Performance

Report

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| Name: | Byron Aged Care |
| Commission ID: | 0030 |
| Address: | 1 Butler St, BYRON BAY, New South Wales, 2481 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 17 January 2024 |
| Performance report date: | 14 February 2024 |
| Service included in this assessment: | Provider: 1591 Byron Aged Care Limited  Service: 46 Byron Aged Care |

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 Byron Aged Care (**the service**) has been prepared by Bruce 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 (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.
* the provider’s response to the assessment team’s report received 7 February 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | 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 3

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| Personal care and clinical care | | Not Applicable |
| 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 |

Findings

The Assessment Team report advised that consumers with high impact risks such as those living with diabetes, experiencing falls, experiencing severe pain, demonstrating changing behaviours, living with dementia, or requiring wound management said they receive the personal and nursing care they need to ensure they experience a healthy life. Consumers described specific examples of how the service managed their care effectively, and care documentation reflected risk management strategies in place to address the individual high impact and high prevalence risks of consumers.

Staff demonstrated knowledge of individual consumers’ care needs with respect to high impact or prevalence risks and were able to describe and access the management strategies in place to ensure these risks were mitigated to prevent harm. For example, registered staff interviewed were aware of interventions required after consumers’ falls, including physical assessment, general and neurological observations, and follow-up.

When incidents occurred, these were documented by care and registered staff and followed up by the management team. Management said changes in consumers’ conditions were always communicated during shift handovers. The Director of Care and Clinical manager met weekly to discuss consumers with high risks. Alerts and other communications about consumers’ needs were placed in the electronic care management system (ECMS), and staff read these when they log on to the system during their shift.

A review of documentation and interviews with consumers by the Assessment Team showed the service is effectively managing instances of deterioration for consumers, with examples such as episodes of diabetes and cognitive decline provided.

Care staff described how they escalate changes in consumers’ conditions to registered staff and provided examples of when they would escalate, such as if the consumer was not eating, or exhibiting extreme tiredness. Registered staff described how they assess deterioration and immediately implement monitoring, charting, and relevant referrals.

Consumers and representatives said staff respond to changes in consumers’ needs quickly.

Following consideration of the above information, I have decided that Requirements 3(3)(b) and 3(3)(d) are Compliant.

# Standard 8

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| Organisational governance | | Not Applicable |
| 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 Assessment Team report contained information which indicated deficiencies in relation to information management, continuous improvement, and regulatory compliance. The report recommended a finding of Non-Compliant.

Regarding financial governance systems, the Assessment Team report indicated the service was able to demonstrate effective financial governance and management described the processes for managing the operational budget of the service, including allocation of funds for additional expenditure when and as required. Management advised in the case of additional funds required above those budgeted, they were able to seek these from the governing body and provided examples of when this had occurred.

Workforce governance systems were observed by the Assessment Team to be sufficient, with a framework in place to ensure staff are skilled and qualified to provide safe and quality care and services to consumers. Staff were aware of their responsibilities, had position descriptions, and there were appropriate managerial systems in place to monitor staff performance and ensure accountability.

Feedback and complaint systems encouraged the provision of consumer and representative feedback. There was evidence of open disclosure processes being engaged when things went wrong, and the Assessment Team report indicated feedback and complaints contributed to improvement initiatives and outcomes. The service had appropriate policies and procedures for the management of feedback and complaints.

With regards to information management, the Assessment Team report noted the service had transitioned to a new ECMS in September 2023. The report said many consumers did not have current care plans in the new ECMS and that consumers’ care documentation lacked the relevant information for staff to understand consumer needs and provide safe care. The report indicated consumers with a diagnosis of diabetes did not have care plans located consistently and that this could cause confusion for staff unfamiliar with these consumers needs.

In the provider’s response to this issue, they advised the following;

* All care plans were reviewed to ensure accuracy and currency within the old ECMS.
* These care plans were printed and were available to all staff via labelled folders in the Nurses Station
* Any updates to care plans occurring in the interim were handwritten onto the printed care plan.
* A read only version of the old ECMS was also available on each computer desktop to ensure that historical data was available.
* All new residents were entered into the new ECMS and as per standard practice an interim care plan was used until the suite of assessments that inform care plans were completed.
* At no time were residents or staff left without current care plans to guide or inform care.

The provider response noted that the Assessment Team report included comments under Requirement 3(3)(b) that care documentation demonstrated appropriate risk assessments, care plans and regular evaluations of high risk for consumers and that the service was effectively managing the health of consumers with diabetes, including management plans and effective Blood Glucose Level monitoring.

I acknowledge and accept the provider response to this issue and note the Assessment Team did not identify any adverse impact upon consumers due to the suggested deficiency.

The Assessment Team report recorded that the medication charting for a consumer with time sensitive medication was inconsistent and evidenced conflicting information for the times of administration. Management advised the consumer often refused the medication when it was due to be administered. The provider response acknowledged this as an issue and advised of action undertaken since the Assessment Contact to ensure the correct administration and documentation of medication. These included each Registered Nurse (RN) receiving education on the importance of time sensitive medication and how to document refusal. An audible alarm has been put into place to alert RNs when the medication is due and reports regarding the administration of time sensitive medication will be run by clinical managers every 48 hours to monitor their delivery.

I am satisfied that the actions taken by the provider are sufficient to address this identified deficiency concerning time sensitive medications.

The Assessment Team report noted two examples of clinical policies that were out of date. The provider response disputed one example and provided evidence the other has now been updated. I am satisfied with the providers response regarding this issue.

The Assessment Team report noted they were advised an incorrect number of consumers had long terms wounds upon their arrival at the service, compared to what was later found in the ECMS. The report advised wound management charts contained inconsistent information of wound check frequency and dressings as per the wound care plan. The provider response confirmed the number of consumers with wound management plans and the Assessment Team report recorded in Requirement 3(3)(b) that consumers’ wounds were appropriately reviewed, assessed, and managed. While there is a potential issue regarding the inconsistent documentation, I am satisfied the service is taking action to address this and that wound care provided to consumers is effective, documented and monitored.

With respect to continuous improvement systems, the Assessment Team report contained information which indicated there were delays and gaps in consumer care documentation available to staff in the new ECMS and that a review of the service’s Plan for Continuous Improvement (PCI), contained open items which were past their planned completion date without documented outcomes.

The provider response acknowledged the date of the completion of the transition to the new ECMS was overdue and that the PCI should have been updated to include completion dates and outcomes. The response provided an updated copy of the service’s PCI with issues identified, planned actions, responsible persons, the applicable Quality Standards, updates, outcomes, and completion dates all present.

I am satisfied the actions taken by the service to address the identified deficiencies regarding continuous improvement are effective and sustainable.

With respect to regulatory compliance, the Assessment Team report indicated the service was not managing environmental restrictive practice processes in line with legislative requirements. These concerns centred around the use of keycodes at building exits, preventing the free movement of consumers, and the lack of consultation and assessment involving consumers and representatives on the use of the environmental restraint. The Assessment Team report also indicated the service’s clinical waste bins were unlocked and accessible by the public.

The provider response acknowledged the issue concerning environmental restrictive practice and advised the service was actively working towards a solution regarding this matter. The response advised management conducted an audit to ensure all residents have the appropriate consent and documentation in place and that the service is currently collaborating with each consumer and their representative to establish their needs and preferences concerning environmental restraint. With respect to the issue of the clinical waste bins, the provider response advised the bins were excess bins that were not in use at the time and were awaiting collection and removal. I accept this explanation from the provider.

With the proviso that the service is required to exercise ongoing vigilance with respect to accidently restraining consumers environmentally and to ensure they are operating in accordance with legislative requirements, I am satisfied the service is taking appropriate actions to address the identified deficiency concerning environmental restrictive practices.

Following consideration of the above information, and particularly noting clarification of issues in the provider response as well as evidenced actions taken by the service to address deficiencies identified by the Assessment Team, I have decided that Requirement 8(3)(c) 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)