

**Performance Report**

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| Name: | BaptistCare Warabrook Centre |
| Commission ID: | 0515 |
| Address: | 14-24 Casuarina Circuit, WARABROOK, New South Wales, 2304 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 12 November 2024 to 13 November 2024 |
| Performance report date: | 23 December 2024 |
| Service included in this assessment: | Provider: 1595 BaptistCare NSW & ACT  Service: 528 BaptistCare Warabrook Centre |

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 Warabrook Centre (**the service**) has been prepared by M.Wyborn, 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, older people/representatives and others, and
* the provider’s response to the assessment team’s report received 16 December 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Compliant |
| **Standard 7** Human resources | **Not applicable as not all requirements were assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements were 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 3(3)(b)**

* implement effective systems to ensure identification and timely management of high impact or high prevalence risks.
* implement effective systems to ensure identification, analysis and development of preventative measures related to high impact and high prevalence consumer risk(s).

**Requirement 3(3)(d)**

* ensure effective systems to identify and respond in a timely manner to deterioration and changes in consumers’ mental health, cognitive or physical condition.

# 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 |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Not Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |

Findings

The Assessment Team reported that the service was unable to demonstrate consumers consistently receive care that is best practice, tailored to their needs and optimises their health and wellbeing. Majority of consumers advised of their satisfaction of the personal and clinical care provided by the service however, some consumers and representatives advised that the delivery of care was not to their liking. This included consumers’ preferences for showering and the service ensuring that all consumers are supported to change out of their pyjamas. Staff demonstrated appropriate knowledge and understanding of processes for caring for each consumer including individual consumer’s clinical and personal care needs. Staff routinely practice their care with consumer preferences in mind.

The service demonstrated that clinical staff and care staff routinely identify and assess signs of consumer pain and staff demonstrated an appropriate knowledge of the assessment and escalation processes when consumer pain is identified. However, the Assessment Team reported that consumer documentation is not consistently reflective of this process occurring, highlighting that some consumers recorded as receiving regular pain relief, or have wounds, or have had an incident occur, pain management is not consistently considered as part of the service’s regular clinical assessment.

In their response to the Assessment Contact report, the Approved Provider supplied their plan for continuous improvement along with supporting consumer clinical documentation that references individual consumers named in the Assessment Contact report. The service has introduced lunch time observation rounds as well as provided direct information to staff to support improvements to the services shower charting system. The Approved Provider demonstrated that the service’s pain management process involves a comprehensive and systematic approach to ensure effective care for consumers. This includes assessment and documentation, care plan and strategies, communication and reporting, and monitoring and follow-up. The service is undertaking training for staff to include reporting if pain occurs on movement and education of when a pain charting is required. I weighed the evidence provided by the Assessment Team against that of the Approved Provider and I determined that the impact on consumers is mitigated reflective of the service’s immediate improvement actions. I determine that the Approved Provider is able to demonstrate that each consumer receives safe and effective personal and clinical care and, with this consideration, I find the service compliant in Requirement 3(3)(a).

The service was unable to demonstrate effective management of high-impact or high-prevalence risks for each consumer. Risk minimisation strategies adopted by the service’s management and clinical management teams do not demonstrate adequate prevention measures established for all consumers. The Assessment Team reported that measures established to support consumers are generally undertaken as a reactive approach to risk. Risk assessments for each consumer were not consistently completed correctly or in full, and when a risk assessment identifies a risk, mitigation strategies for prevention are not routinely considered. The service observes falls management, restrictive practices and behaviour management as their high impact or high prevalence risks.

In their response to the Assessment Contact report, the Approved Provider supplied their plan for continuous improvement along with supporting consumer documentation that references consumers named in the Assessment Contact report. The service has introduced audits of post falls reviews and post falls management, provided staff training on incident management and root cause analysis and provided toolbox talks on incident management and escalation. The service is facilitating education for registered nursing staff on monitoring behaviour charts and delivering education to staff about recognising and charting behaviours. The service is also undertaking a review of consumer files to confirm if deterioration was recognised early with timely response and undertaking an audit of recent consumer falls to identify if referrals occurred and if they were correctly documented in each consumer file. I weighed the evidence provided by the Approved Provider and I determined that the actions work towards compliance against the Aged Care Quality Standards, however, will require time to implement, embed and evaluate. As such, at this time I provide greater weight to the Assessment Team’s information in relation to effective management of high impact or high prevalence risks. Therefore, I find the service non-compliant in Requirement 3(3)(b).

The service was unable to demonstrate that deterioration or change in a consumer’s mental health, cognitive or physical function, capacity or condition is routinely recognised in a timely manner. Some consumers and representatives advised of their dissatisfaction that staff would consistently recognise and respond appropriately in relation to deterioration or a change in their condition. Some consumers and representatives highlighted their concerns about lack of timely diagnosis and treatment which impacts consumers negatively, including delaying recovery. The service demonstrated relevant policies and procedures to guide staff in recognising and responding to a change in consumer condition and staff, respective of their position, demonstrated an appropriate understanding of the process for responding to consumer deterioration. This includes completing an observation tool and care staff escalating observations to the registered nursing staff. The service was unable to demonstrate however, that consumer care documentation was consistent with policy and procedures in relation to recognition and response to deterioration.

In their response to the Assessment Contact report, the Approved Provider supplied their plan for continuous improvement which highlights that the service is undertaking a review of consumer files to confirm if deterioration was recognised early and a timely response was actioned. The service is facilitating refresher training and increased monitoring and daily corrective actions with an increase in the number of CTMs. The Approved Provider highlighted that the service has improved the registered nursing monitoring tool and established calendar appointments for fortnightly use. I determine that the actions work towards compliance against the Aged Care Quality Standards, however, will require time to implement, embed and evaluate. As such, at this time I provide greater weight to the Assessment Team’s information in relation to ensuring that deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. Therefore, I find the service non-compliant in Requirement 3(3)(d).

The Assessment Team reported that the service was unable to demonstrate consistent, timely and appropriate referrals to individuals, other organisations and providers of other care and services. Some consumers and representatives advised of their dissatisfaction. Staff were able to demonstrate however, how individual consumer health and well-being changes prompt a referral to a relevant health professional. Clinical staff evidenced appropriate and timely consumer referral to various allied health services, including speech pathology, dietitian, skin specialist, physiotherapy, psychologist, geriatrician and Dementia Services Australia. In their response to the Assessment Contact report, the Approved Provider supplied their plan for continuous improvement which highlights that the service is undertaking an audit of recent falls to identify if timely and appropriate referrals occurred and if these referrals were documented correctly. The service will take appropriate corrective action if gaps are observed. After weighing the evidence I determine that any impact on consumers is mitigated reflective of the service’s immediate improvement actions. I decide that the Approved Provider is able to demonstrate provision of timely and appropriate referrals and, with this consideration, I find the service compliant in Requirement 3(3)(f).

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The service demonstrated effective recruitment processes that include appropriate reference and qualification checks which include visa status, criminal checks and AHPRA registrations. All staff are checked against the Commission’s banning list. Staff undergo an induction program where education is delivered and assessment checklists are completed. The service demonstrated an ongoing training calendar for staff education including a mandatory annual education program. The Assessment Team reported some deficits in staff education around management of high-impact high-prevalence risks of consumers including falls, consumer behaviour management, restrictive practices, pain management, minimisation of infection related risks, nutritional risks, consumer neglect, deterioration, timely referrals and knowledge related to analysis of incidents. In addition, the Assessment Team reported that non mandatory education records demonstrated low numbers of education completed by staff.

In their response to the Assessment Contact report, the Approved Provider supplied their plan for continuous improvement along with supporting evidence to demonstrate that the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. The Approved Provider highlighted that majority of staff have attended non-mandatory training in falls management, incident management, Dementia, pain management and weight management. The service demonstrated that staff mandatory training is up to date. Further, the Approved Provider supplied a copy of the organisation’s leaning and development policy which highlights that the organisation is committed to building a learning culture that supports its employees to enhance skills and capabilities that meet the current needs of their employment, build skills for career development and also develop capability to meet the future needs of the organisation. I determine that the Approved Provider’s response demonstrates appropriate measures at the service in regard to compliance for this Standard. The Approved Provider’s response demonstrates that the workforce is recruited, trained, equipped and with these considerations, I find the service compliant in Requirement 7(3)(d).

The Assessment Team reported that the service was unable to demonstrate regular assessment, monitoring and review of the performance of each member of the workforce. The service administers an employee performance and development guide and some staff have participated in performance appraisals however, some care staff, registered nursing staff and other staff advised that they had not received a performance appraisal in the last 12 months.

In their response to the Assessment Contact report, the Approved Provider supplied their plan for continuous improvement along with organisation’s Employee Performance and Development Management policy, Learning and Development policy and referenced their training matrix document. The service demonstrated that a majority of staff have completed their performance appraisals for the current financial year and management are maintaining oversight and sending reminders to staff to complete their appraisals and performance plans. In their response, the Approved Provider highlighted the organisation’s main components to monitoring and review which include regular monitoring of performance, management of underperformance, ensuring an effective probationary period of employment and ensuring that agency staff and contractors are well oriented within the workplace.

I determine that the Approved Provider’s response demonstrates appropriate measures at the service in regard to compliance for this Standard. The Approved Provider’s response demonstrates that workforce performance is assessed and monitored regularly and with these considerations, I find the service compliant in Requirement 7(3)(e).

# 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 administration of governance systems related to risk management, however, the Assessment Team reported that the service was unable to demonstrate consistent and effective management of high impact high prevalence risks associated with consumer care.

Staff demonstrated appropriate knowledge of their role and responsibilities in escalating incidents including suspected abuse and the neglect of consumers. However, the Assessment Team reported that some incidents were not adequately addressed.

Consumer care documentation demonstrated that the service is actively supporting consumers to exercise choice and participate in activities that enhance their quality of life. However, the Assessment Team reported that the process for identifying and responding to the deterioration and changes in consumer condition are not consistently followed and that there was a lack of timely referral for some consumers with high impact high prevalence risks.

The organisation demonstrated an effective incident management system however, the Assessment Team reported that some incident reporting highlighted missing or differing information recorded which is vital for staff in the analysis of falls incidents and their prevention.

Senior management demonstrated that the organisation uses relevant quality analysing tools that are monitored at a governance level for risk. Quality indicators, complaints, consumer call bells, and audits are also monitored and regular regional manager meetings are used to review and analyse health and compliance reports, call bell reports and risk mitigation strategies. Clinical risk meetings are undertaken regularly and the clinical governance team meet regularly. The organisation demonstrated regular meetings about restrictive practice and the organisation engages with palliative care, dementia and infection and prevention control consultants. The organisation is preparing for the strengthened standards.

In their response to the Assessment Contact report, the Approved Provider supplied their plan for continuous improvement along with the service’s comprehensive falls management analysis October 2024 and other supporting consumer clinical documentation that references individual consumers named in the Assessment Contact report. I weighed the evidence provided by the Assessment Team against that of the Approved Provider and I determined that the impact on consumers reported in this Requirement is more suitably considered in Standard 3. I determined that the Approved Provider is able to demonstrate effective risk management systems and practices and, with this consideration, I find the service compliant in Requirement 8(3)(d).

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)