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: | on 17 April 2024 |
| Performance report date: | 15 May 2024 |
| Service included in this assessment: | Provider: 468 Warrigal Care  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 G Cherry, 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.
* Performance Report dated 19 December 2023.
* Notice of Direction to Revise Plan for Continuous Improvement dated 20 December 2023.
* Notification Regarding Closure of Direction Notice dated 25 January 2024.

# Assessment summary

|  |  |
| --- | --- |
| Standard 3 Personal care and clinical care | Compliant |
| **Standard 6** Feedback and complaints | **Compliant** |

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

|  |  |  |
| --- | --- | --- |
| 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 |

Findings

Requirement 3(3)(a) - a decision of non-compliance made on 19 December 2023 followed an assessment contact on 31 October 2023 to 2 November 2023. At an assessment contact on 17 April 2024 the provider advised of actions taken to address/remedy previous non-compliance, including changes to systems/processes relating to pressure injury care, pain, diabetic and continence management, behavioural support, restrictive practices and provided staff education/training.

In recent months, the service has undergone key management changes including new general manager, deputies, and quality officer. Consumers consider improved outcomes relating to care and services as a result. Sampled consumers/representatives gave positive feedback relating to personal/clinical care, particularly regarding management of restrictive practices, behaviour support, falls, wound, pain and management of complex nursing care. The assessment team note some documentation deficits which the management team committed to actioning. An effective system exists to ensure authorisation and informed consent in relation to use of restrictive practices. Regular medical officer review occurs to ensure currency, policy/procedure documents guide organisational requirements and document review details consistent adherence to this. A monitoring process captures information in relation to psychotropic medications including details of informed consent and management team advise consent is noted via restrictive practice authorisation form. Review of sampled consumers experiencing changed behaviour detail assessment/monitoring result in current behaviour support plans to guide care delivery. Documented strategies demonstrate comprehensive review including external specialist involvement and strategies tailored to individual needs. Representatives consider management of consumers needs to optimise health and well-being. A process ensures consumers have appropriate authorisation in relation to mechanical and environmental restrictive practices. Consumers have access to freely move throughout the environment. Policies/procedures guide staff practice in relation to management of falls including risk assessment, preventative strategies, and post incident management/monitoring processes, however via document review the assessment team note post fall protocols not adhered to for 1 consumer. Management personnel committed to providing additional staff education/training. A committee exists with an aim to conduct regular review and analysis of data of consumers identified as high risk. Document review for consumers experiencing pressure injury and requiring wound management detail 1 consumer’s wound management not aligned with care plan directives and not all wound photography includes measurement details to monitoring/identify change/healing. Document review for consumers requiring pain management demonstrate overall effectiveness of assessment and monitoring including consideration of pain in wound management. The team note pain monitoring documentation not consistently completed for 1 consumer. For consumers living with complex nursing care needs, review of documentation includes appropriate assessment, care plan, monitoring processes align with consumers individual needs.

Although deficiencies in monitoring documentation exists, it is noted this did not result in negative consumer outcome. In consideration of compliance, I am swayed by the volume of consumer/representative satisfaction and management personnel advise of planned improvement actions to identified issues. I find requirement 3(3)(a) is compliant.

Requirement 3(3)(b) - a decision of non-compliance made on 19 December 2023 followed an assessment contact on 31 October 2023 to 2 November 2023. At an assessment contact on 17 April 2024 the provider advised of actions taken to address/remedy previous non-compliance, including changes to processes relating to medication management, incident monitoring/management, falls prevention and monitoring strategies and provided staff training and education.

Interviewed consumers express general satisfaction of care and services received. Management personnel outline mechanisms to monitor high impact/prevalence risk. Review of systems/documents demonstrate regular ongoing monitoring and governance oversight. Interviews with management and staff result in demonstration of knowledge/understanding of individual risk/consumer impact. Systems demonstrate management of medication, incidents, falls risk, diabetes and relevant mitigation strategies. Sampled consumers/representatives consider appropriate management of high impact/prevalent risks including consultation/engagement in risk mitigation strategies, including satisfaction relating to ensuring administration of time-sensitive medication. Documentation details use of restrictive practices when required, appropriate management of behaviour changes and implementation of responsive/prevention strategies. An effective incident management system exists. Investigations are conducted to ensure all information is captured and a chronological understanding of event, including responsive/preventative strategies. Management demonstrate escalation processes for Board and governance oversight. Legislative reportable events are recorded, investigated, clinically assessed to determine root-cause enabling development of mitigation strategies. Staff receive education/training regarding their responsibility in the event of an incident (including falls management). I find requirement 3(3)(b) is 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. | Compliant |

Findings

A decision of non-compliance made on 19 December 2023 followed an assessment contact on 31 October 2023 to 2 November 2023. At an assessment contact on 17 April 2024 the provider advised of actions taken to address/remedy previous non-compliance, including implementation of systems to ensure review, timely response to feedback/complaints which are used to drive improvement outcomes.

Overall consumer/representative and staff feedback note significant changes in complaints management resulting in improved quality of care and services. Document review demonstrates changed processes for recording/monitoring, and actioning complaints. The service demonstrates an effective process to ensure feedback/complaints are investigated and solutions implemented to improve quality of care. Management team members demonstrate evidence of investigations addressing consumers concerns. Sampled consumers/representatives consider complaints are actioned to their satisfaction and staff demonstrate knowledge of actions undertaken by management team of changes addressing complaints management. Consumers/representatives express positive feedback complaints are appropriately managed, giving specific examples, particularly noting remedy of past concerns regarding meal/food quality. The service implemented regular multidisciplinary team meetings aimed to investigate, monitor, and review complaints. Staff are informed of details and follow up actions plus training. Complaint trends are included in the service’s plan for continuous improvement monitored by management. I find requirement 6(3)(d) is 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)