible at the time no longer work for the organisation. They made efforts to access information about past complaint handling and advised they were reviewing the past feedback and complaints to understand if further work was needed in response.

One consumer advised that their bed linen had not been changed for 5 weeks and although this has improved in the past 2 weeks with it being done weekly, the consumer hopes this will continue. The consumer said they have not received a response to their complaint. The service’s feedback and complaint register does not include information about the consumer’s feedback or complaint. Management said the consumer was reminded during the Site Audit that staff will change the bedlinen on a regular day each week and does not have to try and do this by themself.

One representative made a complaint on 13 January 2023 about the consumer’s call bell and other items like drinks often not left within reach. In the feedback and complaint register no actions were recorded, but there was a note that the complaint was finalised. Further records provided by management included a memorandum to staff issued on 14 January 2023 to always be alert and ensure the call bell is in reach. When the Assessment Team interviewed the representative and asked if someone communicated with them about the actions taken, the representative said, ‘sort of, I don't know, it’s like all things they say they are looking into it and give stock standard answers which don't mean a thing to anyone’. Another representative said about 2-3 months ago they complained that the consumer’s bed was broken and put in a feedback form about this. The representative said the consumer’s king single bed was replaced with a normal single bed while a new bed was ordered. The representative said they had not heard anything further about this until yesterday (speaking on 10 May 2023) and was going to put in a complaint about the lack of feedback, when they ran into the Clinical Care Manager who said the bed had arrived and arrangements were being made to swap over to the new bed. This was being actioned during the Site Audit. There is no information in the service’s feedback and complaint register about this.

None of the consumers or representatives interviewed who had provided feedback or made a complaint in 2023 thought there had been improvement or sustained improvement. Records reviewed did not show improvements made in response to feedback/complaints, including as the effectiveness of the actions taken have not been evaluated. The feedback and complaint register are incomplete, making it more difficult to identify trends and related opportunities for improvement. Some staff said there had been recent improvement in staffing levels, noting according to the register the strongest trend in feedback and complaints is about staffing sufficiency and staff conduct.

Records show one consumer who made a complaint on 9 March 2023 about the meals being inedible and dried out, overcooked or undercooked vegetables, not enough fresh fruit and vegetables offered, and lack of consistency in meal sizes. Notes about complaint handling include the general manager spoke with the consumer on 27 April 2023 and was updated on 28 April 2023 that several issues were being monitored with the catering service and the consumer should see improvements soon. Then on 1 May 2023 it is documented the consumer noted this with thanks. When interviewed by the Assessment Team the consumer said there has not been improvement and the food and meal service continues to be terrible in every respect. The consumer asked the Assessment Team to pass on to reception staff a feedback form the consumer had written, which reflected the dissatisfaction with, and contempt for, the food and meal service. Management said this had been logged and will be dealt through the feedback system.

When the Assessment Team asked about trends in complaints, management said the trends are in cleaning, catering and clinical care. Review of the service’s feedback and complaint register as initially provided did not support this. When earlier records and other records, such as resident and relative meeting minutes, were taken into consideration these trends were evident. Some feedback and complaints are not being captured in the register to assist with monitoring trends and identifying the opportunity for service-wide improvements. The service’s plan for continuous improvement lacked information to show the link between trends in feedback/complaints and improvements.

The approved provider responded to the Assessment Team’s report with their Plan for Continuous Improvement. The provider committed to ensuring all complaints from consumers and representatives are recorded and integrated into the continuous improvement system and the home and actions are taken to resolve them in a timely manner. There will be a review of the previous three months of complaints and the service will ensure the complaints are effectively actioned and responded to. The provider will provide training on complaints management to the leadership team and staff at staff meeting and ensure feedback mechanisms are effective (including incorporating all e-mails and methods of communication to inform the process are integrated into the homes Continuous Improvement System) and improve results for consumer. The service will place an article in the local newsletter welcoming any feedback and ensure open disclosure process is utilised and there is follow up of feedback received.

Whilst I acknowledge the actions listed in the Plan for Continuous Improvement, it will take some time to reflect compliance in these areas.

I find that the approved provider is Non-compliant with requirements 6(3)(c) and 6(3)(d).

**Standard 7**

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

**Findings**

The Quality Standard has been assessed as Non-compliant as three of the five specific requirements have been found to be Non-compliant.

The Assessment Team interviewed management who described the organisational recruitment processes consistent with organisational policy and review of personnel files showed in the main the processes are being followed. Management described the programs for staff mandatory and other training. Review of the training calendar and attendance records show staff training is occurring. Most consumers and representatives interviewed said they did not think the staff needed further training on any particular topics or said they did not know whether staff needed any further training. Staff said they feel well supported with a range of training opportunities.

The Assessment Team found that there are high completion rates for the organisation’s mandatory training. Ten other training topics were sampled, chosen based on recent regulatory changes, best practice updates, non-compliance with the Quality Standards in January 2022 and other regulatory intelligence. Training has been provided to the staff within the last 12 months on all of the topics. A staff member who is a medication competent care staff member said they felt well supported to learn the role, with training, buddy shifts and observations of their practice taking place. They said there is refresher training and observations each year.

There is organisational policy about staff performance management, including regular assessment, monitoring and review of staff performance. Review of a performance appraisal tracker shows most staff have completed a performance appraisal in the past 12 months; and management explained most of those who have not are on long-term leave with some appraisals scheduled for catch-up in May 2023. Staff interviewed who had worked at the service for long enough said they had one or more performance appraisals completed, and some spoke about this being supportive with one talking about an external training development opportunity provided as a result of the process. Review of a sample of staff personnel files showed, where due, that staff had a performance appraisal completed.

Most staff are having their performance appraised regularly. While some staff have not had a recent performance appraisal, overall, the performance appraisal system is being implemented. Some as needed performance management has occurred, although without staff sign off to demonstrate they understand what is expected of them to prevent the same mistakes in the future. Overall, it was demonstrated that there is a system for regular assessment, monitoring and review of the performance of each member of the workforce.

The following requirements 7(3)(a), 7(3)(b) and 7(3)(c) were found to be Non-compliant.

The Assessment Team interviewed consumers and representatives who mostly provided feedback of reservations or concerns about staffing sufficiency and mix; and some provided information about this adversely impacting on consumers. Most staff had concerns about staffing mix and some about sufficiency. Most rostered clinical and care staff shifts are being filled, but some are not and there is significant use of temporary (agency) staff. Call ball/sensor alert responsiveness, while improving, is not timely and is not within the organisation’s benchmark for some consumers. Improvements have been made and workforce planning efforts are ongoing to bring about further improvements and ensure the number and mix of members of the workforce enables safe and quality care and services. However, in recent times and at this time, as deployed the workforce is not ensuring safe and quality care and services.

Some consumers and representatives thought there is enough staff to meet the needs and preferences of consumers and were satisfied. A consumer representative said the staff are busy and it can be difficult for the consumer to find a staff member to speak with when they want to ask something or need something which is non-urgent.

Some representatives shared their thoughts about the underlying problems. This was expressed as a number of longer-term staff leaving the service. Some consumers and representatives also provided feedback about having to repeat requests or explain things and linked this to staff being unfamiliar with the consumer or how things work at the service.

The Assessment Team interviewed nine clinical and care staff. Five said in the main there is enough staff now that the shifts are being filled with agency staff, however one of them still spoke about having to prioritise tasks like giving a consumer a bed bath when they want and are due a shower. They said shifts have only begun to be filled quite recently and prior to that shifts were not being filled and they had some extremely difficult months when they could not provide the care to consumers. Most were worried that shifts would not continue to be filled after the Site Audit.

Four of the nine said there is not enough staff. Two of the four said they did not think there was impact of this on consumers, noting that staff took the brunt of this by working harder and longer hours and being exhausted. The other two thought there had been impact. One of them did not answer when asked for details only saying some days there is enough staff and other days not, whereas the other staff member said there is impact with consumers not getting the care and services they need, or this being significantly delayed. This included delayed response to call bells, assistance with getting up and ready for the day not being provided in a timely manner, and drinks not being given to consumers, so they remain hydrated.

Call bell and sensor alert response times exceeding 10 minutes were reviewed for three recent days: 4, 6 and 8 May 2023. This showed some lengthier response times for some consumers, noting management advised the organisation’s benchmark is for these to be answered in under 5 minutes. Management confirmed that staffing hours have been increased and recruitment continues to fill shifts with Regis staff, which is a real challenge being in a regional area. They advised that call bell audits are undertaken monthly. Review of the March and April 2023 audit results showed improvement from one month to the next however still significant numbers of delayed responses.

Some consumers and representatives said that staff are kind, caring and respectful. Staff spoke about and were observed, in the main, interacting with consumers in caring ways showing them kindness and respect. Review of consumer progress notes shows staff write about consumers in a respectful manner.

A care staff member gave an example of spending extra time with a consumer who was feeling down and upset. Another care staff member said they and other staff are kind to a consumer with is living with dementia, even when that consumer’s behaviour impacts on them physically and emotionally.

However, information gathered by the Assessment Team also shows that some staff are not always kind, caring and respectful to consumers. One consumer provided feedback of their meal being cold one night and asking staff to warm it and the staff member refused, the staff member was heard to say, ‘if they don’t like it then they don’t need to eat it’. The consumer spoke directly with the staff member, who then helped the consumer to heat up the meal and said this situation has not occurred again.

One representative spoke of the staff not always taking time to communicate with the consumer. The staff don’t take the time to listen, so it leaves the consumer feeling they are not being heard. The consumer has complained more recently to the representative about staff turning their back when the consumer tries to speak and leaving the room. The consumer reacted badly on one occasion, yelling at a staff member because the consumer did not like being treated that way.

Consumers and representatives provided mixed feedback about staff knowledge. Management and the office manager said staff have been recruited with the right qualifications for the role. Personnel files reflect staff qualifications relevant to the role. An agency staff member and a new staff member described orientation, and both said they felt supported to get to know what was expected of them when they started, however experienced staff spoke of agency staff and new staff not being knowledgeable. Management outlined the staff competency assessment system. Staff interviewed advised they have knowledge and skills checks undertaken. Records reviewed show high completion rates for staff mandatory competency assessments. Staff interviewed were generally knowledgeable about the topics sampled, such as complaints handling, elder abuse and fire safety.

However, there has been and is significant use of agency staff and new staff are being recruited to permanently fill shifts. Some consumers, representatives and staff provided feedback about this meaning agency staff and new staff lack knowledge to perform their roles effectively.

Gaps in orientation processes to support agency staff and new staff to have the knowledge they need to perform their roles effectively have been identified by the Assessment Team. Staff interviewed by the Assessment Team raised concerns about agency staff knowledge, such as them not knowing to use the slide sheet and hoist and assisting consumers alone when they need the assistance of two staff with tasks.

The Assessment Team notes there has been training for staff about bowel management and behaviour support, including behaviour charting. However, information gathered by the Assessment Team during the Site Audit shows there are gaps in staff practice in both of those areas. The Assessment Team asked management how the effectiveness of the training is evaluated, beyond staff training feedback forms, to know it has improved staff knowledge. They advised the findings are likely due to turnover of staff, with those trained having since left, rather than any gap in the effectiveness of the training provided. The Assessment Team acknowledges this and notes it has not been demonstrated that staff who commenced since the training was provided have the knowledge, they need in bowel management and behaviour support to meet the needs of consumers.

Staff interviewed were not knowledgeable about the aged care worker code of conduct and their related role and responsibilities. For example, a care staff member said they think they remember doing training but could not recall anything about this. Management advised information and training was provided to staff and showed the Assessment Team related records. They advised toolbox talk education commenced during the Site Audit and showed the Assessment Team the progress made (12 staff, noting 125 employed) through an attendance record. While qualified staff are being recruited and there are staff orientation and competency systems, the orientation programs have not been implemented effectively and, seemingly due to staff turnover and the timing of training, some staff do not have the knowledge they need to perform their role effectively.

The approved provider responded to the Assessment Team’s report and refuted the team’s finding that there was insufficient staffing, stating that there had been improvements to the call bells response time for April. The provider acknowledges the feedback from staff in the service and is continuing to support the staff and has been relatively successful in attracting and retaining nursing and care staff resulting in the delivery of care for the consumers. I have considered the information that the provider has submitted, however the feedback from consumers, representatives and staff is overwhelming that the number and mix of members of the workforce deployed does not enable, the delivery and management of safe and quality care and services and the consumers and representatives have provided feedback of the impact of this. The provider submitted their Plan for Continuous Improvement with actions including education to be provided to all staff in customer service for all staff to ensure understanding of expected responses to consumers and to follow HR process required as per Regis Policy, ensuring a culture of optimism, passion, integrity and respect. The General Manager has also prioritised the training calendar for open disclosure, code of conduct and behaviour support planning and top ensure that 100% of orientation is completed by October 2023.

I acknowledge the actions that the provider is initiating, however understand that it will take time to reflect that there is the appropriate mix of staff to satisfy consumers and representatives that their needs are being met in a timely manner and that the staff are knowledgeable and qualified to perform their roles.

I find that the approved provider is Non-compliant with requirements 7(3)(a), 7(3)(b) and 7(3)(c).

**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. | Non-compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Non-compliant |

**Findings**

The Quality Standard has been assessed as Non-compliant as three of the five specific requirements have been found to be Non-compliant.

The Assessment Team interviewed organisational and service management who outlined processes to support consumer engagement and provided examples of this occurring. Some consumers and representatives say they get to have a say in what happens at the service. Documentation shows that engagement surveys and resident/relative meetings occur so that consumers and representatives can have input into what happens at the service. Also, there are regular discussions with consumers and representatives so they can have input in relation to the consumer’s care and services.

There is an organisation-wide consumer advisory committee with eight consumer representatives who meet monthly and provide input and advice to inform organisational business planning and improvement initiatives. Board members and executive management team members visit the service and undertake walk-arounds interacting with consumers and representatives and seeking their direct feedback.

However, the organisation does not have a consumer engagement policy and management said the consumer feedback policy covers this. The consumer feedback policy addresses engaging consumers in the development and delivery of care and services. It does not, for example, detail other opportunities and avenues such as the consumer advisory committee or partnering in care program. Some consumers and representatives did not think they get to have a say in what happens at the service and say they are not listened to, or their feedback is not actioned. Also, information gathered does not show that feedback leads to improvement.

There are some gaps in relation to using feedback and input to evaluate and develop care and services, which has been given weight under other requirements. Overall, it was demonstrated there are organisational and service-level processes to engage consumers in the development, delivery and evaluation of care and services.

The Assessment Team spoke with an organisational representative and senior organisational manager who described the ways the board promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. There are organisational values and behaviours, which encompass quality and safety and include a customer focus and respect for others; and there is organisational diversity policy. There is strategic and business planning to give direction and bring focus to the promotion and delivery of safe, inclusive and quality care and services. Review of minutes of the clinical governance and care sub-committee of the board, and related charter, agenda and reports tabled, shows the board receives information to enable oversight and is providing oversight of safe, inclusive and quality care and service delivery.

The following requirements 8(3)(c), 8(3)(d) and 8(3)(e) have been found to be Non-compliant.

The Assessment Team found in summary, effective governance in relation to information management and continuous improvement were not demonstrated and there are areas for improvement in relation to oversight at service-level of the workforce, regulatory compliance and feedback and complaints. Effective financial governance was demonstrated.

The Assessment Team identified that the service could not demonstrate effective information management and oversight of information management. There have been major organisation-wide projects of upgrading Wi-Fi and introducing an electronic medication management system (EMMS); and of introducing moulded texture modified foods, which was driven by the board in response to consumer feedback. The EMMS was introduced at the service in March 2023 however, the Assessment Team had feedback from consumer representatives at the service that this has not been entirely effective with related information not being well communicated.

The Assessment Team spoke with consumers, representatives and staff who provided feedback about agency staff and new staff, not knowing the needs and preferences of consumers. Orientation and buddy shift records for some of them are incomplete, including in relation to the use of communication devices and familiarity with consumer care plans. Some staff reported that agency care staff do not have access to the electronic care planning system and have not been using it. This means experienced staff have to direct them and do their documentation.

The Assessment Team reviewed minutes of meetings held in 2023 does not show the processes are used for following through of issues raised which could not be addressed at the meetings. Standing agenda items include ‘business arising’ and action planning, however, in the main business arising was not used, the columns to assign actions/responsibility were blank and follow through of issues from one meeting to the next was not evident. Consumers told the Assessment Team their feedback at the meetings is not actioned or they do not get an update. This was also evident for complaints and feedback which were incomplete, consumers and representatives advising the Assessment Team that feedback is not addressed, and complaints are not resolved satisfactorily.

The Assessment Team found that the service could not demonstrate effective continuous improvement and oversight of continuous improvement. At service level necessary improvements have not been made and the service’s Plan for Continuous Improvement has not been well used to record, drive, track and evidence completion of improvement activity.

Organisational and service management spoke of improvement activity, which is not reflected in the Plan for Continuous Improvement such as in relation to addressing the trend in complaints about the consumers’ meals not being hot. Some entries in the Plan for Continuous Improvement do not reflect recent progress or updates and remain open. The executive manager strategy, quality and improvement advised, and the board charter shows, the board is responsible for monitoring the financial position of the organisation.

The Assessment Team found that overall, there was an awareness of the challenges for workforce, including as it is in a regional area; and strategies are being employed to attract, enhance and retain a skilled workforce. However, effective monitoring of the impact of the recent and current workforce challenges on consumer care and service delivery was not demonstrated. These were the existing Regis monitoring mechanisms, with support staff from head office spending more time at the service. There did not seem to be an awareness of many of the gaps and issues which the Assessment Team was identifying and discussing with management.

The Assessment Team found for Regulatory Compliance that restraint minimisation, which is a focus of the restrictive practice’s regulatory changes, was demonstrated for some consumers subject to chemical restraint at the service but not for others. Behaviour support planning did not include all required information for consumers. For example, they do not include how the ongoing use is to be reviewed, whether the intended outcome is being achieved and if a less restrictive form could be used (section 15HE(c) of the Quality-of-Care Principles).

It was demonstrated that overall, the board has oversight of feedback and complaints. Documentation provided confirmed this, including monthly analysis, trending and benchmarking across the organisation. However, awareness of and actions to address the gaps in day-to-day feedback and complaint management at Regis Bunbury were not demonstrated.

An Assessment Contact was conducted at the service on 5 January 2022 and requirement 8(3)(d) was found to be Non-compliant due to the lack of effective risk management systems and processes specifically relating to high-impact and high-prevalence risks. More specifically, that organisational policies and processes relating to bowel management and weight management were not consistently implemented or followed. Also, that in relation to incident reporting, the organisation’s processes had not been effective in ensuring incident data was consistently used to identify improvement opportunities to the delivery of care and services.

There are organisational risk management systems and processes. There is effective risk management relating to abuse and neglect of consumers and supporting consumers to live the best life they can. There is not effective risk management in relation to high impact, high prevalence risks associated with the care of consumers or in relation to the Incident Management System. Some of the same deficits in relation to high impact, high prevalence risks and the Information Management System as identified in January 2022 have been identified during this Site Audit in May 2023.

In relation to managing high impact and high prevalence risks associated with the care of consumers, there is board oversight of service performance measured against quality indicators which is benchmarked across the organisation and with the aged care sector. This includes indicators about high impact and high prevalence risks associated with the care of consumers, such as, but not limited to, consumer behaviours, falls, infections and pressure injuries. However, at service level there has not been effective management of the risks of consumer constipation, choking, falls and unplanned weight loss as documented in this report under Standard 3 Requirement (3)(b). It was not demonstrated that risk management processes have assisted to identify and address these deficits. The Assessment Team notes this is despite the service’s non-compliance in Standard 3 since January 2022, which is about ineffective bowel management and weight management.

In relation to the incident management system, there is board oversight of information about consumer critical and serious incidents. Review of a critical incident investigation showed efforts were made to identify failures that may have contributed to the outcome, and actions were taken to try and prevent this reoccurring. However, at service level incident reporting and management has not been effective for some consumers and review of care and services post-incident has not informed safe and effective care and service delivery as documented in this report under Standard 2 Requirement (3)(e). The Assessment Team notes this is despite the service’s non-compliance in Standard 3 since January 2022, which is about not identifying and using learnings from incidents to make improvements.

Effective monitoring and review at service level proportionate to the risk of non-compliance and of regulatory breach has not been demonstrated. This has meant that information has not been reported to the board so they can exercise their responsibilities as described in the organisation’s risk management policy.

The Assessment Team found that there is an effective clinical governance in relation to antimicrobial stewardship, with systems and processes for effective organisational clinical governance of antimicrobial stewardship. There is organisational policy and procedure to guide management and staff practice. There are performance monitoring mechanisms, such as monthly reporting against performance indicators and external reviews by a pharmacist engaged to provide quality use of medicines support. There are medication advisory committee (MAC) meetings where antimicrobial stewardship is discussed, including with consumers’ doctors. An organisational MAC was recently established, and the terms of reference and agenda show antimicrobial stewardship is an item for discussion.

The Assessment Team found that effective clinical governance in relation to restraint minimisation has not been demonstrated. Overall, a focus on restraint minimisation was not demonstrated and there is high prevalence use of chemical restraint. During the Site Audit the clinical care specialist team reviewed the psychotropic medication register and discussed whether the consumers were or were not being chemically restrained. They advised two of the consumers were not, with updates that a relevant diagnosis was found, and this had not been reflected in the register. This meant information in the register about chemical restraint was not correct. There is an entry in the service’s Plan for Continuous Improvement about improving consumer behaviour management, and this also referred to restraint. The most recent evaluation shows an adverse trend with no information about further actions or progress since March 2023.

The Assessment Team found that effective clinical governance in relation to open disclosure has not been demonstrated. There are organisational systems and processes to support open disclosure and for effective oversight of this. There is policy which incorporates the principles of open disclosure and procedure to guide management and staff practice in relation to complaints and incidents when something is found to have gone wrong. Minutes of the clinical governance and care sub-committee meeting of the board in January 2023 show, for example, information about complaints and incidents is provided and note that open disclosure is being practised in most instances.

However, feedback from representatives and consumers said that they are notified when incidents occur, but not that they are given an explanation of what went wrong or information about how this is to be addressed to prevent future occurrences.

The Assessment Team reviewed incident reports and found that none of the consumer incident reports reviewed where things were found to have gone wrong had the fields for details of open disclosure completed; they were all blank. Management explained these are new fields and when a recent upgrade to the electronic care planning system occurred, unfortunately this affected all historical incident reports. The Regional General Manager said prior to the upgrade, staff were to document open disclosure in consumer progress notes. Review of progress notes on the day, and in the days following, five recent incidents involving three consumers did not show this occurred. The Assessment Team acknowledges routine care conference reviews were conducted for some of the consumers after these incidents occurred, however the records do not show the specifics of the incidents were discussed and open disclosure occurred.

The approved provider responded to the Assessment Team’s report refuting the findings of the team’s report. The provider stated that the incomplete orientation documentation and meeting minutes do not reflect ineffective information management and the failure to document complaints and feedback in the Plan for Continuous Improvement is a gap, however it is noted that staff, consumers and representatives all provided feedback that information management is not effective and the Plan for Continuous Improvement has not been effectively used to record, drive, track and evidence completion of improvement activity. The provider submitted psychotropic flow charts, psychotropic usage report graphs and information pertaining to open disclosure. I have reviewed this information and note that the use of psychotropic medication is reducing, however there is no evidence that open disclosure is being used appropriately and information provided to support compliance in n response to a representative, does not address the representative’s concerns or appropriately address open disclosure. The provider has also furnished a copy of their Plan for Continuous Improvement, with actions including ensure clinical care managers undertake the daily 24-hour progress notes review and the daily task list – to review all incidents in IMS ensuring identification of high impact high prevalence risks and provide education for any identified gaps to knowledge. Identify and use learnings from incidents to drive continuous improvement and to ensure this is captured in the Incident Management System and Plan for Continuous Improvement where appropriate.

Whilst I acknowledge the actions that the provider will implement, I find that it will take time to reflect compliance in these requirements.

I find that the approved provider is Non-compliant with requirements 8(3)(c), 8(3)(d) and 8(3)(e).

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