Performance

Report

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| Name of service: | Performance report date: |
| Blue Care Gracemere Aged Care Facility | 20 September 2022 |
| Commission ID: | Activity type: |
| 5435 | Assessment contact |
| Approved provider: | Activity date: |
| The Uniting Church in Australia Property Trust (Q.) | 25-26 August 2022 |

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 Blue Care Gracemere Aged Care Facility (**the service**) has been considered by K. Reed, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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, 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 14 September 2022
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 3 Personal care and clinical care | Non-compliant |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

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

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.

* Restrictive practices need to be understood and documented as per legislative requirements. Pressure injuries are required to be managed as per best practice guidelines.
* The service is required to plan the workforce to enable the safe delivery of care and services.
* The workforce must be trained, equipped and supported to deliver care outcomes as per the Quality Standards.
* The organisation is required to manage high-impact and high-prevalence risk to consumers and identify incidences of consumer abuse and neglect.

# Standard 3

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| Personal care and clinical care | | Non-compliant |
| 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. | Non-compliant |

## Findings

Consumers did not receive safe and effective care. Two consumers were prescribed psychotropic medication deemed to be chemical restraint without the appropriate consent, assessment, behaviour support plan or effective monitoring processes. Feedback from a consumer regarding staff practices did not support their health and well-being was optimised as they felt pain during care delivery.

Staff at the service did not have a shared understanding of the types of restrictive practice in use at the service. Staff were unable to identify the number of consumers subject to chemical restraint through the use of psychotropic medication. Risk assessments and informed consent had not been completed for consumers subjected to a restrictive practice. The psychotropic register did not include all consumers who were subject to chemical restrictive practice, and the restrictive practice register did not include all consumers who were subject to mechanical restraint. There was insufficient evidence to support regular monitoring or review of consumers prescribed psychotropic medications. Behaviour support plans were not reviewed following incidents involving consumers, when behaviours changed or when clinical review occurred.

The Approved provider’s response acknowledged documentation needs to demonstrate consumers were receiving safe and effective care. The Approved provider has committed to the timely implementation of required improvements relating to clinical and personal care. The Approved provider in its response has submitted a restrictive practice tracker to demonstrate the currency of information. In reviewing the tracker, I noted seven consumers with mechanical restraint in place, there is no information to demonstrate a safety assessment has been conducted for the seven consumers. Three consumers subject to chemical restraint do not have information recorded on the tracker to demonstrate a medical officer or nurse practitioner has authorised the use of the chemical restraint. Six behaviour assessments are yet to be signed by the medical officer or nurse practitioner. Smoking risk assessments are yet to be completed for three consumers and ten consumers requiring restrictive practices do not have an entry on the tracker to support consent has been gained from their next of kin or alternate decision maker prior to the use of restrictive practices.

For two named consumers, processes were not effective in identifying the types of restraint used, and identified the use of psychotropic medication was for behaviour management which was contrary to guidelines of chemical restrictive practices usage, and behaviour support plans were not updated to reflect recommendations made by registered staff. Alternate strategies were not listed prior to the administration of as required chemical restrictive practices used. While care staff were aware of some strategies to manage the consumers’ behaviours, management confirmed the psychotropic register and restrictive practices register were not current or maintained for currency. Management also confirmed behaviour support plans were not consistently reviewed or updated following incidents of behaviour or change in behaviours. Management acknowledged there was ongoing work required to improve processes related to restrictive practices including informed consent, these improvements are listed in the plan for continuous improvement to be completed by the end of September 2022.

The Approved provider in its written response has addressed the specific concerns in relation to the two named consumers, conversations have occurred with the consumers’ nominated representatives, referrals occurred for one named consumer and documentation has been updated to reflect the current needs of the consumers, including behaviour support plans. While I note the attachments included in the Approved provider’s response demonstrated some of these actions had occurred, one Restrictive practice authorisation was not reflective of the consumer’s medication chart submitted to support the consumer is no longer refusing their medication, and the other Restrictive practice authorisation submitted was unsigned by either a medical officer or the consumer’s representative.

Feedback was provided by one consumer that they experienced pain due to rough handling of staff during repositioning. The consumer stated they waited for extended periods of time for assistance and staff numbers who provide them with cares are not consistent with their care planning directives which direct two staff are required for care provision. The consumer was observed to be regularly calling out for assistance from their bed during the Assessment contact. Registered staff provided feedback they had witnessed staff handling consumers roughly resulting in bruising which had been escalated to management. Management confirmed they had received reports of staff handling consumers roughly and had provided manual handling training to staff. Training records to support this training were not provided during the Assessment contact. Training records submitted as part of the Approved provider’s response indicate 23 care staff members have completed manual handling training, other training records submitted in the response do not appear to relate to manual handling but training on assessing, champion training and the use of a hoist. I am unable to determine how many staff are yet to complete manual handling training.

Other information recorded in the Approved provider’s response to the concerns of the consumer relating to rough handling of staff, have included a referral for the consumer to an older persons’ health specialist, a case conference, the provision of a larger bed, weekly monitoring and manual handling training for staff. Further manual handling training is scheduled for 19 and 29 September 2022.

Information was provided in the Approved provider’s response in relation to wound care documentation for one named consumer. In reviewing this information, I noted between 11June 2022 and 12 September 2022, the consumer’s wound was not attended to on 10 occasions in accordance with directives and on eleven occasions in the same timeframe there was a lack of description of the state of the wound, including sizing. A second wound report for the consumer fails to record the location of the wound in wound management details. This information does not support best practice for wound care.

I have come to a decision of Non-compliance in this requirement based on the lack of knowledge of staff in relation to restraint management and the deficiencies in the appropriate consent and recording processes relating to chemical restraint. While I acknowledge the actions the Approved provider has committed to taking to address the Non-compliance in this Requirement, some of these actions are not completed or are in their infancy and therefore have not been tested for their effectiveness.

**Standard 7**

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| Human resources | | Non-compliant |
| 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. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |

## Findings

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| 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. | Non-compliant |

Consumers and representatives provided feedback there was insufficient staff to provide safe and quality care and this resulted in consumers waiting lengthy times for care delivery causing incontinence, hygiene preferences not respected or supported, sustaining bruising due to staff rushing and rough handling, insufficient number of staff to provide care in accordance with care planning guidelines and medication errors.

The Approved provider responded to this information, stating the current occupancy level at the service and staffing requirements demonstrated the service’s staffing establishment is operating above this level. The Approved provider acknowledged service workflows require further review to ensure consumer care needs are met given the staffing profile. In relation to negative feedback regarding staffing levels from consumers, representative and staff, the Approved provider has advised in its response, staffing is an agenda item at consumer and staff meetings. Individual consumers responses are being sought and being completed and reviewed onsite weekly, with improvements or opportunities for improvement actioned and followed up. Feedback is tabled at consumer and staff meetings. Consumer and staff meeting minutes were not provided as part of the Approved provider’s response.

Care staff provided feedback there was insufficient staff to complete their required duties and tasks. Tasks that were unable to be completed included providing care, entering progress notes and completing blood glucose charts. Registered nurse shifts for the evening shift were not consistently filled and management confirmed there was no formal arrangement for a registered nurse to be on call when registered nurse shifts were unfilled.

After hours support and on-call access processes and coverage was detailed in the Approved provider’s response detailing who is responsible for allocating after hours support and identified a local work instruction needs to be created to ensure a clear process is completed in relation to after hours support and on-call arrangements. Following feedback in the Assessment contact report relating to lack of staffing in the service’s memory support unit, the Approved provider submitted five days of staffing allocations to demonstrate staffing levels in the memory support unit. In reviewing this information for Saturday 05 August 2022, I noted three registered staff shifts were not replaced, one registered staff member was required to work from 2pm until 6am the following morning, an eight hour shift in the memory support unit was replaced with a six hour shift, and one staff member was required to work both in one wing of the service and the memory support unit on the afternoon shift. It is my opinion this information does not support sufficiency of staffing or effective replacement strategies for unplanned staff leave.

Two incident reports relating to medication incidents containing information the causative factor was staff fatigue or staff insufficiency. The service’s complaint register contained two complaints relating to the insufficiency of staff. The Approved provider responded to this information stating the two medication errors were a duplicate and the medication error has been reported to the regulatory authorities.

Following the assessment contact visit on 25-26 August 2022, recruitment of four positions occurred including a Care manager, Care Co-ordinator, Residential service manager and Administration officer. A registered nurse is due to commence at the service 20 September 2022. The Approved provider has stated ongoing recruitment for clinical and care staff is occurring.

In coming to my decision of Non-compliance in this Requirement I have consider consumer and staff dissatisfaction in relation to the sufficiency of staff and the impact the lack of staff has had on consumer comfort, dignity and safety.

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| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |

The service was found to be non-compliant in this requirement following a site audit conducted between 30 November and 2 December 2021. Despite actions taken by the service included on the Plan for continuous improvement to address the non-compliance, the workforce has not been trained, equipped or supported to deliver the outcomes required by the Standards.

Feedback was received from registered staff they did not feel equipped or supported to deliver care and services. One registered staff member recruited into their role five weeks prior to the Assessment contact had not completed mandatory training modules or received training on the service’s electronic care management system. Other registered staff provided feedback their requests for training including medication management, cultural diversity and the Quality Standards had not been actioned. A third registered staff member stated they had not received training in the electronic care system or participated in the service’s orientation program.

The Approved provider in its response acknowledged ongoing educational opportunities relevant to staff roles have been inconsistently implemented, particularly in relation to organisational mandatory training. A fortnightly mandatory training report has been recommenced to address the achievement of mandatory training completion. An administration officer will be trained in mandatory training reporting and processes, when they commence at the service 15 September 2022.

Management were unable to provide staff completion rates for mandatory training modules including restraint management and elder abuse. This information is significant as consumers provided feedback staff were at times rough delivering care which had caused bruising, and staff did not have a shared understanding of restraint management.

While the service’s plan for continuous improvement noted completion rates for orientation and mandatory training modules would be reviewed monthly, this has not occurred. Management did not have the required credential to access essential information including training records. The service’s plan for continuous improvement also documents an administrative staff member would be made available to assist staff complete mandatory training modules, however this initiative ceased in July 2022 and the initiative has not been completed. Management stated staff had received training in topics such as manual handling and infection control, however, no attendance records were recorded.

Following feedback provided at the Assessment contact, management committed to a review of the service’s orientation processes to ensure essential information will be communicated to new staff and orientation completion rates will be recorded. Staff accountability education will be provided in September 2022. A review of staff completion rates for mandatory training will be undertaken to identify any outstanding training requirements. Permanent recruitment of key personnel is planned to occur in September 2022, including the Service Manager and Clinical Care Manager, who were temporary staff members.

In coming to my decision of Non-compliance in this Requirement I have taken into account the deficiencies identified at the Site audit 30 November 2021 to 02 December 2021, and the service’s lack of ability to rectify or address these deficits in a timely manner. The service’s plan for continuous improvement originally contained information that deficits in this Requirement would have been addressed and completed by November 2021, this has not occurred, and the service has updated the completion of addressing deficits by October 2022. This has influenced my decision of Non-compliance in this Requirement.

**Standard 8**

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| Organisational governance | | Non-compliant |
| 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. | Non-compliant |

## Findings

The service was found to be non-compliant in this requirement following a site audit conducted between 30 November and 02 December 2021. Despite actions taken by the service included on the Plan for continuous improvement to address the non-compliance, the service was not managing high-impact or high-prevalence risks associated with the care of consumers and was not identifying and responding to potential incidents of consumer abuse and neglect.

While the service had an incident management system, the service was unable to demonstrate how the system was used to identify, manage and prevent high impact or high prevalence risks, prevent incidents, or identify and respond to abuse and neglect of consumers. The incident report register demonstrated not all incidents involving consumer neglect or abuse were reported to the Serious incident response scheme as per the legislative requirement. Three incidents including an allegation of rough handling and a medication related incident were not reported to the Serious incident response scheme. Management at the service did not meet regularly to discuss incidents or to identify risks to consumers. Between 28 May 2022 and 25 August 2022 there were 29 medication related incidents. There was no analysis of the number or type of incidents, and management were not aware of the high number of medication incidents over a three-month period.

While management stated clinical indicators were reviewed at monthly senior leadership meetings, meeting minutes for the senior leadership meetings between 7 July 2022 and 17 August 2022, indicated management from the service did not attend these meetings and the clinical indicators for the service were not discussed.

In its response the Approved provider has acknowledged there is an opportunity to strengthen the implementation of organisational risk management systems at the service level, and acknowledged actions identified in the plan for continuous improvement require ongoing oversight and management to support the service to return to compliance. The Approved provider recognised actions taken since the Non-compliance was first identified at the site audit 30 November to 02 December 2022 have not resulted in a level of sustained improvement.

I note the plan for continuous improvement contains information that indicates improvement actions in this Requirement are due to be completed in November 2022, this has influenced my decision of Non-compliance in this Requirement.

1. The preparation of the performance report is in accordance with section 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)