Performance

Report

**1800 951 822**

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| Name of service: | Bethanie Subiaco |
| Service address: | 45 Bishop Street JOLIMONT WA 6014 |
| Commission ID: | 7445 |
| Approved provider: | The Bethanie Group Incorporated |
| Activity type: | Assessment Contact - Site |
| Activity date: | 16 February 2023 |
| Performance report date: | 14 March 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 Subiaco (**the service**) has been prepared by K Richards, 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 consumers, representatives, staff and management.
* the provider’s response to the Assessment Team’s report received 9 March 2023.
* the Performance Report dated 11 May 2022 for an Assessment Contact - Site undertaken on 9 March 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 | **Non-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.

* In relation to Standard 3 Requirement (3)(b), the service is to ensure high impact and high prevalence risks associated with the care of consumers are effectively managed, including ensuring restraint authorisation and behaviour support plans are completed for impacted consumers, and where chemical restraint is used, it is used as a last resort following trial of personalised non-pharmacological strategies and consumers are monitored for medication effectiveness or adverse effects.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| 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

Requirement (3)(e) was found Non-compliant following an Assessment Contact undertaken on 9 March 2022 in relation to the service not reviewing care and services following changes in health status.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Allocation of a clinical staff member to the memory support unit (MSU) to review behaviour support plans for all consumers, ensuring they capture health and well-being needs and provide meaningful and personalised strategies.
* Provision of training for clinical staff on dementia and management of wounds and pressure injuries.
* The organisation made improvements to the electronic care planning system to ensure care planning is updated automatically with completion of assessments, although this had not been fully implemented at time of Assessment Contact.

At the Assessment Contact undertaken on 16 February 2023, the Assessment Team found the service was able to demonstrate care and services are reviewed regularly for effectiveness, when circumstances change, or when incidents impact on the needs, goals, or preferences of the consumer.

Care plans included evidence of assessment and care planning on a regular basis, or with change of circumstances or incidents such as falls, hospitalisation, wounds, low mood, or deterioration. Representatives said following incidents they were contacted to advise and discuss preferred treatment and strategies. Clinical staff could describe process for review, reassessment, and communication of changes.

I note the Assessment Team’s report identified deficiencies relating to assessment and review of behaviour support plans under Standard 3 Requirement (3)(b). I have placed weight on the service already identifying issues through internal audits, undertaken prior to the Assessment Contact, with management advising investigations determined the assessments had been undertaken, however, the electronic system did not populate the information into care planning.

For the reasons detailed above, I find Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers Compliant.

# 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. | Non-compliant |

Findings

Requirement (3)(b) was found Non-compliant following an Assessment Contact undertaken on 9 March 2022. The service did not demonstrate effective management of high impact or high prevalence risks in relation to pressure injuries and wounds, monitoring of pain, management of behaviours, and the use of psychotropic medications.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Improving monitoring processes for wound and pressure injury care and use of restrictive practices.
* Undertaking fortnightly multidisciplinary meetings with focus on consumer risks, and provide clinical education.
* Undertaking pain assessments for all consumers at least every 3 months, and following incidents.

However, the Assessment Team found the service was unable to demonstrate effective management of high impact or high prevalence risks for consumers subject to restrictive practices. Behaviour support plans were not individualised with strategies to support or monitor consumers, and when chemical restraint had been used on an as required basis there was insufficient documentation to identify the behaviour of concern and demonstrate non-pharmacological strategies trialled before medication had been administered. Documentation did not reflect evaluation effectiveness or monitoring for adverse effects following use of chemical restraint. Medication charts did not have indications for use for prescribed psychotropic medications, and the service did not have restraint authorities for all consumers subject to chemical restraint.

The Assessment Team reported the service had not identified use of mechanical restraint following observation of staff lowering one consumer in bed to the lowest position moving their mobility aid out of reach. Staff advised the bed was lowered as part of the falls prevention strategy, and management provided rationale for not considering this as mechanical restraint, as the bed was not a lo-lo bed and the consumer can get up unassisted even when the bed is at lowest position.

The provider’s response indicates they understand and accept the deficits highlighted in the Assessment Team’s report. The response details actions being taken in response, including but not limited to, updating behaviour support plans, updating medication charts with indications for medication use, staff education, and updating the psychotropic register. The plan for continuous improvement captures these actions and demonstrates further actions including increased oversight of use of psychotropic medications and ensuring all restraint authority forms are completed.

In relation to the use of mechanical restraint, the provider’s response includes further evidence to demonstrate this is not mechanical restraint, including Physiotherapy assessment confirming the consumer can transfer from sit to stand from lower heights. I am persuaded by the provider’s evidence that the lowering of the bed was not mechanical restraint.

Whilst I note the approved provider has taken action in response to the information raised in the Assessment Team report, I find the service did not demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer in relation to the use of chemical restraint.

For the reasons detailed above, I find Requirement (3)(b) in Standard 3 Personal and clinical care Non-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)