Performance

Report

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| Name of service: | Ny-Ku Byun |
| Service address: | 1 Fisher Street CHERBOURG QLD 4605 |
| Commission ID: | 5780 |
| Approved provider: | The Uniting Church in Australia Property Trust (Q.) |
| Activity type: | Assessment Contact - Site |
| Activity date: | 21 June 2023 |
| Performance report date: | 25 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 Ny-Ku Byun (**the service**) has been prepared by T Wurf, 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 Performance Report dated 10 February 2023, for the site audit undertaken from 13 to 15 December 2022, that found six requirements of the Quality Standards non-compliant.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **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.

# Other relevant matters:

A site audit was undertaken at the service from 13 to 15 December 2022. The Performance Report dated 10 February 2023, for the site audit, found six requirements of the Quality Standards non-compliant.

An assessment contact visit was undertaken at the service on 21 June 2023 to assess the performance of the service, with a focus on the improvement actions taken by the approved provider in relation to the six non-compliant requirements. This performance report relates to the assessment of performance.

# Standard 3

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| Personal care and clinical care | |  |
| 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. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

The Performance Report dated 10 February 2023 found the service non-compliant with requirements 3(3)(a) and 3(3)(b). Deficiencies related to the management of personal and clinical care and high impact, high prevalence risks, including restrictive practices, wounds, pain, falls, medication, nutrition and hydration (weight loss) and specialised nursing care.

The Assessment Contact – Site Report found personal and clinical care for sampled consumers was safe and effective, and high impact and high prevalence risks to consumers were effectively managed. The Report identified evidence that the service had taken corrective actions and remediated the previous deficiencies in these requirements. Improvements included:

* Staff education and resources on various topics, including restrictive practices, medication management (including medication competency assessment for relevant permanent and agency staff), and nutrition and hydration.
* Reviewed consumers subject to restrictive practices and ensured they were managed in line with organisational and regulatory requirements.
* Implemented a new restrictive practices folder available to staff and updated the restrictive practice register / psychotropic register.
* Implemented a new medication management system that monitors and alerts when medications need to be ordered, including pain medication.
* Implemented a pain management process to monitor the effectiveness of pain medications.
* Established clinical monitoring and reporting processes, completed by the clinical lead, quality manager and regional services manager. These processes include a focus on risks to consumers, restrictive practices, pain and medication management, and nutrition and hydration (weights). The regional service manager monitors the completion of actions required to address issues identified through clinical monitoring.

The Assessment Team reviewed a sample of consumer care documentation and found improved outcomes for consumers and effective management and documentation of, for example, restrictive practices, wounds, pain, nutrition and hydration (weight loss) and falls.

Staff demonstrated knowledge of the personal and clinical care needs of sampled consumers, risks associated with the care of those consumers, and individualised strategies to support the consumers.

Management and registered staff demonstrated sound knowledge of restrictive practices, the service’s new medication management system, falls management processes, and processes related to specialised nursing care (such as stoma or catheter care).

The Assessment Team found incidents were reported and actioned in a timely manner and clinical indicator data showed a decline in falls, wounds, skin tears and weight loss.

Based on the findings in the Assessment Contact – Site Report, I am satisfied that the deficiencies have been remediated. Therefore, it is my decision that these requirements are compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

The Performance Report dated 10 February 2023 found the service non-compliant with this requirement. Deficiencies related to staff (including agency registered nurses) training and knowledge in areas such as the serious incident response scheme (SIRS), restrictive practices, medication management, and the use of the service’s electronic care management system.

The Assessment Contact – Site Report identified evidence that the service had taken corrective actions and remediated the deficiencies. Improvements included:

* Appointed new roles:
* Clinical Lead to monitor and supervise clinical/registered staff and incidents.
* Education Officer to ensure staff receive full orientation and complete all mandatory training.
* Improved the orientation process for permanent and agency staff, which includes buddy shifts, guidance on using the electronic care management system and a checklist to monitor annual and mandatory training.
* Staff education and resources in various topics, including restrictive practices, SIRS, medication management, and the electronic care management system.
* Implemented a new electronic medication system.

The service has a detailed orientation and training program for agency and permanent staff. Staff said they had received training in various topics and could ask for additional training if required. Registered nurses (including agency) and care staff demonstrated knowledge of their role in managing restrictive practices, SIRS reporting and medications. Agency registered nurses said they received good induction/orientation to the service that included buddy shifts and training.

Based on the findings in the Assessment Contact – Site Report, I am satisfied that the deficiencies have been remediated and that there are systems in place to ensure staff receive mandatory and other training relevant to their role. Therefore, it is my decision that this requirement is compliant.

# Standard 8

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| Organisational governance | |  |
| 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 |
| 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 |
| 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

The Performance Report dated 10 February 2023 found the service non-compliant with requirements 8(3)(c), 8(3)(d) and 8(3)(e). The deficiencies related to:

* Governance systems for information management, workforce governance, and regulatory compliance.
* Risk management systems and monitoring processes relevant to high impact, high prevalence risks associated with the care of consumers.
* Clinical governance systems related to minimising the use of restrictive practices.

The Assessment Contact – Site Report identified evidence that the service had taken corrective actions and remediated the deficiencies. Improvements included:

* Improved organisational-wide governance systems, for example:
* Improved access to the electronic care management system by medical officers and staff and monitoring of care documentation.
* Strengthened orientation and education processes (refer to improvements under requirement 7(3)(d)).
* Clinical monitoring processes to ensure regulatory requirements are met, including in relation to restrictive practices.
* Various education and resources for staff, including on restrictive practices and topics relevant to clinical risks.
* Strengthened clinical monitoring processes, such as:
* A new clinical lead role to supervise clinical staff and monitor care documentation and entries in the electronic care management system.
* An internal audit system managed by the clinical lead, quality manager and clinical support officer.
* Monthly clinical meetings with standing agenda items such as analysis of clinical incidents, restrictive practices, medication management and clinical monitoring.

The Assessment Team found evidence of effective governance systems, and clinical monitoring and oversight of risks associated with the care of consumers. The service has a clinical governance framework and relevant policies available to staff.

Based on the findings in the Assessment Contact – Site Report, I am satisfied the service has remediated deficiencies in relation to organisational governance. Therefore, it is my decision that these requirements are compliant.

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