Performance

Report

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| Name of service: | BaptistCare The Gracewood Centre |
| Service address: | 2 Free Settlers Drive KELLYVILLE NSW 2155 |
| Commission ID: | 1040 |
| Approved provider: | BaptistCare NSW & ACT |
| Activity type: | Assessment Contact - Site |
| Activity date: | 2 May 2023 to 3 May 2023 |
| Performance report date: | 6 June 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 The Gracewood Centre (**the service**) has been prepared by Melissa Buhagiar, 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 conducted 2 May to 3 May 2023, 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 May 2023
* the following information given to the Commission, or to the Assessment Team for the Assessment Contact - Site of the service: Directions Notice dated 16 August 2022 following the Site Audit conducted 24 May to 26 May 2022; Performance Report dated 29 June 2022 following the Site Audit conducted 24 May to 26 May 2022.

**Other related matters:**

* An unannounced Assessment Contact was conducted on 2 - 3 May 2023. The purpose of the Assessment Contact was to assess the 6 requirements determined to be Non-compliant following a Site Audit in May 2022. The Assessment Team was directed to add a seventh requirement to the assessment scope, Standard 3 Requirement (3)(b).

**Assessment summary**

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **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**

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.

**Requirement 2(3)(e)** The approved provider must ensure that staff follow recommended directions and strategies and evaluate the effectiveness of the strategies for further assessment and planning. Assessment and care planning must be updated and reviewed to reflect the current condition of the consumer to prevent future incidents.

**Requirement 3(3)(b)** The approved provider must ensure that the gaps identified in relation to high impact or high prevalence risks with falls and behaviours are effectively managed and that incident investigation is completed accurately, with mitigation strategies reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

**Standard 1**

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |

**Findings**

The assessed requirements 1(3)(a) and 1(3)(d) have been found to be Compliant.

A Site Audit was conducted at the service from 24 - 26 May 2022 and these requirements 1(3)(a) and 1(3)(d) were found to be non-compliant. The reasons for the non-compliance were that there were some instances where the Assessment Team observed consumers not being treated with dignity and respect. This included assisting a named consumer to eat in rapid succession, leaving consumer room doors open while providing them with personal care and not responding to a consumer’s call bell in a timely manner. Three named consumers were smoking in non-smoking areas without staff supervision. This was inconsistent with organisational policy and consumer risk assessments and mitigation strategies. A large amount of cigarette butts were observed with no fire safety equipment in the area. One consumer did not have a risk assessment for walking barefoot.

The Assessment Team conducted an Assessment Contact on 2 - 3 May 2023 to assess the requirements previously found to be non-compliant and found there is a diversity and inclusion policy with organisational commitments and guidance for management and staff about implementation, including roles and responsibilities.

The Assessment Team interviewed consumer and representatives who provided feedback that the staff know the consumers and their backgrounds and culture, and this is also reflected in the care and services records. Observations show recognition and celebration of consumers’ cultural backgrounds through signage and displays within the service environment, and cultural events are being celebrated. Observations made at mealtimes showed consumers were afforded dignity and respect. Observations made at various times showed consumer privacy was maintained. For all consumers sampled information gathered through interview with them or their representative, interview with staff, observations made, and review of the consumer’s care and service records showed they are treated with dignity and respect and their identity, culture and diversity are valued.

The Assessment Team identified that the organisation has a resident decision making and risk policy and procedure to support consumers to take a positive approach to activities that may involve an element of risk. Also, there is a notice about dignity of risk, which is promoted in the service environment, and includes for consumers’ representatives’ information about the importance of affording consumer risk taking to give autonomy and increase the possibility of joy and pleasure. For the consumers sampled, it was evident through interview with them or their representative, interview with staff, observations made and review of the consumers’ care and service records that they are being supported to take risks to enable them to live the best life they can.

The Assessment Team interviewed the consumers and representatives who confirmed that speech pathologists and staff had discussions with them and discussed the risks associated with the consumer’s choice and had signed the risk consent form.

**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. | Non-compliant |

**Findings**

The assessed requirement 2(3)(e) has been found to be Non-compliant.

A Site Audit was conducted at the service from 24 - 26 May 2022 and this requirement was non-compliant due to the care and services of some named consumers had not been reviewed when the consumer’s circumstances changed, or incidents occurred. Weight was given to neurological observations not consistently monitored post-fall for a consumer with head injury and lack of assessment after consumer skin injury.

The Assessment Team conducted an Assessment Contact on 2 - 3 May 2023 to assess the requirement previously found to be non-compliant and identified that although a number of actions had been added to the Plan for Continuous Improvement, there were identified gaps with behaviour support, skin integrity and pain management and the incident management had not been effective in the review and evaluation of these to prevent future incidents.

The Assessment Team interviewed staff who explained the processes for consumer reassessment and monthly care days to review the effectiveness of care and services, including on a regular basis and when needed such as if the consumer’s circumstances change or an incident occurs. Review of consumer care and service records, interviews with the consumer or their representative and the staff, and follow-up with the clinical staff shows this occurs for some consumers. However, care and services were not regularly reviewed for effectiveness for 2 consumers sampled with behaviour support needs and, in the main, were not reviewed when incidents occurred for 6 consumers sampled.

The Assessment Team reviewed documentation which identifies that although behaviours occur daily for some consumers, triggers for behaviours have not been recorded, on some occasions the strategies for staff to try has not been completed or is listed as one to one attention, this is despite several strategies recorded that staff can use to help minimise behaviours. The effectiveness/outcome of the interventions tried are not always completed which does not provide evidence to inform reassessment and care planning. Falls had not been investigated and incident reports show no information about preventative strategies used or revised or new strategies to prevent future incidents from occurring.

The approved provider responded to the Assessment Team’s report with copies of care plans and incident reports. The provider advised if there was an area blank on the incident management form, it was due to staff not being sure of which trigger caused the incident and additional training has been planned with Dementia consultants to further improve care staff understanding for identifying triggers and documentation in behaviour charts. Training on Incident Management for all registered nurses had already been booked prior to the Assessment Contact for 4 May 2023 and is now completed. The training content included investigation of incidents and preventative strategies and documentation in the incident form.

I acknowledge the providers response and the immediate actions that the provider has introduced since the Assessment Contact. I however am not satisfied that the actions and strategies will have an immediate effect, unless the staff can demonstrate the training received in a practical way to review and revise strategies and investigate incidents to prevent further incidents reoccurring.

I find that the approved provider is non-compliant with this requirement.

**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. | Non-compliant |

**Findings**

The assessed requirement 3(3)(b) has been found to be Non-compliant.

The Assessment Team interviewed consumers and representatives, who mostly provided positive feedback about the care provided to the consumer. High-impact and high-prevalence risks for some consumers have been effectively managed, such as in relation to pressure injury prevention and wound management and also management of risks relating to dysphagia and swallowing difficulty. However, effective management of high-impact risks associated with the behaviour of 2 consumers was not demonstrated.

Consumers provided feedback that the behaviours of one consumer had not been dealt with effectively, and said the verbal behaviour makes them and other consumers upset and is not something the consumers should have to deal with at this time of their lives. The consumer advised this started happening last year and has continued into this year.

There is mixed information about effective management of falls as a high-impact or a high-prevalence risk associated with the care of consumers. For some consumers the risk is managed well. However, as documented under Standard 2 Requirement (3)(e) other times there is a lack of review of falls incidents and the effectiveness of related care and services to try and prevent future falls. One example of this, which also demonstrates ineffective management of falls risk up to the present, is a consumer who sustained a fracture from a fall.

Overall, it has not been demonstrated that high-impact and high-prevalence risks associated with the care of consumers are effectively managed. There is a significant gap in relation to risks associated with the behaviour of 2 consumers and also some gaps in relation to falls risk for some consumers.

The approved provider responded to the Assessment Team’s report and advised that they have been trialling every possible non-pharmacological intervention before resorting to medication for managing behaviours and have volunteers visiting to assist with one-to-one activities. The provider advised that multiple strategies are in place to reduce and manage behaviours and keep other consumers safe. However, it was not clear from documentation that the Assessment Team reviewed if these strategies are being used as there is no relevant information included in the behaviour chart to help identify triggers and if the strategies are effective. The provider also advised that they were unaware of the information that the Assessment Team had received from the consumer in relation to the fall.

I acknowledge the actions that the provider is taking to manage the high impact and high prevalence risks, however consumer’s feedback is that there is an impact that is occurring on their emotional health.

I find that the approved provider is non-compliant with this requirement.

**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 |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |

**Findings**

The assessed requirements 7(3)(a) and 7(3)(b) have been found to be Compliant.

A Site Audit was conducted at the service from 24 - 26 May 2022 and these requirements 7(3)(a) and 7(3)(b) were found to be non-compliant following consumer and representative feedback that staff were rushing, and consumers had to wait longer times for staff assistance. Staff said they were short staffed, felt rushed, could not monitor or assist consumers as required, attend to call bells in a timely manner or spend quality time with consumers. Call bell records showed over 20% of responses exceeded the target response time, including some exceeding 30 minutes. The Assessment Team had also observed some instances of staff not acknowledging consumers’ needs, not assisting consumers with their meals in a timely manner and not knowing consumers’ preferences.

The service’s implemented a number of actions in their Plan for Continuous Improvement.

The Assessment Team conducted an Assessment Contact on 2 – 3 May 2023 to assess the requirements previously found to be non-compliant. The Assessment Team interviewed consumers and staff who indicated there is enough staff to provide safe and quality care to consumers. Consumers and representatives consistently provided feedback that staff are kind, caring and respectful and the Assessment Team observed workforce interactions to demonstrate this during the Assessment Contact.

Consumers provided positive feedback that there are enough staff and call bells are answered in a timely manner. One representative said there is possibly not enough staff as the reception is not always manned when they come to pick up the consumer although don’t have to wait for too long. Review of staff rosters and allocation sheets provide evidence that staff who take leave are replaced and there were no unfilled shifts. When consumers call staff assistance via the call bell system their calls are answered in a timely manner.

Staff interviewed indicated that there is sufficient staff for them to complete their work effectively and there are no unfilled shifts as the registered nurses will find permanent or agency staff to replace shifts. Staff also advised that the organisation has a pool of casual registered nurses who they can call upon to replace unfilled shifts.

Management indicated they have restructured the workforce by increasing the number of registered nurses from one to 2 for the morning shift and changed medication administration responsibilities from the care supervisor to the registered nurses, so that the care supervisors can be on the floor to provide more personal care to consumers.

**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**

The assessed requirement 8(3)(c) has been found to be Compliant.

A Site Audit was conducted at the service from 24 - 26 May 2022 and this requirement was found to be non-compliant due to some of the organisation’s governance systems not operating effectively at the time of the Site Audit to pre-emptively identify and address deficiencies in relation to regulatory compliance and workforce governance. At the time of the Site Audit the behaviour support plan of a consumer subject to chemical restraint was not in line with legislative requirements and informed consent was not in place for consumers subject to environmental restraint. Workforce governance systems did not identify and address deficiencies in Standard 7 about reduced staffing levels impacting safe and effective care to consumers.

The Assessment Team conducted an Assessment Contact on 2 – 3 May 2023 to assess the requirement previously found to be non-compliant.

The Assessment Team interviewed staff who indicated that they do not have any challenges in accessing information required to deliver quality care and services to consumers. Management indicated each home has their own newsletters and information is distributed to consumers and representatives via emails and the organisation’s website, including the organisation’s strategic plan.

Management indicated that the organisation’s policy and procedure committee (OPPC) meet monthly to review policies to ensure they are current and relevant, and any changes are managed by this team who distributes a monthly update. The Assessment Team sighted the policy and procedure update from the OPPC dated April 2023 and the service’s policy and procedure newsletter dated 3 March 2023. These show how management and staff were informed of changes to policies and procedures related to the risk management framework, care and clinical governance and clinical documentation.

The Board Chair indicated that they use clinical indicator data and trends to identify improvements and use incidents from other services in the organisation to help identify opportunities for continuous improvement. The Board Chair described how another service in the organisation experienced a security gate hardware failure incident which triggered a review of all the organisation’s services who were using the same hardware and equipment.

The General Manager indicated the service’s Plan for Continuous Improvement is a management tool and major clinical issues or matters rated as serious are flowed out to the board, however the board is not expected to have a detailed understanding of improvements at operational level.

The Assessment Team sighted the minutes of the residential care and clinical governance meeting and the service’s health compliance scorecard that are both shared with the board. They include items related to continuous improvements.

The Regional Manager indicated capital expenditure is reviewed yearly and the budget is reviewed monthly as part of the service’s health compliance scorecard. The Regional Manager indicated the board has approved all requests for out of budget consumer spend, such as providing air mattress equipment and supporting extra physiotherapy hours.

The Board Chair indicated that workforce is discussed at all board meetings, and they have invested in growing the human resources department to become a better and more attractive employer, however, acknowledge the use of agency staff in the short term.

The General Manager explained programs the organisation is using to support recruitment, such as attraction and retention bonus incentives, and referring friends to attract new people and these are discussed at the board.

The Assessment Team sighted the service’s health compliance scorecard which includes an item about people care, reporting on casual staff usage, sick leave, leadership risk and staff turnover. Also, the staff sufficiency policy and procedure were up to date.

The organisation is guided by a care and clinical governance framework to provide overarching guidance for care and clinical governance structures and processes and monitoring and reporting of care and clinical quality and safety at all levels of the organisation. The role of the residential clinical and quality governance committee is to identify, establish and maintain systems and processes to achieve the flow and reporting of data to the board care and clinical governance committee, CEO and executives for delivering care and service, including national quality indicators, external stakeholder activities (ACQSC) and industry legislation updates.

The Assessment Team sampled 3 areas of regulatory compliance to understand whether the systems and processes described were working effectively: restrictive practices, behaviour support planning and the aged care worker code of conduct.

In response to the Commission’s risk-based questions about use of restrictive practices, the management team advised there is no chemical restraint, physical restraint or seclusion ordered or used. They advised there is some use of lo lo beds which are mechanical restraint, and some consumers are environmentally restrained in the DSU.

The Board Chair indicated that complaints and compliments are reviewed at a site level, however for any major complaints or complaints to the Commission, a deep dive for learnings will be conducted. The Board Chair indicated when any board or committee members visit the service, they will spend time having afternoon tea with the consumers so the consumers can ask questions and vice versa. Changes were reflected following the committee speaking with consumers and representatives and have made changes to the meals and menus with improved food committees and introduced a food tasting before the menu is implemented.

The Assessment Team found that there was effective organisational governance demonstrated in relation to information management, continuous improvement, financial governance, workforce governance and feedback and compliance. There is a policy and a system for governance of regulatory compliance, which was demonstrated to be effective in the main in relation to restrictive practice and in relation to implementation of the aged care worker code of conduct. There are gaps in relation to behaviour support planning. However, overall, for the requirement effective governance was demonstrated.

1. The preparation of the performance report is in accordance with section 68A – assessment contact, of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)