Performance

Report

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| Name: | BaptistCare Maranoa Centre - Alstonville |
| Commission ID: | 0003 |
| Address: | 15 The Avenue, ALSTONVILLE, New South Wales, 2477 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 31 July 2024 to 1 August 2024 |
| Performance report date: | 3 September 2024 |
| Service included in this assessment: | Provider: 1595 BaptistCare NSW & ACT  Service: 5 BaptistCare Maranoa Centre - Alstonville |

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 Maranoa Centre - Alstonville (**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.
* the provider’s response to the assessment team’s report received 22 August 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Applicable |
| **Standard 4** Services and supports for daily living | **Not Applicable** |
| **Standard 6** Feedback and complaints | **Not Applicable** |
| **Standard 7** Human resources | **Not Applicable** |

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

Information contained in the Assessment Team report indicated consumers said they did not feel safe when receiving personal care and were not confident their clinical care needs are being monitored regularly and provided in a timely manner. Staff said they are informed of consumers’ personal care and clinical care needs from care documentation completed by registered staff located in the service’s electronic care management system (ECMS). Review of documentation by the Assessment Team indicated some consumers’ personal care and clinical care was not monitored and tailored to meet their individual needs, contained inaccurate information and care was not managed in a timely manner to ensure safe and effective delivery of care. The Assessment Team report recommended a finding of non-compliance for the requirement.

Wound Management

The Assessment Team report indicated for a named consumer with a stage 2 pressure injury, a review of care documentation indicated inconsistent management of the wound, inconsistent photographing/measurements and no directive regarding the regime or care of the wound by a Medical Officer (MO) or wound specialist. An MO had reviewed the wound in May 2024, advised the wound may not be a pressure injury and suggested the service contact a wound specialist. The service had not referred the consumer to a wound specialist since the commencement of the pressure injury 12 months earlier.

The approved provider’s response to the report contested this information. The response disputed comments regarding the consumer’s diagnosis and advised a wound management plan had been in place for the entirety of the consumer’s residency and the consumer’s MO had reviewed the wound 4 times. The response said while there had been some issues with photo storage, consistent photographing and measurement of the wound was available to staff. I accept the information provided in the response.

For another named consumer, the Assessment Team report raised concerns regarding the management of a wound on the consumer’s toe. The report indicated discharge notes from hospital informed the service to follow up with a wound specialist for amputation consideration as the wound was identified as dry gangrene. It was noted the consumer had been admitted to hospital due to a fall and fractured neck of femur. The Assessment Team report indicated concern the consumer had not been referred to a wound specialist but was instead being managed by a registered staff member.

In response, the service said the report did not reflect the extensive interventions and progress notes relating to the identified change in the consumer’s health, which the service identified and communicated with their representative. The response outlined at length the efforts undertaken to manage the complex health needs of the consumer and evidence was provided of reviews of the toe by the MO, a podiatrist, and the registered staff member who, the response advised, is in the final stages of completing a Masters degree in wound management. The response also provided the hospital discharge notes which inform follow up by the MO rather than a wound specialist. The response evidenced numerous discussions with the consumer’s representative regarding management of the wound and their decision not to pursue further interventions in the light of the consumer's peripherovascular disease in her lower limbs and recent fracture, angiogram and angioplasty. I accept the response from the service addresses the concerns raised in the Assessment Team report.

The service also advised since the assessment contact a wound specialist has been booked to review all chronic wounds for consumers at the service to confirm agreement with management strategies and identify any possible areas for improvement.

Time Sensitive Medications

Information in the Assessment Team report identified multiple occasions when administered medications were more than an hour outside of scheduled timeframes. The report the potential for adverse outcomes for some of the consumers involved.

The service response advised all instances of medications administered outside of scheduled timeframes had been reviewed and no adverse effects had been identified. The service has also commenced a review of all residents who receive time sensitive medications and advised a clinical alert has been issued in relation to all consumers on time sensitive medications with actions to identify any potential risks for consumers caused by delays.

I am satisfied the response provided by the service addresses the concerns raised in the Assessment Team report.

Behaviour Support

Information in the Assessment Team report raised concerns regarding behaviour support for two named consumers. One named consumer had made two recent suicide attempts. The report indicated the consumer’s behaviour support plan (BSP) had not been updated to include recommendations by Dementia Support Australia (DSA). The report indicated staff were unaware of the recommendations. The consumer had been moved to the service’s secure area where they could be more closely monitored. Management said they have contacted the Older Persons Mental Health service (OPMH) and are waiting for advice to enable the service to develop a plan for the consumer’s mental health condition.

In response, the service confirmed the consumer had been referred to OPMH and was being monitored in the secure unit. The service advised the recommendations from DSA were in place and recorded in the BSP and had been discussed with staff who care for him.

For a second named consumer, the Assessment Team report indicated the consumer felt they did not receive appropriate care for their psychological needs. The report expressed concern the consumer’s BSP did not identify behavioural triggers.

In response, the service disagreed with the comment that the triggers were not identified in the BSP, advising the BSP has identified the triggers for the consumer, and strategies to manage her psychological needs. The service advised the consumer received weekly support from a psychologist. The service provided copies of the consumer’s BSP, referrals and assessments. The service also advised the service has had a downward trend in behavioural incidents during the last 12 months and provided evidence of this.

I accept the submission from the service provider with the proviso that there are ongoing actions to be completed in relation to the named consumers which must be addressed by the service.

Serious Incident Response Scheme (SIRS)

The Assessment Team report indicated the service was unable to demonstrate a shared understanding of regulatory compliance in relation to the identification and reporting of reportable incidents. An example was provided of a medication error when a consumer was provided an incorrect sedative. The incident was not reported to SIRS. Following review during the assessment contact, it was determined the incident was reportable.

The service’s response advised the particulars of the incident were that the consumer had been started on a new sedative and had been mistakenly provided his previously prescribed medication without adverse effect. The service advised the staff involved have undergone coaching and since the assessment contact, incidents are discussed as a regular part of weekly staff meetings.

Restrictive Practices

The Assessment Team report indicated the consent of 6 substitute decision makers had not been obtained for identified chemical restraints of consumers using psychotropic medications without a diagnosis.

The service’s response disputed the numbers in the report, advising for at least one consumer the medication was for a diagnosed condition and not chemical restraint. The service advised it provides information to consumers and representatives of the side effects of psychotropic medications. In response to the assessment contact an additional email was sent out to all relevant consumer representatives about psychotropic medications and possible side effects. The service confirmed their plan for continuous improvement (PCI) identified education is to be provided to staff regarding restrictive practices relating to chemical restraint and the service will aim to reduce the use of psychotropic medications by 31 October 2024.

Weight Loss

The Assessment Team report indicated 12 consumers had significant weight loss between January and July 2024. The report indicated these consumers had not been reviewed by a dietitian. The report provided significant details regarding the weight loss by the impacted consumers.

In response to the report, the service advised it had been identified prior to the assessment contact that the scales being used were possibly inaccurate. The service advised new scales had been purchased since the assessment contact and provided evidence all the named consumers had been re-weighed. The evidence shows 9 of the 12 consumers have revised weights which show weight gain rather than loss. The service advised they remain cognisant of any consumer weight loss and have commenced a series of remedial actions relating to weight loss, which were noted in the service’s PCI which was provided with their response.

In considering whether this requirement is compliant, I note some of the information in the Assessment Team report was inaccurate or incomplete. I also note the additional information provided in the service’s response to clarify matters and actions completed or being undertaken to address identified deficiencies. In totality, I have persuaded the service has either addressed the concerns raised in the Assessment Team report or has undertaken sufficient remedial actions to ensure deficiencies will be addressed. I have therefore decided the requirement is compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |

Findings

Consumers said they enjoy participating in outings and activities the service organises. All consumers sampled said they spend time with friends and family, with the staff supporting them if needed. Staff were observed by the Assessment Team supporting consumers during activities and social visits. Management demonstrated the processes used to ensure consumers are involved in and approve the activities calendars for the service. Care documentation reviewed detailed the consumers’ interests and what was important to them for their health, wellbeing and quality of life.

Management said they consult and gather information about consumer preferences for their daily supports by informally chatting with consumers, via the monthly resident and relatives meeting, providing feedback forms and asking consumers if they enjoyed the activities.

The Assessment Team reviewed the activities calendars for various wings within the service which evidenced the service has community partnerships with a local hardware store, cultural groups, other regional aged care services, schools, art groups and a dance group facilitator.

Following consideration of the above information, I have decided the requirement is compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |

Findings

Consumers and their representatives said management address and resolve concerns raised following a complaint and when incidents occur. Staff demonstrated an understanding of open disclosure, including providing an apology when things go wrong.

Management and staff demonstrated a shared understanding of the process followed when feedback or a complaint is received. Staff confirmed that if consumers or representatives were to raise an issue with them directly, they would promptly inform the RN who would resolve the issue immediately if possible or escalate to the manager verbally or by email if further action were required. The manager would complete the complaint/feedback form and enter the complaint into the complaints register.

The service’s feedback and complaints policy and procedure and complaints handling processes were reviewed. Management provided the Assessment Team with recent examples of open disclosure used throughout their complaint’s procedure and review of the feedback and complaints register demonstrated open disclosure was consistently practiced when things went wrong.

Following consideration of the above information, I have decided the requirement is compliant.

# 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 service was able to demonstrate the workforce is planned to enable the delivery of safe and quality care and services. Consumers and representatives said there are enough staff at the service to meet consumer needs. Management has contingency plans in place to replace staff when required and rosters are reviewed on a regular basis to ensure staff allocations are adequately meeting changing consumer needs and preferences.

The service uses a base roster for permanent staff with casual staff used to fill remaining shifts. When the service experiences unplanned leave, staff are notified via an electronic application system of available shifts. If no staff are available to fill shifts, shift times can be altered to ensure adequate coverage for that shift. If any shifts remain vacant, agency staff are utilised where possible.

Management said they are actively recruiting new staff and have employed over 50 new staff in all areas of the service over the past 6 months and are currently recruiting another care team manager and a clinical consultant which is a new role for the service.

Following consideration of the above information, I have decided this requirement 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)