Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Waranga Health |
| Service address: | 14 High Street RUSHWORTH VIC 3612 |
| Commission ID: | 3402 |
| Approved provider: | Goulburn Valley Health |
| Activity type: | Assessment Contact - Site |
| Activity date: | 22 May 2023 to 24 May 2023 |
| Performance report date: | 22 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 Waranga Health (**the service**) has been prepared by N Eastwood, 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 20 June 2023.

# Assessment summary

|  |  |
| --- | --- |
| 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** |
| **Standard 6** Feedback and complaints | **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 | **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 2

|  |  |  |
| --- | --- | --- |
| 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

The service was previously found non-compliant with this requirement following a Site Audit performed between 24 May 2022 and 27 May 2022. At the time of the site Audit the service was unable to demonstrate services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals, or preferences of the consumer.

Since the Site Audit the service has implemented a number of effective strategies to address the previously identified deficits including an audit of care files to ensure currency of consumer’s needs and preferences, developing flow charts to prompt staff to follow the service’s processes for file reviews, charting evaluation, and correct documentation in the electronic care document system.

The service demonstrated a strengthened process for regular consumer care review of services through monthly ‘resident of the day’ observations including vital signs, weight and review and evaluation of charting to identify changes in the consumer condition or wellbeing. The service demonstrated review of consumers where their circumstances have changed, or incidents have occurred which was confirmed by the Assessment Team review of documentation and staff accounts.

As a result, and with consideration to the implemented actions and available information I find this requirement now compliant.

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

The service was previously found non-compliant with requirements 3(3)(a) and 3(3)(g) following a Site Audit performed between 24 May 2022 and 27 May 2022. At the time of the site Audit the service was unable to demonstrate:

* each consumer gets safe and effective personal care and clinical care that is best practice; tailored to the individual and optimises their wellbeing. Clinical care including wound management and pain management were found to be inconsistent with consumers pain not managed effectively, and
* infection control practices to effectively reduce the risk of transmission of infections. Nor preparedness to meet an outbreak of an acute respiratory infection such as COVID-19.

While the Assessment Team recommended that these requirements remain not met, specifically related to ongoing concerns related to wound management and infection control practices. After consideration to the Approved Providers response including addition actions and evidence of proposed strategies as well as an updated Plan for Continuous Improvement, I have come to a different view.

Since the Site Audit the service has implemented a number of effective strategies to address the previously identified deficits, however the Assessment Team noted ongoing concerns related to inconsistencies with the wound management policy and procedures.

With regard to requirement 3(3)(a) the Assessment Team noted some ongoing inconsistencies with wound care documentation and opportunities to improve pain management regimes. Pain management generally demonstrated pain charting and evaluation in line with the improved process. The service demonstrated strengthened processes for managing restrictive practice for each consumer. Consumer’s subject to restrictive practice have up-to-date documentation readily available to inform staff on the restraint assessed, authorisations reflect informed consent gained from the consumer or the substitute decision maker, with regular reviews scheduled for opportunities to minimise or cease restraint. A review of care file documentation demonstrated that each consumer has a comprehensive individualised behaviour support plan to inform and guide staff.

The Assessment Team reviewed a range of documents that reflected thorough assessment for all classifications of restraint. Dignity of risk forms are completed where required for consumers who wish to leave the service independently or the consumer’s preference is to not adhere to recommendations for textured food intake, smoking, and other risks are considered and assessed for each consumer. Restrictive practice documentation is complete with review dates scheduled 3-monthly and in circumstances where psychotropic medication including opioid analgesia, antiemetics and medications to modify the progression of dementia are being administered.

The Approved Provider response (the response) and updated Plan for Continuous Improvement (PCI) provided additional context, information, and strategies to address the Assessment Teams observations related to wound management. The response provided evidence of a review of all consumers wound management plans as well as ensuring all consumers have wound care plans in place and consistent wound charting. The service has documented a review cycle to carry out Braden Risk Assessments for skin integrity and pressure injuries and an education plan to further consolidate wound and pain management processes has been implemented.

With regard to requirement 3(3)(g) the Assessment Team noted ongoing concerns with sanitising workstations and clinical equipment trolleys, staff compliance with use of Personal Protective Equipment (PPE) and consistency with screening requirements on entry to the service. The Assessment Team also noted the service was unable to locate the outbreak kit and incomplete documentation included with the outbreak management plan. The service did demonstrate practices to promote antimicrobial stewardship and appropriate antibiotic prescribing. The service’s Standardised Care process – Antimicrobial stewardship policy acknowledges the roles and responsibilities of consumers and/or their representatives, medical and clinical staff, pathology, and pharmacy in the establishment of a process to reduce antimicrobial resistance. The organisational directive of COVID-19 screening for residents and staff to be attended 3 times a week is being actioned, with visitors asked to perform a temperature check and a rapid antigen test (RAT) on each entry to the service. Staff and visitors wear a surgical mask in ‘consumer facing’ and communal areas.

The response and PCI provided additional context, information, and strategies to address the Assessment Teams observations related to PPE use and outbreak management. The response indicates processes have been strengthened to support daily integration of the emergency evacuation list into the Outbreak Management Plan. Wall mounted brackets have been installed to ensure ease of access to sanitising wipes and random audits have been commenced to ensure cleaning in between use takes place. The outbreak kit has been relocated to a central location and communicated to staff.

As a result, and with consideration to the implemented actions and available information I find these requirements now compliant.

# Standard 6

|  |  |  |
| --- | --- | --- |
| Feedback and complaints | |  |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |

Findings

The service was previously found non-compliant with this requirement following a Site Audit performed between 24 May 2022 and 27 May 2022. At the time of the site Audit the service was unable to demonstrate consumers and representatives are made aware of advocacy services, or other avenues for resolving complaints.

Since the Site Audit the service has implemented a number of effective strategies to address the previously identified deficits including the addition of information posters on display explaining the complaints process, details for external advocacy bodies and government departments. Implementation of the Older Persons Advocacy Network (OPAN) toolkit which contains contact information and elder rights literature for advice and dispute resolution. And addition of a standing agenda item at the resident and representative meeting.

Most consumers and one representative confirmed they knew additional external resources were available to assist with complaints handling. Staff confirmed how to support a consumer to make a complaint both internally and externally. The Assessment Team observed 4 feedback collection letter boxes to be prominent and well stocked with compliments, suggestions, and complaints forms for consumers to utilise. The OPAN toolkit is accessible to all consumers and their representatives, on display at the entrance to the facility. The Assessment Team viewed the feedback and complaints register which demonstrated all complaints were closed. Management explained the process to address, escalate, analyse, communicate, and implement a resolution. Complaints are categorised and triaged according to the severity of risk identified, and includes other departments involved, within and without the organisation, when appropriate.

As a result, and with consideration to the implemented actions and available information I find this requirement now compliant.

# Standard 7

|  |  |  |
| --- | --- | --- |
| Human resources | |  |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

The service was previously found non-compliant with requirement’s 7(3)(c) and 7(3)(d) following a Site Audit performed between 24 May 2022 and 27 May 2022. At the time of the site Audit the service was unable to demonstrate that the workforce is competent in the application of restrictive practices regulations and infection prevention and control practices.

Since the Site Audit the service has implemented a number of effective strategies to address the previously identified deficits, including the addition of a designated role of an educator to oversight training requirements, learning calendar and gap analysis of staff training requirements as well as annual performance development reviews. An audit of staff training has been carried with resulting in the development of a training program. Care staff explained that they have undergone a series of training courses including restrictive practices (chemical restraint), open disclosure, dementia care and aged care mental health. Management described how they determine staff competency and capabilities during the recruitment process through interviews, pre-employment checks such as registrations, and reference checks.

The Assessment Team reviewed documentation which demonstrated staff have qualifications relevant to their role, with registration and competency monitored. Education and monitoring records demonstrate staff are required to complete mandatory training, a range of core education and/or competencies relevant to their roles. Attendance records and feedback forms are also completed by staff upon the completion of training modules and sessions. Clinical and care staff who outlined they had completed hand hygiene, and PPE donning and doffing competencies. Records also reflect in-house training in SIRS, fit testing, oral care, and aged care learning had been provided to staff.

Consumers and/or representatives were satisfied staff are trained and supported to provide quality care and services to meet their needs. Staff interviewed confirmed they receive training, equipment, and support to provide the care and services consumers require. Management explained the processes in place to ensure infection protection and control practices including 2 dedicated IPC leads and a third staff member to undergo training. Management further outlined refined cleaning practices with the ability to isolate consumers where an outbreak is identified. The Assessment Team observed signage dedicated to handwashing, and infection protection and control practices throughout the service. The availability and adequate supplies of PPE for staff were also identified within the service.

As a result, and with consideration to the implemented actions and available information I find these requirements now compliant.

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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 |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

The service was previously found non-compliant with requirements 8(3)(c) and 8(3)(e) following a Site Audit performed between 24 May 2022 and 27 May 2022. At the time of the site Audit the service was unable to demonstrate:

* that it effectively tracks changes to the aged care legislation, including restrictive practice requirements, and communication of updates to staff, and
* effective governance systems in place in relation to open disclosure and minimising the use of antibiotics, the service was unable to demonstrate effective governance relating to the minimisation of restrictive practices, notably chemical restraint.

Since the Site Audit the service has implemented a number of effective strategies to address the previously identified deficits including a quality review process, use of formalised and updated policies such as the Residential Care Restrictive Practices policy reflecting best practice in relation to minimising the use of restraint, updates to Behaviour Support Plans (BSP) documentation and consent as well as staff training.

The service utilises a Quality Resource team that undertake audits and communicate changes to staff in relation to legislative requirements. Care staff explained that they have undergone a series of training courses including restrictive practices and Serious Incident Response Scheme reporting. Staff confirmed that changes to policies and practices, relative to updates in legislation are communicated via email, team meetings, and through training opportunities. The service has undertaken broad ranging education of staff which has been reinforced by clinical staff and management.

The Assessment Team noted that the service was now able to demonstrate the use of individualised BSP to inform the strategies implemented to minimise the use of chemical restraint. The Assessment Team viewed the psychotropic register, medication charts and progress notes that aligned with the service’s policy. Behaviour support plans are identified, assessed, monitored, and reviewed in accordance with evidence-based practice and legislation. The service reports quarterly to the Quality Indicator Board as well as reporting to the Medication Advisory Committee. Oversight is provided by the Operational Safety, Quality and Performance Executive Committee (GVH) and reviews audits, reports, incidents, and clinical quality indicators for identification of continuous improvement.

As a result, and with consideration to the implemented actions and available information I find these requirements now 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)