Performance

Report

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| Name of service: | Juniper Bethshan |
| Service address: | 7 Piesse Street KATANNING WA 6317 |
| Commission ID: | 7097 |
| Approved provider: | Uniting Church Homes |
| Activity type: | Assessment Contact - Site |
| Activity date: | 11 July 2023 |
| Performance report date: | 28 August 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 Juniper Bethshan (**the service**) has been prepared by A. Kasyan 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 provider’s response to the Assessment Team’s report received 8 August 2023;
* the performance report dated 20 October 2021 for the Site Audit conducted from 7 to 9 September 2021.

# Assessment summary

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| Standard 3 Personal care and clinical care | Non-compliant |
| **Standard 7** **Human resources** | **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.

**Standard 3 Requirement (3)(b)**

Ensure consumers’ high impact or high prevalence risks are effectively managed, including risks associated with management of medications that have high potential for harm.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

The service was found non-compliant with Requirement 3(3)(b) following the Site Audit undertaken from 7 to 9 September 2021.

At this Assessment Contact, the Assessment Team assessed Requirements 3(3)(b) and 3(3)(g) in this Standard and have recommended Requirement 3(3)(b) as not met and Requirement 3(3)(g) as met.

I have provided reasons for my findings in relation to the above requirements below, including consideration of evidence and information provided by both the Assessment Team and the provider.

**Requirement 3(3)(b)**

The service was found non-compliant with Requirement 3(3)(b) following the Site Audit undertaken from 7 to 9 September 2021 where it was found the service did not demonstrate that clinical oversight and incident management was consistently effective in ensuring safe and effective administration and management of schedule 8 medications. When medication-trained care staff were initiating and administering schedule 8 medications, they were not consistently recording the reason for the administration, or any clinical consultation to support decision making and ensure safe administration of medications with high potential of harm.

At this Assessment Contact, the service advised they were undertaking initiatives to address the deficits identified following the Site Audit in 2021, including:

* liaise with another service regarding staff access to assist in clinical decision making after hours;
* review medication management weekly; and
* provide further medication training and competency completion for staff who have not followed the process.

However, the Assessment Team identified these improvements have not been implemented effectively.

The Assessment Team found high impact risks associated with schedule 8 medication are not managed effectively. The Assessment Team’s report provided the following evidence relevant to my finding:

* Two consumer records showed care staff did not adhere to the organisation’s policies and procedures and established processes for contacting a registered nurse after hours before administering schedule 8 medication on ‘when required’ basis.
* One consumer’s file showed schedule 8 medication was administered on ‘as required’ basis 7 times over approximately a 2-week period. There has been no documented evidence of clinical assessments and approval by a registered nurse to administer the medication or the evidence to show its effectiveness. Another consumer’s file showed schedule 8 medication was administered on at least 3 occasions over a 2-week period. Whilst care staff recorded medication was administered for pain, there have been no documented evidence of a phone call having been made to a registered nurse in line with the service’s processes or evidence of relevant clinical assessments undertaken.

The provider’s response recognises improvements required as identified through the Assessment Team’s report and provided a continuous improvement plan detailing actions which have been or are being implemented to address the deficits. Improvements include providing medication refresher for multiskilled care staff, undertaking their competency assessment, and providing training on the process of administration and management of ‘when required’ medication and record keeping requirements.

I find the service does not effectively manage high impact risks associated with the care of each consumer, specifically in relation to the management of schedule 8 medications administered on ‘when required’ basis.

In coming to my finding in relation to this requirement, I have considered documented evidence of two consumers’ files showing ineffective management of risks associated with schedule 8 medications. I considered the Assessment Team’s report finding that multiskilled care workers interviewed during the Assessment Contact advised that they were aware of the requirement to consult a Registered Nurse before administering schedule 8 medications or to contact the Residential Manager if it is after hours. However, evidence shows staff failed to follow this process in relation to more than one consumer on several occasions.

Furthermore, I have considered findings in relation to this requirement in the performance report for the Site Audit conducted from 7 to 9 September 2021 which shows similar issues in relation to staff not following policies and procedures to ensure effective management of risks associated with schedule 8 medications. While I acknowledge the provider has submitted a plan for continuous improvement (PCI) to remedy the deficits in this Requirement, I consider that the improvement activities require monitoring and time to establish efficacy and improved consumer outcomes.

Therefore, I find the service to be non-compliant with Requirement 3(3)(b).

**Requirement 3(3)(g)**

Evidence gathered through consumer and representative feedback, staff interviews, document review and direct observations showed the service follows both standard and transmission-based precautions to prevent infections effectively. Consumers expressed satisfaction with the care provided highlighting the clean environment and staff's dedication to safety measures, such as hand hygiene and wearing appropriate personal protective equipment. Staff interviews confirmed their clear understanding and consistent application of infection control practises.

Clinical staff described antimicrobial stewardship principles and confirmed pathology specimens are collected to confirm presence of bacteria before antibiotics are prescribed. The service has an Infection Prevention and Control Lead (IPC) who is onsite and has attended the necessary IPC training.

The Assessment Team observed staff were washing their hands appropriately and isolation measures were put place for an infectious consumer.

Based on the information above, I find Requirement (3)(g) in Standard 3 Personal care and clinical care compliant.

# 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

The service was found non-compliant with Requirement 7(3)(a) following the Site Audit undertaken from 7 to 9 September 2021 where it was found the planning of the workforce was not effective and did not enable the delivery and management of safe and quality care and services, specifically in relation to medication management and delivery of lifestyle activities over the weekend.

At this Assessment Contact, the Assessment Team assessed Requirement 7(3)(a) as met.

Whilst the service did not demonstrate all initiatives following the Site Audit in 2021 were actioned, they were able to demonstrate they had enough staff to manage infectious outbreaks and most of their workforce have the range of skills needed to meet consumers’ needs and deliver safe and quality care and services.

Consumers and representatives interviewed expressed satisfaction with staffing levels at the service and confirmed staff respond to their needs and preferences and call bells in a timely manner. Consumers said there are staff to assist every day and usually, there are staff to run activities on the weekend.

Staff confirmed there are enough staff at the service and unplanned leave is filled by staff extending their shifts, taking an extra shift or by casual staff members. Whilst there is not enough permanent registered staff, this is covered by agency staff or at times by management who are registered nurses.

Management advised the rosters are planned 2 weeks in advance and vacant shifts are offered to permanent and casual staff and those that remain unfilled are outsourced to agency staff. The Assessment Team reviewed the allocation sheets for the previous 2 weeks and observed the service did not have any shifts that remained unfilled.

Management advised a block booking for the agency registered nurse commences 19 July 2023 for night shift coverage to ensure the service is meeting the regulatory requirements to have at least one registered nurse on-site and on duty 24 hours a day, 7 days a week.

The provider responded to the Assessment Team’s report in relation to this requirement by stating recruitment for permanent registered nursing coverage continues. The service has been successful in booking agency nursing staff to provide clinical cover and leadership as an interim.

Based on the information above, I find Requirement (3)(a) in Standard 7 Human resources compliant.

1. The preparation of the performance report is in accordance with section s 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)