Performance

Report

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| Name: | Baptistcare Gracehaven |
| Commission ID: | 7914 |
| Address: | 2 Westralia Gardens, ROCKINGHAM, Western Australia, 6168 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 12 September 2024 to 13 September 2024 |
| Performance report date: | 14 October 2024 |
| Service included in this assessment: | Provider: 1595 BaptistCare NSW & ACT  Service: 4919 Baptistcare Gracehaven |

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 Gracehaven (**the service**) has been prepared by J Wilson, 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; and
* the provider’s response to the assessment team’s report received 4 October 2024.

# Assessment summary

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

* Ensure staff are supporting consumers to manage high impact and high prevalence risks including weight loss, medication management and fluid monitoring.

Standard 8 requirement (3)(d)

* Ensure high impact and high prevalence risks associated with consumers care are effectively being managed and monitored, with effective processes in place to support and guide staff practices in the management of risks.
* Ensure staff are familiar with incident management processes and record all consumer incidents through the incident management system.
* Undertake root cause analysis practices to investigate incidents and implement mitigating strategies to prevent incidents from reoccurring.
* Ensure incidents are identified and reported through the serious incident response scheme where appropriate.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

The service was found non-compliant in requirement (3)(e) following an assessment contact undertaken in January 2024 as the service was not undertaking reassessments following incidents, or when changes are identified which impact on the needs, goals and preferences of consumers. The assessment team’s report included improvements undertaken to address the non-compliance, including but not limited to:

* Training on care planning undertaken, and care planning and assessments are allocated to clinical staff.
* The clinical nurse undertakes ongoing progress note reviews.

The assessment team recommended requirement (3)(e) as met, as they were satisfied the service demonstrated ongoing reassessments are undertaken at regular intervals, and when changes are identified or when incidents occur.

Consumers and representatives confirmed the service undertakes reviews of their care on a regular basis and where incidents occur. Staff and management confirmed processes in place to ensure ongoing reviews of consumers’ assessments are undertaken in line with service’s policies and could identify events which trigger additional reviews. Care documentation demonstrated assessments are reviewed following incidents or when changes occur, including behaviour related incidents or changes in mobility.

Based on the assessment team’s report, I find requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers compliant.

# 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. | Not Compliant |

Findings

The service was found non-compliant in requirement (3)(b) following an assessment contact undertaken in January 2024 where it was found the service did not demonstrate the high-risk and high-prevalent risks associated with the care of each consumer was effectively managed, particularly in relation to pain, wounds, falls, infections and refusal of care. The assessment teams report included improvements implemented to address the non-compliance, including but not limited to:

* Progress note reviews undertaken multiple times per week to capture high-impact and high-prevalence risks.
* Induction and refresher training undertaken for medication competent staff, inclusive of online and practical components.
* High-impact and high-prevalence risks are tabled at multidisciplinary meetings.

The assessment team recommended requirement (3)(b) not met, as they were not satisfied the improvements implemented were sufficient in managing the high-impact and high-prevalence risks associated with the care of each consumer, particularly in relation to weight loss, medication management, oxygen management and fluid restrictions. The assessment teams report included the following evidence relevant to my finding:

* In the month prior to the assessment contact, care documentation for one named consumer showed they had recorded a significant weight loss, and while a dietician review occurred 8 days later, there recommendations had not been implemented consistently.
* Care documentation and medication charting for 3 consumers showed staff were not effectively managing medications resulting in medications being administered incorrectly or were not administered resulting in adverse effects.
  + Management stated they had followed all medication incidents up with the staff member responsible for the incident.
* Observations, care documentation and staff feedback demonstrated inconsistencies with the management of oxygen administration for one consumer, with directives for oxygen administration and monitoring inconsistent.
* Care documentation for 2 consumers who required fluid restrictions demonstrated monitoring of fluid intake was not consistently being undertaken, nor was fluid intake evaluated by clinical staff.
  + Clinical and care staff said there had been no clear guidance or instruction on where to document and monitor fluid intake for consumers with fluid restrictions.
  + Management responded to assessment teams feedback by creating a task for clinical staff to review fluid intake for consumers with a fluid restriction, while also implementing paper-based fluid balance sheets.

The provider acknowledged the assessment team’s findings and provided the following proposed and completed actions relevant to my finding:

* Actions have been undertaken for named consumers to increase monitoring and rectify deficits for individual consumers, including:
  + Implementation of nutritional supplement sign charts for weight loss, however, provided charting showed inconsistent completion of charts.
  + Review of oxygen administration directives across care documentation and medication charting in consultation with the medical practitioner.
  + Review of fluid restrictions for named consumers, and provided additional monitoring of fluids, however, fluid charting showed inconsistencies with monitoring or actioning episodes where fluid charted had exceeded the restriction.
* Additionally, the service has implemented actions to address systemic deficits, including:
  + Toolbox training on medication safety undertaken on 30 September 2024.
  + The provider stated they would undertake frequent auditing by the clinical governance team to monitor compliance. Additionally, staff would be provided education and training, with the current plan for continuous improvement updated.

While I acknowledge the providers response and the proposed and implemented actions to rectify the identified deficits, I find the service could not demonstrate effective management of the high impact and high prevalence risks associated with the care of each consumer.

In coming to my finding, I have considered the evidence in the assessment team’s report which demonstrates deficits in the management and monitoring of weight loss, fluid restrictions and oxygen administration. While the service has implemented and proposed a range of actions in response in relation to the named consumer’s, the provided care documentation demonstrates ongoing deficits in monitoring, for example, one consumer’s nutritional supplement charting provided had not been consistently completed in line with dietitian directives. Additionally, while charting to monitor fluid restrictions had been completed, the documentation did not show actions taken when they recorded amounts above the fluid restriction. I acknowledge the provided plan for continuous improvement; however, the actions will take time to be fully embedded into practice and evaluated for effectiveness.

I find that while the service has a plan to improve the current management of high impact and high prevalence risks associated with the care of each consumer, high impact and high prevalence risks are not being effectively managed at the time of the assessment contact. Therefore, I find requirement (3)(b) in Standard 3 Personal and clinical care non-compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |

Findings

The service was found non-compliant in requirement (3)(c) following an assessment contact undertaken in January 2024 where it was found the workforce did not have the right skills and competencies to undertake their roles. The assessment teams report included improvements implemented to address the non-compliance, including but not limited to:

* Undertaking staff education and training, and review of the management of training records.
* Monitoring of quality indicators to identify areas of development.

The assessment team recommended requirement (3)(c) as met, as they were satisfied the workforce has the skills and abilities to undertake their roles, and the service reviews performance when a potential or actual skills gap is identified.

Consumers and representatives expressed satisfaction with the care and services provided and felt confident staff have the skills and ability to perform their roles. Staff described completing mandatory training, including manual handling, infection prevention and control and first aid. Clinical staff described undertaking medication training both online and in person. Management described, and training records confirmed, annual mandatory training requirements and qualifications required by staff.

Based on the assessment team’s report, I find requirement (3)(c) in Standard 7 Human resources 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. | Not Compliant |

Findings

The service was found non-compliant in requirement (3)(d) following an assessment contact undertaken in January 2024 where it was found the organisation’s risk management systems were ineffective in identifying and managing the high impact and high prevalence risks associated with the care of consumers. The assessment teams report included improvements implemented to address the non-compliance, including but not limited to:

* Medication incidents were included as an agenda item for discussion at multidisciplinary team meetings.
* The organisation is in the process of implementing an electronic medication management system to go live in October 2024.
* Completed education and training to support staff in incident responsibilities, including the serious incident response scheme (SIRS) reporting obligations.

The assessment team recommended requirement (3)(d) not met, as they were not satisfied the organisations risk management system is effective in managing risks to consumers care through the use of an incident management system. The assessment team’s report included the following evidence relevant to my finding:

* The service does not maintain a risk register, however, identifies and monitors consumers considered to be high risk through the multidisciplinary team meeting.
* The clinical governance team undertakes reviews of clinical documentation and audits to ensure compliance and identify gaps in clinical care, and an internal audit undertaken the month prior to the assessment contact identified consumers on fluid restrictions did not have reviews or outcomes recorded.
* Care documentation for consumers who require fluid restrictions, changes to medication management and oxygen administration not include guidance to support staff.
* Where medication incidents occur, staff reflections are not considered in the investigation of incidents. Reflection forms included comments on staffing levels not being adequate to deliver medications, or medication changes not being communicated to medication competent staff.
* Incident information demonstrated a root cause analysis was not undertaken consistently, with 4 medication incidents and 2 incidents for skin integrity and falls being reviewed and found to not have a root cause analysis completed.
* Medication incidents demonstrate not all incidents were documented in the incident management system, including the medication incident for one consumer C.
* SIRS incidents had not been reported consistently in line with service policies and procedures for one incidents relating to physical aggression and 3 incidents related to missed medications.

The provider did not agree with all aspects of the assessment team’s findings and provided the following evidence relevant to my finding:

* Multidisciplinary team meetings are held weekly, and meeting minutes included discussion of high impact and high prevalence risks and quality of care reviews.
* Clinical analysis meetings are undertaken monthly between clinical leaders on site and supporting member of the clinical governance team and discuss high impact and high prevalence risks, clinical incidents, SIRS, and education and training are discussed.
* The provider acknowledged the incident management practices have not been effective in preventing the reoccurrence of similar incidents, or capturing all incidents, however, have been effective in managing incidents individually to provide immediate support to consumers. To ensure incidents are effectively trended and analysed at the service, the provider has implemented the following actions:
  + Increased oversight of consumer incidents by general manger and clinical governance team.
  + Supporting the clinical manager at multidisciplinary meetings to review high risk consumers and mitigate associated risks.
  + The clinical governance team to provide support and modelling with data analysis to onsite management.
  + Mandatory training for staff in incident reporting and additional monitoring of staff practices.
* The service provided evidence of the incidents identified in the assessment team’s report being investigated and considered for reporting through SIRS.

I acknowledge the providers response; however, I find the service did not demonstrate effective risk management systems, particularly in relation to using incident data to trend and analyse information to prevent similar incidents from occurring, including undertaking root cause analysis, capturing all incidents, and recognising and responding to elder abuse. In coming to my finding, I have considered the providers acknowledgment of the deficits identified within the management of incidents and the proposed actions to provide clinical management additional support and mentoring in reviewing incidents, including undertaking root cause analysis of incidents. In relation to high impact and high prevalence risks, I find the service does not demonstrate effective risk management processes in relation to high impact and high prevalence risks, including assessment and planning processes to ensure the risks are identified and monitored effectively by staff, as evidenced in Standard 3, requirement (3)(b), by providing guidance to staff in assisting consumers to manage risks.

While I recognise the service has implemented a plan for continuous improvement to rectify the deficits identified, the planned improvements will need time to be embedded into staff practice to be effective in managing incidents and preventing the reoccurrence of similar incidents, therefore, I find requirement (3)(d) in Standard 8 Organisational governance non-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)