Performance

Report

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| Name of service: | Blue Care Maleny Erowal Aged Care Facility |
| Service address: | 1274 Landsborough Rd MALENY QLD 4552 |
| Commission ID: | 5327 |
| Approved provider: | The Uniting Church in Australia Property Trust (Q.) |
| Activity type: | Assessment Contact - Site |
| Activity date: | 3 April 2023 to 4 April 2023 |
| Performance report date: | 13 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 Maleny Erowal Aged Care Facility (**the service**) has been prepared by K. Reed, 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
* other information and intelligence held by the Commission in relation to the service
* the site audit report and performance report for the site audit conducted 15 August -18 August 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 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 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)(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

Consumers and representatives confirmed clinical staff regularly discussed care needs with them, and any changes requested were addressed in a timely manner. Care planning documentation identified evidence of review on both a regular basis and when circumstances changed, such as consumer deterioration or incidents including infections, falls and wounds. Clinical staff describe how and when consumer care plans were reviewed. Staff were aware of incident reporting processes and how these incidents may trigger a reassessment or review. The service monitored clinical indicators, including pressure injuries, medication incidents, restraint and falls.

The service was found to be Non-compliant in this requirement following the Site Audit conducted on 15 August 2022 to 18 August 2022, relating to care and services were not reviewed regularly for effectiveness, and when circumstances change or when incidents impact the goals needs and preferences of the consumer.

Actions were undertaken by the service in response to the non-compliance, including a full review of consumers’ assessments and care plans to ensure they were up to date individualised and reflected the consumers’ current needs, goals and preference including wound care directives and behaviour support plans. A review of 13 care plans and assessments evidenced care plans were individualised reflected consumers current needs and have been evaluated in the last three months.

A care plan review schedule was put into place to ensure that care plans and lifestyle plans were reviewed at three-monthly intervals or sooner if required. The service engaged two clinical coordinators and a full-time quality compliance support officer to oversee clinical documentation including care planning and lifestyle planning and procedures at the service. The clinical coordinators conducted daily clinical documentation reviews to ensure any changes were documented and care plans updated.

Registered staff stated, and education record confirmed they received education on the skin check process that was required on entry and after discharge from hospital. Documentation confirmed staff received education on restrictive practices and minimising restraint along with documentation education.

Based on the information recorded above, it is my decision deficits identified have been rectified and care and services are reviewed regularly and when required. Therefore, it is my decision this Requirement is now 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)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

Requirement 3(3)(a)

The service demonstrated timely identification, effective assessment, management and evaluation of consumers’ restrictive practices, skin integrity and pain. Where restrictive practices were used, assessments, authorisation, consent and monitoring were demonstrated. Consumers and representatives provided positive feedback in relation to care provided to consumers.

Behaviour support plans were in place for consumers who were subject to restrictive practices. The psychotropic register maintained by the service identified diagnosis, medications prescribed and consumers who have had their medications reduced or ceased.

Care documentation supported wounds were consistently attended to in accordance with the wound management plan. Pressure area care was completed as prescribed. Consumers with active pressure injuries or wounds had a wound care plan and chart which were completed following treatment and at every review.

Care documentation for consumers noted those with chronic pain had regular pain assessments to identify the site, severity and type of pain experienced by the consumer. Staff used assessment tools depending on the consumer’s ability to verbalise their pain. Pharmacological and non-pharmacological strategies were included in care plans and when pain relief medication was used, it was reviewed for effectiveness.

The service had policies and procedures in place to support the delivery of care provided, in relation to restrictive practices, pressure injury prevention and management, and a pain management policy that incorporated ongoing pain assessment to guide staff practice.

The service was found to be non-compliant in this requirement following the Site Audit conducted on 15 August 2022 to 18 August 2022, and this related to consumers not receiving safe and effective care including skin integrity, pain and restrictive practices.

Actions were undertaken to address the Non-compliance which included engaged the services of a wound care consultant to support and educate staff and provide reviews of wounds if they deteriorated or show signs of slow healing. Wound care documentation evidenced two consumers were referred to a wound care consultant for assessment and ongoing management of the wound when a deterioration was found by the service.

The organisation contracted the services of a nurse practitioner to provide regular clinical oversight at the service and to provide staff education and mentoring to the clinical team. Restrictive practice assessment, authorisations and Behaviour support plans evidenced consent have been gained from the consumer or their representative and the Medical officer.

The service audited all consumers who were subject to a restrictive practice, updated and gained consents from the consumer or their authorised representative and the Medical officer for the use of the restrictive practice. Restrictive practice authorisations were current and in line with legislative requirements. The service conducted a full review of behaviour management plans and updated them to ensure they reflected consumers’ needs and wishes and included non-pharmacological strategies to instruct staff prior to using a restrictive practice. The service’s restrictive practice register was accurate and in line with other information such as consumer care plans and medication charts.

Wound care documentation and education records evidenced registered staff have undertaken wound care education and daily and weekly wound reviews were undertaken. Wound reports were reviewed daily and tracked to monitor compliance and the healing process. A review of wound records for 5 consumers evidenced monitoring by both registered staff and management at the service.

The service engaged an external service who conducted a full review of psychotropic medications which in turn resulted in a reduction of psychotropic medication and chemical restraints. The service received a monthly psychotropic usage report which was used to audit any changes in medication usage resulting in a referral to the Medical officer and or an external pharmacist for a Residential Medication Management Review.

The service conducted daily clinical meetings to discuss and escalate any changes in consumers’ condition and monitoring of staff practices. Care pathways via a flip chart have been placed in each nurses’ station and education was provided on these charts. Staff interviewed confirmed the charts were a valuable resource. Twice daily clinical meetings were introduced to ensure information is passed on between staff. The service has conducted a review and purchased new equipment to assist with maintain skin integrity such as, air mattresses and anti-pressure cushions. Education on a variety of topics relevant to this Requirement was provided.

Based on the information contained above, it is my decision consumers are receiving safe and effective care and therefore this Requirement is now Compliant.

Requirement 3(3)(d)

Consumers and representatives provided positive feedback in relation to the timely response to deterioration or changes in consumers’ condition made by staff at the service. Care planning documentation reflected the identification of, and response to, deterioration or changes in consumers’ condition. Registered staff explained the assessment process following changes to a consumer’s condition. Staff reported changes to the Clinical coordinator. If a consumer deteriorated after business hours, staff could telephone a Medical officer or transfer the consumer to hospital. Clinical records indicated consumers were regularly monitored by registered staff and if deterioration or change of a consumer’s mental, cognitive or physical function, capacity or condition occurred, this was recognised and responded to in a timely manner and representatives were notified.

The service was found to be non-compliant in this requirement following the Site Audit conducted on 15 August 2022 to 18 August 2022 and related to deterioration of consumers was not recognised and responded to in a timely manner, including referring consumers to other services if relevant.

Actions were taken to address the deficits relating to the Non-compliance including a clinical pathway flowchart was placed in nurses’ stations to assist in the early detection of deterioration of consumers and referrals to specialist services. Daily clinical meetings were held to discuss consumer deterioration and escalation. Two Clinical coordinators were employed to oversee clinical care delivery, provide education and review referral processes. Education was provided on a variety of topics relevant to this Requirement.

Based on the information recorded above, it is my decision consumers who have deteriorated are recognised and responded to in a timely manner. Therefore, it is my decision this Requirement is now Compliant.

Requirement 3(3)(g)

The service had documented policies, procedures and an outbreak management plan to guide staff in relation to antimicrobial stewardship, infection control and for the management of a COVID-19 outbreak. The service had an influenza and COVID-19 vaccination program for staff and consumers and appointed an Infection prevention and control lead. Staff provided examples of practices to prevent and control infections such as hand hygiene, encouraging fluids, the use of personal protective equipment and obtaining pathology results prior to commencing antibiotics.

Management used monitoring tools, monthly and quarterly reporting to maintain oversight and benchmark antibiotic usage against national standards and other services within the organisation. Antibiotics were typically commenced following a confirmed pathology result to ensure their appropriateness and antiviral medication was available if required.

The service had policies and procedures to support the minimisation of infection related risks and promotion of antimicrobial stewardship. Consumers confirmed the service was clean and they observed staff using personal protective equipment and washing their hands.

Visitors were observed going through a screening process prior to entering the service, this process included rapid antigen testing, temperature checks and a questionnaire and declaration. All visitors, contractors and staff were observed to be wearing surgical masks at the service.

Based on the information recorded above, it is my decision 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

Consumers confirmed they enjoyed the meals and the meals were of good quality, quantity and they were provided with alternative meals if they wish. Catering staff knew consumers’ dietary needs and preferences and how consumers’ dietary cards were updated. Staff described the process for providing consumers with alternative meals and choices and could provide examples of when a consumer did not like their meal and wished to provide feedback.

Observations of the lunch meal service demonstrated the environment was welcoming, with consumers treated respectfully and being able to ask for additional portions and or alternative meals. Feedback provided during the meal service indicated consumers were happy with their meals and the service provided by staff.

The service was found to be non-compliant in this requirement following the Site Audit conducted on 15 August 2022 to 18 August 2022, relating to consumers and representatives were dissatisfied with the meals provided to consumers stating the food was not of suitable quality, variety and quantity.

Actions were taken to address the deficits relating to the Non-compliance including catering staff received education on the new menu and ordering system used at the service, including choice for consumers at meal times, alternative meals and options being available outside of regular meal times. The service implemented a new system for staff to take orders for consumers the prior to their meal service. Each consumer was asked what they would like based on the menu, and if they did not wish to eat what is on the menu, they then have other options which included sandwiches, a choice of two additional meals of their choice (hot or cold meals) and a salad of their choice. This is an increase of an additional two meals that was not offered previously.

Catering staff confirmed they received education and that meal service was discussed at regular staff and consumer meetings. Consumers supported the meal service was improved and they had no concerns regarding the quality and alternative of meals provided. Monitoring processes were in place, including surveys, audits, meetings and daily visual observations by the Hospitality Team Leader.

Review of consumer Food Focus Meetings evidenced continued consumer consultation regarding meals and service and that concerns, or requests raised had been actioned. For example, consumers had asked for additional sauces to be made available in the lodge dining rooms and this was provided. Feedback that the soup was watery had been addressed with comments from consumers that the tomato soup is now very good.

All consumer eating and drinking assessments were reviewed and updated involving input from both the consumer and representative. Interview with consumer and representatives confirmed they have been consulted in care plan reviews involving meal preferences.

Organisational monitoring of consumer feedback on meals was gathered through the Voice of the Consumer surveys conducted every three months. The service demonstrated additional monitoring processed through monthly Food Focus Group and Consumer meetings, and a site-specific survey conducted at the service by the Hospitality staff. Review of the March 2023 Food and Dining Survey results showed that 93% of consumers sampled mostly or always liked the meals served and said the meals tasted good. All consumers sampled said they liked the smell of the food. Of consumers sampled 94% said they had enough choices and that their preferences were considered, including the portion size of their meals. Consultation with consumers who were not satisfied with their meal service occurred and actions to resolve their concerns were implemented.

Based on the information recorded above it is my decision consumers are satisfied with meals at the service, and therefore, this Requirement is now 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

Consumer and representatives were aware of advocacy services, ways to raise a concern or provide feedback and confirmed the service actioned areas of concern they raised, including feedback regarding the meal service at the home.

The service trended, and analysed feedback and concerns raised by consumers or representatives to inform continuous improvement activities across the service which were documented in various systems and documentation. The service had an established comments and complaints process whereby all comments and complaints were entered into the electronic incident and feedback mechanism, which in turn was supported by their Analysis of Leading Indicators in Care Excellence which then fed into the Plan for Continuous Improvement to improve the quality of care and services.

The service was found to be non-compliant in this requirement following the Site Audit conducted on 15 August 2022 to 18 August 2022, relating to complaints and feedback regarding meals were not consistently recorded, reviewed through their processes, and not used to improve care and services.

Actions have been taken to address the deficits resulting in Non-compliance. These actions included the service undertook a process of reminding consumers and representatives of ways they could raise complaints and the use of advocacy to assist in the complaints processes. Complaints process and advocacy was discussed with consumers at meetings. Review of the consumer meeting minutes dated 11 October 2022 and 14 March 2023 evidenced explanation of how the service wanted to hear from consumers regarding complaints, suggestions, or compliments. Advocacy was discussed and was added to the service’s monthly newsletter accompanying a full page devoted to the complaints process and how it fed into continuous improvement processes at the home. Consumers and representatives confirmed they had received this information and knew how to use it. The service monitored the success of this through feedback received and ongoing discussion through meetings.

The service provided education to all staff and management on the feedback and complaints process. All staff received education on 25 January 2023 on open disclosure and feedback and complaints. All registered staff received education on the electronic incident management system and documentation of feedback and complaints. Staff knew how to support consumers when they raised a complaint, they knew who to report this to and the documentation process involved.

Catering staff received education and training during orientation and meetings on supporting consumers and their meal preferences. This included how feedback was reported and managed.

Management at the service knew how to log feedback and complaints into the electronic incident and feedback system, respond to complaints using an open disclosure method and resolve the complaint. If the complaint results in an improvement to the service, this was entered into the services Continuous Improvement Plan for action and monitoring. The service monitored feedback and complaints processes through consumer and staff meeting minutes, surveys, consumer feedback form usage and verbal consumer feedback. Staff were aware of the feedback system and how this could feed into the continuous improvement processes of the service to improve care and service delivery.

Based on the information contained above it is my decision feedback and complaints were used to improve care and services and therefore, it is my decision this Requirement is now 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 |

Findings

The service was able to demonstrate effective governance systems in relation to regulatory compliance in the management of restrictive practices. Consumers identified as requiring restrictive practices in relation to chemical restraint had current behavioural support plans in place which were reviewed in accordance with the service’s three-monthly care plan review process or when a consumer’s condition changed. Consumers who required a chemical restraint to be administered had clear documentation evidenced in their progress notes documenting alternatives to restrictive practices that had been considered and used and why they had not been successful prior to the use of a chemical restraint.

The service was found to be non-compliant in this requirement following the Site Audit conducted on 15 August 2022 to 18 August 2022, relating to the service did not have current up to date behavioural support plans for consumers requiring restrictive practices and did not have documented evidence that prior to the use of chemical restraint, that alternative methods had been considered and or used and why they had not been successful for the consumer.

Actions were taken to address the deficits relating to the Non-compliance, including, the service reviewed all consumer care plans and assessments for each consumer who required a restrictive practice had a current behavioural support plan in place. Clinical staff received education and training on restrictive practice and documentation of alternative strategies applied to consumers prior to the administration of a chemical restraint.

Monthly reporting to the organisation’s management and governance teams included restrictive practices at the service, ensuring that a governance monitoring approach was maintained. If the service usage of chemical restrictive practices was identified as high, then the service must evidence that the use was within the service’s policy on restrictive practice use. Review of monthly reports indicate that restrictive practice involving chemical restraint is used minimally for consumers and only when other strategies have been trailed.

Based on the information recorded above it is my decision the organisation has an effective governance system relation to regulatory compliance and the use of restrictive practices. Therefore, it is my decision this Requirement is now 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)