Performance

Report

**1800 951 822**

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| Name of service: | Blue Care Tallebudgera Talleyhaven Aged Care Facility |
| Service address: | 54 Dudgeon Drive TALLEBUDGERA QLD 4228 |
| Commission ID: | 5303 |
| Approved provider: | The Uniting Church in Australia Property Trust (Q.) |
| Activity type: | Assessment Contact - Desk |
| Activity date: | 21 December 2022 |
| Performance report date: | 6 January 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 Tallebudgera Talleyhaven Aged Care Facility (**the service**) has been prepared by B Bassett, 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 - Desk; the Assessment Contact - Desk report was informed by review of documents and interviews with staff.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 5** Organisation’s service environment | 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)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |

Findings

The performance report dated 12 August 2022 found the service non-compliant with requirement 1(3)(d). Deficiencies related to consumers not being supported to take their preferred risks, with some deficits regarding documentation also identified.

The Assessment Contact - Desk report provided evidence that consumers and representatives were supported to take risks of their choosing to enable them to live the best life they can and were consulted regarding the assessment and mitigation of these risks.

Care planning documentation included risk assessments for all consumers taking risks and included documented strategies to support consumers in the mitigation of risks.

The Assessment Contact - Desk report provided evidence that the service has acted to improve its performance under this requirement, including:

* Implementation of a dignity of risk register process to ensure all consumers taking risks have dignity of risk assessments reviewed every 3 months or when there are changes in a consumer’s choices.
* Staff have received education and additional training on dignity of risk and assisting consumers to live their best life.
* Organisational resources, policies and procedures that guide delivery of consumer decision making and risk assessment.

For the reasons detailed, it is my decision that this requirement is Compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |

Findings

The performance report dated 12 August 2022 found the service non-compliant with requirement 5(3)(b). Deficiencies concerned equipment being observed to be blocking consumer access to rooms or exits or posing movement hazards.

The Assessment Contact - Desk report provided evidence that the service is now demonstrating that consumers are able to move freely around the service, utilise common areas and access fire exits should an emergency arise.

The Assessment Contact – Desk report provided evidence that the service has acted to improve its performance under this requirement, including:

* Implementation of a weekly observation tool to monitor compliance in maintaining an obstacle free and safe environment, as well as bi-monthly environmental audits monitoring freedom of access and movement within the service for consumers.
* A process for safe storage of mobility equipment and clinical stores with an identified responsible staff member tasked with ensuring consumers access to safe exit through designated emergency exits.
* The approval of a storage shed as a capital works project for the service.

For the reasons detailed, it is my decision that 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 |

Findings

The performance report dated 12 August 2022 found the service non-compliant with requirement 8(3)(c). Deficiencies were identified regarding effective governance of regulatory compliance with respect to restrictive practices.

The Assessment Contact - Desk report provided evidence that the service has undertaken a range of quality improvements to address the previous non-compliance to ensure regulatory compliance systems and processes were complying with relevant legislative and regulatory requirements. Quality improvements undertaken included but were not limited to, measures to identify and understand if compliance tasks were being undertaken, education to clinical staff on restrictive practices, increase of monitoring practices including regular review of the psychotropic register and ensuring all behaviour support plans, care planning documentation and risk assessments of consumers subject to restrictive practices are reviewed every 3 months. The service was able to demonstrate policies and procedures were reflective of current practice and legislative requirements for assessment, authorisation and documentation of restrictive practices for consumer’s subject to restrictive practices were met.

For the reasons detailed, it is my decision that 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)