Performance

Report

**1800 951 822**

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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: | 8 September 2023 |
| Performance report date: | 12 October 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 Gill Jones, 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 29 September 2023.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 3** **Personal care and clinical care** | **Not applicable as not all requirements have been assessed** |

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

# 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

This Requirement was found non-compliant following an Assessment Contact conducted from 2 to 3 May 2023. The service was unable to demonstrate each consumer’s care and services were reviewed for effectiveness following incidents. Information was not sufficient to effectively investigate and minimise potential occurrence and guide staff in providing appropriate care. There were inconsistencies in documentation relating to falls risk, behaviour supports, skin integrity, and pain management.

The service has implemented several actions to address the non-compliance identified including conducting staff education, incidents reviews and audit activity.

The Assessment Team found a routine consumer review process occurs each month to review each consumer’s care to enable any concerns to be followed up. Documentation showed care plans are reviewed every six months and case conferences are held yearly or when there is a change in a consumer’s condition. While most records documented reviews and incident follow up occurred, the Assessment Team found not all consumers were reviewed within the scheduled time frames or had appropriate post-incident clinical assessment completed. This related to falls and post falls monitoring for two consumers. The Assessment team also identified issues with the ongoing assessment and monitoring of behaviour for one consumer.

The Approved Provider provided a response to the Assessment Team’s report on 29 September 2023. The provider responded to the issues raised, providing a comprehensive response, including clinical documentation, for each of the consumers cited in the Assessment Teams’ report. I have reviewed this response and I am satisfied that the provider was able to demonstrate that post falls monitoring and post-incident clinical assessment occurred for the consumers cited in the Assessment Teams report. I am also satisfied that ongoing behaviour assessment and monitoring occurred for the consumer cited in the Assessment Teams report. The Provider acknowledged that their system for recording the monitoring of behaviour needed improvement and they have set up a new process as a continuous improvement action.

Having considered the Assessment teams report and the response from the Approved Provider, I find Requirement 2(3)(e) 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. | Compliant |

Findings

This Requirement was found non-compliant following an Assessment Contact on 2-3 May 2023. The service was unable to demonstrate effective management of high impact risks for consumers with changed behaviours. The plan for continuous improvement indicated a range of actions to address the non-compliance including staff training for both staff and consumers about dementia and care plan reviews to ensure behaviour strategies are documented.

The Assessment Team found observations and consumer and representative feedback about management of high impact high prevalent risks was positive. Staff knowledge around high impact, high prevalent risks was sound. The Assessment team reviewed a number of care plans and found deficits in the recording of consumer goals and triggers for behaviours identified.

The Assessment Team also identified that the psychotropic register had not been updated recently updated and contained information that was not current. Having reviewed medications being prescribed, the Assessment Team identified several consumers as being potentially chemically restrained and not all consents for restrictive practices were in place or current.

The Assessment Team found one consumer’s restrictive practices care plan had not been reviewed weekly, as required, and behaviour plans reviewed did not comprehensively address the consumer’s goals or the triggers to the consumer’s behaviour.

The Approved Provider provided a response to the Assessment Team’s report on 29 September 2023. The provider responded to the issues raised, providing a comprehensive response, including care documentation, for each of the consumers cited in the Assessment Teams’ report. I have reviewed this response and I am satisfied that the provider was able to demonstrate that the provider is able to demonstrate the effective management of high impact or high prevalence risks associated with the care of each consumer.

The provider acknowledged that deficits were present in the consent forms reviewed including where signatures may have not been in the correct place and consents were no longer current. The provider stated they have now corrected these consent forms and have reviewed their processes to ensure this issue is addressed. I am satisfied that ongoing behaviour monitoring occurred for the two consumers cited in the Assessment Teams report based on the information submitted by the provider. As previously discussed in Requirement 2(3)(e) the provider acknowledged that their system for recording the monitoring of behaviour needed improvement and they have set up a new process as a continuous improvement action. The provider was able to demonstrate goals and triggers were identified for the consumers cited in the Assessment Team’s report however acknowledged that this information is scattered and not easy to see across the consumer’s different care plans. This has been identified by the provider as a continuous improvement action in their Continuous Improvement Plan. Lastly, the provider was able to demonstrate that the psychotropic medications in use, which may have been classified as chemical restraint, were being used with consumers with a suitable diagnosis. The provider explained that the register for logging information about psychotropic medications is updated monthly on the 15th of the month and was due for review with days of the Assessment Contact which is why some information may not have been current. The provider may wish to consider whether updating this register on a monthly basis is sufficient.

Having considered the Assessment teams report and the response from the Approved Provider, I find Requirement 3(3)(b) 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)