Performance

Report

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| Name of service: | Waroona Multipurpose Centre |
| Service address: | 72 King Street CHARLEVILLE QLD 4470 |
| Commission ID: | 5328 |
| Approved provider: | Queensland Health |
| Activity type: | Assessment Contact - Site |
| Activity date: | 11 July 2023 to 12 July 2023 |
| Performance report date: | 7 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 Waroona Multipurpose Centre (**the service**) has been prepared by T Wurf, 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 25 July 2023
* the Performance Report dated 10 October 2022 for the site audit undertaken from 16 to 18 August 2022, where 10 requirements of the Quality Standards were found non-compliant.

# Assessment summary

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| 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 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.

# Other relevant matters:

A site audit was undertaken at the service from 16 to 18 August 2022. The Performance Report dated 10 October 2022 for the site audit, found 10 requirements of the Quality Standards non-compliant.

An assessment contact visit was undertaken at the service on 11 and 12 July 2023 to assess the performance of the service, with a focus on the improvement actions taken by the approved provider in relation to the 10 non-compliant requirements. This performance report relates to the assessment of performance.

# Standard 2

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| 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 Performance Report dated 10 October 2022 found the service non-compliant with this requirement because care was not reviewed regularly, including in response to behavioural incidents or changes in consumers’ condition.

The Assessment Contact – Site Report identified evidence that the service had taken corrective actions and remediated the deficiencies. Improvements included:

* Implemented a resident of the day (ROD) schedule and process to review each consumer’s care plan and ensure each consumer/representative is engaged in the review process.
* Initiated a process where the nursing unit manager (NUM) and clinical nurse (CN) undertake a daily review of incidents and the ROD, and discuss these with staff at daily meetings.
* Ensured the NUM and/or CN consult with consumers and/or representatives to ensure consumer behaviours and restrictive practices are effectively managed at the time of ROD review or when circumstances change.
* Included a 3-monthly review of all psychotropic medications in the ROD process.
* Reviewed all consumers subject to chemical restraint in consultation with their medical officer (MO) and included these consumers in MO clinics for ongoing reviews.
* Appointed a registered nurse to the role of restrictive practice specialist.

The Assessment Contact – Site Report also included the following findings relevant to this requirement, which I have considered in my decision.

Consumers and representatives said clinical staff regularly discuss consumers’ care needs with them, and any changes identified or requested are addressed in a timely manner.

Clinical staff could describe how and when consumer care plans are reviewed, including that changing behaviours or a wound would trigger a care plan review. Staff said that the risks associated with skin integrity, weight loss, behaviours are assessed and considered monthly during ROD.

Care documentation identified evidence of review on both a regular basis and when circumstances changed or incidents occurred and were updated as per the ROD schedule.

Based on the findings in the Assessment Contact – Site Report, I am satisfied that the deficiencies have been remediated and that consumers’ are and services are reviewed regularly. Therefore, it is my decision that this requirement is compliant.

# 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 |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |

Findings

The Performance Report dated 10 October 2022 found the service non-compliant with requirements 3(3)(a), 3(3)(b) and 3(3)(f). Deficiencies related to:

* 3(3)(a) – The service’s management of restrictive practice was not aligned with best practice, personal care was not tailored to personal preferences, medications were not administered as prescribed, wounds were not monitored, skin conditions were not identified, and oxygen equipment was not cleaned as required.
* 3(3)(b) – Risks to consumers associated with unplanned weight loss, wounds, and escalating behaviours were not effectively managed.
* 3(3)(f) – Timely referrals to other providers of care were not undertaken for consumers who experienced unplanned weight loss.

The Assessment Contact – Site Report identified evidence that the service had taken corrective actions and remediated the deficiencies. Improvements are listed below under relevant requirements, along with other relevant findings made by the Assessment Team, which I have considered in my decision.

*Requirement 3(3)(a)*

Improvement actions:

* Dementia Support Australia (DSA) delivered all-staff training in managing changing behaviours.
* Appointed a registered nurse to the role of restrictive practice specialist.
* Delegated responsibility for ordering medications and conducting weekly checks of existing medication expiry dates to the CN.
* Ensured the medication ordering procedure was consistent with the pharmacy’s capacity.
* Held toolbox training and daily meetings to reinforce the importance of care staff recognising and reporting any skin conditions to registered staff, and for registered staff to report to the CN and/or NUM.
* Added the cleaning and replacement of any oxygen equipment to the whiteboard task list in the medication room, to nominate and remind the allocated staff to undertake the activity each Monday.

The Assessment Team reviewed a sample of consumers’ care documentation and found identification, assessment, management and evaluation of consumers’ restrictive practices, skin integrity and weight loss. Where restrictive practices were used (mechanical and environmental), assessments, authorisation, consent, and monitoring were completed.

Consumers and representatives were satisfied with the care consumers receive. One representative described how a consumer’s psychotropic medication was reduced and strategies to manage the consumer’s changing behaviors were effective. A consumer who uses oxygen equipment advised the Assessment Team that the equipment was cleaned regularly and as scheduled.

Staff demonstrated solid knowledge of individual consumers and their care needs and preferences.

*Requirement 3(3)(b)*

Improvement actions:

* Delivered a range of staff training, including on
  + weight loss management and referrals
  + ‘dementia essentials’ (delivered by DSA)
  + the use of non-pharmacological interventions to be implemented and documented prior to the use of psychotropic medications.
* Appointed the CN and NUM to oversee records of any skin conditions and making referrals when required.

The Assessment Team reviewed a sample of consumers’ care documentation and found that risks associated with weight loss, changed behaviours, and wounds were effectively managed. Other health professionals such as wound specialists, dementia specialists and dietitians were involved in consumers’ care where required. Staff were familiar with strategies to manage risks to individual consumers. Consumers and their representatives were satisfied with the care consumers receive.

*Requirement 3(3)(f)*

Improvement actions:

* Nominated registered staff as responsible for making referrals, and the NUM and CN support registered staff to make timely referrals.
* Established a referral table in a prominent position to prompt registered staff to list consumers for referrals.
* Delivered a range of staff training, including on:
  + weight loss management and referrals
  + referral pathways (delivered by the older persons mental health unit)
  + behavioural support plans (delivered by DSA)
  + appropriate use of psychotropic medications (through the Commission’s pharmacy project).

Consumers reported being seen by other health professionals including a dietitian for weight loss, an optometrist, a physiotherapist, a podiatrist, an occupational therapist, and a dentist for mouth ulcers.

Care documentation supported input from other health services. Referrals, where required, were made to dentists, optometrists, physiotherapist, podiatrists, hearing specialist, and specialist dementia services. Consumers have access to a medical officer. Staff described how the input of other health professionals informs care and services.

Registered staff are responsible for referrals to external support such as allied health or medical specialists. Management said for specialist referrals, registered staff will provide the medical officer with evidence to enable them to make the referral.

Based on the findings in the Assessment Contact – Site Report including evidence of improvements made by the service, I am satisfied that the deficiencies have been remediated in relation to personal and clinical care. Therefore, it is my decision that these requirements are 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 |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The Performance Report dated 10 October 2022 found the service non-compliant with requirements 7(3)(a), 7(3)(d) and 7(3)(e). Deficiencies related to:

* 7(3)(a) – An insufficient number and skill mix of the workforce to enable the delivery of safe and quality care and services. Consumers reported delays in staff responding to calls for assistance, gender preferences of staff were unable to be met, and staff were unable to meet the needs of consumers who required assistance.
* 7(3)(d) – Staff had not completed mandatory or role-specific training, including aged care-specific modules, incident management and restrictive practices.
* 7(3)(e) – The performance of each member of the workforce was not regularly assessed, monitored and reviewed.

The Assessment Contact – Site Report identified evidence that the service had taken corrective actions and remediated the deficiencies. Improvements are listed below under relevant requirements, along with other relevant findings made by the Assessment Team, which I have considered in my decision.

*Requirement 7(3)(a)*

Improvement actions:

* Recruited more permanent staff.
* Implemented weekly recruitment meetings with the organisation’s recruitment team, which has now taken on the responsibility of recruitment in the region and is providing ongoing support to the service.
* Temporarily restricted the number of occupied places, in line with staffing capacity.
* Developed call bell reports which are analysed, investigated where appropriate and reported.

Most consumers/representatives said staff are available when needed and respond promptly to call bells. Whilst one consumer raised concern about the responsiveness of staff on several occasions, management was actively working with that consumer in relation to their needs.

Staff advised there are sufficient staff to provide care and services in accordance with consumers’ needs and preferences. The service has a system to manage planned and unplanned leave to avoid staff shortages. For example, the service has a dedicated roster coordinator who utilises permanent or casual staff to cover unplanned leave. Agency staff used at the service are given 3 to 6-month contracts. The service is engaging newly graduated nurses interested in aged care.

The Assessment Team observed staff responding promptly to requests for assistance from consumers, activities occurring at scheduled times, and consumers being assisted to eat their meals.

*Requirement 7(3)(d)*

Improvement actions:

* Updated the induction and orientation process to include mandatory and aged care-specific training for new starters and agency staff.
* Developed an intensive 3-month training calendar from October to December 2022 to bring all staff up to date in mandatory training, and from January to June 2023 engaged an aged care nurse educator who delivered in-person aged care training.
* Developed a more user-friendly website that highlights aged care-specific resources enabling easier access for staff.
* Completed training for all staff in the serious incident response scheme and restrictive practices, as well as refresher training.
* Implemented alerts for staff and line managers where training is due.

Consumers/representatives expressed confidence in the ability of staff to deliver care and services, and said they believe staff are well trained and equipped to perform their roles.

Staff said they have received significant amounts of training over the last 6 months and feel supported in their roles. Staff had a shared understanding of their role in incident reporting, restrictive practices, and the Aged Care Quality Standards, and said they are supported to complete mandatory training and undertake further training and professional development.

The service has an orientation process that includes buddy shifts, online mandatory training, competency assessments, role-specific training and in person training on the Aged Care Quality Standards.

All staff had completed mandatory training and the majority of staff had completed other training such as antimicrobial stewardship, serious incident response scheme and restrictive practices. Management advised that education is ongoing with monthly refreshers, particularly for areas of legislative and policy changes.

*Requirement 7(3)(e)*

Improvement actions:

* Continued to implement ‘Project Reset’ to improve various human resource processes and included the human resource team attending the service and assisting with the performance appraisal process. All appraisals were completed by the end of January 2023.
* Created a schedule of performance reviews which is maintained by management. Staff performance reviews and goal setting are completed within the probation period and then annually or more frequently if required.
* Staff appraisals are now staggered rather than due at the same time and staff and managers receive an electronic alert when appraisals are due.

Staff confirm they undergo self-performance appraisals, receive feedback about their performance from their manager and identify areas for further improvement and training.

All eligible staff had completed their annual self-performance appraisal and performance discussion with their manager. Management advised feedback about staff performance is captured in different ways, such as consumer/representative surveys and feedback, staff feedback, clinical audits, and observations.

The service has a performance management process to guide staff.

Based on the findings in the Assessment Contact – Site Report including evidence of improvements made by the service, I am satisfied that the deficiencies have been remediated in relation to human resources. Therefore, it is my decision that these requirements are compliant.

# 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 |
| 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. | 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 Performance Report dated 10 October 2022 found the service non-compliant with requirements 8(3)(c), 8(3)(d) and 8(3)(e). Deficiencies related to:

* Requirement 8(3)(c) – Workforce governance and regulatory compliance systems, specifically related to serious incidents and restrictive practices.
* Requirement 8(3)(d) – Risk management systems were ineffective in ensuring serious incidents were reported and responded to, and risks to consumers were managed.
* Requirement 8(3)(e) – Clinical governance systems were ineffective in relation to minimising restrictive practices and ensuring antibiotics were appropriately used to reduce antimicrobial resistance.

The Assessment Contact – Site Report identified evidence that the service had taken corrective actions and remediated the deficiencies. Improvements are listed below under relevant requirements, along with other relevant findings made by the Assessment Team, which I have considered in my decision.

*Requirement 8(3)(c)*

Improvement actions:

* Delivered a program of staff training including:
  + aged care compliance, including serious incident reporting and restrictive practices, and
  + role-specific training with an aged care specialist and clinical nurse educator. Refresher training continues monthly.
* Updated the service’s policies and procedures and rolled these out to staff through in-person and online training, and implemented additional internal and external checks and audits.

The service has systems and processes for organisational-wide governance relating to workforce governance and regulatory compliance. For example:

* The service has systems to ensure the workforce is appropriately planned, and to monitor workforce competency and training.
* The service has documentation, policies and procedures with clearly established roles, responsibilities, and accountability for the monitoring of staff conduct and performance.
* The organisation has a team dedicated to ensuring legislative changes are identified and disseminated across the organisation. Legislative changes are disseminated through organisational newsletters, electronic mail, meeting minutes, and training documents.
* The service has policies and procedures in relation to incident reporting which capture types of incidents to report under the serious incident response scheme and reporting timeframes.
* Incident reports are accessed and analysed daily by management and the executive.

*Requirement 8(3)(d)*

Improvement actions:

* Updated the service’s policies and procedures and rolled these out to staff through in-person and online training, and implemented additional internal and external checks and audits.
* Delivered staff with training in the policies and procedures for nutrition and hydration, wound management, clinical care and appropriate documentation, mandatory reporting, reportable incidents workflow, non-pharmaceutical strategies in managing changed behaviours, and mandatory reporting responsibilities.
* Conducted competency assessments for all staff.
* Reviewed all care plans and assessed, discussed, and documented the risks for each consumer.

The service has governance frameworks, policies and procedures to support the management of risk associated with the care of consumers. Management and staff could provide examples of risks and how they are managed within the service.

High impact and high prevalence risks are discussed at monthly meetings and escalated through clinical systems. Consumers’ clinical incidents including wounds, skin integrity, weight loss, and infections were documented, reviewed and analysed weekly, and trended by the management team on a monthly basis.

Management identified key risks for the consumer cohort at the service and reported positive and effective improvements in wound care and a significant decrease in instances of changing behaviours.

The Assessment Team reviewed the service’s incident documentation and found incidents were recorded and reported in a timely manner and in accordance with reporting requirements. The service has policies and procedures that detail the types of incidents to report under the serious incident response scheme. Incidents classified as high severity are reported to the executive team.

*Requirement 8(3)(e)*

Improvement actions:

* Updated antimicrobial stewardship and minimising restrictive practices policies and procedures and delivered staff in-person and online training on these. The service implemented additional internal and external checks and audits.
* Engaged the Commission’s pharmacy project to provide pharmacist-facilitated training in relation to antimicrobial stewardship in February 2023.
* Ensured that 100% of staff had completed the antimicrobial stewardship online module.
* Reviewed all care plans and assessed, discussed, and documented non-pharmacological strategies and interventions for staff to consider in managing changing behaviours.

Consumers/representatives said consumers receive safe and effective care. Staff described their roles in antimicrobial stewardship and minimising restrictive practices. The service delivers regular antimicrobial stewardship refresher courses to staff. Management explained how the service minimises the use of restraint by consulting with experts and finding alternative strategies for consumers. The service has an active ongoing improvement action to monitor restrictive practices and behaviour support planning through audits, feedback, and consumer reviews.

Based on the findings in the Assessment Contact – Site Report including evidence of improvements made by the service, I am satisfied that the deficiencies have been remediated in relation to organisational governance. Therefore, it is my decision that these requirements are 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)