Performance

Report

**1800 951 822**

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| Name: | Warralily Gardens |
| Commission ID: | 4578 |
| Address: | 2-28 Freda Road, ARMSTRONG CREEK, Victoria, 3217 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 4 June 2024 |
| Performance report date: | 2 July 2024 |
| Service included in this assessment: | Provider: 2316 Western Residential Aged Care Pty Ltd  Service: 22873 Warralily Gardens |

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 Warralily Gardens (**the service**) has been prepared by J Cayabyab, 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 (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others, and
* the provider’s response to the assessment team’s report received 25 June 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 7 Human resources** | **Not applicable as not all requirements have been assessed** |
| **Standard 8 Organisational governance** | **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 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

In response to the Assessment Contact undertaken on 4 June 2024, the Assessment Team recommended that Requirement 3(3)(b) was not met as the service was unable to demonstrate consistency in record keeping and information management associated with the consumer care around management of wounds, diabetes, and time sensitive medication. Having weighed the Assessment Team recommendation against the Approved Provider’s response I have come to a different view.

The Assessment Team Report dated 4 June 2024, noted that consumers and representatives provided positive feedback on the care they receive including their identified high impact and high prevalence risks. The service was generally demonstrating effective management of high impact and high prevalence risks in relation to clinical deterioration, falls, diabetes and wound care management. However, information management relating to risks associated with consumer care including wound management, diabetes, and time sensitive medication is inconsistent.

In their response to the Assessment Team Report, the Approved Provider supplied their plan for continuous improvement (PCI). The Approved Provider has acknowledged a number of areas for improvement and has commenced strategies to ensure relevant actions are in place. I have also considered the immediate response of the Approved Provider following feedback from the Assessment Team on site. It is noted that care needs and interventions have been actioned promptly after discussion with the Assessment Team on site. The response and PCI demonstrated the identified deficits have now been addressed, there is evidence of effective care review, updates, and monitoring and staff training, education, and meetings. I am satisfied that the implemented and proposed actions address the deficiencies identified.

As a result, I find Requirement 3(3)(b) is 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 |

Findings

Consumers and representatives confirmed they were happy with the level of care provided and felt there were sufficient levels of staff to meet consumer’s needs. Staff advised they have adequate time to complete their duties and confirmed vacant shifts or unplanned leave are immediately filled as required. Management demonstrated a range of strategies to replace staff on planned and unplanned leave including shift extension, recruiting additional casual staff, or providing additional shifts to existing staff. A review of the service’s roster evidenced a mix of clinical and care staff to provide care to consumers. The organisation owns a Registered Training Organisation (RTO) that they utilise internally to train, educate, and recruit staff while undertaking formal qualification.

In relation to their workforce responsibilities, the service has RN on site and on duty 24/7 and there is additional clinical support provided by the care managers, team leaders and department managers throughout the day or after hours on call if escalation is required.

In relation to meeting the mandatory care minutes requirements, the service acknowledged they have shortfall and are under reporting direct care minutes including RN minutes. However, the service provided information on the strategies they have in place to ensure the delivery of holistic care to consumers which they are unable to record as direct care minutes. These include engaging trainee staff, full time medical officers on site, the use of a range of professional staff on site, extensive well-being staff, and counselling services undertaken by specialist counsellor and dementia support staff.

I have considered the information within the Assessment Team Report, and I am satisfied the organisation ensures a workforce that enables delivery and management of safe and quality care and services. This is reinforced by the positive feedback from consumers and staff in relation to the delivery of care and services and the additional support established by the service to ensure any concerns are escalated and addressed in a timely manner.

It is my decision Requirement 7(3)(a) is Compliant.

# Standard 8

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| Organisational governance | |  |
| 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

Consumers advised they consider the service is managed well. The organisation demonstrated a clinical governance framework that supports clinical care practice within the service and is monitored by the organisation at multiple levels of management. The service demonstrated clinical care practice is governed by organisational policies and procedures that is available and accessible electronically to guide the staff in delivering safe and effective care. This includes antimicrobial stewardship, restraint minimisation and open disclosure. Staff demonstrated an appropriate understanding of the policies and procedures including the strategies they utilise to minimise the use of restrictive practices, to promote antimicrobial stewardship, and to practice open disclosure. A review of the service’s documentation and management interviews evidenced inconsistency in reporting percentage of consumers who are subject to restrictive practices. The service acknowledged the information inconsistencies and demonstrated immediate action to accurately report this data in line with its regulatory obligations. Management highlighted that a clinical governance committee oversees the development and implementation of legislative regulatory and operational responsibilities to ensure a strong safety culture across the organisation.

I have considered the information within the Assessment Team Report, and I have placed weight on the positive feedback from consumers, staff knowledge of the systems and processes in place, and the evidence of effective implementation of the clinical governance framework at the service.

It is my decision Requirement 8(3)(e) is Compliant.

1. The preparation of the performance report is in accordance with section 68A – assessment contactof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)