Performance

Report

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| Name: | Blue Care Redcliffe Aged Care Facility |
| Commission ID: | 5750 |
| Address: | 91 Anzac Avenue, Redcliffe, Queensland, 4020 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 6 September 2023 |
| Performance report date: | 5 October 2023 |
| Service included in this assessment: | Provider: 314 The Uniting Church in Australia Property Trust (Q.)  Service: 6438 Blue Care Redcliffe Aged Care Facility |

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 Redcliffe Aged Care Facility (**the service**) has been prepared by P. Sherin, 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 site audit report for the site audit conducted 03 to 05 May 2023.
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **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 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 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |

Findings

The service has taken action to remediate deficits leading to non-compliance in this Requirement as identified under the Site audit conducted 03-05 May 2023.

Consumers and representatives confirmed consumers are treated with dignity and respect. Staff demonstrated knowledge of consumers’ personal care needs, and were observed engaging with consumers in a friendly, dignified, and respectful manner.

Review of documentation such as consumer meeting minutes and feedback and complaints logs did not identify complaints trends regarding consumers not being treated with dignity and respect. Where concerns were raised in relation to provision of continence care, the service demonstrated actions taken to resolve these concerns.

The service was found to be non-compliant in the previous Site audit due to not demonstrating each consumer’s dignity is maintained specifically regarding waiting long periods for toileting assistance, including experiencing episodes of incontinence as a result. The service provided evidence, and interviews with staff confirmed, the following improvement actions to remediate these deficits:

* Introduction of quarterly surveys to seek feedback from consumers and representatives. Review of the survey responses identified 98% positive response to the question on being treated with dignity and respect ‘all of the time’, and 2% as ‘most of the time’.
* Education and training for staff on dignity and respect and the impact of delays in attending to continence care, including via staff meetings and huddles.
* Review of call bell response times for each consumer identified as having raised concerns in the previous Site audit report to conduct a root cause analysis and implement strategies to minimise recurrence.
* Case conferences with consumers identified as having raised concerns in the previous Site audit to provide an apology and discuss actions going forward.
* Implementation of a workplace observation tool as a spot check to monitor staff practice and response to call bells. Observations were raised with staff immediately and feedback provided to the staff cohort

Based on the information recorded above and the positive feedback received from consumers and representatives, it is now my decision this Requirement is compliant.

# 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

The service has taken action to remediate deficits leading to non-compliance in this Requirement as identified under the Site audit conducted 03-05 May 2023.

Consumers and representatives said staff regularly discuss consumers’ care needs and preferences with them and are responsive when there is a change. Review of care documentation identified care plans are reviewed every 3 months, and when circumstances change or following an incident. Staff described how, when an incident occurs or there is a change to a consumer’s condition, this triggers a review of the consumer’s care plan and referrals to allied health professionals or other specialists, where necessary.

The service was found to be non-compliant in the previous Site audit due to not demonstrating regular review of the effectiveness of care and services for consumers experiencing frequent falls or exhibiting ongoing escalation of changed behaviours; and some representatives reporting they did not receive timely communication from the service following changes to consumers’ conditions. The service provided evidence, and interviews with staff confirmed, the following improvement actions to remediate these deficits:

* Training for the service’s Clinical manager and Clinical coordinator on clinical monitoring and incident management.
* Staff training on incident management and open disclosure to ensure correct processes are completed, including care review and consultation, following an incident.
* Changes in consumers’ conditions and procedures for consumer care review included as a standard agenda item in monthly registered staff meetings.
* Establishment of a process to allocate care plan reviews to registered staff with a date specified by which the reviews must be completed. This is monitored by the Clinical manager and Clinical coordinator.
* Daily review of consumers by the Clinical manager and Clinical co-ordinator, in consultation with registered staff, to identify any changes to condition or care needs.
* Use of a live document to capture changes to consumers’ condition or care needs and assign actions to staff for further review or treatment.
* Reminders about case conferencing and care plan reviews at consumer/representative meetings to encourage participation in these processes.
* Establishment of a monthly falls prevention committee for the oversight, monitoring and management of falls risks.

Based on the information recorded above and the positive feedback received from consumers and representatives, it is now my decision this Requirement 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)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |

Findings

The service has taken action to remediate deficits leading to non-compliance in the below Requirements as identified under the Site audit conducted 03-05 May 2023.

Requirement 3(3)(a)

Consumers and representatives said whilst call bell response times can sometimes be delayed, particularly around meal services, the service is sufficiently staffed to meet their continence care needs.

Registered staff demonstrated a thorough understanding of chemical restraint requirements, which was reflected in the service’s monitoring and management of consumers receiving psychotropic medications. Where restrictive practices are in place, documentation evidenced appropriate assessments, authorisations, consent, and behaviour support plans in place.

The service was found to be non-compliant in the previous Site audit due to not meeting the continence care needs of individual consumers; and staff not demonstrating a shared understanding of chemical restraint requirements. The service provided evidence, and interviews with staff confirmed, the following improvement actions to remediate these deficits:

* Training for staff in consumer dignity and respect, with particular regard to the impact on consumers where there are delays to continence care.
* Education to registered staff on regulatory requirements for chemical restraint.
* Increased call bell monitoring and analysis of response times to ensure consumer continence care needs are met.
* Review of the service’s psychotropic register to ensure consumers receiving psychotropic medications have the appropriate diagnosis and consumers subject to chemical restraint have required documentation in place.

Based on the information recorded above and the positive feedback received from consumers and representatives, it is now my decision this Requirement is compliant.

Requirement 3(3)(f)

The service demonstrated referrals to other healthcare providers or organisations are made in a timely way and are appropriate. Review of care documentation identified, and consumers/representatives confirmed, other health professionals assess consumers and provide directives for their care. The service is supported by medical officers and a range of allied health professionals including physiotherapists, dieticians, and speech pathologists. Referrals are made to other providers of care including dementia support services, wound specialists, and psychological services.

The service was found to be non-compliant in the previous Site audit as consumers were not consistently referred to other health professionals when their condition deteriorated or when existing strategies had not been effective in keeping consumers safe. The service provided evidence, and interviews with staff confirmed, the following improvement actions to remediate these deficits:

* Ongoing monitoring of consumers experiencing falls and exhibiting changed behaviours to identify consumers requiring referral to other health professionals and services.
* Discussions with staff via meetings regarding the importance of escalation and referral of consumers to other providers of care, where required.
* Daily review of consumers by the Clinical manager and Clinical coordinator, in consultation with registered staff, to identify any changes to consumers’ condition and need for referrals.

Based on the information recorded above and the positive feedback received from consumers and representatives, it is now my decision 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 service has taken action to remediate deficits leading to non-compliance in this Requirement as identified under the Site audit conducted 03-05 May 2023.

Consumers/representatives said staff are available when needed and there are generally enough staff to respond to calls bells in a timely manner. Staff described they felt there was enough time to attend to consumers’ personal care in accordance with their needs and preferences. Staff confirmed they had received training and discussions in staff meetings on the importance of timely response to toileting and hygiene care needs of consumers.

Management provided examples of changes made to shift times in response to feedback from consumers and staff, and monitoring of calls bells. The assessment team observed staff responding to call bells and attending to consumers in a timely manner.

The service was found to be non-compliant in the previous Site audit as staffing levels were insufficient to ensure the timely provision of toileting and hygiene care needs of consumers. The service provided evidence, and interviews with staff confirmed, the following improvement actions to remediate these deficits:

* Case conferences with consumers identified as having raised concerns in the previous Site audit to provide an apology and discuss actions going forward.
* Review of call bell response times for each consumer identified as having raised concerns in the previous Site audit report to conduct a root cause analysis and implement strategies to minimise recurrence.
* Implementation of a call bell escalation system with calls escalated to a registered nurse after 5 minutes and the Clinical manager after 10 minutes. Toolbox training was provided to staff on the call bell escalation system.
* Staff duty lists revised and implemented following consultation with staff.
* Implementation of a workplace observation tool as a spot check to monitor staff practice and response to call bells. Observations were raised with staff immediately and feedback provided to the staff cohort.

Based on the information recorded above and the positive feedback received from consumers and representatives, it is now my decision 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)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

The service has taken action to remediate deficits leading to non-compliance in the below Requirements as identified under the Site audit conducted 03-05 May 2023.

Requirement 8(3)(c)

Management described the processes and systems in place to monitor regulatory updates, disseminate information, and to ensure the service is compliant with legislative requirements.

Management described how the workforce is monitored for competency and sufficiency, and the availability of various policies, procedures, and role descriptions to guide staff practice.

The service was found to be non-compliant in the previous Site audit as the service was not meeting its regulatory compliance responsibilities relating to restrictive practices or ensuring effective workforce governance. The service provided documentary evidence, and interviews with staff confirmed, the following improvement actions to remediate these deficits:

* A weekly discussion between the service’s Quality support officer and Clinical manager to ensure all restrictive practice documentation is reviewed and current. A review of documentation for consumers subject to restrictive practices identified appropriate assessments, authorisations, consent, and behaviour support plans in place.
* Implementation of a new tool to monitor consumers receiving psychotropic medication and appropriately identify consumers subject to chemical restraint. A monthly review of the psychotropic register is conducted. Review of the register identified consumers were appropriately identified as subject to chemical restraint or having a relevant diagnosis.
* Education for staff on timely call bell response and restrictive practices.
* Ongoing monitoring and auditing of call bell response times including investigation of overlength calls to prevent recurrence.
* Discussion on restrictive practices and call bell response via staff and consumer meetings.

Based on the information recorded above, it is now my decision this Requirement is compliant.

Requirement 8(3)(e)

Management described the clinical governance framework and processes to ensure ongoing monitoring of clinical care and oversight of restrictive practices, including through weekly and monthly reporting, and discussions via staff meetings, quality meetings, and governance meetings.

The service was found to be non-compliant in the previous Site audit as the service did not demonstrate the clinical governance framework was effective in the oversight of restrictive practices. The service provided documentary evidence, and interviews with staff confirmed, the following improvement actions to remediate these deficits:

* Weekly assurance reporting prepared by the service’s Quality officer to monitor staff clinical care responsibilities and to report any overdue care delivery, care plan reviews, or clinical assessments for follow-up to ensure completion. This has led to an overall decrease in overdue tasks.
* Implementation of a tool to assist staff with monitoring clinical care on a daily, weekly, and monthly basis.
* Discussion on restrictive practices at regional management meetings, quality meetings and staff meetings.
* Introduction of a monthly falls prevention committee meeting to discuss consumers with recurrent falls and implement strategies for falls prevention.

Based on the information recorded above, it is now my decision 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)