Performance

Report

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| Name of service: | Blue Care Warana Beachwood Aged Care Facility |
| Service address: | 124 Nicklin Way WARANA QLD 4575 |
| Commission ID: | 5185 |
| Approved provider: | The Uniting Church in Australia Property Trust (Q.) |
| Activity type: | Assessment Contact - Site |
| Activity date: | 2 February 2023 |
| Performance report date: | 6 March 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 Warana Beachwood Aged Care Facility (**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 - 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.
* the provider’s response to the assessment team’s report received 22 February 2023.

# Assessment summary

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| Standard 3 Personal care and clinical care | Compliant |
| **Standard 8** Organisational governance | Compliant |

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 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

Requirement 3(3)(a) was previously found non-compliant following a Site Audit conducted from 15 to 18 November 2021.

The Assessment Team provided information that whilst consumers/representatives sampled considered they receive care and treatment which meets their needs and preferences, the service was unable to demonstrate that clinical care delivery is best practice to optimise each consumer’s health and wellbeing and is tailored to their needs in relation to management of the psychotropic register and restrictive practices.

Review of the psychotropic register identified five consumers did not have a documented diagnosis or documentation to support the use of the psychotropic medication. Additionally, two consumers did not have environmental restraint authorisation and had generic behaviour support plans. Is its also noted that anonymous representatives did not feel they were provided sufficient information around the use of restraint.

Previously identified deficits with wound care have been rectified and the Assessment Team confirmed the improvements have occurred.

The Approved Provider provided a response to the Assessment Team report that included clarifying information as well as supporting documentation including meeting minutes, information and communication materials, clinical records extracts and an education attendance record. I note the Approved Provider has a new leadership team at the Service.

The Approved Provider has reviewed the psychotropic register and updated the missing diagnosis for three consumers and continues to work with the medical officers for the remaining two consumers without a diagnosis to support to the use of the psychotropic medication. Education materials have also been distributed to representatives of consumers subject to restraint, with additional case conferences arranged.

I note the Approved Provider has engaged a new pharmacy service to support in providing oversight and ongoing monitoring of the psychotropic register and the Approved Provider is conducting ongoing education for staff.

For the two consumers who are subject to environmental restraint, they now have the required consent and authorisations in place.

The Approved Provider has updated the behaviour support plans of consumers and supplied examples of the revised support plans as part of the response to the Assessment Team report. I also note from the Assessment Team report that whilst the Behaviour Support Plans reviewed on the day of the audit may have been generic, staff working with the consumers had detailed individual knowledge of the consumers behaviour needs.

I have considered the Assessment Team report as well as the Approved Provider response. I am satisfied that the actions taken by the Approved Provider has reduced the risks to consumers clinical care and that additional monitoring process have been implemented to ensure ongoing compliance with this Requirement. I also note from the Assessment Team report that Interviews with staff at all levels evidence a common understanding of wound management and restraint minimisation and staff know where the policies are located.

I find 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

Requirement 8(3)(c) and Requirement 8(3)(e) were previously found non-compliant following a Site Audit conducted from 15 to 18 November 2021.

The Assessment Team provided information that the Approved Provider demonstrated compliance with the Requirement 8(3)(c) and Requirement 8(3)(e).

In relation to Requirement 8(3)(c) the Approved Provider is now able to demonstrate the systems and processes of organisational wide governance relating to information management and continuous improvement. The organisation has structures in place to ensure consistency is maintained in relation to information management and continuous improvement.

The Approved Provider provided a response to the Assessment Team report that included clarifying information as well as supporting documentation including meeting minutes, information and communication materials, clinical records extracts and an education attendance record.

I note the Assessment Team identified some inconsistency with information related to care plan reviews and information on the psychotropic register. The Assessment Team identified that the care needs of consumers had not been impacted by an overdue care plan review. The psychotropic register has been reviewed and updated to reflect the current status of consumers. Additional education has been provided to registered staff and additional monitoring process have been commenced to ensure information remains current and accurate.

In relation to Requirement 8(3)(e) the Assessment Team provided information that the Approved Provider has an effective clinical governance framework. A new management model has been established to provide increased clinical monitoring and oversight. I note the clinical matters raised under Requirement 3(3)(a) and I am satisfied with the actions taken by the Approved Provider to manage ongoing risk to consumers.

The Approved Provider has also implemented a range of improvement activities related to the original noncompliance, the Assessment Team verified these improvements have occurred.

I have considered the information presented by the Assessment Team as well as the Approved Provider response. I am satisfied that the Approved Provider has organisational wide governance systems and a clinical governance framework.

I find both Requirements 8(3)(c) and 8(3)(e) 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)