Performance

Report

**1800 951 822**

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| Name: | Blue Care Star of the Sea Elders Village |
| Commission ID: | 5373 |
| Address: | 121 Waiben Esplanade, THURSDAY ISLAND, Queensland, 4875 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 31 October 2023 to 1 November 2023 |
| Performance report date: | 15 December 2023 |
| Service included in this assessment: | Provider: 314 The Uniting Church in Australia Property Trust (Q.)  Service: 12327 Blue Care Star of the Sea Elders Village |

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 Star of the Sea Elders Village (**the service**) has been prepared by Stewart Brumm, 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 (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* Performance report dated 15 May 2023.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not fully assessed |
| **Standard 3** Personal care and clinical care | **Not fully assessed** |
| **Standard 7** Human resources | **Not fully assessed** |
| **Standard 8** Organisational governance | **Not fully 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)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| 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

These requirements were previously found non-compliant at a Site Audit conducted in March 2023.

The Assessment Team Provided information that the Approved Provider has completed a range of improvement actions to address the previous non-compliance, including the review and updating of consumer care documentation, reviewing a range of systems and process and providing additional education and training to staff.

Care documentation demonstrated individualised and effective assessment and planning to inform the delivery of care in relation to consumers who have changing behaviours and/or are at a high risk of falling. Wound care documentation demonstrated effective assessment and planning to inform the delivery of care and services provided to consumers with wounds and/or requiring skin care.

The Approved Provider demonstrated care and services are reviewed on a 3-monthly and ‘Resident of the day’ basis and when changes occur. The care plan review guideline includes an instruction on reviewing restrictive practice as part of the process. Care documentation reflected consumers’ current needs, goals and preferences are reviewed and updated for their effectiveness when changes occur.

I have considered the improvement actions completed as well as the information presented in the Assessment Team report, and I am persuaded by this information that the Approved Provider has demonstrated compliance with these requirements.

I find these requirements compliant.

As not all requirements were assessed no overall Standard rating is provided.

# 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)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | 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)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |

Findings

These requirements were previously found non-compliant at a Site Audit conducted in March 2023.

The Assessment Team Provided information that the Approved Provider has completed a range of improvement actions to address the previous non-compliance, including the review and updating of consumer care documentation, reviewing a range of systems and process and providing additional education and training to staff.

The Approved Provider demonstrated safe and effective personal and clinical care in relation to skin and wound care, behaviour management and restrictive practices: which is tailored to the consumers’ needs. Staff are aware of individual consumers’ personal and clinical care needs and strategies. Consumers said call bells are within reach when they need them, and the Assessment Team observed call bells to be within reach for consumers who require them. Several consumers were observed to use a pendant call bell when required.

The Approved Provider demonstrated high impact high prevalence risks to consumers are managed effectively. Review of care planning documentation confirmed the service is effectively managing wounds, pressure area care, pain, falls and behaviour management including restrictive practices where applicable.

Care documentation demonstrated staff recognise and respond within a timely manner to consumers who experience clinical deterioration.

Care documentation demonstrated change in care needs for consumers were identified and communicated with individuals who share care responsibilities. Staff confirmed change in care needs are communicated with consumers and those who share care responsibilities.

I have considered the improvement actions completed as well as the information presented in the Assessment Team report, and I am persuaded by this information that the Approved Provider has demonstrated compliance with these requirements.

I find these requirements compliant.

As not all requirements were assessed no overall Standard rating is provided.

# 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**

This requirement was previously found non-compliant at a Site Audit conducted in March 2023.

The Assessment Team Provided information that the Approved Provider has completed a range of improvement actions to address the previous non-compliance, including recruitment of a staff member to provide support to the workforce in the completion of training, reviewing a range of systems and process and providing additional education and training to staff.

Consumers/representatives expressed confidence in the knowledge of the staff delivering care and services to consumers. Staff and management could describe the systems and processes for the delivery of training to staff as well as monitoring processes to ensure completion rates for the workforce.

All relevant staff have completed mandatory training requirements including, general evacuation. Management have completed specific training in relation to risk management and clinical education has been provided to registered staff.

I have considered the improvement actions completed as well as the information presented in the Assessment Team report, and I am persuaded by this information that the Approved Provider has demonstrated compliance with this requirement.

I find this requirement compliant.

As not all requirements were assessed no overall Standard rating is provided.

# 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

These requirements were previously found non-compliant at a Site Audit conducted in March 2023.

The Assessment Team Provided information that the Approved Provider has completed a range of improvement actions to address the previous non-compliance, including the review and updating of consumer care documentation, A restrictive practices folder was created for ease of access and review, reviewing a range of systems and process and providing additional education and training to staff.

The Assessment Team identified the service has effective wide governance systems. Staff have access to policies and procedures which guide staff practice. Consumers and representatives reported they were satisfied with the way the service communicates information to them.

Review of care documentation demonstrated information about consumers was contemporary, individualised, and monitored by the Clinical lead to ensure continuity of care.

The service has an established continuous improvement framework which identifies opportunities for improvement. The service demonstrated continuous improvement actions are evident within the plan for continuous improvement document. Continuous improvement opportunities are discussed in Clinical Governance meetings. I note the range of improvements completed to ensure compliance with the Aged Care Quality Standards.

Workforce governance systems ensure the workforce have completed relevant training. Processes are monitored to ensure compliance with mandatory training requirements. Management and staff said orientation processes provide them with the information they need to deliver care and services. Staff advised they receive training and undertake supervised work until they are familiar with the consumers and the operational requirements of the service.

The organisation has a regulatory compliance framework in place for the management of restrictive practices and reporting requirements for the Serious Incident Response Scheme. Management advised restrictive practices are monitored by registered staff and the Clinical lead. Systems for the review of restrictive practices are in place and staff are guided by processes to ensure legislative requirements are met. Incidents are monitored by management and the organisation’s Central office to ensure compliance with reporting requirements for the Serious Incident Response Scheme.

The Approved Provider has clinical governance policies and procedures available to staff including for the management of risks. Policies include, but are not limited to, guidance for restrictive practice minimisation, behaviours of concern, falls prevention, deterioration and choice and decision making. Staff have received training in relation to the management of risk including but not limited to falls, wounds, behaviour management and restrictive practices.

Staff have access to an incident management system to record incidents. Incidents are monitored and reviewed by management, the Clinical lead and the Quality and compliance manager to ensure compliance with any identified reporting requirements.

The organisation has a documented clinical governance framework and policies in relation to wound management, pressure injury management, deterioration and restrictive practices. Management described the clinical governance framework in place to ensure safe and quality care to consumers, including reporting processes, monitoring systems, analysing clinical indicators, and training provided to staff.

I have considered the improvement actions completed as well as the information presented in the Assessment Team report, and I am persuaded by this information that the Approved Provider has demonstrated compliance with these requirements.

I find these requirements compliant.

As not all requirements were assessed no overall Standard rating is provided.

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)