Performance

Report

**1800 951 822**

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| Name of service: | Bethanie Gwelup |
| Service address: | 72-74 Huntriss Road GWELUP WA 6018 |
| Commission ID: | 7457 |
| Approved provider: | The Bethanie Group Incorporated |
| Activity type: | Assessment Contact - Site |
| Activity date: | 20 June 2023 to 21 June 2023 |
| Performance report date: | 19 July 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 Bethanie Gwelup (**the service**) has been prepared by G Cherry, 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; 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
* Performance Report dated 19 October 2022
* Non-Compliance Notice dated 21 November 2022.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | 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.

# 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)(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 was not fully assessed, and therefore has not received a compliance rating. Two of five requirements were assessed and found compliant.

A decision was made on 19 October 2022 that the service was non-compliant in requirements 2(3)(a) and 2(3)(e) after a site assessment conducted 30 August 2022 - 1 September 2022.

Requirement 2(3)(a)

The service did not demonstrate an effective system of assessment and planning (including consideration of risk) informs delivery of safe and effective care/services specifically in relation to falls, skin integrity, choking, oral/dental, communication, behaviours, pain, diabetes and nutrition/hydration.

The approved provider advised the assessment team conducting an assessment contact visit on 20-21 June 2023 of improvement activities/actions in response to previous non-compliance and supplied a Plan for Continuous Improvement (PCI) received 14 June 2023 addressing issues previously raised. Improvements relevant to this requirement were confirmed with management and staff as follows:

* Education (requiring mandatory attendance) occurred for registered/enrolled nurses and care staff.
* All new consumers’ care discussed at Care Team Meetings (CTM) in relation to assessments and care planning requirements.
* A review of the service’s care plan review schedule resulted in development of new monitoring documentation/processes to ensure completion of assessments/care planning guidance in a timely manner.
* Monthly key performance indicators to reflect percentage of care plan completion.
* A review of effectiveness of staff ‘handover’ discussion resulted in commencement of a daily meeting to monitor care deliver, changes to consumers’ condition determining appropriate care intervention/provision.

During this assessment contact information was gathered through interviews, observations and document review. Overall, sampled consumers/representatives express satisfaction with admission/assessment processes, including identification of risk leading to a documented (and agreed) care plan guiding care delivery. Via review of documentation the assessment team note a process of accurate identification/assessment of risk to consumer’s health/well-being and development of care plans to safely manage risks due to system enhancements. Examples include changed behaviours and medication management. Interviewed staff demonstrate knowledge of improved processes, expressing positive feedback relating to readability/accuracy and methods of obtaining current information. Daily meeting forums are utilised to transfer information relating to changes in care, consumers deemed at risk, transfers to/from hospital and infection data. Amendments to admission processes ensure comprehensive assessments completed within delegated timeframes, nominated staff responsibility, medical officer, consumer, and representative involvement. Sampled consumers and representatives express satisfaction with processes and regular communication/involvement when changes occur.

In consideration of compliance, I am swayed by the evidence brought forward by the assessment team, feedback received from consumers/representatives/staff and the service’s demonstration of actions/outcomes to ensure assessment and planning, include consideration of risk, and inform delivery of safe care and services. I find requirement 2(3)(a) is compliant.

Requirement 2(3)(e)

The service did not demonstrate an effective system of care/services regularly reviewed for effectiveness, when circumstances change and/or incidents impact consumers’ needs/goals/preferences, specifically following hospital transfers and falls.

The approved provider advised the assessment team conducting an assessment contact visit on 20-21 June 2023 of improvement activities/actions in response to previous non-compliance and provided a Plan for Continuous Improvement (PCI) received 14 June 2023 addressing issues previously raised. Improvements relevant to this requirement were confirmed with management and staff as follows:

* Education (requiring mandatory attendance) for registered/enrolled nurses and care staff.
* Conducted a review of all consumers recently discharged from hospital – this topic to be discussed at all CTMs.
* Discussion between general manager and clinical governance team resulted in a trial of pain related issues titled ‘Pain Check’.
* Review conducted relating to all consumers with a diagnosis of pain.
* Consumers receiving palliative care and/or requiring wound management for chronic wounds reviewed to ensure prescribing of appropriate pain management medication.
* Review ‘as required’ (PRN) medication to ensure effectiveness, notation in relevant documentation and appropriate frequency of administration.
* Conduct a review to ensure congruence between assessment and care planning documentation to guide/direct care provision.

During this assessment contact information was gathered through interviews, observations and document review. Demonstration that care and services are regularly reviewed for effectiveness, when consumer’s condition deteriorates, circumstances change and/or when incidents impact consumers’ needs are evident. Via documentation review the assessment team note review/changes are mostly reflected in care planning documentation. While noting one consumer’s documentation did not contain current information post dietitian review, interviewed staff demonstrate knowledge of current dietary requirements. Interviewed consumers and representatives express satisfaction care and services are regularly reviewed, representatives noting improved communication from management and staff. Effectiveness of regular meeting forums involving clinical nursing managers, registered nurses and allied health staff is evident. Documentation detail discussion of individual consumer actions/outcomes.

In consideration of compliance, I am swayed by the evidence brought forward by the assessment team, feedback received from consumers/representatives/staff and the service’s demonstration of actions/outcomes to ensure regular review of care and services, when circumstances change and/or incidents impact consumers’ needs. I find requirement 2(3)(e) is 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. | Compliant |

Findings

The Quality Standard was not fully assessed, and therefore has not received a compliance rating. Two of seven requirements were assessed and found compliant.

A decision was made on 19 October 2022 that the service was non-compliant in requirements 3(3)(a) and 3(3)(b) after a site assessment conducted 30 August 2022 - 1 September 2022.

Requirement 3(3)(a)

The service did not demonstrate each consumer received safe and effective personal/clinical care, that is best practice, tailored to their needs and optimises health/well-being, specifically in relation to management of pain, skin integrity, nutrition/hydration and delivery of personal care.

The approved provider advised the assessment team conducting an assessment contact visit on 20-21 June 2023 of improvement activities/actions in response to previous non-compliance and provided a Plan for Continuous Improvement (PCI) received 14 June 2023 addressing issues previously raised. Improvements relevant to this requirement were confirmed with management and staff as follows:

* Education (requiring mandatory attendance) for registered/enrolled nurses and care staff.
* Introduction of ‘resident of the day’ monitoring/review process to ensure regular/ongoing review of consumer’s needs.
* Conduct a review to ensure congruence between assessment and care planning documentation to guide/direct care provision.

During this assessment contact information was gathered through interviews, observations and document review. The service demonstrates providing each consumer with safe and effective personal/clinical care tailored to their needs to optimise health and well-being. Sampled consumers/representatives consider staff provide appropriate care, and express satisfaction with outcomes including improved pain, wound, diabetes management and referral to medical officer, allied health and/or other specialists when required. Effective systems and processes ensure identification, assessment, management and evaluation of consumers’ clinical care include diabetes, pain, continence management and restrictive practices. Documentation review detail monitoring processes, adherence to medical officer/allied health/specialist directives. Psychotropic medication documentation details relevant diagnosis, medication use, appropriate consent processes conducted, monitoring processes ensure accuracy/currency of information.

In consideration of compliance, I am swayed by the evidence brought forward by the assessment team, feedback received from consumers/representatives and the service’s demonstration of actions/outcomes to ensure consumers receive safe and effective personal/clinical care. I find requirement 3(3)(a) is compliant.

Requirement 3(3)(b)

The service did not demonstrate effective management of high impact high prevalence risks associated with each consumer’s care, specifically in relation to falls, diabetes and medication management.

The approved provider advised the assessment team conducting an assessment contact visit on 20-21 June 2023 of improvement activities/actions in response to previous non-compliance and provided a Plan for Continuous Improvement (PCI) received 14 June 2023 addressing issues previously raised. Improvements relevant to this requirement were confirmed with management and staff as follows:

* Education (requiring mandatory attendance) for care staff.
* Monitoring of 3-day pain chart for new and/or increased pain requirements, monthly pain monitoring review as a component of newly introduced ‘resident of the day’ process.
* Monitoring and auditing of all documentation relating to falls, continued discussion of falls management at care team meetings.
* Review internal processes relating to psychotropic medication to ensure inclusive of individualised directives from medical officer/referral process.
* Monitoring of 7-day behaviour charting for new and/or increased unmet/changed behaviours, continued discussion of falls management at care team meetings, Completion of a behaviour management study - currently implementing identified actions.
* Review effectiveness of shift ‘handover’ discussions/communication resulting in a daily meeting to monitor care delivery.
* Provision of strategies for staff to improve the well-being of residents living with Dementia.
* Engagement of an external party (nurse advisor) to identify causal factors associated with ongoing deficits in incident reporting.

During this assessment contact information was gathered through interviews, observations and document review. The service demonstrates effective management of high impact high prevalence risks for sampled consumers. Management personnel detailed systems/processes to monitor consumers identified at risk, related clinical risks and processes to minimise/mitigate these, including daily clinical meetings to discuss individual consumer’s needs and subsequent interventions. Documentation review detail risks such as pressure injury/wound care, falls and pain management are identified, reviewed and strategies implemented. Examples include appropriate staff response in relation to consumers experiencing an unwitnessed fall, neurological observations, medical officer/allied health referral, pain medication and ongoing monitoring, completion of incident documentation for review. Behaviour support plans contain appropriate information to guide care delivery when changed behaviours occur, speech pathology/dietitian review in response to unplanned weight loss, administration of pain medication and ongoing monitoring regarding wound care. Sampled consumers/representatives express satisfaction in responsiveness to care needs, implementation of strategies to minimise/mitigate risks including positive/improved outcomes.

In consideration of compliance, I am swayed by the evidence brought forward by the assessment team, feedback received from consumers/representatives and the service’s demonstration of actions/outcomes to ensure effective management of high impact/prevalence risks associated consumer’s care. I find requirement 3(3)(b) is compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | 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 was not fully assessed, and therefore has not received a compliance rating. Two of four requirements were assessed and found compliant.

A decision was made on 19 October 2022 that the service was non-compliant in requirements 6(3)(c) and 6(3)(d) after a site assessment conducted 30 August 2022 - 1 September 2022.

Requirement 6(3)(c)

The service did not demonstrate appropriate action is consistently taken in response to complaints and principles of open disclosure utilised when things go wrong.

The approved provider advised the assessment team conducting an assessment contact visit on 20-21 June 2023 of improvement activities/actions in response to previous non-compliance and provided a Plan for Continuous Improvement (PCI) received 14 June 2023 addressing issues previously raised. Improvements relevant to this requirement were confirmed with management and staff as follows:

* Ensuring all staff have access to electronic feedback system resulting in increased/improved reporting.
* Leadership team response to all complaints in line with organisational open disclosure policy.

During this assessment contact information was gathered through interviews, observations and document review. In general, the service demonstrates appropriate action taken in response to complaints, including use of principles relating to open disclosure when things go wrong. Most sampled consumers/representatives express satisfaction of response received to suggestions/feedback/complaints; several consumers stating they did not have reason to formally complain, expressing satisfaction with care and services received. They gave examples of satisfactory responsiveness to lost items and requested repairs. While one representative expressed dissatisfaction in achieving required outcome, management demonstrate ongoing communication/trialling of actions to achieve positive outcomes. Interviewed management personal and staff demonstrate awareness/familiarity with open disclosure processes and documentation details utilisation of this practice when required. Policy documents guide organisational requirements. Some interviewed staff demonstrate methods used when receiving feedback from consumers/representatives including escalating concerns to registered staff and/or management team. Documentation detail provision of staff education during orientation processes.

In consideration of compliance, I am swayed by the evidence brought forward by the assessment team, positive feedback received from most consumers/representatives and the service’s demonstration of actions to achieve desired outcomes in relation to feedback/complaints received. On balance, I find requirement 6(3)(c) is compliant.

Requirement 6(3)(d)

The service did not demonstrate feedback and complaints are consistently reviewed and utilised to improve/inform quality care and services.

The approved provider advised the assessment team conducting an assessment contact visit on 20-21 June 2023 of improvement activities/actions in response to previous non-compliance and provided a Plan for Continuous Improvement (PCI) received 14 June 2023 addressing issues previously raised. Improvements relevant to this requirement were confirmed with management and staff as follows:

* Feedback/suggestions/complaints a standing agenda item at all meeting forums.
* Implement a system to ensure feedback is monitored, reviewed and analysed on a monthly basis.

During this assessment contact information was gathered through interviews, observations and document review. The service demonstrates systems and processes to utilise feedback and complaints received to inform/improve quality of care and services. Documentation review demonstrates complaints are documented, individually investigated and result in continuous improvement items. Management demonstrate knowledge of trends relating to complaints management. For example, a review of laundry dissatisfaction resulted in changes to processes. Whilst ongoing, management note increased satisfaction and interviewed consumers express satisfaction with improved laundry services. Other quality improvements directly related to consumer complaint/feedback resulted in menu changes.

In consideration of compliance, I am swayed by the evidence brought forward by the assessment team, positive feedback received from most consumers/representatives and the service’s demonstration of actions to demonstrate and effective process of reviewing complaints to improve quality of care and services. I find requirement 6(3)(d) is compliant.

# Standard 7

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| Human resources | |  |
| 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 |

Findings

The Quality Standard was not fully assessed, and therefore has not received a compliance rating. One of five requirements was assessed and found compliant.

A decision was made on 19 October 2022 that the service was non-compliant in requirement 7(3)(c) after a site assessment conducted 30 August 2022 - 1 September 2022. The service did not demonstrate and effective system to ensure a competent workforce and/or members of the workforce demonstrate knowledge to effectively perform their roles; specifically relating to falls/pain/medication management, changed behaviours, diabetes and implementation of health specialist directives.

The approved provider advised the assessment team conducting an assessment contact visit on 20-21 June 2023 of improvement activities/actions in response to previous non-compliance and provided a Plan for Continuous Improvement (PCI) received 14 June 2023 addressing issues previously raised. Improvements relevant to this requirement were confirmed with management and staff as follows:

* Education (requiring mandatory attendance) for registered/enrolled nurses and care staff.
* Internal and external training to include an example of the presentation and evaluation of completed training within all staff education records.
* Review (including staff consultation) of staff duty statements ensuring staff accessibility.
* Implement process to ensure staff performance review.
* Review skill mix required to deliver safe care/services – resulting in employment of a second clinical nurse manager and an increase of 5 staff.

During this assessment contact information was gathered through interviews, observations and document review. Most sampled consumers/representatives express satisfaction of staff responsiveness and competency resulting in appropriate care delivery. The service demonstrates effective systems/processes to ensure workforce competency and staff have qualifications and knowledge to effectively perform their roles. Management demonstrate monitoring systems to ensure staff are trained to deliver required outcomes of the Quality Standards and performance management processes in relation to an identified need. Interviewed staff note receipt of comprehensive and responsive training and education programs inclusive of topics relating to the Quality Standards. Via review of documentation the assessment team note completion of continuous improvement actions relating to this requirement, training records, duty statements/competency requirements and plans for future education/training. Staff were observed providing a comprehensive handover/transfer of information relating to consumer needs.

In consideration of compliance, I am swayed by the evidence brought forward by the assessment team, feedback received from consumers/representatives and the service’s demonstration of actions/outcomes to ensure a competent workforce with qualifications and knowledge to effectively perform their roles. I find requirement 7(3)(c) is compliant.

# Standard 8

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| Organisational governance | |  |
| 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

The Quality Standard was not fully assessed, and therefore has not received a compliance rating. One of five requirements was assessed and found compliant.

A decision was made on 19 October 2022 that the service was non-compliant in requirement 8(3)(d) after a site assessment conducted 30 August 2022 - 1 September 2022. The service did not demonstrate effective risk management systems (including incident management system) and practices specifically in relation to managing and preventing incidents.

The approved provider advised the assessment team conducting an assessment contact visit on 20-21 June 2023 of improvement activities/actions in response to previous non-compliance and provided a Plan for Continuous Improvement (PCI) received 14 June 2023 addressing issues previously raised. Improvements relevant to this requirement were confirmed with management and staff as follows:

* Education (requiring mandatory attendance) for registered/enrolled nurses and care staff.
* Review all consumer risk assessment documentation to ensure choice agreements are current.
* Review effectiveness of shift ‘handover’ discussions/communication resulting in a daily meeting to monitor care delivery.
* Ensure systems/processes focus on consumers’ safety, health, well-being, and quality of life.
* Engagement of an external party (nurse advisor) to identify factors associated with ongoing deficits in incident reporting.

During this assessment contact information was gathered through interviews, observations and document review. Effective risk management systems and practices were demonstrated. Senior management advise monthly leadership meetings review clinical indicators, consumer’s risks are discussed/reviewed to ensure contributing factors/appropriate interventions and/or continuous improvement activities implemented. Review of incident documentation occurred to ensure appropriate legislative reporting, implementation of monitoring processes and provision of staff education. Further education is planned by Dementia Support Australia to enhance staff skills in managing/responding to consumers living with a diagnosis of dementia. Review of systems/processes resulted in amendments to ensuring consumer’s choice in relation to risk-taking activities, providing documented information relating to risk/subsequent interventions and management to guide care delivery. Changes to the clinical governance framework occurred relating to incident reporting/management (including legislative reporting) to ensure reporting and trend identification for executive team review and/or actioning where required. Amendments to Behaviour support plan (BSP) have occurred to ensure assessment process congruent with legislation and incorporating all care domains within care planning documentation to guide staff in care provision.

In consideration of compliance, I am swayed by the evidence brought forward by the assessment team and the service’s demonstration of actions/outcomes to ensure effective risk management systems and practices. I find requirement 8(3)(d) is compliant.

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