Performance

Report

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| Name of service: | Garrawarra Centre |
| Service address: | 1810 Old Princes Highway WATERFALL NSW 2233 |
| Commission ID: | 1456 |
| Approved provider: | NSW State Government (NSW Ministry of Health) |
| Activity type: | Assessment Contact - Site |
| Activity date: | 4 July 2023 |
| Performance report date: | 9 August 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 Garrawarra 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 4 July 2023, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the following information given to the Commission, or to the Assessment Team for the Assessment Contact - Site of the service: Assessment Contact report from Assessment Contact conducted 4 July 2023, Directions Notice dated 1 November 2022 following Site Audit conducted 6 July to 8 July 2022, Performance Report dated 14 September 2022 following Site Audit conducted 6 July 2022 to 8 July 2022.

# Assessment summary

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| 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

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# 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 Quality Standard does not have a Compliance rating as only one of the specific requirements were assessed.

The Assessment Team have found that requirement 8(3)(c) is Compliant.

The service was found to not meet this requirement in the Site Audit conducted between 6 July 2022 to 8 July 2022. The rationale for this non-compliance was due to consumers’ behaviour support plans not specifying the circumstances in which chemical restraints should be used and the psychotropic register did not identify chemically restrained consumers. The service’s register of consumers being administered a psychotropic medication was not current and did not always include an appropriate diagnosis or indication for the medication’s usage. The service’s Plan for Continuous Improvement lacked details of actions taken, outcomes or evaluation dates.

This previous non-compliance was discussed with management, and the service’s Plan for Continuous Improvement was reviewed to outline the strategies implemented.

The Plan for Continuous Improvement included that a review of the service’s restrictive practices policy and procedure has been conducted and ratified by NSW Health Ministry and is currently in the process of being added to the organisational intranet portal. Management said current practices align with the policy.

The Assessment Team were advised by management, that following the Site Audit a restrictive practice committee was established, attended by a geriatrician and clinical staff who act as an in-charge position after hours. This committee meets monthly to ensure consistency in the care and service provided to those consumers who are subject to a restrictive practice. All consumers are evaluated for the ongoing use of an antipsychotic medication at least monthly or when clinically indicated by a geriatrician. The service has a register of psychotropic medications, and this is reviewed on an ongoing basis by a clinical nurse consultant in behaviour management.

The service conducted staff surveys to identify a ‘gap’ analysis in relation to restrictive practice which was utilised in implementing its restrictive practice education.

The service maintains a register identifying the consumer’s person responsible, this includes details of any guardianship orders. This enables clinical staff to identify the appropriate contact for the consumer when seeking consent for the care and services to be provided.

During the Assessment Contact on 04 July 2023, information about this requirement was gathered through interviews, observations and document review. Overall, the service demonstrated the governance systems that are in place, and their application in considering best outcomes for consumers. The service is monitored by NSW Health Ministry and reviews routine reporting and analysis of data related to consumer experience. The board then satisfies itself that systems and processes are in place to ensure the right care is being provided in accordance with the aged care quality standards.

The Assessment Team identified that the service is currently transitioning their paper-based documentation system to an electronic documentation system (EDS). Management said staff have been trained to use the new system and they are in the process of ‘uploading’ consumers’ clinical files, including manually updating Behaviour Support Plans, and that a ‘hybrid’ of paper and electronic documentation is being recorded to mitigate risk. The Assessment Team reviewed a sample of consumers clinical files and found the information to be reflective of their current health status.

The organisation has a policy framework for the management of policies, procedures and supporting instruments, and alignment to relevant regulatory compliance instruments. Policies and procedures are available to all staff on-line. The quality management system includes a program of surveys, audits, and reports. This is overseen at a local and organisational level.

The Assessment Team asked management about how opportunities for improvement are identified, management stated this is achieved through input from consumer feedback, complaints, audits, surveys, staff suggestions, review of clinical indicators, incidents, meetings, organisational initiatives, and external reviews. This is integrated into a quality management system which is managed by NSW Health. The audits cover all the Quality Standards each year and include feedback from consumers and staff. The system is overseen by the management team.

The service has financial governance systems and processes to manage its finances and resources in order to deliver a safe and quality service. Management stated they have the resources they need for the delivery of care. They explained they are given a budget and a delegation authority for discretionary spending. They said they can approach the regional manager and seek authorisation for further spending as required. Staff interviewed said that they felt they had sufficient resources to perform their role. Management gave examples of recent approvals and grants submissions. For example, to secure funding to train two additional IPC Leads.

The Assessment Team reviewed the recruitment system used by the service which demonstrated the organisation has sound governance in relation to its workforce. Management advised workforce deployment is analysed regularly to coincide with consumer acuity at the service. The organisation utilises a healthy surge workforce that supports services in crisis, such as during an outbreak. In association with NSW Health, management is continuously recruiting to meet the workforce allocation needs and has built a casual pool to cover leave, which management said was at 96% utilisation last month.

The Assessment Team were advised by management that the organisation maintains up to date information on legislative guidelines. Regulatory compliance is managed centrally by the Director of Nursing and the Nurse Manager Operations, who receive updates to legislation changes from the Ministry of Health. Changes or updates to policies and procedures at the service are communicated via staff meetings and forums, emails, memos and newsletters.

The organisation provides oversight of restrictive practices and psychotropic registers. The service introduced an update to policies and procedures to guide staff in the use and management of restrictive practices. As a result of the findings of the Site Audit 6 July 2022 to 8 July 2022, the service conducted education in relation to restrictive management practice, this is ongoing and provided by the clinical educators. Management said that they believed the most effective method of training was at point of care coaching with the care staff. This is delivered through staff safety huddles as required.

The service has systems in place to encourage and support consumers and other stakeholders to provide feedback and make complaints. There are policies and procedures for responding to complaints, including a process of open disclosure to communicate with consumers and representatives about incidents that have caused harm.

I have found that the approved provider is Compliant with requirement 8(3)(c).

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)