Performance

Report

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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 21 September 2023 |
| Performance report date: | 5 December 2023 |
| 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 S Byers, 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
* the provider’s response to the assessment team’s report received 24 October 2023
* other information and intelligence held by the Commission
* on-site observations by an Authorised Officer from the Commission’s Restrictive Practices Unit

# Assessment summary

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

All consumers and/or their representatives in the memory support unit (MSU) said they feel safe, and risks related to consumer care, including changed behaviours, are effectively managed. While all representatives were satisfied staff understand how to manage consumer changed behaviours and implement personalised support strategies, not all representatives were satisfied meaningful activities were available to consumers in the MSU. Staff explained the activity program for the MSU has been reviewed and revised in line with consumer interests.

Management and clinical staff described how individualised behaviour management strategies are planned and implemented in consultation with consumers and their representatives, the memory support specialist, general practitioners, and a geriatrician. Staff demonstrated knowledge of each consumer’s changed behaviours, triggers and effective individualised strategies to prevent the escalation of behaviours. Consumer care documentation including progress notes reflected regular medical review. The Assessment Team reviewed consumers involved in recent Serious Incident Response Scheme (SIRS) incidents and identified effective assessment and management of changed behaviours and associated risks to mitigate reoccurrence.

The Authorised Officer observed behaviour support plans for some consumers did not provide person-centred and individualised support for consumers with changed behaviours. The Assessment Team identified that while the electronic care management system generates generic behaviour care plans for consumers, personalised behaviour management strategies tailored to each consumer sampled were recorded in free text areas of consumer records to guide staff practice. Management acknowledged the electronic care management system generates generic pre-text information and confirmed that there are text boxes for staff to enter individualised strategies. The Approved Provider submitted a Plan for Continuous Improvement (PCI) that details improvement actions in the MSU including review of the wellbeing calendar in consultation with the memory support specialist to ensure ongoing meaningful engagement for consumers in MSU, review and updating of behaviour support plans to ensure personalised interventions and ongoing training and support of the workforce by the memory support specialist.

The Approved Provider demonstrated it has commenced continuous improvement actions to review and address the deficits identified in relation to personalised behaviour support plans and other documentation. I have placed weight on the Assessment Team’s evidence that staff demonstrated robust knowledge of individual consumers and changed behaviours as well as personalised support strategies, observations of consumers in the MSU and identified issues with the generic content of the electronically generated behaviour support plans. I acknowledge the Authorised Officer’s observations and encourage the Approved Provider to ensure all documentation for consumers who exhibit changed behaviours or are subject to restrictive practice are personalised and support best practice and to continue implementing, embedding and evaluating its continuous improvement actions. With consideration to the available evidence, I agree with the Assessment Team’s recommendation and find Requirement 3(3)(b) is Compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

Most consumers and representatives said staff are equipped and trained with the knowledge to meet individual consumer care needs, particularly in relation to the care of consumers living with dementia and exhibit changed behaviours. All clinical and care staff interviewed described the mandatory and supplementary training that is available face to face and online. Management described the additional training and education support available within the Memory Support Unit (MSU) from the organisation’s internal memory support specialist. Education records confirmed staff have completed a range of mandatory training in relation to Code of Conduct, dementia care and the Serious Incident Response Scheme (SIRS). While records of recent toolbox education delivered to staff by the memory support specialist were not available at the time of the assessment contact, management said these records were still with the memory support specialist as sessions were yet to be completed. The memory support specialist and staff confirmed education sessions for staff in the MSU had occurred.

The Approved Provider submitted a Plan for Continuous Improvement (PCI) that details improvement actions including ongoing workforce support by the memory support specialist and training and education in incident management including SIRS reporting and documentation and behaviour assessment and care plans.

I have reviewed the evidence in the assessment team report and the Approved Providers response. While some training documents were not available at the time of the assessment contact, staff and the memory support specialist confirmed participating in the relevant training. I have also placed weight on the demonstrated workforce knowledge about incident management, SIRS and behaviour support as detailed in Requirements 3(3)(b), 8(3)(c) and 8(3)(d). The Approved Provider’s PCI demonstrates it is actively reviewing and amending its education and training needs and engaging the memory support specialist to support its workforce. I encourage the Approved Provider to continue implementing, embedding and evaluating its continuous improvement actions to ensure its workforce continues to be effectively trained, equipped and supported to deliver outcomes under these standards. On the balance of available evidence, I agree with the Assessment Team’s recommendation and find Requirement 7(3)(d) is 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 |

Findings

Requirement 8(3)(c)

The organisation demonstrated effective organisation-wide governance systems in relation to information management, continuous improvement, financial governance, workforce governance and feedback and complaints. However, some deficits were identified relating to regulatory compliance regarding alignment of restrictive practices documentation consistent with legislative requirements.

While a consent process had been completed for all consumers subject to restrictive practices, the Authorised Officer observed restrictive practice authorisations and some behaviour support plans did not align with legislative requirements. The service demonstrated it has a system in place to monitor the appropriate use of restrictive practices for consumers and maintains a register of consumers who are subject to chemical and environmental restraints. The organisation demonstrated regulatory compliance is managed at an organisational level, with updates or changes to legislation, and policies and procedures communicated to staff. I have considered deficits regarding behaviour support plans and documentation deficits under Requirement 3(3)(b) where I consider it more relevant to the management of risks associated with the care of consumers with changed behaviours.

Staff were satisfied they can readily access information through the electronic care management system and verbal handover to support consumer care. Changes to legislation, policy or procedure is regularly updated through quarterly updates and discussed at staff meetings. Management described service and quality care improvements are monitored through its Plan for Continuous Improvement (PCI) which is informed by internal audits, incidents, feedback and complaints. PCI activities are reported monthly to the quality team. At the time of the assessment contact the service demonstrated it had commenced addressing improvement actions in relation to incident management and Serious Incident Response Scheme (SIRS) reporting, as well as training and support of staff in the memory support unit in relation to incident reporting, dementia care and code of conduct. I have considered deficits related to these improvement actions in more detail under Requirements 3(3)(b), 7(3)(d) and 8(3)(d).

The Approved Provider submitted a PCI that details continuous improvement actions implemented post assessment contact. This includes reviewing and amending the incident management policy and procedures, reviewing and updating behaviour support plans in consultation with the memory support specialist, ongoing training and education in relation to the incident management system, SIRS reporting obligations and behaviour assessment and care plans.

I have reviewed the evidence in the assessment team report and the Approved Provider’s response. While there are areas for improvement in relation to the service’s consent processes and behaviour support plans for consumers who are subject to restrictive practices, there was no identified impact to the consumers quality of care. The Approved Provider demonstrated governance systems are in place to manage and oversee regulatory compliance and that changes are communicated to staff. I encourage the Approved Provider to continue to implement, embed and evaluate its continuous improvement actions to ensure behaviour support plans and restrictive practices consent documentation align with legislative requirements. On the balance of available evidence, I agree with the Assessment Team’s recommendation, and find Requirement 8(3)(c) is Compliant.

Requirement 8(3)(d)

The organisation demonstrated it has risk management systems in place supported by policies and procedures documented to manage risk, abuse and neglect of consumers, and supporting consumers to live the best life they can. Risks are investigated, reviewed and reported. The service has an incident management system in place that enables the escalation of serious incidents. Staff demonstrated understanding of incident reporting including SIRS. All clinical staff described how incidents relating to unreasonable use of force, abuse, and neglect of consumers are immediately reported and escalated to management as guided by organisational policies and procedures. Service management and the organisation’s quality team oversee SIRS incidents at the management level, where they assess and decide the SIRS classification and are responsible for reporting SIRS. Management said they are guided by the organisation’s policy and the Commission’s decision-making resources to report within the timeframes. Investigations of incidents including SIRS incidents were observed to be documented within the incident management system and reporting registers. Investigations were documented as completed by management. Service management collates and analyses data that is provided in monthly reports. This aligned with monthly reports reviewed by the Assessment Team. The organisational quality team review the reports and provide the information to the governing body.

The Assessment Team identified some inconsistencies in the organisations policies and procedures relating to SIRS classifications. While investigations of incidents including SIRS incidents were observed to be documented within the incident management system and reporting registers, the Assessment Team were unable to verify whether the service had accurately reported all SIRS under the appropriate classification. The Approved Provider submitted a Plan for Continuous Improvement (PCI) that details continuous improvement actions implemented post assessment contact including reviewing and amending the incident management policy and procedures to reflect best practice, ongoing training and education in relation to the incident management system and SIRS reporting obligations, and communication of the policy and procedure review to the workforce.

I have reviewed the evidence in the assessment team report and the Approved Provider’s response. The Approved Provider has demonstrated it is taking steps to review and update its incident management policies and procedures to align with best practice. I have placed weight on staff understanding of their responsibilities in relation to the service’s risk and incident management systems including SIRS obligations and that incidents were investigated. I encourage the Approved Provider to continue to implement, embed and evaluate the continuous improvement actions to ensure its incident management and SIRS policies, procedures and classifications continue to align with legislative requirements. On the balance of available evidence, While I agree with the Assessment Team’s recommendation, and find Requirement 8(3)(d) is Compliant.

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