Performance

Report

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| Name of service: | Bethania Gardens |
| Service address: | 87 - 91 Station Road BETHANIA QLD 4205 |
| Commission ID: | 5499 |
| Approved provider: | Pu-Fam Pty Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 3 May 2023 |
| Performance report date: | 6 June 2023 |

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

**This performance report**

This performance report for Bethania Gardens (**the service**) has been prepared by Stewart Brumm, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Assessment Contact – Site 3 May 2023; 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 provider’s response to the assessment team’s report received 19 May 2023.
* the assessment team’s report for the Assessment Contact – Desk 31 March 2023; the Assessment Contact - Site report was informed by a review of documents and interviews with staff, consumers/representatives.
* Information from the intake, complaints, and resolution group of the Commission.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

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

# 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 required to actively pursue continuous improvement in order to remain compliant with the Quality Standards. The provider is encouraged to complete the review of the Falls Prevention, Assessment and Monitoring Policy as indicated would occur.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

The Assessment Team provided information that consumers/representatives said consumers’ care is safe and right for the consumer, care documentation sampled for consumers at risk of falling and developing a pressure injury demonstrated risk mitigation strategies and wound care was completed as planned. However, for consumers who fall, care documentation demonstrated post fall observations were not completed as per the service’s post fall guidelines to identify potential consumer deterioration in a timely manner.

For the named consumers, the Assessment Team identified that post fall neurological observations and vital signs were not being consistently recorded as per the organisation policy.

The Approved Provider provided a response to the Assessment Team report with included clarifying information as well as clinical records extracts and a plan for continuous improvement.

The Approved Provider acknowledged that staff had not been consistently following the organisation post falls policy and processes. Interviews were also conducted with the registered nurses to identify why the policy was not being followed.

Following this the Approved Provider has implemented a range of improvement actions to address the identified deficits. This included commencing mandatory online education for registered staff on falls prevention, post falls observations and how to identify rapid deterioration post fall. Further onsite education is also being arranged. Increased monitoring of post falls processes has commenced with the care manager conducting review of all post falls management. Weekly and fortnightly falls reviews are also being conducted by the care manager, clinical team, and physiotherapist. The Approved Provided clinical records extracts for two consumers who had recent falls, and these records demonstrate that neurological observations and vital signs have been recorded.

I note the Approved Provider advised the Assessment Team that the policy regarding falls would be reviewed. This has not yet occurred and is not recorded to occur on the plan for continuous improvement.

I have considered the Assessment Team information as well as the Approved Provider response. I find that with the exception of reviewing the falls policy, the Approved Provider has taken corrective action to address the deficit of staff not recording neurological observations and vital signs for consumers post fall and provided clinical records extracts confirm this is occurring.

I am persuaded by the actions taken by the Approved Provider that the deficits in the process have been corrected and additional monitoring activities have been established to ensure ongoing compliance.

I find this requirement is compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

The Assessment Team provided information that the Approved Provider is providing meals which are of suitable quality and quality, taking into consideration individual consumer needs and preferences.

Consumer representatives interviewed were satisfied with the variety and suitability of meals provided to consumers. Staff were able to describe how they know consumers’ nutrition and hydration needs and preferences.

The Approved Provider has implemented a range of improvement activities to address previous non-compliance with this requirement. This included additional education for staff on the improvements being implemented, as well education on the management of special diets. Staffing in dining rooms at meals times has been increase and a colour coded tray system for special diets introduced. Additional monitoring and audits have also been introduced.

I have considered the information provided by the Assessment Team and I am persuaded by the consumer representative feedback and the range of improvement activities completed.

I find this requirement is compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The Assessment Team provided information that the Approved Provider is acknowledging issues raised in a timely manner to the satisfaction of consumer representatives and using feedback and complaints to continually improve the care and services provided to consumers

Consumer representatives interviewed expressed confidence that the Approved Provider uses feedback and complaints to improve the quality of care and services and confirmed consumers and representatives are involved in improvements.

Management advised the service trends and analyses complaints; feedback and concerns raised by consumers/representatives and uses this information to inform continuous improvement activities across the service which are documented under the plan for continuous improvement

The Approved Provider has implemented a range of improvement activities to address previous non-compliance with this requirement. This included additional education for staff on complaints handling. A review of policies and procedures was completed, and improvements made to the processing of complaints.

I have considered the information provided by the Assessment Team and I am persuaded by the consumer representative feedback and the range of improvement activities completed.

I find this requirement is 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 |

Findings

The Assessment Team provided information that the Approved Provider was able to demonstrate staffing allocations meet consumers’ needs and most consumers felt they are well cared for by the staff and had no complaints about the care they received. Consumer representatives considered there are enough staff to meet consumer needs. Staff said there are adequate staff to provide care and services in accordance with consumers' needs and preferences and staff generally have sufficient time to undertake their allocated tasks and responsibilities. Management has contingency plans in place to replace staff when required and rosters are reviewed on a regular basis to ensure staff allocations are adequately meeting changing consumer needs and preferences.

The Approved Provider has implemented a range of improvement activities to address previous non-compliance with this requirement. This included ongoing recruitment of care and registered staff. A new call bell system is being installed, and call bell wait times are monitored every day, and the care manager or facility manager will investigate all call bell responses not attended for more than 5 minutes. The organisation has recruited a business development manager, who will have responsibility around implementing flexible staffing arrangements across the organisation, which will provide the service with additional staff.

I have considered the information provided by the Assessment Team and I am persuaded by the consumer, representative and staff feedback and the range of improvement activities completed.

I find this requirement is compliant.

# Standard 8

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| Organisational governance | |  |
| 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. | Compliant |

Findings

**Requirement 8(3)(c):**

Ineffective governance systems were previously identified in relation to regulatory compliance, workforce governance and feedback and complaints. This requirement was previously non-compliant following a site audit in April 2022.

The Assessment Team provided information that the Approved Provider demonstrated processes are in place for continuous improvement, workforce governance, regulatory compliance and management of feedback and complaints. The organisation has structures in place to ensure consistency is maintained.

Management advised the plan for continuous improvement is consistently edited and updated to accurately reflect changing consumer needs. The Approved Provider demonstrated an effective system to capture complaints and compliments used to directly influence new and ongoing actions recorded on the plan for continuous improvement. The Assessment Team reviewed the service’s plan for continuous improvement which identifies planned and completed improvement actions in relation to various areas of care and service delivery.

The Approved Provider has a workforce governance framework in place to ensure staff are skilled and qualified to provide safe, respectful, and quality care and services to consumers.

The Approved Provider demonstrated systems are in place to encourage the provision of consumer feedback and complaints to ensure appropriate and proportionate action is taken.

Management advised the organisation had communicated updates and provided resources to staff regarding the introduction of Serious incident reporting scheme, changes to restrictive practices and the requirement for behaviour support plans via electronic mail, staff meetings, dissemination of policies and training.

The Approved Provider has implemented a range of improvement activities to address previous non-compliance with this requirement. This included additional education for staff and monthly internal audits against the Aged Care Quality Standards.

I have considered the information provided by the Assessment Team and I am persuaded by Approved Providers ability to demonstrate compliance and the range of improvement activities completed.

I find this requirement is compliant.

**Requirement 8(3)(d):**

The Assessment Team provided information that the Falls Prevention, Assessment and Monitoring Policy is not consistently followed by staff and the policy to be lacking sufficient detail to guide staff effectively. The electronic care management system did not provide fields for the recording of sufficient post fall monitoring observations in one location. Gaps in staff practice have resulted in post falls monitoring and recording deficits and subsequent management of high impact and high prevalence risk.

An incident had not been reported as required under the Serious Incident Response Scheme.

The Approved Provider provided a response to the Assessment Team report with included clarifying information as well as clinical records extracts and a plan for continuous improvement.

The Approved Provider acknowledged that staff had not been consistently following the organisation post falls policy and processes. Interviews were also conducted with the registered nurses to identify why the policy was not being followed.

Following this the Approved Provider has implemented a range of improvement actions to address the identified deficits. This included commencing mandatory online education for registered staff on falls prevention, post falls observations and how to identify rapid deterioration post fall. Further onsite education is also being arranged. Increased monitoring of post falls processes has commenced with the care manager conducting review of all post falls management. Weekly and fortnightly falls reviews are also being conducted by the care manager, clinical team, and physiotherapist. The Approved Provider provided clinical records extracts for two consumers who had recent falls, and these records demonstrate that neurological observations and vital signs have been recorded.

I note the Approved Provider advised the Assessment Team that the policy regarding falls would be reviewed. This has not yet occurred and is not recorded to occur on the plan for continuous improvement.

In relation to the failure to report an incident to the serious incident response scheme, I note the Approved Provider did not agree that the incident was required to be reported. The consumer did not die from an unexpected cause, but rather hospital records indicated that the consumer died from the known medical condition, and it was a reasonably expected outcome of the medical condition. Based on this, I find the Approved Provider had met their responsibilities for this consumer, in relation to the serious incident response scheme.

I have considered the Assessment Team information as well as the Approved Provider response. I find that with the exception of reviewing the falls policy, the Approved Provider has taken corrective action to address the deficit of staff not recording neurological observations and vital signs for consumers post fall and provided clinical records extracts confirm this is occurring.

I am persuaded by the actions taken by the Approved Provider that the deficits in the process have been corrected and additional governance and monitoring activities have been established to ensure ongoing compliance.

I find this requirement is compliant.

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