Waratah Lodge

Performance Report

6 Arnott Street
WAGIN WA 6315
Phone number: 08 9861 1755

**Commission ID:** 7118

**Provider name:** Wagin Frail Aged Inc

**Assessment Contact - Site date:** 22 February 2022 to 23 February 2022

**Date of Performance Report:** 5 May 2022

# Performance report prepared by

Rebecca Beaman, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

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| --- | --- |
| **Standard 2 Ongoing assessment and planning with consumers** |  |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(g) | Non-compliant |
| **Standard 6 Feedback and complaints** |  |
| Requirement 6(3)(c) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(c) | Non-compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | Non-compliant |

# Detailed assessment

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 Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies areas in which improvements must be made to ensure the Quality Standards are complied with.

The following information has been taken into account in developing this 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 Approved Provider’s response to the Assessment Contact - Site report received 30 March 2022;
* the Performance Report dated 8 September 2021 for the Site Audit undertaken from 13 July 2021 to 16 July 2021.

# STANDARD 2 Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The purpose of this Assessment Contact was to assess the service’s performance in relation to Requirements (3)(a), (3)(d) and (3)(e) in this Standard. These Requirements were found to be Non-compliant following Site Audit conducted on 13 to 16 July 2021 where it was found the service did not demonstrate it appropriately considered risks in assessment and planning, effectively communicated the outcomes of assessment and planning or reviewed care and services for effectiveness when circumstances changed, or incidents occurred that impacted the needs, goals or preferences of consumers.

The Assessment Team found at the Assessment Contact on 22 to 23 February 2022 that actions and improvements to rectify these deficiencies have been effective and the service was able to demonstrate assessment and planning processes consider risks to consumers’ health and well-being, outcomes of those are communicated effectively and care and services are reviewed when changes in circumstances or incidents occur.

I have considered the Assessment Team’s finding and the evidence documented in the Assessment Team’s report and find Requirements (3)(a), (3)(d) and (3)(e) in this Standard to be Compliant. I have provided reasons for my finding in the specific Requirements below.

All other Requirements in this Standard were not assessed, and therefore an overall rating for the Quality Standard is not provided.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

*Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.*

This Requirement was found Non-compliant following a Site Audit conducted on 13 to 16 July 2021 where it was found consumer care plans did not include information to guide staff in the delivery of safe and effective care. The service implemented actions and improvements to address the deficiencies identified, including (but not limited to):

* A review of all clinical assessments completed undertaken by an external registered nurse.
* Implementation of an integrated electronic care management system to enable to staff access to accurate consumer care and services information.

The Assessment Team found through interviews, observation and review of documents that the service was able to demonstrate assessment and planning consider risks to the health and well-being of consumers. The Assessment Team provided the following evidence and information for sampled consumers to support my finding:

* Consumer care documentation demonstrated clinical and other risks to consumer care are considered, recorded and discussed during the assessment and planning process.
* Consumer feedback indicated satisfaction with the assessment and planning process.
* An admission planner is utilised to ensure assessments are completed in a timely manner.
* Assessments completed are reviewed by an independent external registered nurse.

For the reasons detailed above, I find Wagin Frail Aged Inc, in relation to Waratah Lodge, to be Compliant with Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers.

### Requirement 2(3)(d) Compliant

*The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.*

This Requirement was found Non-compliant following a Site Audit conducted on 13 to 16 July 2021 where it was found the service did not demonstrate outcomes of assessment and planning were not effectively communicated to consumers. The service implemented actions and improvements to address the deficiencies identified, including (but not limited to):

* Case conferences undertaken with consumers and/or their representatives during care and service reviews.

The Assessment Team found through interviews, observation and review of documents that the service was able to demonstrate the outcome of assessment and planning are effectively communicated to consumers and those outcomes are documented in a care and services plan. The Assessment Team provided the following evidence and information for sampled consumers to support my finding:

* Sampled consumer care and service plans evidenced outcomes are discussed with consumers and/or their representatives.
* Consumers interviewed indicated the service discusses the outcomes of assessment with them.
* Observations of care plans being readily available and accessible to consumers.

For the reasons detailed above, I find Wagin Frail Aged Inc, in relation to Waratah Lodge, to be Compliant with Requirement (3)(d) in Standard 2 Ongoing assessment and planning with consumers.

### Requirement 2(3)(e) Compliant

*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.*

This Requirement was found Non-compliant following a Site Audit conducted on 13 to 16 July 2021 where it was found the service did not demonstrate care and services were being reviewed for effectiveness when a change in circumstances or incidents occurred. The service implemented actions and improvements to address the deficiencies, including (but not limited to):

* A review of all clinical assessments has been undertaken by an independent external registered nurse.

The Assessment Team found through interviews, observation and review of documents that the service was able to demonstrate the effectiveness of care and services are reviewed when circumstances change, or incidents occur that impact the needs, goals and preferences of consumers. The Assessment Team provided the following evidence and information for sampled consumers to support my finding:

* Consumer progress notes are reviewed by senior clinical staff to monitor consumer health status and identify any changes in circumstances or occurrence of incidents to review care and services.
* A consumer care file sampled showed staff identified a change in behaviour and referred the consumer to the Medical Officer for review in a timely manner and registered staff undertook a clinical review of all assessments for that consumer.
* The service monitors incidents and analyses clinical incident data monthly to identify trends and appropriate strategies.

For the reasons detailed above, I find Wagin Frail Aged Inc, in relation to Waratah Lodge, to be Compliant with Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers.

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The purpose of this Assessment Contact was to assess the service’s performance in relation to Requirements (3)(a), (3)(e) and (3)(g) in this Standard. These Requirements were found to be Non-compliant following Site Audit conducted on 13 to 16 July 2021 where it was found the service did not demonstrate it had delivered safe and effective clinical care in relation to medication management; the service did not have effective systems and processes in place to ensure accurate information about consumers’ condition, needs and preferences was communicated within the organisation or others where responsibility for care is shared; and staff were not following the service’s outbreak management policies and procedures to manage an infectious outbreak.

The Assessment Team found at the Assessment Contact conducted on 22 to 23 February 2022 that actions and improvements to rectify the deficiencies in Requirements (3)(e) in this Standard have been effective and have recommended this Requirement as met. However, in relation to Requirements (3)(a) and (3)(g) in this Standard, the Assessment Team found the service was unable to demonstrate:

* Safe and effective clinical care is delivered in relation to wounds, falls and medication management;
* Appropriate prescription and use of antibiotics. For one consumer identified with an infection, the service did not collect pathology to determine the appropriateness and effectiveness of antibiotics prescribed to treat the infection. For one consumer, staff operated outside their scope of practice and administered and ceased anti-fungal medication used to treat an infection without escalating the decision to registered staff for review; and
* An antimicrobial stewardship process to guide staff practice in the monitoring and administration of antibiotics.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and find Requirements (3)(a) and (3)(g) to be Non-compliant and Requirement (3)(e) to be Compliant. I have provided reasons for my findings in the specific Requirements below.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-compliant

*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.*

This Requirement was found Non-compliant following a Site Audit conducted on 13 to 16 July 2021 where it was found personal and clinical care was not being delivered in line with best practice, specifically regarding medication management. The Assessment Team found at this Assessment Contact actions and improvements to rectify these deficiencies had been implemented, including (but not limited to):

* Establishment of a falls protocol and education provided to staff.
* A review of clinical assessment and care plans to update information to guide staff with the delivery of safe and effective care.
* Policies and procedures being developed with the assistance of external resources.

The Assessment Team found that while the service has implemented actions and improvements to rectify the deficiencies found at the Site Audit in July 2021, the service was unable to demonstrate consumers receive care tailored to their needs or in line with best practice in relation to wound and falls management. The Assessment Team provided the following evidence and findings relevant to my finding:

* One consumer was observed to have wound care dressings on their right forearm, right calf and left shin with the dressing on the right calf observed displaced and leaking clear fluid.
	+ The consumer did not have any wound care treatment plans in place and there was no evidence the consumer’s wounds had been monitored.
	+ Clinical staff reviewed the wound during the Assessment Contact visit and found it had deteriorated, requiring further review and interventions.
* One consumer reported they like to maintain their independence with personal care and doesn’t think staff need to help them. The consumer is prescribed medication that may cause drowsiness and the care plan records they are a high falls risk. The consumer reported staff had not discussed ways to manage and reduce their risk of falling and had experienced three falls during January and February 2022.
	+ The consumer’s care plan did not include any specific strategies to guide staff to reduce the consumer’s risk of falling and staff did not complete appropriate assessments to monitor the consumer post falls. The consumer’s mobility was not reviewed post fall to determine if they required further assistance.

The Approved Provider’s response acknowledges the deficits identified by the Assessment Team and provided a detailed action plan of actions taken to address the deficits. Evidence included the additional recruitment of a registered nurse, confirmed as starting on 28 February 2022 for a period of three months, endorsement of a revised suite of policies and procedures that reflect current best practice and providing professional development to existing and new staff.

While the service is taking immediate actions to address the deficits, at the time of the Assessment Contact visit the service was not ensuring clinical care in relation to wounds and falls were managed in line with best practice and there were no clear policies and procedures to guide staff practice. Consumers with pressure injuries did not have those managed appropriately and consumers with increased falls did not have those monitored to identify additional strategies to prevent further incidents or harm. The service’s own monitoring systems had not identified deficits in the management of wounds and falls not being in line with best practice to ensure the issues were addressed and consumers’ health and well-being optimised.

For the reasons detailed above, I find Wagin Frail Aged Inc, in relation to Waratah Lodge, to be Non-compliant with Requirement (3)(a) in Standard 3 Personal care and clinical care.

### Requirement 3(3)(e) Compliant

*Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.*

This Requirement was found Non-compliant following a Site Audit conducted on 13 to 16 July 2021 where it was found handover processes were ineffective resulting in medication incidents. The Assessment Team found at this Assessment Contact conducted on 22 to 23 February 2022 that actions and improvements to rectify these deficiencies had been implemented, including (but not limited to):

* Review of handover documentation and removal of inappropriate information.
* Reviews and assessments completed by other health professionals, including allied health, uploaded to the electronic care management system with directives for staff practice updated.

The Assessment Team found the implemented actions to rectify the deficiencies have improved the deficits identified and they found the service was able to demonstrate consumers’ condition, needs and preferences are documented in care plans and communicated within the organisation and externally. The Assessment Team provided the following evidence and findings relevant to my finding:

* Consumers have an active care plan that is up-to-date and active, progress notes are maintained and contain accurate information about referrals and reviews by other services, including allied health. One sampled consumer’s care file showed information recorded accurately and in a timely manner.
* Handover documentation included appropriate and accurate information specific to consumers’ needs, goals and preferences.

For the reasons detailed above, I find Wagin Frail Aged Inc, in relation to Waratah Lodge, to be Compliant with Requirement (3)(e) in Standard 3 Personal care and clinical care.

### Requirement 3(3)(g) Non-compliant

*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.*

This Requirement was found Non-compliant following a Site Audit conducted on 13 to 16 July 2021 where it was found effective outbreak management procedures had not been implemented in response to a suspected outbreak. The Assessment Team found at this Assessment Contact conducted on 22 to 23 February 2022 that actions and improvements to rectify these deficiencies had been implemented, including (but not limited to):

* The engagement of an infection control consultant for on call assistance where required.
* Providing additional training to staff specifically in relation to infection control processes and outbreak management.

The Assessment Team found that while the service has implemented actions and improvements to rectify the deficiencies, they found the service was unable to demonstrate they minimise infection related risks with no antimicrobial stewardship to support the appropriate administration of antibiotics. The Assessment Team provided the following evidence and findings relevant to my finding:

* On 10 February 2022, one consumer was identified with an infection on their lower leg and prescribed a 7-day course of antibiotics by the medical officer. The service recorded on the infection register the infection was resolved on 17 February 2022. However, the service did not collect antibiotic sensitivities for this consumer. During the Assessment Contact visit, the consumer was observed by the Assessment Team to have a red and inflamed left shin with a wound dressing applied, however, no evidence of ongoing monitoring of the effectiveness of antibiotics or improvements were noted and there was no wound care plan.
* One consumer, identified with a fungal infection, was prescribed anti-fungal cream to be applied twice a day to the infected area with directives from the medical officer to continue application of cream for a week post clearance of the infection. However, medication competent care staff made a decision to stop application of the cream and recommenced application during February 2022 without gaining approval from clinical staff or management resulting in medication errors.
* The service does not have an antimicrobial stewardship policy to guide staff practice.

The Approved Provider’s response acknowledges the deficits identified by the Assessment Team and provided a detailed action plan of actions taken to address the deficits. Evidence included the additional recruitment of a registered nurse, confirmed as starting on 28 February 2022 for a period of three months while two sponsored clinical staff are onboarded and action to work with the service’s Medical Officer.

While the service is taking immediate actions to address the deficits, at the time of the Assessment Contact visit the service did not have an Infection Prevention Control Lead, was not monitoring the effectiveness of antibiotic usage, monitoring staff administering anti-infection medications and did not have an antimicrobial stewardship policy to guide staff practice. At the time of the Assessment Contact, the service did not demonstrate the minimisation of infection related risks through implementing appropriate antimicrobial stewardship principles and practices.

For the reasons detailed above, I find Wagin Frail Aged Inc, in relation to Waratah Lodge, to be Non-compliant with Requirement (3)(g) in Standard 3 Personal care and clinical care.

# STANDARD 6 Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

The purpose of this Assessment Contact was to assess the service’s performance in relation to Requirement (3)(c) in this Standard. This Requirement was found to be Non-compliant following Site Audit conducted on 13 to 16 July 2021 where it was found the service did not demonstrate it took appropriate action to feedback and complaints or that open disclosure was used when something went wrong.

The Assessment Team found at the Assessment Contact on 22 to 23 February 2022 that actions and improvements to rectify these deficiencies have been effective and the service was able to demonstrate that appropriate actions are taken in response to feedback and complaints and open disclosure is used when things go wrong.

I have considered the Assessment Team’s finding and the evidence documented in the Assessment Team’s report and find Requirement (3)(c) in this Standard to be Compliant. I have provided reasons for my finding in the specific Requirement below.

All other Requirements in this Standard were not assessed, and therefore an overall rating for the Quality Standard is not provided.

### Assessment of Standard 6 Requirements

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

This Requirement was found Non-compliant following a Site Audit conducted on 13 to 16 July 2021 where it was found the service did not demonstrate it took appropriate action to feedback and complaints or that open disclosure was used when something went wrong. The service implemented actions and improvements to address the deficiencies identified, including (but not limited to):

* Provision of open disclosure training to staff.
* A review undertaken of the Approved Provider’s complaints processes and the development of procedural flow charts to guide staff practice in relation to actioning feedback and complaints appropriately.
* Analysis of complaints data undertaken and reported to the Board.

The Assessment Team found through interviews and review of documents that the service was able to demonstrate appropriate actions are taken in response to feedback provided by consumers and/or their representatives and open disclosure is used when things go wrong. The Assessment Team provided the following evidence and information for sampled consumers to support my finding:

* All consumers sampled by the Assessment Team indicated satisfaction with the actions taken in response to a complaint they had made to the service.
* Staff interviewed described how they used open disclosure when things go wrong for consumers and how they action feedback and complaints made by consumers.
* Feedback documentation sampled indicated the service responds to each complaint made by consumers and/or their representatives in a timely manner and actions those appropriately using open disclosure.
* The service undertakes monthly analysis of all complaints made and provides a report to the Board.

For the reasons detailed above, I find Wagin Frail Aged Inc, in relation to Waratah Lodge, to be Compliant with Requirement (3)(c) in Standard 6 Feedback and complaints.

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The purpose of this Assessment Contact was to assess the service’s performance in relation to Requirements (3)(c) and (3)(e) in this Standard. These Requirements were found to be Non-compliant following Site Audit conducted on 13 to 16 July 2021 where it was found the service did not demonstrate its workforce was competent and had the skills and knowledge to provide safe and effective personal and clinical care in relation to management of medications, wound care and falls. The service did not demonstrate where errors were made, staff performance was reviewed, and improvements implemented to prevent further occurrences.

The Assessment Team found at the Assessment Contact conducted on 22 to 23 February 2022 that actions and improvements to rectify the deficiencies in Requirement (3)(e) in this Standard have been effective and have recommended this Requirement as met. However, in relation to Requirement (3)(c) in this Standard, the Assessment Team found the service was unable to demonstrate:

* Staff provided safe and effective wound care in line with best practice for one consumer;
* Staff are effectively managing falls, including post fall management;
* Medication competent staff work within their scope of practice; and
* Medication errors are always recorded and reported in a timely manner to prevent further occurrences.

I have considered the Assessment Team’s finding and the evidence documented in the Assessment Team’s report and find Requirement (3)(c) to be Non-compliant and Requirement (3)(e) to be Compliant. I have provided reasons for my findings in the specific Requirements below.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(c) Non-compliant

*The workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

This Requirement was found Non-compliant following an Site Audit conducted on 13 to 16 July 2021 where it was found staff were not competent in the management of wounds, falls, weight loss, pain and the application of restrictive practices. The service implemented actions and improvements to address the deficiencies, including (but not limited to):

* Development of an education calendar covering mandatory training, including in relation to the deficit areas identified during the Site Audit in July 2021.

The Assessment Team found that while the service has implemented actions and improvements to rectify the deficiencies found at the Site Audit in July 2021, they found the service was unable to demonstrate the workforce is competent with the skills and knowledge to effectively perform their roles in relation to the management of wounds, falls and medication. The Assessment Team provided the following evidence and findings relevant to my finding:

* Staff did not provide safe and effective wound management for one consumer. The consumer has three wounds and staff did not identify when one of three wounds was deteriorating, and dressings were observed to be incorrectly applied and staff are not recording progress of the wound or when it had been dressed or reviewed for effective management.
* Staff did not effectively manage falls for one consumer. Staff did not follow clinical directives from registered staff and did not report or record information or care delivered post falls.
* Medication competent staff worked outside their scope of practice and made decisions to administer and cease medications without seeking approval from clinical staff.
* Staff were not competent or knowledgeable in relation to the management of wounds or falls for two consumers.

The Approved Provider’s response acknowledges the deficits identified by the Assessment Team and provided a detailed action plan of actions taken since the Assessment Contact to address the deficits. Evidence included the additional recruitment of a registered nurse, confirmed as starting on 28 February 2022 for a period of three months while two sponsored clinical staff are onboarded, updated the information sheet for the on call clinical support, updated the process chart for staff to follow for falls management and established training procedures for medication competent staff.

While the service is taking immediate actions to address the deficits, at the time of the Assessment Contact visit the service did not demonstrate their staff competently performed their roles in relation to the management of wounds, falls and medications safely and effectively. Staff were identified to not be competently delivering wound care, managing post falls effectively or undertaking medication management safely.

For the reasons detailed above, I find Wagin Frail Aged Inc, in relation to Waratah Lodge, to be Non-compliant with Requirement (3)(c) in Standard 7 Human resources.

### Requirement 7(3)(e) Compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

This Requirement was found Non-compliant following a Site Audit conducted on 13 to 16 July 2021 where it was found the service did not monitor or review the performance of its workforce consistently. The service implemented actions and improvements to address the deficiencies, including (but not limited to):

* The development of an education calendar, mandatory training and general education as well as specific training in relation to deficits identified during the previous Site Audit visit (July 2021).
* Development of a staff performance framework and guidelines to improve staff performance.

The Assessment Team found through interviews, observations and review of documents that the service was able to demonstrate it has a system in place to monitor the performance of each member of its workforce and undertake regular assessment of their performance. The Assessment Team provided the following evidence and information for sampled consumers to support my finding:

* Staff interviewed indicated their performance is monitored and when they make errors they have discussions with their supervisor and are provided with suggestions to improve their practice to prevent errors.
* Documentation showed performance appraisals had been completed where a complaint about staff practice was made.

For the reasons detailed above, I find Wagin Frail Aged Inc, in relation to Waratah Lodge, to be Compliant with Requirement (3)(e) in Standard 7 Human resources.

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

The purpose of this Assessment Contact was to assess the service’s performance in relation to Requirements (3)(c), (3)(d) and (3)(e) in this Standard. These Requirements were found to be Non-compliant following Site Audit conducted on 13 to 16 July 2021 where it was found the service did not demonstrate it had effective organisation wide governance system in relation to information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints, risk management or clinical governance.

The Assessment Team found at the Assessment Contact conducted on 22 to 23 February 2022 that actions and improvements to rectify the deficiencies in Requirement (3)(c) in this Standard have been effective and have recommended this Requirement as met. However, in relation to Requirements (3)(d) and (3)(e) , the Assessment Team found the service was unable to demonstrate:

* An effective risk management system to manage high impact and high prevalent risks for two consumers in relation to wounds and falls;
* An effective incident management system as medication errors are not always captured accurately or appropriate investigations undertaken to identify areas for improvement to prevent further occurrences or harm;
* An antimicrobial stewardship framework with policies and procedures to guide staff practice in relation to the promotion of appropriate prescribing and use of antibiotics; and
* Effective systems and processes to minimise the use of restraint in relation to administration and review of psychotropic medications.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and find Requirement (3)(c) of this Standard to be Compliant and Requirements (3)(d) and (3)(e) to be Non-compliant. I have provided reasons for my findings in the specific Requirements below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(c) Compliant

*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.*

This Requirement was found Non-compliant following a Site Audit conducted on 13 to 16 July 2021 where it was found organisation wide governance systems were not effective, specifically in relation to information management, continuous improvement, regulatory compliance, workforce governance and feedback and complaints. The service implemented actions and improvements to address the deficiencies, including (but not limited to):

* Development of a policy and procedure manual undertaken in collaboration with an external consultant.
* Development of a plan for continuous improvement.
* Clinical monitoring reports actioned to provide accurate and timely directions for staff practice.
* Recommencement of peak body memberships to obtain regular legislative updates and track changes regarding the Quality Standards.

The Assessment Team found through interviews, observations and review of documents that the service was able to demonstrate it has effective organisation wide governance systems in place. The Assessment Team provided the following evidence and information for sampled consumers to support my finding:

* The service holds various meetings to provide members of the workforce access to information that guides and assists them in performing their roles.
* Staff confirmed they have access to consumer information via the electronic care system, handover documentation and meeting minutes.
* The service has a documented plan for continuous improvement with consumer focused actions as a result of feedback provided by consumers.
* Feedback and complaints are actioned appropriately and in a timely manner.

For the reasons detailed above, I find Wagin Frail Aged Inc, in relation to Waratah Lodge, to be Compliant with Requirement (3)(c) in Standard 8 Organisational governance.

### Requirement 8(3)(d) Non-compliant

*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.*

This Requirement was found Non-compliant following an Site Audit conducted on 13 to 16 July 2021 where it was found the organisation did not have an effective risk management system regarding the management of high impact and high prevalent risks, managing and preventing incidents and supporting consumers to live their best life. The service implemented actions and improvements to address the deficiencies, including (but not limited to):

* Implementation of a consumer incident management system with built-in process charts to identify and guide reporting of serious incidents as part of the Serious Incident Response Scheme (SIRS).
* The establishment of a risk and governance committee.
* Development of a service level risk register that includes clinical risks.

The Assessment Team found that while the service has implemented actions and improvements to rectify the deficiencies found at the Site Audit in July 2021, the service was unable to demonstrate the risk management system is effective. The Assessment Team found the service does not effectively manage high impact and high prevalent risks, support consumers to live their best life, have an effective incident management system or identify and respond to allegations of abuse and neglect appropriately. The Assessment Team provided the following evidence and findings relevant to my finding:

* Since November 2021, the service has been recording incidents for monthly analysis and the Assessment Team found that while the service recognised medication errors were increasing from November 2021 to January 2022 and it was often staff error, they did not undertake thorough investigations, incident forms were not always completed and there was no consideration of potential harm to consumers. The Assessment Team found not all medication errors were captured via the incident management system and found four additional errors that occurred in January 2022 that were not recorded. The Assessment Team provided evidence where medication errors had occurred for six of the 17 consumers at the service.
* The service did not effectively manage the risk of falls for one consumer whose choice it is to maintain independence by not engaging staff assistance to mobilise.
* The service did not recognise or respond to one consumer’s allegation of rushed and rough handling by a staff member. The service did not report the allegation via SIRS and did not investigate further.

The Approved Provider’s response acknowledges the deficits identified by the Assessment Team and provided a detailed action plan of actions taken since the Assessment Contact to address the deficits. Evidence included the additional recruitment of a registered nurse, confirmed as starting on 28 February 2022 for a period of three months while two sponsored clinical staff are onboarded, recognising the lack of a registered nurse on the floor has contributed to medication errors, engagement of additional staff to audit medications on a weekly basis and development of a risk management framework.

While the service is taking immediate actions to address the deficits, at the time of the Assessment Contact visit, the service did not demonstrate their risk management system was effective in relation to management of high impact and high prevalent risks to consumer care, recognising and responding to abuse and neglect, supporting consumers to live their best life or an effective incident management system.

For the reasons detailed above, I find Wagin Frail Aged Inc, in relation to Waratah Lodge, to be Non-compliant with Requirement (3)(d) in Standard 8 Organisational governance.

### Requirement 8(3)(e) Non-compliant

*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.*

This Requirement was found Non-compliant following an Site Audit conducted on 13 to 16 July 2021 where it was found the organisation did not have an effective clinical governance framework. Specifically, clinical data was not accurate as there was no effective incident management system, the service did not always administer as required psychotropic medications appropriately and the organisation did not have an antimicrobial stewardship framework. The service implemented actions and improvements to address the deficiencies, including (but not limited to):

* Drafting of a clinical governance framework which includes a process for managing clinical risks.
* Weekly clinical review meetings are held.
* Development of clinical monitoring reports as part of the monthly clinical governance meetings.

The Assessment Team found that while the service has implemented actions and improvements to rectify the deficiencies found at the Site Audit in July 2021, they found the service was unable to demonstrate the clinical governance framework is effective. The Assessment Team found the service does not accurately collect and analyse clinical data to support improvements. The Assessment Team provided the following evidence and findings relevant to my finding:

* The organisation does not have an antimicrobial stewardship policy to guide staff practice and they did not have any strategies in place to promote appropriate antibiotic prescribing and use.
* For one consumer, the service did not collect pathology for an infection to confirm appropriate antibiotic prescription or show non-pharmalogical interventions had been considered.
* For one consumer, oversight of administration and cessation of anti-infection medication by staff was not monitored.
* The service does not capture information regarding consumers receiving psychotropic medications, including as required administration, and did not show they are actively minimising the use of psychotropic medication. For five consumers who are prescribed psychotropic medications on a regular or an as required basis, they do not have a diagnosis to support the use of these medications, the service has not documented consent or authorisation to support the use of the medications and was not able to show when medications were last used.
* For one of the five consumers being administered psychotropic medications, the service obtained a diagnosis to support the use of the medication during the Assessment Contact.

The Approved Provider’s response acknowledges the deficits identified by the Assessment Team and provided a detailed action plan of actions taken since the Assessment Contact to address the deficits. Evidence included the additional recruitment of a registered nurse, confirmed as starting on 28 February 2022 for a period of three months while two sponsored clinical staff are onboarded, recognising the lack of a registered nurse on the floor has contributed to the deficits; moving on audits in place for only two months prior to the Assessment Contact visit; an antimicrobial stewardship policy has been developed and ready for Board endorsement; identification and training of a registered staff to be infection control lead; a pharmacy review to identify any consumers on relevant medications; and advised at the time of receiving the report the service has no consumers receiving psychotropic medications.

While the service is taking immediate actions to address the deficits, at the time of the Assessment Contact visit, the service did not demonstrate their clinical governance framework was effective in relation to antimicrobial stewardship, the service does not have a policy to guide staff practice or strategies to promote the appropriate prescription and use of antibiotics. The service did not demonstrate it has effective processes in place to minimise the use of restraint particularly in relation to the appropriate administration of psychotropic medication.

For the reasons detailed above, I find Wagin Frail Aged Inc, in relation to Waratah Lodge, to be Non-compliant with Requirement (3)(e) in Standard 8 Organisational governance.

# 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.

Standard 3 Personal care and clinical care:

* Requirement (3)(a): Ensure consumers receive safe and effective personal care and clinical care, including effective wound care, falls and safe medication management.
* Requirement (3)(g): Ensure the service’s policies and procedures around standard and transmission based precautions to prevent and control infection are implemented in a timely manner and an Infection and Prevention Control Lead is identified and appropriately trained in line with government requirements.

Standard 7 Human resources:

* Requirement (3)(c): Ensure staff are competent in performing their roles, including in delivering clinical care, wound care, falls and safe medication management. Ensure effective systems are implemented to monitor staff competency.

Standard 8 Organisational governance:

* Requirement (3)(d): Ensure the service effectively implements the organisation’s risk management system, including an effective incident management system. Ensure ongoing monitoring of staff practice in relation to the management of high impact and high prevalent risks associated with consumer care, recognising and responding to elder abuse and neglect and supporting consumers to live their best life occurs to ensure the risk management system is effective and identifies areas requiring action, improvement or staff training.
* Requirement (3)(e): Ensure the service implements an antimicrobial stewardship policy, as indicated in the Approved Provider’s response. Ensure the service implements restrictive practices framework policies and procedures effectively and monitoring prescription, administration and review of psychotropic medications.