Performance

Report

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| Name: | Kubirri Residential Care Centre |
| Commission ID: | 5783 |
| Address: | 49 Johnston Road, MOSSMAN, Queensland, 4873 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 3 September 2024 |
| Performance report date: | 24 September 2024 |
| Service included in this assessment: | Provider: 437 The Salvation Army (Queensland) Property Trust  Service: 22863 Kubirri Residential Care Centre |

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 Kubirri Residential Care Centre (**the service**) has been prepared by S Turner, 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 23 September 2024
* information held by the Commission that relates to the service, including its compliance history.

# 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 | |  |
| 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

Requirement 3(3)(b)

Consumers and representatives said consumers’ care is safe and right for them and provided examples of how staff discuss risk and risk mitigation strategies with them, including in relation to falls management. Consumers and representatives said when a consumer has a fall, staff complete a full review to determine if the consumer has any injuries, monitor the consumer for any changes to their health status and refer to appropriate services if a need is identified.

Care documentation included falls risk assessments and reflected individualised risk mitigation strategies. Strategies in place to minimise risk of falls included increased staff monitoring, placement of call bell and the use of falls prevention equipment. Staff were familiar with strategies to minimise falls for consumers and were observed monitoring consumers at risk of falling and removing obstacles that may impact consumers’ mobilising.

Care documentation for consumers who had experienced a fall evidenced three days of monitoring the consumer including vital signs, presence of pain, changes in functional and cognitive capacity and, if required, referral to other health care providers. A post fall checklist supported this process. Where health care providers had made recommendations relating to care, staff had actioned the recommendations. For example, for one consumer who had experienced a fall, a medical officer advised the service to encourage the consumer’s fluid intake. The service monitored the consumer’s fluid intake for three days and the consumer continues to be encouraged with fluids. Additionally, there was evidence staff ensured falls and injury prevention strategies, such as hip protectors, were in place prior to the consumer falling.

A risk register detailed falls management for consumers who were identified as having high risk of falls. Management advised the service conducts a monthly check to ensure falls prevention equipment is in situ and is operational, and a review of audit documentation confirmed this. The service’s electronic care management system alerted staff to check sensor beams and consumers provided feedback that this was done.

While consumers spoke highly of the care they received, some consumers provided feedback that they could not leave the service independently due to the doors being locked. One consumer said they required staff assistance to open the doors to the service and delays in staff opening the doors on weekends had dissuaded them from leaving the service. Reception staff were observed assisting consumers to exit and enter the service however reception was staffed Monday to Friday during office hours.

Staff did not demonstrate a shared understanding of environmental restraint. They advised that consumers residing outside the memory support unit were not considered as being possibly subject to environmental restraint; they said assessment and planning of care to support consumers to independently leave the service had not been completed.

Management commenced addressing this during the Assessment Contact and provided one consumer with a swipe card to support their ability to exit and return to the service independently. Additionally, the continuous improvement plan was updated to include a review of relevant policies and procedures, a review of the automatic functions relating to the main entrance door, and a review of assessment and care planning for consumers impacted by the situation.

The approved provider’s response received 23 September 2024 stated the organisation’s commitment to actively promoting a restraint-free environment, ensuring that restrictive practices are only used as a last resort. The response included an excerpt from the plan for continuous improvement, evidence of communications with consumers and representatives, a work request to a service provider and consumer feedback.

The approved provider asserts that a keypad is located at the main entrance door and the pin code is displayed at eye level. The approved provider states this was in place on the day of the Assessment Contact; I accept this. The response demonstrated prompt action was taken to remediate the deficiencies brought forward in the Assessment Contact report. Actions included:

* The outcome of the Assessment Contact was discussed at the consumer and representative meeting held 17 September 2024.
* A letter was issued to consumers and representatives 19 September 2024, outlining changes that had been made to the entrance door’s automatic functions and providing them with access information; including the ability to be provided with a swipe card.
* The service has had the main entrance door re-programmed to open automatically Monday to Friday during business hours. The doors do not require a pin code to open during these hours.
* All consumers who reside in the general area of the service have been re-assessed using a risk assessment to determine their ability to see the pin code and use the keypad. Those consumers who demonstrated some limitation with their dexterity were provided with a swipe card to support their ability to independently leave the service outside business hours.
* Information has been disseminated to staff through memoranda, clinical handover and staff ‘huddles’.

The approved provider advised a nurse call bell system is located outside and can be used to alert staff to open the doors after hours. Evidence of positive feedback provided by a consumer outlining their satisfaction with the provision of a swipe card was included as an element of the response. Further, the approved provider has said the service continues to review restrictive practice and there are processes established to report on all active restrictive practices.

I am satisfied high-impact and high-prevalence risks are being effectively identified and managed. Risk assessments are conducted, equipment is utilised to minimise risk, medical officers and allied health inform care planning and registered nurses monitor clinical care delivery. The approved provider has taken action to ensure care delivery is safe and effective and that assessment and care planning ensures care is being delivered in the least restrictive service environment. I find Requirement 3(3)(b) is compliant.

Requirement 3(3)(d)

Consumers and representatives spoke highly of staff and said staff responded to consumers’ health changes quickly and provided examples of how consumers had been supported and referred to other health care providers when a need was identified. Consumers reported and care documentation confirmed staff closely monitor consumers, spend time with them and implement recommendations made by other health care providers. Management described how staff support consumers who experience a change in their condition; this included through regular visual observations, and staff described the actions they take when a consumer has a change in health status. Daily staff meetings were used to communicate information about consumers and nursing staff said a hospital transfer form is used to detail the consumer’s deterioration and the actions taken in response to this; a review of these documents demonstrated timely interventions by staff and appropriate referral.

I am satisfied staff recognise and respond to a change or a deterioration in a consumer’s condition. I find Requirement 3(3)(d) is compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |

Findings

Consumers and representatives said the service delivered safe and effective care for consumers. Care planning and assessment of risks were discussed with consumers and representatives and included others such as lifestyle staff and the Chaplain where appropriate. Risks were explained and measures to minimise harm were negotiated with the consumer. Consumers said staff included them in identifying and planning their goals and preferences and provided examples of how they were supported to continue to engage in activities that were meaningful and of interest to them even when they contained an element of risk. Documentation, observations and staff interviews demonstrated the service was managing risks, responding to abuse and neglect and supporting consumers to live their best life.

The organisation had a governance structure that effectively managed risk; the organisation worked in partnership with consumers and had established monitoring and reporting mechanisms. A quality and compliance team used a quality assurance framework for auditing, and supports the service using a risk assessment matrix and a high-risk register that identified trends in high prevalence incidents. The service implemented actions to address deficits identified during audit processes and demonstrated a commitment to continuous improvement. Serious incidents, incident management and clinical indicator trends were reviewed at an organisational level.

Information management systems displayed statistics and trends in incidents and care planning review dates. The risk rating system supported the service to plan work, identify outstanding tasks, and allocate actions to the clinical team. The information management system alerted staff to individual consumer risks which were monitored by management; incident reviews included a root cause analysis. Management staff met weekly and liaised with the senior clinical team to discuss trends that were identified through reporting mechanisms. Initiatives relating to continuous improvement were discussed and where a need was identified, ongoing support for staff was provided.

Nursing staff documented a weekly progress report that documented each consumer’s wellbeing status. Nursing staff reviewed the consumer’s progress notes and engaged with the consumer and staff to identify any concerns or clinical care needs. Where required, a referral to a medical officer or allied health provider occurred.

Staff training included mandatory annual training, monthly staff meetings with targeted training, and as needed one to one training. Staff training that had occurred recently included:

* neglect, abuse and the Serious Incident Response Scheme,
* Quality of Care principles, and
* dementia care and the use of simple language to de-escalate changes in behaviour.

Staff meeting minutes demonstrated discussions about serious incidents had occurred and included strategies for prevention and continuous improvement initiatives. Staff had a shared understanding of abuse and said they would immediately report any incidence of inappropriate staff behaviour to a member of the nursing staff or the care manager.

A quality indicator improvement project plan for the period July 2024 to February 2025 included initiatives relating to pressure injuries, falls prevention and unplanned weight loss. The project included auditing schedules, documentation review, identification of improvement opportunities, and implementation and evaluation of actions. Individual consumer recommendations were provided to staff to improve the development, implementation and documentation of individualised care strategies.

For the reasons detailed I am satisfied the organisation is managing risk and find Requirement 8(3)(d) 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)