Performance

Report

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| Name of service: | BaptistCare Bethshan Gardens Centre |
| Service address: | 70 Forest Road WYEE NSW 2259 |
| Commission ID: | 0194 |
| Approved provider: | BaptistCare NSW & ACT |
| Activity type: | Assessment Contact - Site |
| Activity date: | 12 July 2023 to 13 July 2023 |
| Performance report date: | 15 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 BaptistCare Bethshan Gardens Centre (**the service**) has been prepared by B 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 - 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 2 August 2023.

# 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** |

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)(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 |

Findings

The service was found non-compliant in this requirement following a Site Audit conducted 20 to 22 June 2022. Deficiencies identified related to wound care management and the identification of consumers subject to a chemical restrictive practice.

The service provided evidence of actions undertaken to address the previous non-compliance.

For wound management the Assessment Team report noted:

* The purchase of new beds to assist with pressure area care. The beds allowed adjustment of the consumer’s position providing relief for pressure areas. The service allocated the beds to consumers assessed to have the highest risk for Pressure Injuries (PI).
* The service also introduced a new electronic care management system (ECMS) that prompted staff to complete skin checks and repositioning charts. The new ECMS allow staff to upload wound photographs more easily and measure wounds more accurately.
* The service implemented wound monitoring processes including wound tracking and regular discussion of consumers with PI or wounds at clinical meetings.
* The wound management system within the ECMS identified detailed wound management plans, wound charting and photographs included measurements. Management reported implemented improvements had resulted in a decrease in consumers with wounds/PI.
* Care documentation showed wounds were consistently attended to in accordance with the consumer’s wound management plan and pressure area care was completed as prescribed.
* Consumers with active PI or wounds had have a wound care plan and chart which were completed following treatment and at every review.

For identification of consumers subject to a chemical restrictive practice the Assessment Team report noted:

* Implementation of a monthly review of the service’s psychotropic register with the assistance of the consumer’s medical officer (MO). This review ensured a supporting diagnosis for the use of the medication or identification of a chemical restrictive practice where appropriate and helps the service assess when it was appropriate to cease a consumer’s restrictive practice.
* Review of the psychotropic register indicated a supporting diagnosis for the use of the medication or identification of a chemical restrictive practice where appropriate.
* the service was able to identify consumers have authorisations, consent, assessments and Behaviour Support Plans (BSP) in place for the use of restrictive practices.

Based on the observations of the Assessment Team and reported actions of the Approved Provider, the previously identified deficiencies for wound and restrictive practices have been remediated.

Overall, consumers and representatives said they were happy with care provided to consumers. For example, a consumer who had chronic pain issues said staff were very good at managing their pain and medication. Another named consumer with insulin dependent diabetes, said staff monitored her Blood Glucose Levels (BGL) regularly and gave her insulin as required. Her care documentation included a diabetes management plan and regular documentation of her BGLs. The Assessment Team report indicated staff understood the consumer’s clinical needs and there was a diabetes management plan in place.

Information in the Assessment Team report indicated some consumers were being negatively impacted by the behaviour of another consumer. Behaviours reported included verbal outbursts and aggression, including physical aggression towards staff. Representatives for two consumers said the consumers were distressed by these incidents.

The Assessment Team report stated the service did not have effective management strategies for the challenging behaviours. Staff said they were unaware if the consumer had a BSP in place. The Assessment Team reviewed the BSP and noted it did not include behavioural triggers or strategies for managing the consumer’s challenging behaviours. The consumer had not been reviewed by a geriatrician or external specialists since entry to the service.

The Approved Provider response to the Assessment Team report detailed a variety of actions taken to address the consumers behaviours including:

* Relocating the consumer to another part of the service.
* Updating the BSP with known behavioural triggers.
* Having the consumer reviewed by a specialist geriatrician and a speech pathologist.
* Ensuring staff were aware of the strategies to manage the consumer’s behaviour in the updated BSP.
* Investigating the incidents where consumers were said to be distressed.
* The Approved Provider said the challenging behaviours had ceased since the consumer was relocated.

I acknowledge the actions undertaken by the service to address the concerns with respect to these issues.

The Assessment Team report also contained information indicating deficiencies in the management of environmental restrictive practices for two consumers who did not have appropriate assessments or BSP. The Approved Provider produced evidence that assessments were in progress at that time of the assessment contact and have now been completed.

The Assessment Team report identified two consumers who had signed their own consent form for the use of restrictive practices. The Approved Provider supplied evidence that the consumers had decision making capacity and that discussions had occurred to ensure informed consent.

The evidence submitted by the provider demonstrates appropriate assessments and consent practices have been followed.

The Assessment Team report recommended Requirement 3(3)(a) as Non-Compliant. I have taken into consideration the evidence supplied by the Approved Provider of the actions taken to address the previous non-compliance and actions taken since the Assessment Contact. I am satisfied that the actions taken by the provider have remediated the previous non-compliance. With respect to the other issues identified by the Assessment Team related to the management of challenging behaviours and consent for restrictive practices I am satisfied the actions taken by the provider and practices in place are appropriate. I find the service is Compliant with Requirement 3(3)(a).

# 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 Assessment Team reported consumers and representatives said there were insufficient staff to attend to consumers’ requests for assistance in a timely manner and provide cares particularly in relation to the delivery of hygiene cares, toileting needs and activities of daily living. For example:

* One consumer said she had to wait unreasonably long periods of time for staff to respond when she used the call bell and that while she was on a course of eye drops, she did not receive them one morning as per her care plan as staff were too busy to administer them.
* Another consumer said she had recently been unwell for an extended period and was not able to be seen by registered staff for ‘days’ due to low staffing, which led to a deterioration of her condition. She also said she had to wait for twenty minutes for assistance to return to bed following toileting.
* A third consumer’s representative said low staff numbers on night shift had resulted in the consumer sleeping in her recliner chair as she did not wish to bother staff and she needed to be hoisted into bed.

The Assessment Team reported staff raised concerns about there being insufficient staff to support safe and quality care. For example, staff reported delays in continence care, feeding, cleaning, and transferring consumers to activities. The Assessment Team report recorded comments from four staff members raising concerns about staff shortages impacting upon consumer care. While it was acknowledged by staff members that management were proactive at attempting to fill vacant shifts, some staff considered the day-to-day roster to be insufficient to meet consumer needs.

The Assessment Team reviewed the service’s roster for the four weeks prior to the Assessment Contact which identified many unfilled shifts. The service’s full-time roster coordinator said the service rosters to full capacity, and when actual consumer numbers are considered against the service’s ‘staff sufficiency guidelines’, there were a much lower number of unfilled shifts over the period.

On the second day of the Assessment Contact, management advised the figures provided were incorrect as the roster coordinator did not have an adequate understanding of the service’s staff sufficiency guidelines. Management stated the service was actually in surplus of shifts over the previous four weeks. The Assessment Team reported management was unable to provide them with clarification for the discrepancy of unfilled shift numbers provided by the roster coordinator.

The Assessment Team reported management advised the service is not short staffed, but there is a ‘culture issue’ involving some staff and consumers, leading them to believe the service is short staffed. Management advised staffing is sufficient against the organisations staff sufficiency guidelines. Management advised they would consider completing audits to determine how staff can effectively manage their time and care of consumers.

In responding to the Assessment Team report, the Approved Provider addressed each of the issues raised in the report. For example;

* With respect to the consumer who complained of unreasonable response times for her call bell, the response included call bell records which evidenced calls to her room were answered on average in less than four minutes. Concerning the issue that her eye drops had been missed one morning due to staff being too busy, the response provided evidence that the eye drops were not in stock at that time but were supplied and administered to the consumer within hours and the issue was not related to staffing. I accept that the evidence put forward by the Approved Provider indicates the service has responded appropriately to meet the consumer’s needs.
* Regarding the consumer who said they were unable to be seen for ‘days’ by registered staff, the service provided progress notes for the period in question which demonstrated regular ongoing assessment, monitoring and clinical oversight by Registered Nurses (RN) and a medical officer, contrary to the information provided by the consumer and her representative. As noted in the Assessment Team report, the issue where there had been a twenty-minute delay in returning this consumer to bed following toileting had been reported and responded to by management through the service’s complaint processes. The Approved Provider also supplied additional information about this incident advising that it had occurred in January 2023 during an outbreak of COVID-19. Again, I accept that the evidence provided demonstrates appropriate actions have been taken by service given the context of the situations, as appropriate clinical review and monitoring of the consumer’s condition had occurred and the incident involving the twenty minute delay, while regrettable, appears to have been a one off situation in difficult circumstances.
* Finally, with respect to the named consumer reported to have slept in her recliner rather than disturb staff who needed to hoist her into bed, the Approved Provider supplied evidence via a mobility assessment which indicated the consumer occasionally chose to sleep in her recliner and that the recliner had remote ‘tilt to stand’ capability which allowed the consumer to mobilise independently. A mobility assessment dated 10 July 2023 (two days prior to the Assessment Contact) recorded the consumer requires only minimal assistance and one staff to transfer to bed and does not require the use of a hoist. This evidence does not support the version of events put forward by the consumer’s representative.

In summary, the Approved Provider response submits that impact on consumers as a result of reported staff and consumer perceptions of short staffing are not supported by clinical documentation, call bell response times or the service’s consultations with consumers and staff following the Assessment Contact. Considering the evidence available I accept the Approved Provider explanations are reasonable and likely reflect the actual situations.

The Approved Provider response expanded upon explanations provided to the Assessment Team during the Assessment Contact regarding seemingly contradictory information provided regarding the service’s roster. The response said inaccurate information had initially been provided by the roster coordinator as they had not referred to the day-to-day occupancy data or take into consideration where re-allocation of staff had covered an apparent vacancy.

The service supplied an extensive explanation of how staffing levels are planned, monitored, and adjusted in relation to current occupancy and consumer needs noting the staffing sufficiency guidelines used within the service are based upon a high ratio of care staff to consumers. An analysis of roster data provided by the Approved Provider supported the argument the service had a surplus rather than deficit of shifts during the four weeks prior to the Assessment Contact. Again, I have found the evidence provided by the service to be comprehensive, credible and supported by documentation.

In addition, in responding to issues raised concerning this Requirement, the Approved Provider supplied evidence demonstrating;

* Call bell figures from across the service provided for the four months prior to the Assessment Contact averaged response times of four minutes or less.
* Consumers surveys conducted in 2023 indicated 95% of consumers surveyed agreed with the proposal they get the care they need on time ‘always or most of the time’.
* Staff had been reminded of their obligation to report to management any instance when they had been unable to meet the requirements of their role due to workload issues including staffing levels.

In considering my decision regarding this Requirement, I have had to weigh what are acknowledged perceptions of some consumers and staff members that the service is short staffed against evidence provided from the service to the contrary. The Approved Provider response addressed all the issues raised within the Assessment Team report and provided evidence which refuted the implications of the report. Additional information clarified the context in which incidents took place and the response outlined subsequent actions taken by the service to address the concerns raised. I acknowledge the thoroughness of the Approved Provider response in addressing the issues. I have also taken into consideration the service’s long history of compliance with the Quality Standards.

While the Assessment Team report recommended Requirement 7(3)(a) as Non-Compliant, following consideration of all of the above, it is my decision that Requirement 7(3)(a) is 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)