Performance

Report

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| Name of service: | Brightwater Oxford Gardens |
| Service address: | 30 Regents Park Rd JOONDALUP WA 6027 |
| Commission ID: | 7238 |
| Approved provider: | Brightwater Care Group Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 21 June 2023 |
| Performance report date: | 11 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 Brightwater Oxford Gardens (**the service**) has been prepared by M Glenn, 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.

# 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 consumers, representatives, staff, and management;
* the provider’s response received 6 July 2023 acknowledging the Assessment Team’s report and recommendations; and
* a Performance Report dated 6 September 2022 for a Site Audit undertaken from 2 August 2022 to 4 August 2022.

# Assessment summary

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| 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

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 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |

Findings

Adequate staffing levels to meet consumers’ needs were demonstrated, with the mix of the workforce deployed enabling the delivery of safe and quality care. There are processes to manage planned and unplanned leave, and allocation sheets for the month of June 2023 up to 19 June 2023 showed all shifts had been filled except for one partial care staff shift. All staff sampled felt there was generally sufficient staff and the correct mix of staff on each shift to ensure care was provided at the correct time and was not rushed. Two staff members raised concerns relating to staffing numbers rostered between 2:00pm and 3:00pm in part of the memory support unit, however, noted there had been no related incidents. Management were aware of this concern and planned actions had been considered. Most consumers sampled were confident they receive the care they need, when they need it, and while they noted mornings were always busy, they said staff are very friendly in their interactions, and they do not feel rushed. All representatives sampled said they were beginning to see a lot more regular staff during their visits which reassured them, and said staff had good knowledge of each consumer and their care needs.

For the reasons detailed above, I find requirement (3)(a) in Standard 7 Human resources compliant.

# Standard 8

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| Organisational governance | |  |
| 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 (3)(e) was found non-compliant following a Site Audit undertaken from 2 August 2022 to 4 August 2022 where the clinical governance framework was found to not be effective in minimising the use of restraint. The Assessment Team’s report provided evidence of actions taken to address the deficiencies identified, including, but not limited to, developed restrictive practice flow charts; implemented a comprehensive restrictive practice register which is regularly reviewed and includes all consumers subject to restraint; migrated the service’s electronic quality management system to a cloud-based system to provide transparency of information and improved monitoring and review of restrictive practices within designated policy timeframes; and provided training to staff in relation to restrictive practices.

At the Assessment Contact undertaken on 21 June 2023, an effective clinical governance framework, inclusive of antimicrobial stewardship, minimising use of restraint and open disclosure was demonstrated.

Behaviour support plans are in place and described changed behaviours experienced by consumers, triggers, and non-pharmacological management strategies. Psychotropic medications are reviewed by the General practitioner on a 3-monthly basis or when circumstances change. Restrictive practices are reported as part of the monthly analysis and discussed at staff, clinical review, and quality meetings to assist with minimising restraint use.

Prescribing of antibiotics aligns with the organisation’s antimicrobial stewardship policy requirements. Consumers are reviewed by the General practitioner and suspected infections are confirmed through microbiology testing prior to commencement of therapy. The correct antibiotic to target the infection is prescribed for the shortest possible duration of therapy, and is considered in consultation with the General practitioner, clinical staff and consumers and their representatives, where appropriate. Infection rates are reported, and review and evaluation of infectious incidents are conducted as part of the monthly review and clinical incident reporting and analysis process.

An open disclosure policy is available to guide management and staff practice, and staff are trained in the principles of open disclosure as part of the onboarding process. Management and staff provided examples of where open disclosure had been used, and complaints, incident and care planning documentation sampled demonstrated the use of open disclosure, when negative events had occurred.

For the reasons detailed above, I find requirement (3)(e) in Standard 8 Organisational governance 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)