Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Blue Care Shalom Elders Village |
| Service address: | 190 Hervey Range Road CONDON QLD 4815 |
| Commission ID: | 5753 |
| Approved provider: | The Uniting Church in Australia Property Trust (Q.) |
| Activity type: | Assessment Contact - Site |
| Activity date: | 21 June 2023 |
| Performance report date: | 25 July 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 Shalom Elders Village (**the service**) has been prepared by T Wurf, 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 1 July 2022, for the site audit undertaken from 31 May 2022 to 2 June 2022, that found five requirements of the Quality Standards non-compliant.

# Assessment summary

|  |  |
| --- | --- |
| 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 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.

# Other relevant matters:

A site audit was undertaken at the service from 31 May 2022 to 2 June 2022. The Performance Report dated 1 July 2022, for the site audit, found five requirements of the Quality Standards non-compliant.

An assessment contact visit was undertaken at the service on 21 June 2023 to assess the performance of the service, with a focus on the improvement actions taken by the approved provider in relation to the five non-compliant requirements. This performance report relates to the assessment of performance.

# Standard 2

|  |  |  |
| --- | --- | --- |
| 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 Performance Report dated 1 July 2022 found the service non-compliant with this requirement. Deficiencies included:

* Consumer care plans were not routinely or regularly reviewed or updated, including for consumers with complex care needs and consumers who smoke cigarettes, and
* Consumers and/or their representatives were not involved in regular reviews of care and services.

The Assessment Contact – Site Report identified evidence that the service had taken corrective actions and remediated the deficiencies. Improvements included:

* Reviewed all consumer care plans.
* Implemented a schedule for consumer care plan reviews, which is generated by the service’s electronic care management system. This schedule was consistent with care planning documentation and reflected three-monthly care plan reviews and monthly ‘consumer of the day’ reviews.
* Reviewed consumers who smoke and assessed their capacity to smoke and risks associated with their smoking practices.

The Assessment Team found the service reviewed consumers’ care and services regularly. Consumers and their representatives were involved in care review processes every three months, or when changes occurred.

The service and organisation track and report the completion of consumer care plan reviews by an alert in the electronic care management system. Action is taken when reviews are flagged as due or overdue.

The service manager described how care plan reviews are completed with consumers/representatives, including for:

* those representatives who live in remote locations and are unable to be physically present for a review
* the public guardian, where relevant, and
* instances where the service is unable to contact representatives, and how changes are highlighted and discussed later.

Based on the findings in the Assessment Contact – Site Report, I am satisfied that the deficiencies have been remediated and that care and services are reviewed regularly with consumers/representatives. Therefore, it is my decision that this requirement is compliant.

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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 1 July 2022 found the service non-compliant with this requirement, based on:

* The management of restrictive practices was not best practice or aligned with legislative requirements.
* Staff did not have a consistent understanding of the legislative requirements and organisational procedures relating to restrictive practices.

The Assessment Contact – Site Report identified evidence that the service had taken corrective actions and remediated the deficiencies. Improvements included:

* Reviewed all consumers subject to restrictive practices and ensured the management of those restrictive practices was aligned with legislative requirements.
* Management and staff education and resources on restrictive practices.

The Assessment Team reviewed a sample of care documentation for consumers subject to restrictive practices and the service’s restrictive practices registers and found:

* The service has a process to identify consumers subject to restrictive practices.
* Management of restrictive practices was aligned with legislative requirements.
* Strategies were used to minimise the use of restrictive practices.
* Behavioural support plans contained individualised strategies to support consumers.

Staff demonstrated knowledge and understanding of restrictive practices. Management attended the Commission’s restrictive practices road show and described how this education session increased their understanding of psychotropic medications, chemical restraint, and monitoring and recording of chemical restrictive practices.

Based on the findings in the Assessment Contact – Site Report, I am satisfied that the deficiencies in relation to the service’s management of restrictive practices have been remediated. Therefore, it is my decision that this requirement is compliant.

# Standard 6

|  |  |  |
| --- | --- | --- |
| Feedback and complaints | |  |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The Performance Report dated 1 July 2022 found the service non-compliant with this requirement because feedback and complaints were not consistently documented, reviewed and used to improve the quality of care and services.

The Assessment Contact – Site Report identified evidence that the service had taken corrective actions and remediated the deficiencies. Improvements included:

* Formalised the process of collecting feedback and complaints and documenting them in the feedback and complaints register.
* Implemented a new feedback and complaints register, which is maintained by the service manager. The service manager was trained in the service’s feedback management policy.
* Added feedback and complaints as a standing agenda item at consumer/representative monthly meetings.
* Established a process whereby feedback and complaints are reviewed by the service manager and quality and compliance officer to identify any trends for reporting to the executive and for inclusion in the service’s plan for continuous improvement.

Consumers/representatives were confident the service uses feedback and complaints to improve the quality of care and services. Management described the processes to record and act on feedback and complaints.

The service’s feedback and complaints register and plan for continuous improvement included examples of improvements made to care and services in response to feedback and complaints. For example, changes were made to the menu and food options available to consumers based on feedback and complaints.

Based on the findings in the Assessment Contact – Site Report, I am satisfied that the deficiencies have been remediated, and the service uses feedback and complaints to improve the quality of care and services. Therefore, it is my decision that this requirement is compliant.

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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 Performance Report dated 1 July 2022 found the service non-compliant with requirements 8(3)(c) and 8(3)(e). The deficiencies related to:

* Governance systems for continuous improvement, workforce governance, regulatory compliance, and feedback and complaints.
* Clinical governance systems related to antimicrobial stewardship and minimising the use of restrictive practices.

The Assessment Contact – Site Report identified evidence that the service had taken corrective actions and remediated the deficiencies. Improvements included:

* Improved organisational-wide governance systems, for example:
* Improvements included under requirement 6(3)(d) relevant to continuous improvement and feedback and complaints
* Workforce governance – in May 2023, appointed a trained infection and prevention control (IPC) lead. Provided an additional clinical team member to assist with care plan reviews.
* Improvements included under requirement 3(3)(a) relevant to regulatory compliance with restrictive practices.
* Education and resources for staff on restrictive practices. The service manager tests staff understanding following training sessions.
* Increased monitoring of restrictive practices by senior clinical staff.
* Appointed a qualified IPC lead. Antimicrobial stewardship is supported by clinical, enrolled and care staff and the IPC lead.

I have considered the findings throughout the Assessment Contact – Site Report, and am satisfied that the deficiencies in relation to organisational governance have been remediated. Therefore, it is my decision that these requirements are 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)