Performance

Report

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| Name: | Baptistcare Morrison Gardens |
| Commission ID: | 7186 |
| Address: | 1A North Street, MIDLAND, Western Australia, 6056 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 23 January 2024 to 24 January 2024 |
| Performance report date: | 15 March 2024 |
| Service included in this assessment: | Provider: 1595 BaptistCare NSW & ACT  Service: 4714 Baptistcare Morrison Gardens |

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 Morrison Gardens (**the service**) has been prepared by R. Beaman, 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 14 February.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not Fully Assessed |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 8** Organisational governance | **Not Fully Assessed** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

**Standard 3, Requirement (3)(b):**

* Ensure high impact or high prevalence risks associate with the care of each consumer are effectively managed, specifically in relation to pressure injuries.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |

Findings

Consumers and representatives confirmed they are supported to make their own decisions about the way care and services are delivered and who is involved in that process. Consumers were satisfied with the way their decisions about care and services were communicated and confirmed they were able to make connections with others with whom they wished to. Staff described ways in which they supported consumers to exercise choice including through meal and lifestyle choices. Documentation showed consumer choice and preferences for care and services is recorded within care planning to guide staff practice.

Based on the assessment team’s report I find Requirement 1 (3)(c) in Standard 1 Consumer dignity and choice is compliant. As all requirements for this Standard were not assessed an overall rating is not provided.

# 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 assessment team have recommended Requirement (3)(b) as not met as they were not satisfied the service effectively manages high impact or high prevalence risks associated with consumer care, specifically in relation to the management of risks with pressure injuries, falls and weight loss. The assessment team provided the following evidence and information gathered through interview, documentation, and observation relevant to my finding:

* Two named consumers’ pressure injuries were not effectively managed. For one consumer staff did not follow care plan directives and check skin integrity daily and did not identify a stage 2 pressure injury until advised by an allied health specialist. Wound swabs were delayed, and the wound had deteriorated and required medical attention. Staff were unable to describe the intervention strategies provided to the consumer. For both consumers their care plan was not reviewed post wound identification to identify effective pressure relieving strategies and for one consumer the care plan did not provide strategies to guide staff practice.
* One consumer’s health condition which included vomiting and nausea was not effectively managed and their condition had deteriorated further since December 2023. The medical officer has reviewed the consumer on 4 occasions between November 2023 and January 2024, however no actions to manage the condition were recorded or implemented. The consumer’s representative confirmed they had requested staff to trial anti-nausea medication three times daily which had not occurred, and they have observed the consumer vomiting when visiting. Staff confirmed this is a daily occurrence for the consumer and they administer anti-nausea medications prior to the morning meal.
* Four named consumers did not have neurological observations taken as per policy after they sustained falls. One of the named consumers had a head strike in their fall sustaining an injury to the back of the head and another consumer had an unwitnessed fall with injuries to their forehead and cheek. Three of the four consumers are prescribed and administered blood thinning medication and at higher risk of bleeding.

The provider did not agree with some of the findings in the assessment team’s report and included additional commentary and information in their response. In relation to pressure injuries for the consumer with the pressure injuries on their toes, the provider asserts the wound deterioration was due to another medical condition the consumer experienced at the time and provided evidence to show there was no delay investigating if infection was present and swabs to determine infection were undertaken in December 2023.

The provider acknowledges the observation made by the assessment team of a bed cradle not in situ for the consumer and provided staff with additional training around delivering pressure relieving strategies. In relation to the other named consumer with pressure injuries to their toes, the provider asserts the consumer has had ongoing issues with pressure injuries, and the consumer was reviewed by the occupational therapist with recommended pressure relieving interventions of which the consumer declined and as such these were not included on the consumer’s care plan. The provider confirmed the information of apply moisturiser twice daily is accurate and in line with care delivery for that consumer. The provider also acknowledges the risk of pressure injuries was caused by the footwear the consumer used of which was unable to be mitigated due to the consumer’s refusal of interventions.

In relation to the four consumers who experienced falls, the provider included additional information that showed neurological observations were completed for all consumers and for the two consumers who were transferred to hospital the provider included information to show they had been medically cleared prior to their transfer back and as such did not need further monitoring.

I acknowledge the additional information and commentary included in the provider’s response; however, I find high impact and high prevalence risks associated with care of each consumer have not been managed effectively, specifically in relation to pressure injuries. In coming to my finding, I have considered the information in the assessment team’s report for the two consumers with pressure injuries. For the consumer who acquired two pressure injuries on their toes that were not identified until they were stage 2 for one, and unstageable the other. I have considered information that shows there was no review of the consumer’s risk of pressure injuries when the first pressure injury was identified to determine other causes or mitigate further from occurring and another pressure injury occurred soon after the first. I have also considered the Information included in the provider’s response that shows the consumer was complaining of pain at the site of their pressure injuries during December 2023.

I have considered observations made by the assessment team of the consumer in bed without pressure relieving devices including the bed cradle that was recommended observed on the floor in the consumer’s bathroom, along with the bed sheets being pulled tight across the consumer’s feet which is not in line with the care plan directions. I have also considered the information in the assessment team’s report that shows staff do not have knowledge of the pressure relieving strategies in place for this consumer to deliver effective pressure area care.

In relation to the second consumer with 2 pressure injuries on their toes. I acknowledge the additional commentary included in the provider’s response that the consumer is non-compliant with the recommended strategies from the podiatrist and have considered the provider’s acknowledgement that the indication for pressure injuries is caused by the consumer’s footwear of which was unable to be mitigated, however the review completed by the occupational therapist in October 2023 included in the provider’s response, records the consumer is at risk of pressure injuries but does not document the consumer’s footwear is a possible contributor to this and the care plan provided does not show footwear to be a possible cause.

I acknowledge the initiatives implemented and continuous improvement actions planned to improve pressure area care by staff and improve outcomes for consumers but find these will need time to be embedded fully to determine efficacy.

For the reasons above, I find Requirement (3)(b) in Standard 3, Personal care and clinical care non-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. | Compliant |

Findings

The organisation demonstrated an effective risk management system is in place with processes for the management of high impact or high prevalence risks to consumer care, recognising and responding to abuse and neglect, supporting consumers to take risks safely and managing incidents. A risk register is maintained with consumer specific risks and reviewed regularly through the clinical care meetings. Incidents are investigated to determine causes and identify mitigation strategies to prevent recurrence. Staff demonstrate understanding of risk identification and how and when to report incidents Documentation confirmed incidents are reported appropriately and in a timely manner. Where consumers wish to take risks, risk assessments are completed with strategies to prevent harm recorded within care planning documentation.

Based on the assessment team’s report, I find Requirement (3)(d) in Standard 8 Organisational governance compliant. As all requirements for this Standard were not assessed an overall rating is not provided.

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)