Performance

Report

**1800 951 822**

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| Name of service: | Blue Care Gracemere Aged Care Facility |
| Service address: | 35 Conaghan Street GRACEMERE QLD 4702 |
| Commission ID: | 5435 |
| Approved provider: | The Uniting Church in Australia Property Trust (Q.) |
| Activity type: | Assessment Contact - Site |
| Activity date: | 16 May 2023 to 17 May 2023 |
| Performance report date: | 16 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 Blue Care Gracemere Aged Care Facility (**the service**) has been prepared by K. Reed, 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 09 June 2023
* the Performance report for the Assessment contact conducted 25-26 August 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 | Not applicable as not all requirements have been assessed |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Non-compliant** |

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.

* Incidents must be reported, recorded, and escalated when required.

# 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 |

Findings

The Assessment contact report identified two consumers who were prescribed psychotropic medication, but the consumers were not listed on the service’s psychotropic medication register. The Approved provider in its response has provided evidence one of the named consumers was included on the psychotropic register, however, their Christian name was used rather than their surname which may have caused confusion at the Assessment contact. For the second consumer prescribed an antipsychotic medication on 1 April 2023 but not listed on the psychotropic register, the Approved provider has instigated processes to ensure medication changes prompt the inclusion of the consumer on the psychotropic register. These processes include weekly checking of revised medication charts and a 50% audit of all medication charts.

It is my decision the omission of one consumer from the psychotropic medication register does not constitute a lack of care delivery and this information has not influenced my decision.

The Assessment contact report contained information behaviour support plans contained similar directives for most consumers who required a behaviour support plan. The Approved provider in its response has indicated the electronic care system will produce an assessment which includes a pre-populated option and areas for free text, this may explain why some consumers’ behaviour support plans appear similar. As an action to improve individualised strategies to be included in behaviour support plans, a review of all behaviour support plans has commenced, and consumers named in the Assessment contact record and consumers residing in the Memory support unit have been prioritised for review. This action will be completed for all consumers requiring a behaviour support plan by 30 June 2023. While the Assessment contact record stated challenging behaviours were still occurring and staff use strategies such as redirection, I do not consider the cause of challenging behaviours to be linked to a lack of individualised strategies in behaviour support plans. I am satisfied processes to review behaviour support plans is underway and consumers most at risk have been prioritised and their care plans amended. Two consumers identified as perpetrators of aggressive behaviours have been referred to a dementia behaviour specialist service. I also have considered education provided to staff will assist when dealing with challenging behaviours of consumers.

The Assessment contact report included information relating to the provision of wound care was not in accordance with wound care directives. For one named consumer with a pressure injury, wound care was not delivered in accordance with directives. The Approved provider in its response has stated the consumer’s wound chart has been reviewed and is now being dressed in accordance with directives. Wound care charting submitted as part of the response confirms wound care is being attended as prescribed, and I also note the wound is healing.

For a second named consumer with a pressure injury and associated sinus, the Assessment contact report includes information that photographs have not been taken as prescribed and wound care was not attended as prescribed. The consumer’s wound was dressed by management due to the cost of the dressing product required. The Approved provider in its response has stated additional photos were kept in a separate file which was not available during the Assessment contact. The Approved provider has accepted this is not organisational process and has included appropriate wound charting and documentation to the service’s Plan for continuous improvement, discussed at the clinical staff meeting and wound care documentation guidelines have been distributed to staff who perform wound care. The Assessment contact report includes information this named consumer was not referred to a wound specialist, the Approved provider noted the consumer was referred to a wound specialist on 7 May 2023, but sadly passed away on 29 May 2023, prior to the wound specialist completing the requested review.

In respect to wound care, I agree best practice wound care includes documentation to support the monitoring of wounds to gauge the healing process or identify when wound care regimes may need revising, however I have not identified any impact for consumers in relation to wound healing due to poor documentation.

Diabetic management plans were identified in the Assessment contact report as not being completed as directed by medical officers. Two consumers who require insulin were identified, including one consumer who requires blood glucose monitoring five times daily, and additional insulin as required. The Approved provider has provided information that the consumer attends dialysis three times weekly and their blood glucose levels, and insulin are monitored by staff at the dialysis unit. On one occasion it was recorded the blood glucose reading was not recorded at 2 am and the consumer had a high blood glucose reading at 8 am and required additional Insulin later in the day. I am unable to establish a link between the absence of a 2 am blood glucose level and high blood glucose levels later in the day. Given the complexity of the consumer’s diabetic needs, it is my decision the service is managing the consumer’s diabetic needs.

For the second named consumer, the Assessment contact report contained information the service was unable to locate the consumer’s diabetic management plan and while directives on their medication chart indicated blood glucose levels were to be taken twice a day, there were gaps in blood glucose readings on six occasions in May 2023. The Approved provider has documented diabetic management plans were in a folder awaiting review by the medical officer. The named consumer has a revised diabetic management plan which indicates the consumer is for daily blood glucose monitoring, this was confirmed by the submitted diabetic management plan and handover sheet. I have considered that in the absence of impact for the consumer and the revised diabetic management plan supporting daily blood glucose readings, I am satisfied with the diabetic care provided to the consumer.

The service was previously found to be Non-compliant in this Requirement following an Assessment contact conducted 25 to 26 August 2022. While the above information suggests there are remaining documentation deficiencies at the service, I am confident that care and service delivery to consumers is safe and effective. I am also confident actions included in the current Plan for continuous improvement will address and rectify these issues. Therefore, it is my decision this Requirement is now Compliant.

# 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)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

Consumers and representatives were generally satisfied with the number of staff available to attend to their cares. Most staff said they were generally satisfied with the number of rostered staff and the ability to complete their workload. Management demonstrated vacant shifts were generally filled.

Five consumers out of 25 consumers and representatives interviewed provided feedback they believed the service was still short of staff. The Approved provider in its response has included this feedback into a register and will seek to resolve the issues for the consumers. I considered the weight of the positive feedback from the other 20 consumers and representatives when making my decision.

The service was found to be Non-complaint in Requirement 7(3)(a) following an Assessment contact conducted 25 to 26 August 2022 and has taken actions to address deficiencies in this Requirement. Actions have included the removal of four staff members from the roster following an internal investigation into medication incidents and poor staff practices. Registered staff positions were occupied by agency staff have been replaced with permanent staff and ongoing recruitment continues. Key personnel at the service including the Residential Services Manager and Clinical Manager have transitioned form agency staff to permanent staff. The service is also supported by a Quality Compliance Support Officer. The management team are qualified Registered nurses and are available to assist staff with care delivery. After hours support is shared by the Residential Services Manager and the Clinical Manager. Training has been reviewed and provided to staff via face to face or self-directed learning.

In reviewing the above actions and considering the lack of concerns raised through staff and consumer meetings, and the positive feedback from most consumers and representatives interviewed in relation to care and service delivery, It is my decision Requirement 7(3)(a) is now Compliant.

Consumers and representatives were satisfied staff were trained to provide safe and effective care to consumers. Staff considered they were appropriately trained, supported, and equipped to perform their roles. Management monitored staff compliance with mandatory training through an electronic learning management system and provided staff with additional training when the need was identified. Consumers and representatives did not feel staff required further training in any areas and were satisfied the service supported staff to undertake their roles. Staff described the training, support, professional development, and supervision they received during orientation and on an ongoing basis. Management advised and staff confirmed, additional training was provided where requested by staff or identified by management. The service had a monthly monitoring process of all training completed, assigned and overdue being reported to management and presented at the organisation’s governance team meeting. Review of training compliance reports identified strong compliance rates for mandatory training.

The service was found to be Non-complaint in Requirement 7(3)(d) following an Assessment contact conducted 25 to 26 August 2022 and has taken actions to address deficiencies in this Requirement. Actions included review and update of the service’s orientation process to include essential information and the tracking of training completion. Training occurred in relation to the service’s electronic care system for existing staff and new staff during orientation. A dedicated staff member was assigned to monitor all training outcomes. Staff were provided additional paid support time to complete training.

Considering the information contained above, it is now my decision Requirement 7(3)(d) is now 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. | Non-compliant |

Findings

The service demonstrated a system where incidents relating to behaviours, medication errors, infections, weight loss, pressure injuries, skin tears and falls were documented. The service did not demonstrate it effectively documents all behaviour incidents in the incident management system or consistently identifies incidents requiring reporting to the Serious incident response scheme.

The Assessment contact report contains information 10 incidents of aggression by consumers were not reported in the service’s incident management system. Two incidents of aggression which were documented in the incident management system which met the criteria for escalation to the Serious incident response scheme had not been escalated or reported to meet legislative time frames.

The Approved provider in its response reported a Nurse practitioner delivered education to onsite management on 22 May 2023 relating to effective clinical monitoring, explaining effective clinical monitoring is to ensure behavioural and any other clinical incidents reported in progress notes are reported in the incident management system. The Nurse practitioner also reinforced to onsite management the identification of incidents that must be reported to the Serious incident response scheme and the classification of priority one or two incidents. A Quality Compliance and Innovation partner provided one on one support to onsite management relating to requirements of reports being provided to the Serious incident response scheme and instructions provided relating to electronically report the incidents.

A clinical staff meeting was held 18 May 2023 whereby eight registered staff were present. Registered staff were reminded they must immediately notify management of all incidents that may need reporting to the Serious incident response scheme to enable reporting within legislative time frames. Serious incident reporting refresher training was delivered to 23 staff on 24 May 2023, and resources were displayed in nurses’ stations to guide staff.

The incidents identified in the Assessment contact report have been retrospectively reported in the incident management system. The two reportable incidents have been reported to the Serious incident response scheme.

A register of all reportable incidents has been developed to identify consumers or staff who were involved in more than one incident. This will be used to inform next steps to minimise or mitigate the risk of recurrence.

While the service has taken actions to address the deficits identified in the Assessment contact report, I am not convinced the processes of managing and reporting incidents has been embedded or tested for effectiveness, and staff knowledge relating to the reporting of incidents was poor despite the service being Non-compliant in this Requirement since 20 September 2022.

It is my decision the Service remains Non-compliant 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-1)