Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Warrigal Care Albion Park Rail |
| Commission ID: | 0291 |
| Address: | 2 Pine Street, ALBION PARK RAIL, New South Wales, 2527 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 31 October 2023 to 2 November 2023 |
| Performance report date: | 19 December 2023 |
| Service included in this assessment: | Service: 307 Warrigal Care Albion Park Rail |

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 Warrigal Care Albion Park Rail (**the service**) has been prepared by T Solomon, 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.

# Assessment summary

|  |  |
| --- | --- |
| Standard 3 Personal care and clinical care | Not Compliant |
| **Standard 4** Services and supports for daily living | **Not Compliant** |
| **Standard 6** Feedback and complaints | **Not Compliant** |

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

# 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.

Requirement 3(3)(a)

* Ensure consumers are receiving safe and best-practice care that is tailored to their needs and optimises their health and well-being, specifically related to pressure injuries, pain management, behaviour supports and restrictive practices.

Requirement 3(3)(b)

* Ensure the effective management of high impact or high prevalence risk associated with the care of each consumer, specifically in relation to medication management, pressure injury management, diabetic management, and pain management.

Requirement 4(3)(f)

* Ensure where meals are provided, they are varied and of suitable quality and quantity.
* Ensue consumer feedback is received and incorporated in the plan for continuous improvement specifically related to meals.

Requirement 6(3)(d)

* Ensure and complaints are reviewed and used to improve the quality of care and services.

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |

Findings

Consumers and/or representatives indicated they were satisfied with the provision of clinical and personal care. However, the Assessment Team identified deficiencies in relation to prevention and management of pressure injuries, pain management, diabetic management, behaviour supports and restrictive practices, as well as bowel management.

The Assessment team identified pressure injury prevention measures were not consistently followed and effective, and pressure relieving devices were not used correctly. Recent deterioration of pressure injuries was not escalated and was not referred to a wound specialist in a timely manner. In addition, assessment was not consistently undertaken following changes in skin integrity, and pain assessment and planning were not undertaken following a return from hospital. The service did not demonstrate that care was best practice and completed in a timely manner.

The service does not ensure that assessments and care plans regarding the use of chemical restraint are individualised and provide specific information about the reasons and circumstances for the use of the chemical restraint. Care plans contain generic information and strategies, with limited information on the effectiveness of the interventions and strategies.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(a) is found Non-compliant.

The service does not ensure that high-impact or high-prevalence risks associated with the care of each consumer are effectively managed. The Assessment Team identified deficiencies in management of high-impact and high-prevalence risks in relation to medication, incident, falls and diabetic management. A review of medication incidents at the service indicates a large number of medication errors occurred over a short period of time, including pharmacy errors, no stock, missing medication, and medication given to the wrong consumer.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(b) is found Non-compliant.

# Standard 4

|  |  |  |
| --- | --- | --- |
| Services and supports for daily living | |  |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Not Compliant |

Findings

Requirement 4(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated that information regarding consumer's needs, goals and preferences is communicated effectively. Consumers and/or representatives indicated staff are aware of consumer needs and they do not have to repeat information to staff. Staff indicated they are aware of consumers needs and preferences around meals and activities.

Catering staff stated they use dietary information and preferences provided by clinical staff to update their electronic meal management system. Food and fluid texture, special diets including dairy free, low fibre, weight management, palliative care, diabetic and coeliac and preferences including extra gravy are identified in the dietary restrictions list and mapped against the lunch and dinner menu for the day.

Consumers and/or representatives provided mixed feedback around food, stating food is often served cold, there are long delays in serving meals, and not enough clean crockery available. The service could not demonstrate that consumer concerns were being addressed and sustainable actions implemented to ensure meals are of sufficient quality and were served at suitable temperatures.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 4(3)(f) is found Non-compliant.

# Standard 6

|  |  |  |
| --- | --- | --- |
| Feedback and complaints | |  |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant |

Findings

The Assessment Team found the service is unable to demonstrate that complaints and feedback are investigated, assessed, actions implemented and reviewed to improve the quality of care and services. Feedback received from consumers and/or representatives indicate a lack of urgency displayed from the service in relation to responding to complaints and identifying suitable solutions.

The complaints register contained complaints closed with no outcome recorded, many complaints that are still open and ongoing as well as a large number of complaints with no recorded investigation into the complaint. The plan for continuous improvement was reviewed and contained actions in response to some feedback and complaints, however the plan did not address how the implemented actions will improve the quality of care and services.

Although the management team could provide individual examples where feedback was addressed, it was not clear from a review of the complaints register and service plan for continuous Improvement that feedback and complaints are used to drive improvement for all consumers at the service. Review of documentation and interviews with management indicated there is not a sustainable process in place where feedback and complaints are used to improve the quality of care and service for all consumers.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 6(3)(d) is found Non-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)