Performance

Report

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| Name: | Baptistcare Bethel |
| Commission ID: | 7206 |
| Address: | 2 Bethel Way, ALBANY, Western Australia, 6330 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 6 August 2024 |
| Performance report date: | 5 September 2024 |
| Service included in this assessment: | Provider: 1595 BaptistCare NSW & ACT  Service: 4734 Baptistcare Bethel |

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 Baptistcare Bethel (**the service**) has been prepared by G Tonarelli, 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 27 August 2024. The provider submitted commentary and supporting documentation; and
* the performance report following an assessment contact conducted from 18 September 2023 to 19 September 2023.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Compliant |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Compliant** |

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)(a)

* Embed appropriate measures to ensure continued and sustained implementation of the corrective actions for all relevant consumers, in particular mechanisms to ensure care plans and client records are updated to reflect actual needs.
* When continence care needs are identified strategies are assessed, implemented and monitored for effectiveness
* Embed appropriate measures to ensure post-falls, neurological and clinical observations are undertaken, discontinued when clinically appropriate, and adequately consulted and documented in line with organisational policies and procedures.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |

Findings

Requirement (3)(a) was found non-compliant following an assessment contact undertaken in September 2023 as assessment and planning did not include consideration of risks to consumers’ health and well-being to inform the delivery of safe and effective care and services. Specifically in relation to the management of continence care, pressure injuries, weight loss, and time sensitive medications. Assessments were not completed in a timely manner and in line with admission processes. The assessment team’s report included actions taken in response to the non-compliance including updating a root cause analysis into the incidents; an audit of recent admission checklists to monitor compliance around initial assessment and planning; mechanisms to ensure all care plans are reviewed monthly, and; education and training in continence management.

At the assessment contact in August 2024 the service demonstrated effective assessments and care planning processes to ensure staff are delivering safe and effective care. Consumers and representatives are satisfied with the services provided. Care documentation demonstrated initial and ongoing assessments identify risks to consumers’ health and well-being and include individualised management strategies to inform the provision of care and services. Sampled consumer files demonstrated assessments and care plans are completed in a timely manner and are updated in accordance with the post-hospital and admission checklist. Care files also demonstrated the involvement of general practitioners and the use of validated assessment tools and charting in planning and assessment processes. Staff described how they assess and identify risks to consumers’ safety and wellbeing and articulated risk mitigation strategies for sampled consumers, including those who have recently been admitted to the service or returned from hospital.

For the reasons outlined above, I find requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers compliant. **Ongoing assessment and planning w**

# 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. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

Requirement (3)(a) was found non-compliant following an assessment contact undertaken in September 2023 as consumers requiring continence care were not provided safe and effective care that was best practice, tailored to consumer needs, and optimised their health and well-being. The assessment team’s report included actions the service has taken in response to the non-compliance including, but not limited to, delivering education to staff on continence management; updating continence management as a standing agenda on regular management forums and employed staff oversight and consumer feedback mechanisms.

At the August 2024 assessment contact, the assessment team recommended requirement (3)(a) not met as the service was unable to demonstrate four consumers were receiving safe and effective personal care and clinical care that is best practice and in line with their assessed needs. The assessment team’s report highlighted deficits in relation to:

* Continence management and toileting support, whereby the provider failed to demonstrate it consistently assisted or prompted consumers with toileting needs as stated in individualised continence care plans. Consumer A, with urinary incontinence was found to experience difficulties with continence management, leading to discomfort and a lack of dignity due to the strategies and interventions not being effective.
* Physical assistance with mobility, whereby the assessment team observed Consumer B, who requires assistance with mobility, was not consistently provided with the necessary physical support in line with their care plan to effectively manage consumer B’s risk of falls.
* Ineffective assistance with meals and nutrition for Consumer A and B, who require help during mealtimes. The assessment team identified inconsistencies in the provision of meal assistance, potentially affecting their nutritional intake and overall health. Additionally, the assessment team identified gaps in staff compliance with dietary recommendations. Consumer D, who experienced significant weight loss, did not receive timely and appropriate dietary interventions due to a communication breakdown, risking further deterioration in their health.
* Undertaking and documenting post fall monitoring consistent with the service’s policies and procedures. The documentation of neurological observations for Consumer C following a fall was insufficient, indicating a failure to fully assess and mitigate falls related risks and any potential adverse impact.

The provider, in their response to the assessment team’s report, acknowledged but did not accept all the assessment team’s findings. The response included clarifying and additional information and supporting documentation, including actions taken following the assessment contact:

* The provider acknowledged the concerns regarding continence management for Consumer A and have implemented a tailored continence care plan, which includes overnight assistance with the use of an additional aid to minimise discomfort. A review of consumer A’s continence aid schedule was conducted and adjustments were made to ensure the continence aid's capacity matched the consumer’s needs. Alternative toileting methods were trialled with successful outcomes, including increased staff assistance, trialling and implementing an alternative continence aid and implementing a portable call bell pendant.
* In response to the concerns regarding Consumer B’s physical assistance with mobility, the provider noted at the time of the audit the consumer had made an improvement in their mobility and no longer required the same level of assistance as specified in their care plan. The provider acknowledged the care plan had not been updated to reflect the improvement in the consumer’s care status and improvement in mobility care needs. Since the assessment contact the provider undertook a reassessment of the consumer’s care plan which has led to the implementation of revised support measures that align with the consumer’s current needs. The care plan has been updated to reflect these changes, emphasising the consumer’s autonomy while ensuring safety during mobility transfers.
* In response to the issue of meal assistance and compliance with dietary recommendations, the provider conducted a case conference with Consumer A and B and their representatives. The conferences confirmed Consumer A was provided with the necessary supports during meals, including the use of adaptive utensils and assistance with cutting up food. Documentation confirms Consumer A’s preferences were discussed and respected, leading to adjustment in meal practices to align with their needs. The inconsistencies observed with Consumer B’s meal assistance is attributed to their care plan not being updated to reflect improvement in their health status and subsequent reduced level of care. The provider has since reassessed the consumer’s needs and updated their care plan to reflect appropriate interventions.

The provider acknowledged a communication breakdown regarding the implementation of dietary recommendations for Consumer D who experienced significant weight loss, however confirmed the consumer was receiving nutritional supplements prior to the audit to mitigate the risks. The provider has since implemented further measures to monitor the resident's nutritional intake closely and ensure staff are aware of the intended dietary interventions required. The consumer’s care plan has been updated to reflect these changes, as a strategy to ensure the resident's weight and nutritional needs are consistently managed.

* The provider recognised the need for improvement in documenting falls and subsequent observations and acknowledged the lack of comprehensive neurological observation entries following the incident relating to Consumer C. The provider outlined actions to improve staff’s documentation processes including discussing matter with the staff member involved and follow up with appropriate assessments and interventions for Consumer C.

Based on the assessment team’s report and the provider’s response, I am not satisfied the provider has demonstrated each consumer is receiving safe and effective, personal and clinical care that is best practice, tailored to their needs and optimises their health and wellbeing. I accept the explanations provided for Consumer D’s dietary recommendations and Consumer A’s meal assistance and consider safe and effective care has been provided in those instances, despite gaps in documentation. However, the findings identify deficits in the provision of continence care, falls risks including post-falls neurological observations and mobility assistance, and care being delivered in alignment with consumers' care plans.

In relation to the clinical and neurological observations for Consumer C following the fall, the evidence indicates staff on duty at the time exercised their judgment to discontinue neurological observations after 4 hours. While the provider suggests the staff member may have relied on their clinical judgment to stop the observations, the documentation shows no clear reflection of this decision. Upon reviewing the documents submitted by the provider, there is no evidence to demonstrate relevant consultation with the GP or consideration was undertaken of the potential risks associated with ceasing the neurological observations 4 hours following an unwitnessed fall.

The assessment team’s review of the provider's policies and procedures for post-fall management indicates staff are directed to perform neurological observations for at least 72 hours for post-falls or suspected falls, with signs recorded every four hours. The consumer's Falls Risk Assessment Tool (FRAT) assessment conducted two days after the incident highlights the interventions in place, including requiring staff to check on the consumer throughout the day and on routine rounds overnight, as well as arranging a medical review in the week following the incident and engaging a physiotherapist to assess the fall. Documentation confirms a GP review occurred four days after the fall.

Despite this, appropriate clinical judgment was not demonstrated by the staff member in question when discontinuing neurological observations after four hours. The provider has not provided evidence of compliance with their policy to maintain these observations for at least 72 hours, nor of consultation with the relevant personnel regarding ceasing earlier. There is also no evidence to support sufficient neurological observations were undertaken. The failure in relevant monitoring being undertaken and appropriate clinical oversight and consultation posed a significant risk to the consumer. Additionally, I have noted staff failed to clarify the need for continuous observations post-fall, as required by policy.

In relation to Consumer B’s assistance with mobility and meal support, while the provider asserted at the time of the assessment contact there were improvements in their condition and care delivery, the provider has not demonstrated Consumer B’s care aligned with the consumer’s current needs as specified in their care plan. The provider infers improvements in Consumer B’s condition were communicated informally to staff rather than documented or reflected in updates to the consumer's care plan. The documentation provided, including associated progress notes did not demonstrate a relevant reassessment had occurred to change the consumers’ needs or risk mitigation strategies prior to adjusting mobility and meal assistance.

Regarding continence management, I have reviewed the details in the assessment contact, including the assessment contact conducted prior in September 2023, which identified deficiencies in the continence care provided. The August 2024 assessment showed strategies listed in the care plan, such as scheduled toileting, were ineffective in addressing the consumer's needs. Additionally, the interventions in place during the assessment contact did not effectively manage the consumer’s continence, failing to promote the consumer's dignity and wellbeing. While the provider has taken corrective steps for this consumer, I have insufficient evidence to be satisfied best practice tailored care is being provided to all consumers consistently.

The provider must ensure that care is not only safe and effective but also personalised to meet each consumer's needs. Although some steps have been taken to address the issues for the named consumers, the provider has not submitted a comprehensive plan for continuous improvement to demonstrate how some of these deficits will be resolved broadly across all consumers.

The provider should take appropriate measures to ensure continued and sustained implementation of the corrective actions for all relevant consumers, in particular mechanisms to ensure care plans and client records are updated to reflect actual needs to support safe and effective delivery of personal and clinical care.

In relation to Requirement 3(3)(b), the service demonstrated effective management of high impact, high prevalence (HIHP) risks, including unplanned weight loss, skin integrity, wounds, pain management and minimising restrictive practices. Management demonstrated an understanding of the risks associated with each sampled consumer’s care and demonstrated a system to monitor and manage HIHP risks. Staff demonstrated adherence to policies and procedures to mitigate risks and documentation confirmed the use of validated screening tools to support the development of effective mitigation strategies. Consumers and representatives are satisfied with care provided by staff.

For the reasons outlined above I find Standard 3, requirement (3)(a) non-compliant and requirement (3)(b) compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirement (3)(b) was previously found non-compliant following an assessment contact in September 2023 as it did not demonstrate kind and caring interactions by staff. The service has implemented a range of actions including staff training in various clinical and personal care subjects, regular meetings with staff to increase awareness and reinforce organisational values. At the assessment contact in August 2024, the service demonstrated workforce interactions are kind, caring and respectful. Consumers and representatives confirmed staff treat them with respect and are responsive to their needs, which was also reflected in feedback data. Staff from various disciplines said they know their consumers well and the assessment team observed respectful and kind interactions between staff and consumers.

In relation to requirement (3)(e), the service was previously found non-compliant in this requirement following an audit in September 2023 as it did not demonstrate that each staff member was performing their duties effectively. The service implemented improvement actions which include ongoing monitoring of incident reports and performance management of staff deficits. At the August 2024 assessment contact, the assessment team found the service was unable to demonstrate regular monitoring and review of staff’s performance in relation to medication incidents. In relation to incidents involving medication errors:

* the service failed to demonstrate regular monitoring and review of staff members who made medication errors during the months of May and June 2024.
* Incident reports showed that on multiple occasions, the service did not adhere to organisational policies and procedures, including failing to implement interventions when errors occurred.
* Specific incidents highlighted involved staff members not following correct procedures, such as not staying to supervise consumers taking psychotropic medications or failing to administer prescribed medications despite recording medications being administered.

The provider, in their response to the assessment team’s report acknowledged staff did not follow organisational policies and procedures for the two medication error incidents and provided commentary to explain the identified gap. The response also provided supporting documentation, including actions taken to address the deficits following the assessment contact:

* The staff member involved in the incidents works non-standard shifts with reduced workload and this delayed the return of medication reflection error forms requested by the service.
* Meetings were held with the staff member to address the incidents, and additional support and re-training were provided. This included supervised medication rounds, refresher training on medication management and clinical induction, and completion of a medication competency theory booklet.
* Continuous efforts are underway to ensure regular and meaningful performance reviews, particularly for staff members involved in medication management.
* An electronic medication management system with training scheduled for October 24 is being implemented to ensure better compliance and monitoring.
* Consumers involved in the incidents were reviewed by their GPs at the time to mitigate any possible risks.

I acknowledge the evidence brought forward by the assessment team. However, I have come to a different finding to the assessment team’s recommendation of not met and find this requirement compliant. While there were significant delays in the provider’s follow-up on the medication reflection error forms and in demonstrating the steps taken to assess and review the staff member’s performance, I have given weight to the fact the provider did, in fact, commence the process of performance assessment prior to the assessment contact. This indicates that despite the delays, the service had initiated the reasonable steps to monitor and review the performance of the staff member involved in the medication incident. Moreover, the provider has demonstrated they have taken reasonable actions, including additional training and regular performance evaluations to review and monitor this staff member's performance to prevent future errors. The service is also implementing an electronic medication management system, with training scheduled for October 2024, aimed at ensuring better compliance and monitoring. This initiative is expected to further support staff performance in this critical area.

I have also given weight to the assessment team’s findings that the provider demonstrated it undertakes regular and robust annual formal performance development reviews for staff more broadly, confirmed by staff from various disciplines.

For the reasons outlined above I find Standard 7, requirements (3)(b) and (3)(e) 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 |

Findings

Requirement (3)(c) was found non-compliant following an assessment contact undertaken in September 2023 as the service was unable to demonstrate effective workforce governance. The service had insufficient staff to deliver safe and effective care, including clinical care. The assessment team’s report included actions the service has taken in response to the non-compliance, including a complete review of its roster to identify staffing gaps, refined recruitment processes to ensure staff’s values and attitudes align with those of the organisation, and; mentorship education for clinical staff to uplift capability and processes.

At the assessment contact in August 2024 the organisation was able to demonstrate a governance structure, including policies and procedures, is in place to support all aspects of the organisation, including information management, continuous improvement, financial governance, workforce and clinical governance, regulatory compliance and feedback and complaints. In relation to workforce governance the provider demonstrated improvements in recruitment processes and the organisational structure clearly defines reporting lines and ensures the appropriate mix of staff to deliver quality care to consumers.

For the reasons outlined above I find Standard 8, requirement (3)(c) 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)