Performance

Report

**1800 951 822**

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| Name of service: | Warrawee Nursing Home |
| Service address: | 854A Centre Road EAST BENTLEIGH VIC 3165 |
| Commission ID: | 4444 |
| Approved provider: | City of Glen Eira |
| Activity type: | Assessment Contact - Site |
| Activity date: | 17 May 2023 |
| Performance report date: | 9 June 2023 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Warrawee Nursing Home (**the service**) has been prepared by N Eastwood, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(d) | 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. | Compliant |

Findings

The service was previously found non-compliant with this requirement following a Site Audit performed between 4 October 2022 and 6 October 2022. At the time of the Site Audit the service was unable to demonstrate outcomes of assessment and planning were effectively communicated to all consumers and representatives and care plans were not readily available to the consumer and/or representatives.

The service has implemented several effective actions in response to the non-compliance identified at the Site Audit. A seven-week training course was provided to staff related to assessment and care planning as well as implementation of a supporting policy and procedure which is accessible through the organisations online platform. Care consultation and the ‘resident of the day’ (ROD) process is tabled as an agenda item during consumer and representative meetings and weekly clinical meetings are now conducted to discuss care planning and ensure completion of care plan reviews.

Consumers and representatives described how outcomes of consumer assessments and planning are communicated to them through the regular monthly ROD process. Consumers and representatives confirmed the care plan is offered to them as part of the monthly review process. Staff described how they have access to the electronic care file system and staff are provided with an updated handover sheet each shift which reflects any relevant information and care that is planned. The Assessment Team reviewed education documentation which confirmed education has been provided to staff in relation to care planning consumer care planning documentation which identified consumers and representatives are offered a copy of the care plan during the ROD process. The Assessment Team also reviewed consumer and representative meeting minutes which identified the care planning process is discussed with consumers and representatives.

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

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |

Findings

The service was previously found non-compliant with this requirement following a Site Audit performed between 4 October 2022 and 6 October 2022. At the time of the Site Audit the service was unable to demonstrate that consumers were able to freely move outside the facility as there was limited access to the code for the exit keypad.

The service has implemented several effective actions in response to the non-compliance identified at the Site Audit. All doors leading to external areas of the service now have the code for the keypad visible for consumers to access, education has been provided to staff in relation to restrictive practices and doors opening to the courtyard now open automatically for consumers to easily access outdoor garden areas.

Consumers and representatives described how the service is safe, clean, well maintained and they can easily access outdoor areas if they choose to do so. Consumers also confirmed that if they require assistance to access outdoor areas, staff are available to help. The Assessment Team reviewed training records which demonstrated staff have received education in relation to restrictive practices and observed doors with keypad codes available next to the keypad in large font for consumers to utilise. Consumers were observed freely accessing outdoor areas.

As a result, and with consideration to the implemented actions and available information I find this Requirement is now 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 |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The service was previously found non-compliant with Requirements 7(3)(d) and 7(3)(e) following a Site Audit performed between 4 October 2022 and 6 October 2022. At the time of the Site Audit the service was unable to demonstrate:

* mandatory training schedules or staff competency in manual handling practises and use of lifting equipment, and
* assessment monitoring and performance review of each member of the workforce.

The service has implemented several effective actions in response to the non-compliance identified at the Site Audit including a mandatory training schedule, training analysis for all staff and implementation of a performance appraisal schedule and supporting policies.

With regard to Requirement 7(3)(d) consumers and representatives stated they believe staff had the training they required to competently undertake their work duties. Management explained there was a mandatory training schedule in place and staff confirmed they had received training related to restrictive practices, open disclosure, Serious Incident Response Scheme (SIRS) and manual handling training in the last 6 months. The Assessment Team reviewed training records including staff professional development plans, a training calendar and attendance records which confirmed all staff have completed mandatory training units.

With regard to Requirement 7(3)(e) the service has implemented policies and procedures in relation to staff performance and disciplinary matters. Performance reviews for all staff are being scheduled annually, based on the month of their commencement date. Current staff are notified when their performance appraisals are due. Staff confirmed they have completed performance appraisals in the last year, with an opportunity to receive and provide feedback. Management described the process taken when adverse feedback from consumers or representatives is discussed directly with the staff. Any incidents are investigated and followed up by discussion with staff. The service has a performance appraisal schedule that is overseen by the facility manager to ensure compliance. A review of the appraisal schedule demonstrated that 20 staff appraisals have occurred from November to February 2023.

As a result, and with consideration to the implemented actions and available information I find these Requirements now 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)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

The service was previously found non-compliant with Requirements 8(3)(c) and 8(3)(e) following a Site Audit performed between 4 October 2022 and 6 October 2022. At the time of the Site Audit the service was unable to demonstrate:

* effective organisation wide governance systems to enhance information management, workforce governance and regulatory compliance, and
* consistent understanding nor application in relation to minimising the use of restraint and possessed draft policies on clinical governance framework, and antimicrobial stewardship.

The service has implemented several effective actions in response to the non-compliance identified at the Site Audit including employment of dedicated quality and education staff, mandatory training implementation of performance development, implementation of a formal appraisal process and clinical governance framework including a formalised antimicrobial stewardship policy.

With regard to Requirement 8(3)(c) management initiated the employment of staff specific to the role of quality and education positions. An audit was conducted of staff training schedules identifying gaps and mandatory training needs. A learning calendar was subsequently developed and made available to all staff. Care staff explained that they have undergone a series of training courses including wound management, care planning and antimicrobial stewardship. The Assessment Team reviewed training records which confirmed over 83 percent of staff attended and completed mandatory training requirements and a specific 12-week ‘bootcamp’ aimed at Registered Nurses was provided which included education related to antimicrobial care, care planning and geriatrician nursing care.

Management explained that all policies have been formalised and are made available to staff on a shared drive and accessible to all staff. Policies are reviewed every two years and quality management practices ensure regulatory compliance by ensuring that all documents adhere to legislative standards. Staff evaluation is now undertaken on an annual basis and includes the formalising of individual’s Performance Development Plan (PDP), training needs are addressed and documented during this process. The service has reviewed and redesigned the 3-monthly consumer care evaluation, to incorporate its Resident of the Day reviews with care planning and a case conference process to develop effective consumer care evaluation. The Assessment Team reviewed electronic records which confirmed this process has been implemented.

With regard to Requirement 8(3)(e) management has initiated a review of several policies and procedures including clinical governance framework, minimising the use of restraint and antimicrobial stewardship. Policies have been formalised and made available to all staff with changes communicated at staff meetings and by email. Care staff explained that they have undergone a series of training courses related directly to minimising restraint and antimicrobial stewardship. The Assessment Team noted that systems are in place for delivering safe, quality clinical care and for continuously improving services. The service uses clinical governance and quality systems to maintain and improve the reliability, safety, and quality of clinical care. The Assessment Team reviewed policies relating to clinical governance framework, minimising the use of restraint and antimicrobial stewardship.

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

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