Performance

Report

**1800 951 822**

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| Name of service: | Brightwater Joondalup |
| Service address: | 6 Jolstra Crescent JOONDALUP WA 6027 |
| Commission ID: | 7187 |
| Approved provider: | Brightwater Care Group Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 27 September 2022 |
| Performance report date: | 08 November 2022 |

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 Brightwater Joondalup (**the service**) has been prepared by R Beaman, 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 Approved Provider’s response to the Assessment Team’s report received on 18 October 2022; and
* the performance report dated 25 August 2021 in relation to the site audit conducted on 22 June 2021 to 23 June 2021.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Not applicable as not all requirements have been assessed** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **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 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **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

Areas have been identified in which **improvements must be made to ensure compliance with the Quality Standards**. This is based on non-compliance with the Quality Standards as described in this performance report.

* Requirement 3(3)(a) – the Approved Provider ensures each consumer gets safe and effective personal and clinical care, including in the areas of nutrition, optical care and personal hygiene.
* Requirement 6(3)(c) – the Approved Provider ensures appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong, including documenting when feedback and complaints are provided by consumers and/or their representatives and the resulting actions and outcomes.

# 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 was found to be Non-compliant in Requirement 2(3)(e) in this Standard following a Site Audit undertaken from 22 to 23 June 2021 where the service was unable to demonstrate care plans were consistently reviewed when circumstances changed, or incidents impacted the needs, goals and preferences of the consumer. The service implemented a range of improvements to address the deficits, such as increased registered staffing hours, including a clinical nurse to oversee clinical assessment and care and the use of a well-being assessment for consumers identified with changes in condition.

The Assessment Team found in relation to Requirement 2(3)(e) the service reviews care and services for effectiveness when circumstances change, or incidents happen. Consumers confirmed when there is a change or incident that impacts their needs and preferences for care delivery, registered staff review their assessments and care plans in consultation with them.

Documentation showed where there is a change in consumer condition or incident occurs clinical staff review consumers’ assessments and strategies to deliver care, including for wounds, nutrition, behaviour, mobility and pain.

Staff demonstrated understanding of their role in the assessment and planning process and confirmed where there are changes identified or incidents occur they review consumers’ care and services for effectiveness and update strategies for delivery of care where required.

Accordingly, I am satisfied Requirement 2(3)(e) Assessment and planning with consumers is compliant.

# Standard 3

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| Personal care and clinical care | | NON COMPLIANT |
| 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. | Non-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 |

Findings

The service was found to be Non-compliant in Requirements 3(3)(a) and 3(3)(d) in this Standard following a Site Audit undertaken from 22 to 23 June 2021 where the service was unable to demonstrate safe and effective personal and/or clinical care in relation to pain and medication management or deterioration or changes of a consumer’s mental health, cognitive or physical function or condition was recognised or responded to in a timely manner. The service implemented a range of improvements to address the deficits, including an additional clinical staff member to monitor and improve consumers’ clinical care and the introduction of a daily clinical huddle to discuss current consumer needs in relation to clinical care and any changes identified to consumers during personal care delivery.

The Assessment Team found in relation to Requirement 3(3)(a) the service did not demonstrate that each consumer gets safe and effective personal and clinical care. The Assessment Team found the service for two consumers (Consumer A and B), personal and/or clinical care was not delivered in a safe or effective manner, in line with best practice or tailored to their needs, specifically in relation to personal hygiene, nutrition and weight management.

* Consumer A’s pain was not monitored or managed effectively and personal care to their eye was not delivered.
  + Consumer A confirmed they were experiencing pain.
  + Documentation showed a review by the medical officer during September 2022 confirmed Consumer A complained of pain in their eye and provided directives to be given twice daily. The Assessment Team found this was not delivered in line with directives and the consumer’s pain not recorded to direct review or staff to monitor.
  + Consumer A’s current weight is below recorded weight parameters and a weight loss of 4kg from May 2022 to August 2022 was recorded. While Consumer A’s care plan directs staff to supervise all meals, observations showed this did not occur, staff confirmed it takes the consumer a long time to consume supplements and they do not always finish them, and they discard.
* Consumer B’s representative confirmed Consumer B is not as clean as they liked to be, and whilst happy with the care the consumer receives, confirmed they did not receive regular personal hygiene as they wished to.
* Staff confirmed Consumer B enjoys personal hygiene and hair care being delivered and has requested specialised equipment to do so, but it had not been received as yet.
* Documentation confirmed Consumer B’s care plan directs personal hygiene to be delivered daily, while progress notes confirmed this is not done consistently. Records showed only two occasions where hygiene occurred for the month of September 2022.

The provider responded acknowledging the deficits identified in the Assessment Team’s report, however, made a statement in their response that the gaps identified in relation to Consumers A and B were addressed, communicated or monitored during the Assessment Contact visit.

In relation Consumer A’s nutrition and weight management, the Approved Provider has provided documentation to show a referral to the Dietitian was actioned on 29 September 2022 with directives for Consumer A’s nutrition. The Approved Provider has included further evidence showing Consumer A was reviewed by the Dietitian on 17 October 2022. In relation to Consumer A’s eye care, the Approved Provider acknowledged this was not being delivered in line with the medical officer’s directives and included evidence to show eye care documented to be completed twice daily with a commencement date of 30 September 2022.

Whilst I acknowledge the Approved Provider has actioned a review of Consumer A’s nutrition following feedback from the Assessment Team on the day of the visit, with those reviews occurring after the visit, at the time of the visit, Consumer A was not receiving eye care in line with medical officer directives and was experiencing pain as confirmed by the consumer and documented by the medical officer in progress notes. In relation to nutrition at the time of the visit, Consumer A was not observed to be monitored by staff with their meal and food intake not being consistently recorded which is reasonable to expect to be done for a consumer with identified food intake issues as noted for Consumer A, and the requirement for staff assistance and prompting with meals. The Approved Provider did not provide evidence to show they had identified this issue without the Assessment Team’s feedback or report.

In relation to Consumer B’s personal hygiene, the Approved Provider acknowledged the specialised equipment was obtained at the time of the visit and is now in place. The Approved Provider also included documentation to show the care plan recorded daily personal hygiene and the use of equipment to do so. Whilst I acknowledge the evidence provided in the Approved Provider’s response shows personal hygiene is documented to be delivered daily with evidence of equipment to enable that, the response does not provide evidence to show this is occurring, including any personal hygiene charts or progress notes documenting care is delivered. In coming to my decision, I have placed weight on the feedback provided by Consumer B’s representative that personal hygiene was not regular, and evidence provided in the Approved Provider’s response that confirms the specialised equipment to enable daily care was not in place at the time of the Assessment Contact.

Accordingly, I am satisfied Requirement 3(3)(a) in Standard 3 Personal care and clinical care Non-compliant.

I am satisfied Requirement 3(3)(d) is Compliant.

* Consumers were observed being supported with additional care needs where their change in condition required, including meal assistance.
* Registered staff demonstrated understanding of the processes in place to respond to a consumer’s change in condition or signs of deterioration and described ways in which they monitor for those signs.
* Documentation confirmed staff respond to changes in condition, physical, mental or cognition in a timely manner and consumers are monitored for those signs and referred to specialist services where appropriate, including for behaviour management and palliative care.

# Standard 6

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| Feedback and complaints | | NON COMPLIANT |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Non-compliant |

Findings

The service was found to be Non-compliant in Requirement 6(3)(c) in this Standard following a Site Audit undertaken from 22 to 23 June 2021 where the service was unable to demonstrate appropriate action was taken in response to complaints or open disclosure was used when things went wrong. The service implemented a range of improvements to address the deficits, including conducting a survey with consumers to gain feedback on care and service delivery during January 2022 and resident relative meetings again to commence from September 2021.

The Assessment Team found actions identified had not been implemented in response to the deficits identified and the service was unable to demonstrate actions are taken in response to feedback or complaints made and open disclosure used when things go wrong.

* Three consumers and one representative confirmed they were dissatisfied with the service’s complaints process. Two consumers confirmed they had made complaints on multiple occasions and no action was taken or response from the service received.
* Documentation confirmed of three complaints recorded on the service’s feedback register, two had no actions or outcomes recorded.
* Documentation confirmed the resident relative meetings did not occur until 17 August 2022 and feedback provided by consumers about dissatisfaction with the quality of food were not recorded on the service’s feedback register as complaints and no action had been taken. One consumer confirmed they were still being served the food they had made a complaint about, they had not been consulted about their complaint and no improvement noticed.
* One consumer (Consumer C) confirmed they provided feedback about the quality of food and staffing during the August 2022 meeting, however, neither were recorded in the minutes of that meeting or on the service’s feedback register.

The Approved Provider in their response acknowledged the deficits identified in the Assessment Team’s report, including a statement that the issues identified with Consumer C were addressed with Consumer C on the day of the visit after being provided feedback by the Assessment Team. The Approved Provider acknowledged the gaps in their documentation for recording complaints and confirmed access to the system has been provided to another administrator for additional monitoring of complaints to ensure they are recorded, and outcomes documented. The Approved Provider has confirmed practices in relation to recording complaints and the documentation of outcomes, including a discussion with the complainants is being addressed and improvements made.

I acknowledge for Consumer C, the Approved Provider addressed the issues raised by the Assessment Team at the time of the Assessment Contact visit, however, in coming to my finding, I have placed weight on the feedback provided by Consumer C, evidence presented in the Assessment Team’s report and the Approved Provider’s response that confirms if the feedback was not raised, Consumer C’s complaints may not have been addressed. While I note the Approved Provider has taken actions in response to the information in the Assessment Team’s report, I was not provided sufficient evidence in the Approved Provider’s response to satisfy me the deficiencies identified during the Assessment Contact have all been addressed, including documenting feedback and complaints made by consumers and/or their representatives, recording their outcomes or using open disclosure. I would encourage the Approved Provider to embed the improvements to their feedback and complaints processes and practices to ensure consumers’ complaints are recorded and documented to direct appropriate actions and consultation with consumers around the outcomes.

Accordingly, I am satisfied that Requirement 6(3)(c) in Standard 6 Feedback and complaints is Non-compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |

Findings

The service was found to be Non-compliant in Requirement 7(3)(c) in this Standard following a Site Audit undertaken from 22 to 23 June March 2021 where the service was unable to demonstrate the workforce was competent in relation to recognising and responding to deterioration in a consumer’s condition or managing consumer pain. The service implemented a range of improvements to address the deficits, including an additional clinical staff member to monitor and improve consumers’ clinical care.

The Assessment Team found the service was able to demonstrate the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. Consumers confirmed staff know what they are doing and manage their care needs. One consumer confirmed they are confident with staff knowledge and they deliver wound care to them appropriately.

Documentation confirmed staff recognise consumer deterioration and respond in a timely manner and manage wounds and medications in a safe and effective manner.

Accordingly, I am satisfied that Requirement 7(3)(c) Human resources in relation to workforce competency is 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)