Blue Care Warana Beachwood Aged Care Facility

Performance Report

124 Nicklin Way   
WARANA QLD 4575  
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**Commission ID:** 5185

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

**Assessment Contact - Site date:** 10 June 2020

**Date of Performance Report:** 2 July 2020

# Publication of report

This Performance Report **may 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** | **Compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |

# Detailed assessment

This performance report details the Commission’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 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.

# STANDARD 2 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

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – reviewing their care planning documents in detail, asking consumers about how they are involved in care planning, and interviewing staff about how they use care planning documents and review them on an ongoing basis.

Overall sampled consumers confirmed to the Assessment Team that they feel like partners in the ongoing assessment and planning of their care and services. Consumers and representatives interviewed reported to the Assessment Team being involved in the initial assessment and ongoing planning of their care. Consumers and representatives interviewed reported they are informed about the outcomes of assessment and planning and have access to their care and services plans if they wish.

Care plans reviewed by the Assessment Team showed they have been developed in consultation with the consumer and/or their representative and that they have been reviewed regularly and updated when changes have been required. Staff interviewed are aware of the consumer’s needs, goals and preferences and the strategies to follow to ensure the needs and preferences are met.

The Quality Standard is assessed as Compliant as five of the five specific requirements have been assessed as Compliant.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

*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.*

Consumers and representatives interviewed by the Assessment Team were satisfied with the care and services provided at the service and said that staff supported their health and well-being. The Assessment Team confirmed assessments for the consumers sampled are completed upon entry to the service and have been reviewed three monthly and/or as consumers’ needs change. The Assessment Team identified care plans sampled are individualised and contain information relative to the risks of each consumer’s health and well-being.

Registered staff complete the initial assessments to identify consumers’ needs, choices and preferences. Consumers, representatives, medical officers, allied health professionals such as physiotherapists, dieticians and occupational therapist are involved where necessary during assessments.

Staff interviewed by the Assessment Team demonstrated they were aware of the commencing assessment and reassessment processes, which identifies risks to the consumer’s safety, health and well-being. These risks included but were not limited to falls, skin integrity, challenging behaviours, pain and nutrition. Staff reported they are provided information about new consumers or updates to a consumer’s care needs through handovers, team discussions and reading care plan documentation. Care documentation is available to staff through an electronic care management system.

Staff reported to the Assessment Team, the outcomes of assessments are documented in care plans and discussed with the consumer and/or representative. Registered staff reported this information could be provided though face to face discussions, telephone calls or electronic mail.

The Assessment Team identified the service has a suite of evidence-based assessment tools available for staff to use. The service has developed policies, procedures, guidelines and flowcharts for staff to refer to and these are available through the intranet or in hard copy at the nurse’s station. Staff have access to education and training relevant to their position. Management advised, and the Assessment Team confirmed through review of documentation that clinical indicators are compiled and reviewed each month to monitor consumers’ health and well-being.

### Requirement 2(3)(b) Compliant

*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.*

Consumers and representatives sampled by the Assessment Team stated staff involve them in the assessment and planning of their care through conversations with staff, case conferences and care plan reviews. Consumers and representatives sampled said they are happy with their care and services and feel their care and services are delivered the way they wish. Consumers and representatives who were asked by the Assessment Team if they had discussed end of life wishes of the consumer with the service. They said they had either made their end of life wishes clear or did not wish to discuss it at this stage and feel comfortable to approach the clinical staff or management if they needed.

For the consumers sampled by the Assessment Team, care planning documentation details the individual’s current needs, goals and preferences. Care planning documents detail their advance care planning and end of life planning. Care documentation for consumers receiving diabetes management confirms each consumer has their blood glucose levels monitored according to their MO instructions.

Registered staff described processes to the Assessment Team for assessing consumer needs and these are evidenced in assessments and care planning documentation. Care staff said consumers’ current needs were documented in their care plan and could describe what is important to the consumers sampled regarding how their personal and clinical care is delivered, including their needs, goals and preferences. Clinical management staff identified to the Assessment Team the service attempts to discuss end of life wishes with consumers and their representatives on entry to the service and if the consumer/representative does not want to discuss end of life plans at that stage, they revisit the conversation at the consumer’s three-monthly review and weekly consumer reviews.

The clinical management staff has a schedule when care plan reviews are due, a review of this schedule by the Assessment Team indicated that no care plans were currently due for review. Review of consumer care documentation by the Assessment Team demonstrate the care plans had been evaluated within the last three months and reflect the consumer’s current care needs, goals and preferences. Staff are guided by organisational policies to support palliative care and advance care planning, which directs a collaborative and holistic approach to assessment and care planning for end of life care.

### Requirement 2(3)(c) Compliant

*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.*

For the consumers sampled by the Assessment team, clinical files and care planning documents reviewed reflected that others are involved in the assessment, planning and review of the consumer’s care and services such as the consumer and/or their representative, Medical officer, lifestyle staff, physiotherapist, occupational therapist, dietitian, speech pathologist. Consumers and representatives sampled by the Assessment Team described how they are involved in assessment and planning on an ongoing basis. Consumer documentation reviewed by the Assessment Team identified the consumer/representative has been involved in the assessment process and the development of goals and the care delivered is updated as consumer needs change. Documentation confirms representatives are contacted following incidents or changes in consumers’ health.

Staff could describe to the Assessment Team the processes for referral to medical specialists or allied health professionals. Staff advised the process for ensuring any changes made by external professionals is communicated to the staff by handover from the registered staff, or at the daily staff meeting. Registered staff described the involvement of others in consumers’ assessment and planning from entry to the service and on an ongoing basis. Staff said they are guided by what the consumer wants and who they wish to be involved in their care and planning. There is evidence in clinical file reviews by the Assessment Team of referrals to, and consultation by the Medical officer, physiotherapist, dietitian and speech pathologist.

Clinical management staff described to the Assessment Team how they partner with the consumers/representatives through telephone conversations, email and consumer/representative meetings. Staff reported they are informed of any changes to consumers’ needs during handover discussion, directly by the registered staff or clinical management staff following a review of the clinical documentation or the staff meeting that is held daily.

### Requirement 2(3)(d) Compliant

*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.*

Consumers and representatives sampled by the Assessment Team stated staff talk to them about their care and services and explain information regarding their care and services to them. The Assessment Team confirmed care plans and referral information is available to consumers/representatives if they wish to have a copy of their information, including the consumer’s care plan. A review of consumer files by the Assessment Team identified care plan reviews with the consumer/representative have occurred in the past three months, and care and services are discussed with the consumer/representative.

Care and service plans reviewed by the Assessment Team are relevant to the consumer’s needs and include, but are not limited to, pain management, skin integrity, behaviour management, restraint, nutrition and hydration, and mobility. Outcomes of assessments and care planning is discussed with consumers/representatives at care plan reviews, weekly reviews and during case conferences or when required if there is a change in the consumer’s health.

Clinical management staff and registered staff reported to the Assessment Team consumers/representatives are involved in the assessment and care review process through three monthly care plan reviews, case conferences and weekly consumer review processes. Staff said they are made aware of changes to care plans through handover processes as well as through notes on the handover sheets or verbally by the registered staff. Registered staff stated care staff notify them if they identify changes in a consumer’s needs and this leads to further assessment and changes to care plans if appropriate. Care staff said they access consumers’ care plans either in paper copy or electronically. Care planning documentation was observed by the Assessment Team to be readily available to staff delivering care and visiting health professionals had access to consumers’ documentation relevant to their role.

### Requirement 2(3)(e) 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.*

Consumers and their representatives interviewed by the Assessment Team confirm the service keeps them informed of any changes in their or their representative’s care and they are involved in care planning and three-monthly care reviews. Representatives and consumers advised the Assessment Team the service actively involves them care plan reviews and seeks their input about any changes or preferences to care needs. Care plans for consumers sampled by the Assessment Team show evidence of review on a regular basis and when circumstances change and/or incidents occur. For the consumers sampled by the Assessment Team, staff could describe how and when care plans are reviewed. A review of consumer care documentation by the Assessment Team identified care plans have been reviewed in the past three months with changes made as necessary in line with the service’s policies and procedures.

Clinical management and registered staff interviewed by the Assessment team demonstrated an awareness of the service’s three-monthly re-assessment process, the consumer weekly review process and when consumers’ needs change including following incidents, review by the Medical officer, other allied health practitioners or on return from hospital.

Staff reported shift handovers and team discussions are used by registered and care staff to discuss identified changes in consumers’ needs or preferences. Staff are aware of the incident reporting process, escalation of incidents including informing the Enduring power of attorney, the requirement to report a change in consumer’s needs or preferences and how these incidents may trigger a re-assessment. Registered staff reported details are recorded in progress notes regarding any changes in the consumers’ health status or when care and services are unable to be delivered in line with their documented care plan.

The service monitors and trends monthly clinical indicators including falls, skin integrity and pressure injuries, medication incidents and incidents of hospitalisation. The service has policies and procedures regarding assessment, re-assessment and care planning processes including referral and review by allied health professionals and a Medical officer on return from hospital. Clinical management staff monitors and maintains the service’s care plan tracker to ensure that all consumers’ care plans are reviewed and updated in line with the service’s policy.

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is, however, required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.