

**Performance Report**

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| Name: | Bethany Aged Care Plus Centre |
| Commission ID: | 2723 |
| Address: | 2-6 Gray Street, PORT MACQUARIE, New South Wales, 2444 |
| Activity type: | Site Audit |
| Activity date: | 10 December 2024 to 12 December 2024 |
| Performance report date: | 4 February 2025 |
| Service included in this assessment: | Provider: 943 The Salvation Army (NSW) Property Trust  Service: 1080 Bethany Aged Care Plus Centre |

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

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

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

# Material relied on

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

* the Assessment Team’s report for the site audit, which was informed by a site assessment, observations at the service, review of documents and interviews with staff, older people/representatives and others; and
* the provider’s response to the Assessment Team’s report received 16 January 2025.

# Assessment summary

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

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

# Areas for improvement

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

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

* Ensure staff have the skills and knowledge to:
* identify, manage, monitor and provide appropriate care relating to high impact or high prevalence risks, including weight loss, wound and pain management; and
* recognise changes to consumers’ health and wellbeing, including clinical deterioration, and implement appropriate and timely monitoring and management strategies.
* Ensure the needs, goals, and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.

**Standard 6 requirement (3)(c)**

* Ensure appropriate action is taken in response to complaints, including capturing those made verbally by consumers that are recorded in progress notes, and an open disclosure process is used when things go wrong.

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

* Review organisational risk management systems and processes, including those relating to managing high impact or high prevalence risks and managing and preventing incidents.
* Review the organisational clinical governance framework, including in relation to minimising use of restrictive practices and non-compliance identified in Standard 3.

# 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. | 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

Consumers and representatives confirmed consumers are treated with dignity and respect, their culture and identity is valued and they can make decisions on their care and services and who is involved in those. Consumers were satisfied staff supported them to take risks to live their best lives and confident their personal information was kept private. Staff were observed interacting with consumers in a respectful manner and were able to describe the ways in which they tailor care and service delivery to consumers’ preferences.

Staff described ways in which they deliver care and services that maintained consumers’ privacy and dignity, including not discussing consumer information in communal areas and delivering personal care. Staff provided examples of how they support consumers to exercise choice, including through meal and lifestyle choices, and how they support consumers to take risks to do the things they wish.

Care documentation reflected consumers’ choices for care and services, their cultural care needs, and who they wished to involve in their decisions. Documentation confirmed consumers are able to exercise choice around activities of risk and strategies to do those in a safe manner are recorded with evidence of discussion about risks in consumer care plans.

For the reasons detailed above, I find Standard 1 Consumer dignity and choice compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | 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. | Compliant |

Findings

The Quality Standard is compliant as all 5 requirements are compliant. The Assessment Team recommended requirement (3)(b) not met.

**Requirement (3)(b)** Two consumers did not have their care and services reviewed or updated following hospital transfer after incidents or change in condition. One consumer, who had a fall in October 2024 and sustained 2 fractures, returned to the service with recommendations for pain relieving medications but their pain assessment was not reviewed or updated on return, it was done 3 days later. The consumer passed away 5 days later and there was no palliative pathway included in their care documentation. One consumer who was transferred to hospital with severe abdominal pain was transferred back to the service with a palliative pain chart to provide directives to staff to manage pain. Registered staff did not review the consumer’s pain care plan, and their care documentation did not include a palliative pathway to guide staff.

Staff confirmed they do not always review, and update consumers’ care plans when they are transferred back to the service from hospital due to not having enough time. Registered and care staff confirmed they are informed of consumer changes and incidents at shift handovers. Management confirmed the service’s process is for registered staff to review consumers as they return from hospital and advised education would be provided of this.

Consumers and representatives confirmed they are involved in regular communication when changes occur to consumers’ care and services and are informed of the outcomes of reviews. Registered staff undertake reviews of care and services every 3 months or when changes occur, and information is provided to the medical officer if further review is required.

The provider does not agree with the Assessment Team’s recommendation and included additional information around the review of care and services for the 2 named consumers. For the consumer with severe abdominal pain, the provider’s response included progress notes showing review by the medical officer was undertaken regularly between October 2024 and December 2024 with changes to care where identified, including pain management. Information included shows a case conference with the consumer and their representative occurred in December 2024 after the site audit visit, where pain management was discussed. For the consumer who experienced a fall, the provider included pain management documentation showing pain was assessed and medication administered following their return from hospital.

I acknowledge the information in the Assessment Team’s report, however, have come to a different view and find the service does regularly review care and services, when changes or incidents occur. In coming to my finding, I have considered the information in the Assessment Team’s report that shows consumers and representatives are satisfied care and services are reviewed and confirmed they are included in these processes. I have also considered the service has a system in place to review consumer care every 3 months or when changes occur.

In relation to the 2 named consumers who had been transferred to the service from hospital with recommendations for pain management and palliative care, I have considered this information further in requirement (3)(b) in Standard 3. I also acknowledge for both consumers there are some deficits in relation to the review of care upon return from hospital, however, I do not find these to be systemic in nature and have taken into consideration the actions the service has taken to review both consumers following the site audit.

For the reasons above, I find requirement (3)(e) compliant.

In relation to **requirements (3)(a), (3)(b), (3)(c), and (3)(d),** consumers and representatives confirmed they are included in the development of consumers’ care and services plan and confident staff consider any risks to their health and wellbeing in the development of their care. Documentation confirmed risks assessment are completed and included in care planning, care and services are reflective of consumers’ current needs and preferences and consultation with consumers is recorded.

Care planning documentation confirmed outcomes of assessment and planning are provided to consumers and their representatives and communicated to other providers of care. Staff demonstrated knowledge of consumers’ care needs and described the ways in which they include consumers in assessment and planning processes, including advanced health planning.

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

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Not Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Not Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

The Quality Standard is non-compliant as 3 of the 7 requirements are non-compliant. The Assessment Team recommended requirements (3)(b), (3)(c), (3)(d) and (3)(f) not met.

**Requirement (3)(b)** The Assessment Team was not satisfied the service manages high impact or high prevalence risks, including pain, wounds, time sensitive medications, weight loss and nutrition effectively. Documentation review identified 9 consumers with gaps in care delivery resulting in negative impacts.

Two consumers have not had their pressure injuries or wounds managed effectively or in line with the service’s policy or wound care directives. Staff did not monitor a wound for one consumer with gaps in the required review times of up to 10 days where the wound was not checked and recorded as worsening. Wound management documentation is not consistent with wound measurements or photographs to enable staff to identify deterioration. Where the wound was identified as worsening, staff did not action a referral for a wound specialist review to provide additional wound care directives.

Staff have not managed weight loss effectively and 3 consumers have continued to lose weight without effective interventions in place. For one consumer, dietary requirements recommended by the service’s dietitian to prevent further weight loss were not communicated by staff to the kitchen and the consumer continued to lose weight. The consumer experiences pain and has to request as required pain relief, and the consumer’s pain is not monitored or managed by staff consistently. One consumer who has a gluten and diary free diet has had weight loss of almost 6 kilograms between June 2024 and November 2024 and has not been assessed by the dietitian since March 2023.

One consumer who requires time sensitive medications for a medical condition that impacts their mobility and swallowing has had multiple occasions where medications have been administered late, on one occasion up to 3 hours late. The consumer had an choking incident in November 2024 where medications had been administered late.

Staff do not manage oxygen care effectively and do not monitor and change equipment that is used by one consumer as per directives.

The provider acknowledges some of the deficits identified in the Assessment Team’s report and included in their response additional actions they have taken to rectify those. In relation to wound care, the provider acknowledges gaps in the wound care processes and have added actions to the service’s plan for continuous improvement (PCI) to address those. For the consumer who did not have their wound monitored, referred to a specialist, or measurements taken as per policy or wound care directives, an investigation of wound care for this consumer was undertaken and as a result, the service reported the incident as neglect via the serious incident response scheme (SIRS). In relation to wound care, additional information included in the provider’s response shows a process is in place for wounds to be reviewed by the registered nurse and discussed in clinical meetings.

In relation to ongoing weight loss, the provider has actioned further education to staff around weight loss management and a new process has been implemented of the clinical manager reviewing consumers who have been identified with weight loss. In relation to the consumer with weight loss, wound and pain management issues, the provider acknowledged wound management was not actioned in line with the service’s expectations and after investigation, reported an incident of neglect via SIRS.

I acknowledge the actions the provider has taken in relation to the deficits identified and review of the care for named consumers. However, I find the service does not have an effective system in place for the management of high impact or high prevalence risks to consumer care. In coming to my finding, I have considered the information in relation to the management of wounds for 2 consumers where wound care was not delivered by staff in line with directives and 2 consumers were negatively impacted resulting in incidents of neglect being reported via SIRS. Staff did not follow directives for monitoring the wound of one consumer and as a result their wound deteriorated. I have also considered information in relation to weight loss and staff not communicating recommendations for diet following dietitian review to the kitchen to be updated for meal provisions. For one consumer those recommendations included dietary changes to improve weight which did not occur.

I have considered for the consumer who experienced ongoing breakthrough pain, staff are not monitoring their pain effectively. The consumer raised concerns about pain management and information shows additional pain relief is administered when they request it to be, not through staff monitoring their pain. I have also considered for this consumer information in requirement (3)(e) in Standard 2 that includes review of the consumer was not done in a timely manner after a hospital transfer, and acknowledge the actions taken by the service to address those deficits immediately following the site audit.

In relation to medication management, I have considered evidence for one consumer where they have had time sensitive medications administered late on multiple occasions placing them at risk of negative impacts. For this consumer I have further considered the information regarding the choking incident in requirement (3)(d) in Standard 8.

I acknowledge the actions the provider has taken immediately following the site audit and those planned to be implemented that have been included on the service’s PCI, to rectify the deficits identified. However, I find these will need further time to be fully embedded for efficacy.

For the reasons above, I find requirement (3)(b) non-compliant.

**Requirement (3)(c)** Consumers could not recall having their wishes for end of life care discussed with them. One consumer who was transferred back to the service from hospital following a fall where they sustained fractures with palliative chart and medications did not have a palliative pathway developed to guide staff delivering care. Care documentation showed the consumer passed away at the service 5 days following their fall and staff documented in the 5 days prior to their passing the consumer was showing signs of pain, including groaning, agitation and trembling. Another consumer who experienced pain returned to the service from hospital with palliative medications charted but no palliative pathway developed. The consumer confirmed staff have not discussed their preferences for end of life care with them. Staff said the consumer changes their mind frequently about whether they wish to receive end of life care.

Staff confirmed information about consumers’ comfort care is communicated during shift handover and is generally documented in care plans. Management confirmed registered staff review consumers receiving end of life care daily and if any changes are required this is documented in the consumer’s care plan.

The provider acknowledges some of the deficits identified in the Assessment Team’s report. For the consumer who passed away shortly after being transferred by post hospitalisation, the provider asserts they used the gaps in care as a case study at the December 2024 clinical meeting to identify areas for improvement with registered staff and following investigation after the site audit have reported a delay in receiving pain medications as a neglect incident via SIRS.

I acknowledge the information, including actions taken following the site audit in the provider’s response, however, I find the needs, goals and preferences for consumers nearing end of life are not preserved and their dignity and comfort maximised. In coming to my finding, I have considered information in the Assessment Team’s report that shows for the consumer who passed away in October 2024, they returned to the service from hospital stay with a palliative chart and medications in place, but this was not actioned by the service nor a palliative care plan developed. I have also considered for this consumer their comfort was not maximised during end of life care as they experienced ongoing pain that was not managed effectively. I acknowledge the actions taken by the service following the site audit visit and those added to the service’s PCI for planned implementation and encourage the provider to continue with those.

For the reasons detailed above, I find requirement (3)(c) non-compliant.

**Requirement (3)(d)** Staff did not consistently monitor or respond to one consumer’s signs of pain during palliative care resulting in delays in pain relief being administered. Documentation confirmed the consumer was in significant pain on multiple occasions, including one recorded entry in progress notes describing the consumer in severe pain. The consumer had palliative medications charted on return from hospital following a fall, and as required pain relief prescribed by the medical officer. Staff did not recognise or respond to the consumer’s signs of pain and the consumer during end of life care had a delay in pain relief being administered.

The provider acknowledges the deficits identified in the Assessment Team’s report and included actions taken immediately following the site audit and planned improvements. The provider asserts an investigation of the consumer with deficits in pain management during end of life care was completed and the consumer was used as a case study to further educate registered staff. The provider’s response included additional information to show as a result of the investigation an incident of neglect was submitted via the SIRS for the delay in pain relief being administered to the consumer who was showing signs of significant pain during end of life care. The provider asserts as required medication and pain management education was conducted immediately following the site audit with staff, and a new suite of medication management documents is planned to be implemented.

I acknowledge the actions the provider has taken and has planned to implement to address the deficits identified in the Assessment Team’s report, however, I find deterioration or change in a consumer’s health or condition is not recognised and responded to in a timely manner. In coming to my finding, I have considered the information in the Assessment Team’s report in relation to the consumer who did not have signs of pain identified or responded to in a timely manner. I have also considered while staff documented visible signs of pain on multiple occasions in the days the consumer was receiving end of life care, they did not escalate further or administer pain relief. I acknowledge the actions the service has taken to educate staff and investigate the delay in pain relief, however, I find those improvements will need further time to be fully embedded and drive improvements to the systems and processes in place.

For the reasons detailed above, I find requirement (3)(d) non-compliant.

**Requirement (3)(f)** The Assessment Team was not satisfied the service actioned timely and appropriate referrals to other organisations or providers of care, including allied health and wound care specialists. The Assessment Team identified 2 consumers who had ongoing weight loss but had not been referred to the dietitian for review and strategies to manage the weight loss. Between March 20204 and November 2024, one consumer had a significant weight loss of 17 kilograms, and did not have further referrals to the dietitian in December 2024. A consumer with a sacral pressure injury that deteriorated further was not referred to a wound care specialist for additional review and strategies to manage the wound effectively.

Consumers were confident staff would refer them to other providers of care when it was required. Staff confirmed other health professionals, including allied health and medical officers are available to review consumers when required. Management described the process followed by staff when changes in consumer health or condition occurs prompting a referral to the relevant health professional.

The provider does not agree with the deficits identified in the Assessment Team’s report and included additional information and documentation in their response in relation to those. For the consumers identified with weight loss, the provider included reviews by the dietitian and the recommendations made for each post review. For the consumer with a wound that was not referred to a wound care specialist, the provider has outlined actions taken immediately following the site audit, including education of registered staff around wound management and a referral to and review by an external wound care specialist that occurred in January 2025.

I acknowledge the information in the Assessment Team’s report, however, I have come to a different view and find the service actions appropriate and timely referrals to other individuals, organisations and providers of care and services. In coming to my finding, I have considered feedback from consumers that showed they were confident the service would refer them to other providers of care when they needed it, and staff confirmed the process in place to refer consumers when they identified any changes in health or condition. I have also considered the additional information in the provider’s response that shows one consumer’s multiple reviews by the medical officer and dietitian following referrals and find there is an effective system in place and staff have knowledge of this process and take actions when required.

For the reasons detailed above, I find requirement (3)(f) compliant.

In relation **requirements (3)(a), (3)(e), and (3)(g),** consumers and representatives were satisfied with the personal and clinical care provided and confirmed it was delivered in a way that was tailored to consumers’ needs, goals and preferences. Consumers are confident staff know their care needs, and confirmed they didn’t have to repeat their information. Staff know consumers and their needs and preferences for personal care and described ways in which they tailor personal and clinical care delivery to meet consumers’ preferences. Documentation confirmed communication with consumers and representatives when there are changes or other providers of care review consumers. Consumers were confident staff maintained good infection control practices and confirmed staff wash their hands before delivering care to them. The service has an infection prevention control (IPC) lead who confirmed staff are trained regularly around infection control. Registered staff described the ways antimicrobial stewardship is maintained.

For the reasons detailed above, I find requirements (3)(a), (3)(e), and (3)(g) in Standard 3 Personal care and clinical care compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Consumers confirmed staff support them to maintain their independence, including to undertake daily tasks, such as personal care themselves. Consumers described the ways staff supported their emotional and spiritual needs, including when they felt low, providing additional support or arranging for the service’s chaplain to visit with them. Consumers expressed satisfaction with the quality and quantity of meals provided, and confirmed they had choice and were able to input into the menu development. Consumers confirmed they are able to do things of interest to them and there are provisions made to do individualised activities they wish to do, including gardening and cycling.

Care documentation included consumer needs, goals and preferences for lifestyle activities, likes and dislikes for meals and information about dietary requirements, including allergies to guide staff delivering care. Sampled care files demonstrated referrals to other organisations and providers of care, including volunteers and the local library to engage in the service’s lifestyle program with consumers.

The service has a bus used to support consumers to engage with the community and undertake social activities that is regularly serviced and maintained. Staff confirmed equipment used by consumers to support and maintain independence or engage with the activity program is cleaned after each use, maintained and safe to use.

For the reasons detailed above, I find Standard 4 Services and supports for daily living compliant.

# Standard 5

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

Findings

The Quality Standard is compliant as all 3 requirements are compliant. The Assessment Team recommended requirement (3)(b) not met.

**Requirement (3)(b)** The service has a key coded door at the entry, and a register of consumers subject to environmental restraint is maintained with 2 consumers recorded. The Assessment Team identified a further 26 consumers subject to environmental restraint, without informed consent. The lifestyle office was observed unlocked, unattended with scissors on the tables. The room is close to the room of a consumer who has expressed suicidal ideation. Two utility rooms were observed unlocked with bottles of ethanol based cleaning solution and an open sharps container visible. Outdoor blinds of one consumer’s balcony were damaged and documentation confirmed the service was aware of the damage and recommended to replace awning fabrics.

The service’s designated smoking area has been set up in the same location as the emergency gas shut off valve. A property risk assessment was completed in June 2024 by an external contractor, but did not include the risk assessment of the smoking area or any fire related risks of the co-location of smoking area and gas valve. The most recent fire safety reported to November 2024 confirmed 10 non-compliances identified, which have not been addressed by the service.

The provider acknowledged the deficits identified in the Assessment Team’s report and included in their response actions taken during and immediately following the site audit to address those. In relation to environmental restraint the provider asserts they have obtained consent for the 26 consumers identified without restrictive practices in place. In relation to the lifestyle office being open and unlocked, the provider includes commentary to show actions were taken during the site audit visit to rectify this practice and the process in place for ongoing monitoring. The provider asserts management removed all chemicals and sharps from the utility rooms with evidence all staff had been advised this practice is not to continue.

In relation to the deficits identified in the service environment, including the smoking area and fire safety audit, the provider has taken a number of immediate actions during and immediately following the site audit to rectify those. Works have been completed to move the emergency gas valve from the smoking area to another location and the deficits in the property inspection are being worked through. The provider included the PCI which has actions to address all deficits included.

I acknowledge the information in the Assessment Team’s report and balanced that against information in the provider’s response and have come to a different view and find the service environment is safe, clean and maintained and consumers have access to indoor and outdoor areas. In coming to my finding, I have considered actions the provider took during the site audit to rectify deficits, including the safety of consumers with unlocked and open lifestyle and utility rooms, and the actions following the site audit of making the external environment safer and mitigating the risks to consumers using those external areas. In relation to environmental resraint, I have considered this information and evidence in requirement (3)(e) of Standard 8.

For the reasons above, I find requirement (3)(b) compliant.

In relation to **requirements (3)(a) and (3)(c)**, consumers were satisfied with the cleanliness of the service and found it easy to navigate. Consumers confirmed they were able to personalise their rooms with their own items, were satisfied with the maintenance of their own items along with the service in general and confident staff reported any issues that required fixing in a timely manner. Documentation showed the service has a routine and preventative maintenance schedule that is managed by staff appropriately and in a timely manner. Staff described the schedules they follow for cleaning and maintenance and provided examples of how they monitor items and the environment in general for hazards and report those when they see them.

Based on the Assessment Team’s report, I find requirements (3)(a) and (3)(c) in Standard 5 Organisation’s service environment compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Not Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The Quality Standard is non-compliant as one of 4 requirements are non-compliant. The Assessment Team recommended requirement (3)(c) not met.

**Requirement (3)(c)** Twelve complaints identified through progress note review had not been captured on the service’s feedback register, had not been investigated or open disclosure used. Two of the 12 complaints were made by one consumer requesting a medical review, of which none were actioned. Multiple complaints were made by consumers in one area of the service about their sleep being disrupted by another consumer. There was no action undertaken about these complaints.

Management were not aware of the complaints identified by the Assessment Team through care documentation review. Management added an action to their PCI which included actions to address staff not escalating consumer complaints.

Consumers interviewed were satisfied concerns they raised were resolved in a timely manner. Staff confirmed they received training in relation to open disclosure and were able to describe the principles of it.

The provider acknowledges the deficits identified in the Assessment Team’s report in relation to feedback and complaints not being actioned or open disclosure used. In their response, the provider included a range of actions undertaken post visit to address the deficits, including follow up investigations of all consumers named in the report with complaints identified through progress notes, including investigations undertaken and consultation with consumers. The provider also added actions to the PCI to address deficits in relation to management not being aware of complaints raised by consumers in progress notes, including enabling a keyword searches of progress notes and detailed reviews to be undertaken by clinical management.

I acknowledge the information and actions included in the provider’s response, however, find appropriate actions are not undertaken or an open disclosure process used in relation to feedback and complaints. In coming to this finding, I have considered information in the Assessment Team’s report that shows the systems and processes for actioning feedback and complaints is not effective when staff document consumer concerns in progress notes as they are not further escalated for investigation. I have also considered information that shows staff are not consistently applying principles of open disclosure where something goes wrong.

I acknowledge the actions the provider has taken since the site audit visit and encourage them to continue embedding those into their systems and processes to improve the deficits identified.

For the reasons above, I find requirement (3)(c) in Standard 6 Feedback and complaints non-compliant.

In relation to requirements **(3)(a), (3)(b) and (3)(d),** consumers and their representatives confirmed they are encouraged to provide feedback and felt safe doing so. Consumers felt they were well informed about advocacy services. Management advised they have an action to presentations from various advocacy bodies at their future consumer meetings. Information about how to make a complaint was observed throughout the service and documentation confirmed the feedback and complaints process is included in the consumer admission handbook. Staff confirmed consumer feedback and complaints are discussed during staff meetings and at shift handovers. The service’s PCI shows actions are included as a result of feedback and complaints from consumers.

Based on the information detailed above, I find requirements (3)(a), (3)(b), and (3)(d) compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | 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

Consumers and representatives confirmed staff were kind and caring, and there were enough staff to deliver care in a way that meets consumers’ needs and preferences. Consumers were satisfied staff were trained well and competent at the role they were undertaking. Staff interactions with consumers are done so in a kind, caring, respectful and attentive manner.

Documentation reflected staff were trained in all aspects of care and service delivery as it relates to their role. Rosters showed a mix of staff allocated across the service for each shift with processes in place to cover staff where planned or unplanned leave occurs. Management confirmed staff are recruited based on qualifications, knowledge, and experience and all new staff undertake an orientation program that includes several training modules. Management described the system in place to monitor staff training which is done so through a register and any staff not compliant are stood down until they complete mandatory training.

Staff performance is monitored through formal and informal processes. Mangement confirmed they observe staff on the floor, use consumer and representative feedback, and clinical and incident data to monitor staff performance and where issues are identified through these processes they are addressed directly with staff at the time of occurrence and a performance review is then triggered to monitor for improvement.

Staff are satisfied with the number and mix of staff allocated on shifts and confirmed they are supported to deliver care in line with consumers’ needs. Staff confirmed they received regular training and have performance appraisals and have access to additional training if they request. Documentation confirmed staff credentials, including qualifications, police clearances, and where required visas are maintained on a register and monitored for currency.

For the reasons detailed above, I find Standard 7 Human resources compliant.

# Standard 8

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

**Findings**

The Quality Standard is non-compliant as 2 of the 5 requirements are non- compliant. The Assessment Team recommended requirements (3)(c), (3)(d), and (3)(e) not met.

**Requirement (3)(c)** The Assessment Team was not satisfied effective organisational governance systems are in place in relation to information management, regulatory compliance, and feedback and complaints. Information about consumer care and condition is communicated to staff in various ways, including through handover, and regular staff meetings and staff confirmed information is accessible. There are inconsistencies in communicating and documenting information in relation to consumers’ changing care needs, dietary requirements, recording of incidents, treatment of wounds and delivery of time sensitive medications.

There is a process in place to monitor changes in legislation or regulatory updates. The service does not have a consumer advisory group established. There are mechanisms in place to encourage consumers to provide feedback and make complaints, monitor and action those, and use the information to drive improvements. Staff do not always escalate complaints and those recorded in progress notes are not consistently recorded on the feedback register.

The service’s PCI includes actions driven by consumer feedback, issues identified from audits, and incident data, and is discussed at organisational regular meetings. An annual budget is provided to management to be used for recruitment, equipment and capital expenditure. There is a process to monitor the workforce to ensure the right mix and number is available, competencies and training are recorded.

The provider acknowledges the deficits identified in relation to organisational governance in the Assessment Team’s report. The provider asserts a consumer advisory board has been challenging to establish at the service as there has been no interest despite multiple requests to consumers and it has been added to the agenda of the next resident relative meeting. In relation to feedback and complaints, the provider has reviewed the current process and put in place measures to ensure feedback and complaints recorded in progress notes are captured, including daily reviews by clinical management and education of staff to escalate.

I acknowledge the information in the Assessment Team’s report and in balance with the provider’s response, I have come to a different view and find there are effective organisational governance systems in place. In coming to my finding, I have considered the service has systems in place to communicate information to staff to drive consumer care, and information in Standards 2 and 3 show care planning is current and reflective of consumers’ care needs, staff know consumers’ needs and preferences and deliver care in a way that meets those needs. I have also considered while the service has not captured all complaints this is not reflective of a systemic issues as there are systems in place that are effective in capturing feedback in other ways and actioning those. I have considered feedback and complaints deficits in Standard 6.

In relation to the consumer advisory board, I have considered and place weight on the information in the provider’s response to show they continue to make attempts to establish this group. I have also considered information in requirement (3)(a) of this Standard that shows various ways in which consumers have input into care and service development, delivery and evaluation.

For the reasons details above, I find requirement (3)(c) compliant.

**Requirement (3)(d)** The Assessment Team was not satisfied an effective risk management system is in place in relation to management of high impact or high prevalence risks, including wounds and weight loss or incident management. While there are policies and procedures to guide staff delivering care in relation to high impact or high prevalence risks, these are not consistently applied by staff with gaps in the delivery and monitoring of clinical care for consumers. The service’s incident management system is not effective in capturing incidents or reporting those that are required to be. Incidents are not consistently investigated to determine causes or identify strategies for further occurrence. A choking incident that occurred in October 2024 was not reported or captured in the incident management system for investigation to occur. Documentation showed an incident where a consumer experiencing extreme pain was administered pain relief using incorrect equipment which was not captured on the incident management system (IMS) or investigated. Interviews with staff and management confirmed 2 consumers have existing conflict that includes threats of harm which has been escalated to police by one of the consumers without systems in place to keep the consumer safe.

The are policies and procedures in place to guide staff practice to support consumers to take risks and live their best lives and make choices about the risks they wish to take.

The provider acknowledges the deficits identified in the Assessment Team’s report and included in their response multiple incidents in relation to those identified during the site audit that have been logged as incidents in the IMS or reported as SIRS. In relation to the 2 consumers with existing conflict, the provider has included additional information, including incidents reported via SIRS, reporting to police and measures already in place within the service, including one on one sight charting of the consumers.

I acknowledge the actions the provider has taken and has planned to address the deficits identified, however, I find there is not an effective risk management system in place, specifically in relation to incident management. In coming to my finding, I have considered information in the provider’s response and in Standard 3 that shows for 2 consumers, incidents in relation to clinical care delivery, including ineffective wound management and delays in pain relief had not been identified as incidents prior to the site audit and had not been escalated or reported further. I have also considered for multiple consumers, incidents in relation to care, including those of physical aggression or in relation to deficits in clinical care delivery have not been captured by the IMS to enable improvements to be made. Information in Standard 3 also shows where incidents do occur investigations do not always occur to develop strategies to prevent further recurrence. I acknowledge the actions the provider has taken with the reporting of multiple incidents via SIRS during and immediately following the site audit, however, I have no evidence before me in relation to addressing deficits overall of the IMS.

For the reasons detailed above, I find requirement (3)(d) non-compliant.

**Requirement (3)(e)** The Assessment Team were not satisfied the organisation has an effective clinical governance framework in place with multiple deficiencies identified in relation to clinical care, including wound and weight loss management and clinical deterioration. Staff did not have an understanding of restrictive practices. The organisation has policies and procedures in place for clinical governance, including minimising restrictive practices and open disclosure and a system for clinical oversight in place. Staff were able to describe ways in which antimicrobial stewardship is actioned.

The provider acknowledges the deficits identified in the Assessment Team’s report in relation to clinical governance and included actions planned to address those. The provider has put in place an incident tracker system to strengthen their oversight of clinical incidents and enabling continuous improvement of those. I acknowledge the provider’s response and actions taken but find they have not demonstrated an effective clinical governance system. In coming to my finding, I have considered information in Standard 3 that shows clinical oversight has been ineffective in identifying clinical incidents in relation to weight loss, wound care and pain management, and identifying and responding to clinical deterioration that have had negative impacts on multiple consumers. I have also considered information in requirement (3)(b) of Standard 5 that shows environmental restraint is not effectively managed, and 26 consumers are subject to environmental restraint without required systems in place, including informed consent. I acknowledge the provider has obtained informed consent for those consumers identified in the Assessment Team’s report and provided education, however, find improvement actions, including oversight of restrictive practices need further time to be fully embedded.

For the reasons detailed above, I find requirement (3)(e) non-compliant.

In relation to **requirements (3)(a) and (3)(b),** consumers were confident the service was run well and confirmed they have input into the development, delivery and evaluation of care and services, including though feedback, surveys and resident meetings. The organisation’s governing body, the board, is kept informed of the performance of the service through reports from monthly audit, clinical governance and compliance committee meetings. Management described ways consumers are engaged, including care plan reviews, surveys and consumer meetings and provided an example of consultation with consumers on selecting furniture for the service’s communal areas.

For the reasons detailed above, I find requirements (3)(a) and (3)(b) compliant.

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