Performance

Report

**1800 951 822**

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| Name of service: | Blue Care Beenleigh Bethania Haven Aged Care Facility |
| Service address: | 67-71 Station Road BETHANIA QLD 4205 |
| Commission ID: | 5182 |
| Approved provider: | The Uniting Church in Australia Property Trust (Q.) |
| Activity type: | Assessment Contact - Site |
| Activity date: | 4 April 2023 |
| Performance report date: | 28 April 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 Blue Care Beenleigh Bethania Haven Aged Care Facility (**the service**) has been prepared by S Turner, 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
* the performance report dated 24 June 2022
* information about the service’s compliance history held by the Aged Care Quality and Safety Commission

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 7** Human resources | **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 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 |

Findings

The performance report dated 24 June 2022 found the service non-compliant in requirement 3(3)(a). The performance report included information that in some instances consent had not been provided for the application of restrictive practices.

On 4 April 2023 an assessment contact was conducted. The Assessment Team found the service had taken action to improve its performance under this requirement and has initiated the following improvements:

* All consumer care documentation has been reviewed to ensure informed consent for the use of restrictive practice has been obtained; assessments, monitoring processes and behaviour support plans were current and in place.
* Consumers’ care planning documentation is reviewed every three months which includes a review of restrictive practice. Staff said the medical officer completes assessments for consumers subject to restrictive practice every six months and consent from consumers or representatives is obtained annually. The Assessment Team confirmed this process was occurring and was up to date.
* There is a schedule to identify those consumers whose care documentation (including various assessments, behaviour support plans and restrictive practice) is due for review. The Assessment Team reviewed the schedule which identified the consumers whose care documentation was due for review in April 2023.
* Meetings are held weekly with management to monitor the completion of consumers’ care documentation reviews. The Assessment Team reviewed meeting minutes and confirmed the meeting included discussion of consumer care planning and restrictive practices.
* Management said the use of restrictive practices and completion of assessment, monitoring, consent and behaviour support plans is reported and monitored at the organisation’s quality meetings.
* The medication advisory committee discusses consumers who are prescribed psychotropic medications as a standing agenda item at the quarterly meetings. The Assessment Team reviewed the medication advisory committee meeting minutes and confirmed discussion involved psychotropic medication and the use of chemical restrictive practice.

Consumers and representatives advised they are satisfied with the care provided to consumers. They described how the service is effectively managing consumers who are subject to restrictive practices and ensuring informed consent has been provided.

Staff have access to the organisation’s restrictive practice policy which outlines the requirements relating to assessment, monitoring, behaviour support plans and informed consent. The Assessment Team reviewed the documentation for all consumers subject to restrictive practice and this evidenced ongoing assessment, monitoring and informed consent; individualised behaviour support plans were in place. Additionally, the service has processes in place to ensure restrictive practice requirements are completed and maintained.

Registered staff identified consumers who were subject to restrictive practices and described the circumstances when as required chemical restrictive practice would be administered such as after alternative strategies were attempted. Registered staff demonstrated understanding of restrictive practices and the requirements for gaining consent for their use.

I am satisfied the service has improved its performance under this requirement and that the service has processes in place to safely and effectively manage restrictive practices.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

The performance report dated 24 June 2022 found the service non-compliant in requirement 7(3)(d). The performance report included information that staff had not completed training in topics relevant to their role and the service had not monitored completion of mandatory training.

On 4 April 2023 an assessment contact was conducted. The Assessment Team found the service has improved its performance under this requirement and the following actions have been implemented:

* New staff complete a two-day orientation program, are provided with peer-to-peer coaching and are supported for their first three months working at the service.
* Mandatory training is monitored via a spreadsheet and is colour coded to demonstrate each staff member’s progress in completion of the various training modules. Administration staff review completed training on a weekly basis and provide a report to management of those staff due to complete training. Reminders are being sent to staff when their training is due.
* The mandatory training program is adjusted to meeting training requirements; for example, a module on voluntary assisted dying has recently been added to the program.
* Training is conducted to address staffs’ specific needs or to address regulatory changes. Records showed that training has been completed in topics including stoma care and the Code of Conduct for Aged Care. Toolbox training is conducted at staff meetings to refresh staff skills and recent meeting minutes demonstrated staff had received training in manual handling and falls prevention.
* A report on the completion of mandatory training is provided to the regional management team and to the governing body.

Consumers and representatives reported overall satisfaction with the knowledge and skills of staff with feedback including that the service had improved.

Mandatory training modules include restrictive practices, consumer protection, positive behaviour support and supporting people living with dementia. The Assessment Team reviewed the mandatory training spreadsheet and confirmed that training is monitored and that staff are completing their required training.

Staff reported being happy with the training they received and said they had sufficient time to complete training modules and that the training program met their needs. Staff demonstrated an understanding of recent regulatory changes including for example restrictive practice. Registered staff said they had been provided with documented guidance for indwelling catheter management and that senior clinical staff are available to assist and supervise when required. Agency staff were observed by the Assessment Team being orientated to the service prior to commencing their shift and reported they had a clear understanding of their duties and their role, had access to the electronic care management system and had the necessary information to care for consumers.

I am satisfied the service has improved its performance under this requirement and that the service has processes in place to ensure staff are trained and equipped to undertake their roles.

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)