Performance

Report

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| Name: | Blue Care Rothwell Nazarene Aged Care Facility |
| Commission ID: | 5922 |
| Address: | 25-39 Higgs Street, ROTHWELL, Queensland, 4022 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 12 September 2023 |
| Performance report date: | 6 October 2023 |
| Service included in this assessment: | Provider: 314 The Uniting Church in Australia Property Trust (Q.)  Service: 3838 Blue Care Rothwell Nazarene 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 Rothwell Nazarene 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 09 to 12 April 2023.

# 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 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

The service has taken action to remediate deficits leading to non-compliance in this Requirement as identified under the Site audit conducted 09 to 12 April 2023.

Consumers and representatives said care and services are reviewed when a consumer’s circumstances change, or incidents occur. The service has a 3-monthly care plan review schedule managed by a Senior registered nurse who oversees the care plan review and consumer of the day monthly process.

Care planning documentation, including for consumers with wounds or pain, demonstrated assessments are reviewed and care plans updated in line with the care plan review schedule. Staff said they are aware of incident reporting processes and how these incidents may trigger a reassessment or review. Staff advised they have access to care plans through the electronic care management system, individual consumer care plan folders located at the nurses' station, and information is regularly shared via daily meetings and handover.

The service was found to be non-compliant in the previous Site audit due to not demonstrating regular review of care and services consistently occurs for all consumers when circumstances change, or incidents occur. The service provided evidence of, and interviews with staff confirmed, the following improvement actions to remediate these deficits:

* The service’s Clinical manager monitors care documentation daily to identify incidents and changes to care needs, in liaison with a Senior registered nurse.
* Education has been provided to staff on care plan awareness, care plan evaluation, and wound management.
* The service’s Quality support officer conducts a monthly audit of 10 percent of care plans and assessments to ensure recency and accuracy.
* All consumer wounds are reviewed by a Nurse practitioner and staff enrolled to attend an annual mandatory wound management course.
* All consumer care plans have been reviewed and a schedule embedded for 3-monthly reviews.
* Establishment of monthly registered staff meetings and education sessions with discussions on clinical trends, assessment and care planning, education, and referral to external service providers.
* Daily staff meetings to review changed consumer needs, staffing strategies, and forecasting to meet consumer needs.

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 |

Findings

The service has taken action to remediate deficits leading to non-compliance in this Requirement as identified under the Site audit conducted 09 to 12 April 2023.

Consumers and representatives provided positive feedback about the care received by consumers at the service. Review of care documentation and charting demonstrated effective care delivery in relation to unplanned significant weight loss, changed behaviours, restrictive practices, and falls management. Consumers subject to restrictive practices had appropriate authorisations, consent, and behaviour support plans capturing pharmacological and non-pharmacological strategies in place. Staff demonstrated a shared understanding of sampled consumers’ needs and the processes to support individualised care delivery. Staff described the trainings undertaken, and the new monitoring and review processes to identify consumers at risk and ensure appropriate referrals to health professionals as required.

The service was found to be non-compliant in the previous Site audit due to not demonstrating each consumer was receiving safe and effective personal and clinical care in relation to changed behaviours, restrictive practices, falls, and weight loss. The service provided evidence of, and interviews with staff confirmed, the following improvement actions to remediate these deficits:

* Establishment of a monthly clinical meeting to discuss consumers with changed behaviours, restrictive practices, falls, significant unplanned weight loss, and other clinical concerns.
* Comprehensive Nurse practitioner review of consumers with more than 4 reported changed behaviours in a month.
* Commencement of fortnightly social worker visits for consumers who have been reviewed and referred for counselling visits.
* A monthly review of the restrictive practice register by the Clinical manager and a monthly audit of the psychotropic register and restrictive practices by the Quality support officer.
* Registers established for significant weight loss and referrals to ensure effective identification and monitoring of consumers at risk.
* Consumers with weight loss are monitored monthly by the Clinical supervising registered nurse, with reporting of any consumers experiencing weight loss of one kilogram to the Clinical manager. The Nurse practitioner completes a monthly analysis of consumers experiencing 5 percent weight loss and/or consumers experiencing more than 4 falls per month.
* Education provided to staff on a range of topics including managing challenging behaviours, restrictive practices, wound management and referrals.
* Behaviour management, restrictive practices, and falls management are standing agenda items at registered and combined staff meetings.

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)(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 |
| 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 09 to 12 April 2023.

Requirement 8(3)(c)

The organisation has established systems for information management and regulatory compliance which are effectively implemented at the service level.

Staff confirmed information is readily accessible within the organisation’s electronic care management system and they have access to policies, procedures, and training via the service’s electronic systems. Staff confirmed handover is conducted at the beginning of each shift and includes information on any changes to the condition or care needs of consumers. Consumers are regularly reviewed with any updates and changes recorded within the electronic system.

Management advised legislative changes, industry standards, and guidelines are monitored by the organisation through subscriptions to various legislative services and peak bodies. The organisation communicates updates to staff regarding regulatory changes via emails, staff meetings, dissemination of policies, and training.

Staff demonstrated a shared understanding of chemical restraint and incident escalation and reporting requirements. Review of documentation such as the service’s psychotropic register, consumer care documentation, and incident documentation, evidenced the service’s compliance with regulatory requirements.

The service was found to be non-compliant in the previous Site audit due to gaps in communication and recording of information preventing continuity of care and monitoring of consumers’ conditions; and not demonstrating staff knowledge and compliance with regulatory obligations in relation to restrictive practices and incident reporting. The service provided evidence of, and interviews with staff confirmed, the following improvement actions to remediate these deficits:

* Introduction of monthly clinical and registered staff meetings which include discussion on care planning, documentation of information, and restrictive practices.
* Education of registered staff in care planning, recording information, management of chemical restraint, the Serious incident response scheme, and processes for escalating and reporting serious incidents.
* Implementation of a new support tool for the identification, management, and monitoring of consumers subject to chemical restraint.
* Daily review of all incidents by the Service manager to ensure serious incident reporting within regulatory timeframes.

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

Requirement 8(3)(d)

The organisation has policies and procedures to guide staff in management of high-impact and high-prevalence risks such as wounds, unintended weight loss, and restrictive practices, and in relation to incident management and reporting. Staff sampled were aware of these policies and processes and how they are actively applied within the service.

Management described how the service conducts monthly clinical indicator analysis and trending and reviews this information at clinical and quality meetings to implement improvement measures. All incidents are recorded within the service’s incident management system and investigated to identify causes and implement actions to prevent recurrence where appropriate.

The service was found to be non-compliant in the previous Site audit due to not demonstrating staff knowledge of serious incident reporting resulting in some incidents not being identified or reported within reportable timeframes; and gaps in staff practice in managing high-impact and high-prevalence risks to consumers. The service provided evidence of, and interviews with staff confirmed, the following improvement actions to remediate these deficits:

* Introduction of monthly clinical and registered staff meetings to review, discuss, and address high-impact and high-prevalence risks.
* Education of clinical staff in restrictive practices, falls management, managing unintended weight loss, the Serious incident response scheme, and processes for escalating and reporting serious incidents.
* Monthly Nurse practitioner review of consumers with multiple falls, chronic wounds, pressure injuries, unintended weight loss, and challenging behaviours to ensure appropriate management and referrals.
* Implementation of a new support tool for the identification, management, and monitoring of consumers subject to chemical restraint.
* Daily review of all incidents by the Service manager to ensure serious incident reporting within regulatory timeframes.

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

Requirement 8(3)(e)

The organisation implements a documented clinical governance framework and policies in relation to antimicrobial stewardship, restrictive practices, and open disclosure. Staff were aware of these policies and could describe what they meant for them in a practical way.

Management described operation of the clinical governance framework to ensure safe and quality care to consumers, including reporting processes, monitoring systems, clinical indicator data analysis, and training provided to staff.

The service was found to be non-compliant in the previous Site audit due to ineffective clinical governance monitoring processes that had not identified deficits in clinical care and management of restrictive practices. The service provided evidence of, and interviews with staff confirmed, the following improvement actions to remediate these deficits:

* The service’s Clinical manager is responsible for oversight of the clinical governance framework application at the service level with support from the service’s 2 Clinical coordinators, a Senior registered nurse, and a Quality support officer. Additional monitoring and oversight is provided by the Service manager, organisation’s Quality partner, and the clinical governance team.
* Introduction of monthly clinical and registered staff meetings which include discussion on care planning, documentation of information, and restrictive practices.
* Education of clinical staff in care planning, recording of information, and management of restrictive practices.
* Implementation of a new support tool for the identification, management, and monitoring of consumers subject to chemical restraint.
* Monthly Nurse practitioner review of consumers with complex clinical care needs.

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 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)