Blue Care Mackay Homefield Aged Care Facility

Performance Report

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**Commission ID:** 5122

**Provider name:** The Uniting Church in Australia Property Trust (Q.)

**Assessment Contact - Site date:** 2 March 2022 to 3 March 2022

**Date of Performance Report:** 08 April 2022

# Performance report prepared by

Kimberley Reed, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

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| --- | --- |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(e) | Non-compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(b) | Non-compliant |
| **Standard 5 Organisation’s service environment** |  |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** |  |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(c) | Non-compliant |

# Detailed assessment

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 Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the Approved provider’s response to the Assessment Contact - Site report received 28 March 2022
* other intelligence and information held be the Commission in relation to the service.

# STANDARD 2 NON-COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Assessment Team did not assess all Requirements in this Standard; therefore, a summary statement is not provided. A decision of Non-compliance for one Requirement results in a Non-compliance rating for the Standard.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(e) Non-compliant

*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.*

Care and services have not been reviewed for effectiveness following a change in circumstances or when incidents have impacted on the needs of consumers. Despite the service developing a Plan for continuous improvement following Non-compliance in this Requirement identified at the Site audit which occurred 17-19 August 2021, actions have not been effective in addressing the Non-compliance.

Care planning directives have not been reviewed when circumstances changed or when incidents occurred. For one named consumer with episodes of threatening behaviours towards staff, care planning directives did not include strategies to guide staff in managing the consumer’s behaviours. A further two named consumers who have sustained recent falls did not have their falls risk assessment completed or updated to reflect their current falls risk status, and further falls prevention strategies were not considered to reduce the risk of future falls. For a fourth consumer who chooses not to follow a diabetic diet and prefers to smoke, care planning guidelines did not reflect these choices or to guide staff in providing care to the consumer.

The Approved provider in its written response to the Assessment contact report implemented, reinforced and developed strategies to ensure care plans are consistently reviewed including when circumstances change, or incidents occur. included a clinical meeting held on 21 March 2022, where numerous clinical aspects were discussed. Some of these strategies included an overview of the Resident of the Day process and falls, behaviour support and pain management. Education and training were also provided to care staff 22 March 2022, whereby the Resident of the day and working duties was discussed. An audit of all consumers care plans is to be completed by 30 April 2022. The individual consumers identified in the Assessment contact report as having deficits in their care planning processes have had their care planning directives reviewed and amended as required, referrals to allied health and specialist services and case conferences have occurred.

The Assessment contact report identified the service experienced a number of changes in relation to clinical oversight and monitoring due to recent changes in clinical management. The Approved provider in its response has indicated a number of actions have occurred since the Assessment contact visit including the appointment of a permanent Care Coordinator, the development of a plan for continuous improvement, a clinical information session relating to clinical monitoring was attended by management, a review of handover processes occurred, and duties lists were revised.

While I acknowledge the actions the Approved provider has completed or has committed to complete to address the deficiencies identified in this Requirement, it is my decision these actions have yet to be completed or tested for their effectiveness. Therefore, it is my decision this Requirement is Non-compliant.

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The Assessment Team did not assess all Requirements in this Standard; therefore, a summary statement is not provided. A decision of Non-compliance for one Requirement results in a Non-compliance rating for the Standard.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(b) Non-compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

Consumers with high-impact or high-prevalence risks associated with their care have not been effectively managed. Despite the service developing a Plan for continuous improvement following Non-compliance in this Requirement identified at the Site audit which occurred 17-19 August 2021, actions have not been effective in addressing the Non-compliance.

Three consumers prescribed psychotropic medication which was classified as chemical restraint had not been identified by the service and therefore appropriate authorisations had not been completed. For a further two consumers their authorisations were not completed to evidence informed consent had occurred.

The Approved provider in its written response to the findings in the Assessment contact report has stated a number of actions have been completed since the Assessment contact to address the deficiencies identified. Actions have included the appointment of a part time Quality and Compliance officer, who commenced 04 April 2022, a folder relating to Restrictive practices has been implemented and will be maintained by clinical management. Fortnightly meetings have been established for the effective review of restrictive practice folder and psychotropic medication register. Following the Assessment contact an initial audit was conducted for all consumers receiving psychotropic medication and the Psychotropic and Chemical restraint register was reviewed. Where gaps were identified, steps were taken to ensure compliance with obligations relating to the use of the restrictive practice. For individual consumers identified in the Assessment contact report as having deficits relating to restrictive practices actions have been taken to address systemic deficits in relation to their restraint authorities. These actions have included recognition of the need for the authorisation and consent for chemical restraint, updating of the Psychotropic Register and Chemical Restraint register, letters have been written to medical officer seeking clarity of consumer diagnosis and the review of the need for individual consumers to be receiving chemical restraint.

The Assessment contact report identified three consumers with behaviours of concern had not been referred to specialist dementia advisory services, behaviour support plans did not contain individually driven directives to manage the consumers’ behaviours. The Approved provider in its response to the Assessment contact record indicated all consumers identified in the Assessment contact report have had their care plan reviewed, have been referred to dementia behavioural specialist services and were included in discussions at a staff meeting.

In relation to falls, the Assessment contact record identified for two consumers post falls management processes were not effective and the consumers were not reviewed by a physiotherapist and falls risk assessments were not updated. The Approved provider in its response has documented that a review of all consumers’ falls risk assessment has been undertaken to ensure they are reflective of consumers’ needs and include additional strategies or equipment to reduce the risk of falls. The two consumers noted in the Assessment contact report have both been referred to the Physiotherapist, their care needs reviewed and for one consumer a case conference has been arranged.

For one named consumer pain assessments had not been completed following a recent fall and pain charting was incomplete. The Approved provider has stated in its response the consumer has been moved to a room closer to the nurse’s station to ensure behaviours that indicate pain are not overlooked in future.

Infection control risks were identified in the Assessment contact report including staff incorrectly wearing masks or wearing cloth masks. The Approved provider has stated in its response that following feedback, management commenced regular walks through the service to immediately address any breach of infection control practices. For a named consumer who prefers to self-catheterise but is experiencing increased levels of confusion, consideration had not been given whether the consumer had a urinary tract that was causing their confusion. The Approved provider stated the consumer’s care needs are currently under review in relation to their capacity to continue to perform self-catheterise, and weekly urinalysis will be performed.

For two consumers who prefer to smoke at the service, it was identified these consumers do not use the designated smoking area and chose to smoke on their verandas. One consumer refuses to wear a smoking apron, however this is not reflected in their care plan, and the other consumer’s care plan does not contain any risk management strategies relating to smoking. The Approved provider in its response have stated a suitable area has been identified which is easily accessible from all areas of the service and work will commence to establish the alternate smoking area in April 2022. Consumers are assisted to the current smoking area in the interim wearing call response lanyards. Consumers who prefer to smoke are listed on a whiteboard within the nurse’s station and handovers are utilised to discuss any changes to consumers’ smoking habits. For the two named consumers, risk assessments and care planning guidelines have been updated and the consumers are encouraged to utilise risk mitigation strategies in relation to their smoking.

While I note and acknowledge the actions taken by the Approved provider in response to the deficits identified in this Requirement documented in the Assessment contact report, I also note these deficits were not identified by the service’s own monitoring mechanisms despite the service being Non-compliant in this Requirement since August 2021. The actions the Approved provider has commenced will need time to be fully implemented and tested for their effectiveness. Therefore, it is my decision this Requirement remains Non-compliant.

# STANDARD 5 Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

The Assessment Team did not assess all Requirements in this Standard therefore a summary statement or compliance rating is not provided.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

Actions have been taken to address the previous Non-compliance in this Requirement identified at the Site audit conducted in August 2021. The service environment was observed to be safe, clean and well maintained. Consumers were satisfied with the comfort and safety of the service. Consumers were observed to be moving freely around the service.

In relation to actions taken to address the previous Non-compliance, the outside gardens are now maintained by a contractor employed to maintain the grounds and complete the lawn mowing. The grounds were observed to be well maintained, well-kept with navigable pathways. Decommissioned equipment has been removed from the outdoor area and this process continues as equipment is no longer required. The maintenance office and shed have been tidied and appropriate storage for chemicals and equipment have been sourced.

While two consumers continue to smoke outside the designated smoking area and the Approved provider is planning to construct an alternative smoking area, the service had installed a designated smoking area which was observed to be clean, tidy and contained fire safety equipment.

The main kitchen was observed to be clean and tidy, and food and supplies were stored appropriately. Cleaning schedules have been adjusted to include regular cleaning of the kitchen including high touch points and vents.

Based on the information contained above and the observations made by the Assessment Team during the audit, it is my decision this Requirement is now Compliant.

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

Actions have been taken to address the previous Non-compliance in this Requirement identified at the Site audit conducted in August 2021. Furniture, fittings and equipment was observed to be safe, clean, maintained and suitable for consumer use. Consumers and representatives expressed satisfaction with the suitability, safety and cleanliness of furniture and equipment.

An external contractor was engaged to conduct an audit of mobility equipment, mattresses and bathroom equipment, as it was previously identified delays were experienced for consumers for mobility equipment to be repaired. Following the audit equipment was either repaired or replaced. Audit results confirmed the suitability and condition of the equipment to be sound. Mobility equipment was observed to be clean, well maintained and fit for purpose.

Responsibility of the preventative and reactive maintenance was previously not clear and therefore did not occur consistently. Actions taken to address this matter have included a record of equipment is maintained via an asset register and the preventative maintenance schedule is in hard copy and electronic format. Maintenance management have oversight of the maintenance schedule to ensure it is accurate and current. The preventative maintenance register was observed to be up to date.

Based on the information contained above and the observations made by the Assessment Team during the audit, it is my decision this Requirement is now Compliant.

# STANDARD 6 Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

The Assessment Team did not assess all Requirements in this Standard therefore a summary statement or compliance rating is not provided.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

Actions have been taken to address the previous Non-compliance in this Requirement identified at the Site audit conducted in August 2021. Appropriate action has been taken in response to complaints and open disclosure processes have been used when required. Consumers and representatives advised their concerns were addressed and responded to appropriately. Management and staff were able to describe the complaints process including open disclosure.

Previous deficits in this Requirement have been addressed and these rectification actions have included the inclusion of feedback and complaints as a standing agenda item at monthly consumer meetings. Meeting minutes demonstrated feedback was captured and consumers were informed of the outcomes of their feedback. A feedback form was included in the monthly newsletter, and information relating to the service’s open-door policy with management was also included in the newsletter. Surveys have been conducted every three months to gauge consumer satisfaction and to drive improvements.

Staff have been provided with education in relation to complaints management and consumer feedback. Education records demonstrated training had been provided to staff across the service in relation to complaints and open-disclosure in December 2021 and January 2022. Complaints are recorded in the electronic register, management are notified of the complaint and the complaints register demonstrated complaints have been recorded and addressed in a timely manner.

Based on the information contained above, it is my decision this Requirement is now Compliant.

### Requirement 6(3)(d) Compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

Actions have been taken to address the previous Non-compliance in this Requirement identified at the Site audit conducted in August 2021. Feedback and complaints have been used to improve the quality of care and services for consumers. Consumers confirmed their complaints have led to improvements in the service, including labelling of laundry, alterations to the dining and lounge room and improved meal temperatures.

Surveys were conducted with consumers over a three-month period following dissatisfaction with food services identified at the site audit in August 2021, results were received to indicate meal temperatures were a concern. Processes were amended to ensure meal temperatures were maintained and meal temperatures were sampled daily. Feedback from consumers was positive regarding meal temperatures following the change in processes.

Based on the information contained above, it is my decision this Requirement is now Compliant.

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The Assessment Team did not assess all Requirements in this Standard; therefore, a summary statement is not provided. A decision of Non-compliance for one Requirement results in a Non-compliance rating for the Standard.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Non-compliant

*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.*

The workforce was not adequate in number to enable the delivery of safe and quality care. Consumers and representatives provided feedback there are insufficient staff to attend to consumer requests for assistance in a timely manner or to provide cares in accordance with consumer preferences and care plan. Staff were not able to consistently meet the care needs of consumers, particularly in relation to the delivery of hygiene cares, toileting needs, activities and providing emotional support. Despite the service developing a Plan for continuous improvement following Non-compliance in this Requirement identified at the Site audit which occurred 17-19 August 2021, actions have not been effective in addressing the Non-compliance.

Consumers and representatives were not satisfied with the sufficiency of staffing and provided examples of how this impacted consumer care delivery. Examples included a lack of pressure area care, hygiene preferences not adhered to, episodes of incontinence and call bell delays.

Staff were unable to complete their allocated workload due to insufficiency of staffing. Staff provided examples of tasks they were unable to complete or were unable to complete in a timely manner. These tasks included responding to consumers’ call bell requests as they were providing care elsewhere. Consumers were provided with a sponge bath in bed rather than their preference of a shower due to time constraints. Continence aids were not changed as per scheduled timeframes due to insufficient staffing. Lifestyle staff were insufficient to provide meaningful activities to all consumers, particularly consumers with cognitive impairments.

The Approved provider in its written response to the Assessment contact report provided an overview of the human resource processes utilised by the service and states the roster at the service has been modelled to suit the needs of the service, to ensure appropriate coverage of clinical, care and other designations of staff to meet the needs of the consumers and the service. The Approved provider acknowledged there are challenging workforce issues in the aged care industry and ongoing recruitment continues to bolster the current clinical, care and support staff workforce at the service.

The Approved provider in its response listed a number of mechanisms used by the service to monitor and review the effectiveness of the current staffing model. These mechanisms included a feedback management system, monitoring of key performance indicators, monthly meetings for consumers and representatives, consumer focus groups, monthly staff meetings and workload forms. The Approved provider has stated that a review of these reports, systems, meetings and procedures identified the service has sufficient staff to provide safe and quality care and services to consumers. The Approved provider states management at the service have not received any recent workload forms lodged by staff. Any lengthy call bell delays are investigated and discussed with relevant staff. The base roster demonstrates staffing coverage. Meeting minutes demonstrate feedback is sought and discussed and management implement strategies to manage staffing number and skill mix.

While I acknowledge the mechanisms the Approved provider has in place to gauge the sufficiency of staffing and the Approved provider’s response that these mechanisms have not identified issues relating to sufficiency of staffing. However, feedback provided to the Assessment Team from consumers, representatives and staff do not support there is sufficient staff available to provide safe and quality care to consumers. Therefore, it is my decision this Requirement is Non-compliant.

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

The Assessment Team did not assess all Requirements in this Standard; therefore, a summary statement is not provided. A decision of Non-compliance for one Requirement results in a Non-compliance rating for the Standard.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(c) Non-compliant

*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.*

Effective organisation wide governance systems were not in place to guide information management, continuous improvement, workforce governance, and regulatory compliance. Despite the service developing a Plan for continuous improvement following Non-compliance in this Requirement identified at the Site audit which occurred 17-19 August 2021, actions have not been effective in addressing the Non-compliance.

Continuous improvement systems were ineffective, this is evidenced by the organisation's inability to return to Compliance in Requirements 2(3)(e), 3(3)(b), 7(3)(a) and this requirement which were identified at the Site Audit conducted between 17 and 19 August 2021. The Approved provider has stated in its response that a review of the Plan for continuous improvement to ensure all activities relating to Non-compliance has been actioned. While activities may have been actioned, the Non-compliance remains in four Requirements.

The organisation remains unable to demonstrate compliance in information management of consumer care documentation, as evidenced by the absence of up- to-date monitoring and reviewing of consumers’ care and services documentation, and failure to review care documentation following an incident or change in condition. The Approved provider has stated a process was implemented to review and update all consumer care documentation and a schedule exists to ensure remaining consumers’ care documentation is reviewed and updated in a timely manner. As this process is ongoing and not completed to be evaluated for its effectiveness, it is my decision this does not support compliance in effective information management.

Staff did not have a shared understanding of regulatory compliance requirements as evidenced by staff failing to demonstrate a shared understanding of, recording of and obtaining authorisation for restrictive practices. This was evidenced through ongoing Non-compliance identified in Requirement 3(3)(b), which does not support effective regulatory compliance systems.

Workforce governance processes were not effective, consumers are not satisfied with staffing levels and this is impacting their care delivery. Staff provided feedback they were unable to deliver safe and quality care to consumers. This was evidenced by ongoing Non-compliance in Requirement 7(3)(a), which does not support effective workforce governance.

While the service was able to demonstrate effective organisational systems were effective in relation to feedback and complaints, with a subsequent return to compliance for these components of the Requirement and financial governance systems were noted to be effective, the remaining aspects of this Requirement remain ineffective and therefore it is my decision this Requirement is Non-compliant.

# 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.

* Care and services are required to be reviewed regularly for effectiveness.
* High-impact and high-prevalence risks associated with the care of consumers needs to be effectively managed.
* Staffing levels need to be sufficient to deliver safe and quality care and services to consumers.
* Organisation wide governance systems relating to information management, regulatory compliance, continuous improvement and workforce governance need to be effective.