Performance

Report

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| Name: | St Mary's Coolum Beach |
| Commission ID: | 5500 |
| Address: | 17 Magenta Drive, COOLUM BEACH, Queensland, 4573 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 19 June 2024 |
| Performance report date: | 16 July 2024 |
| Service included in this assessment: | Provider: 366 Tilburg Proprietary Limited  Service: 5903 St Mary's Coolum Beach |

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 St Mary's Coolum Beach (**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

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Applicable as not all Requirements assessed. |
| **Standard 8** **Organisational governance** | **Not Applicable as not all Requirements 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 |

Findings

The service demonstrated effective processes to manage high-impact or high-prevalence risks associated with the care of consumers. Interviews with staff evidenced knowledge of how to manage risks associated with sampled consumers. Management demonstrated the service monitors risks through clinical meetings where discussion is centred around clinical indicators. Care documentation identified those consumers at risk of falls, changed behaviours and those subject to restrictive practices. Clinical management monitor progress notes daily to identify risks associated with consumers’ care and communicate any changes in consumers’ care needs to registered staff through handover and clinical meetings.

Care planning documentation for consumers at risk of falls included directives for care staff such as manual handling instructions, monitoring, and medical officer (MO) and physiotherapy review. Staff described individualised fall prevention strategies for consumers at risk of falls, which were also recorded in the electronic care management system (ECMS) to guide staff.

The service’s falls management process included staff alerting registered staff to attend and conducting post falls assessment of the consumer, such as neurological and vital sign observations and initiating transfer to hospital or implementing ongoing monitoring as required.

The service has purchased falls prevention equipment such as sensor beams. Management monitors individualised falls prevention strategies and evaluate their effectiveness, with additional support from the governing body who are developing an analysis to identify potential root causes of falls within the service.

Management said all consumers are encouraged to attend exercise classes to improve mobility and balance. Consumers confirmed that they are encouraged to attend exercise classes by the staff.

Care planning documentation for consumers at risk of changed behaviours include individualised behaviour support plans (BSP) informed by behaviour monitoring and assessment, which included identification of triggers and recommended intervention strategies to guide staff during care provision and service delivery. Staff had a shared understanding of behavioural monitoring, including identifying behaviours of concern, behaviour management strategies and intervention evaluation and recording. Staff consistently demonstrated understanding of consumers with changed behaviours who have been assessed as requiring behaviour management.

The service demonstrated, and staff confirmed, the delivery of behaviour management education to staff in February and March 2024.

Management provided organisational procedures to guide staff in the management of consumers displaying behaviours of anxiety, agitation, and aggression, which included reference to behaviour management including BSP documentation and escalation of interventions, including application of restrictive practices as a last resort.

Care planning documentation for consumers subject to restrictive practices includes MO assessment and informed consent for the use of the restrictive practice from the consumer or their substitute decision maker.

Management stated the service’s 2024 quality indicators identified the number of consumers subject to chemical restrictive practices at the service was high compared with the industry average. Management prioritised MO review of those consumer’s current diagnoses, prescription of antipsychotic medications and/or effective alternatives, with the goal of reducing the use of restrictive practices. In addition, consumers entering the service have a medication review. As a result, the service was able to demonstrate a reduction in the number of consumers subject to chemical restrictive practices from 30 consumers on 2 April 2024 to 12 consumers on 5 June 2024. The Assessment Team observed this to be consistent with information contained within the ECMS and medication management application.

The service demonstrated restrictive practice authorisation documentation, which includes evidence of informed consent, is obtained from an appointed restrictive practice substitute decision maker and includes subsequent MO authorisation. Management stated, and sampled representatives confirmed, consent was provided after discussion about assessed risk with the consumer and others, and that restrictive practices are to be used as a last resort after trialling least restrictive behaviour management interventions first. Documentation reviewed by the Assessment Team evidenced environmental restraint for each consumer is reviewed by the MO 6 monthly and chemical restraint for each consumer is reviewed by the MO 3 monthly.

The service demonstrated the use of restrictive practices is consistently monitored and evaluated by staff through observation, identification, intervention, and documentation regarding consumers’ behaviours. Information is shared between staff and management through staff meetings and the ECMS, case conferences with consumers’ representatives and ongoing assessment and planning of consumers’ behaviour management, including investigation into their involvement in incidents. The service evidenced engagement with the consumer’s regular MO, Dementia Servies Australia and allied health professionals to assist with ongoing management of changed behaviours.

Management provided an organisational policy to guide staff in the safe use of restrictive practices. The policy outlines appropriate use of restrictive practices as a last resort, in the least restrictive form and the outcomes are to be monitored and documented. The policy also details the procedure for obtaining informed consent and MO authorisation and related documentation.

The Assessment Team identified the policy to be informative, however provided management with feedback that the policy guidance regarding documenting informed consent was not detailed. In response, management committed to planned improvement actions, which were entered into their plan for continuous improvement (PCI). For example:

* + To individualise the consent process and ensure sufficient information is included in the restrictive practice forms, with a planned completion date of 10 July 2024.
  + Produce a template for senior registered staff to ensure consumers and/or their substitute decision makers understand they are providing informed consent for the use of restrictive practices, with a planned completion date of 10 July 2024.
  + Review procedures to ensure behaviour management and restrictive practice policies and procedures are relevant and best practice, with a planned completion date of 31 October 2024.

Following consideration of the above information, I have decided that requirement 3(3)(b) 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 |

Findings

The service was able to demonstrate effective governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance, and feedback and complaints.

The service is transitioning from a paper-based care management system to an ECMS. Most staff said they had access to information to guide them in providing effective care and services. One staff member said they did not have access to the ECMS to view behaviour support plans. In response to this feedback management added an action on the PCI to provide education to staff in accessing the ECMS and behaviour support plans.

Consumers’ representatives said they are provided with regular updates about the care of their loved one and are happy with the information provided by the service.

Management said continuous improvement initiatives are drawn from a variety of sources, including consumer and representative feedback and complaints mechanisms, regular analysis of incident data, clinical indicators, and staff meetings. Management described continuous improvement actions taken by the service to mitigate risks associated with the care of consumers such as falls. The Assessment Team confirmed these actions were implemented and evaluated for effectiveness via staff interviews and review of documentation, including care documentation and meeting minutes.

Interviews with management, clinical and care staff identified staff had a shared understanding of their roles and responsibilities associated with risk management, incident management and the reporting of serious incidents.

The service demonstrated effective systems to ensure compliance with relevant regulations, including the regulatory compliance associated with the use of restrictive practices and reporting of serious incidents. Management advised changes to legislative requirements are monitored and brought to the organisation’s attention through correspondence received from relevant industry and regulatory bodies.

Staff said, and a review of training records demonstrated, training has occurred on the Quality Standards and the Serious Incident Reporting Scheme (SIRS), which includes information about the prevention of abuse and neglect of consumers. Management described how serious incidents are identified and reported to the SIRS, as per regulatory requirements. A review of the service’s incident register confirmed serious incidents, including abuse, are identified, and reported to SIRS.

The organisation has an established system for logging, escalating, and tracking feedback and complaints. The board reviews all complaints at their monthly meetings and staff meeting minutes demonstrated consumer, representative and staff complaints and feedback are discussed and actions to address the concerns are identified. Consumers and representatives said appropriate action is taken in response to their feedback and complaints.

Consumers and representatives said the service is effectively managing consumer’s risks, including falls and behaviour management, and provided examples of how the service supports consumers to live the best life they can. Management described strategies implemented to identify and manage risks and documentation and interviews with staff confirmed these strategies are implemented. The service was able to demonstrate an effective incident management system and that incidents of abuse and neglect of consumers are identified and responded to.

The service has a risk register which is updated when risks associated with the care of a consumer are identified. The clinical manager said risks are discussed during weekly clinical meetings to identify trends and risk mitigation strategies. Clinical Meeting minutes for February, March, and April 2024, confirmed risks are discussed and risk mitigation strategies are identified.

The service has an embedded incident management system. Management and staff said progress notes are reviewed daily by management to ensure serious incidents, such as abuse, and neglect of consumers are identified and recorded. A review of the incident management system identified incidents of abuse are identified, recorded, investigated, and reported to SIRS.

Following consideration of the above information, I have decided that requirements 8(3)(c) and 8(3)(d) 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)