Performance

Report

**1800 951 822**

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| Name of service: | Warrigal Care Calwell |
| Service address: | 43 Were Street CALWELL ACT 2905 |
| Commission ID: | 2948 |
| Approved provider: | Warrigal Care |
| Activity type: | Assessment Contact - Site |
| Activity date: | 22 November 2022 to 23 November 2022 |
| Performance report date: | 18 January 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 Warrigal Care Calwell (**the service**) has been prepared by M.Wyborn, 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.
* the provider’s response to the assessment team’s report received 16 December 2022.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Not applicable as not all requirements have been assessed** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **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 6** Feedback and complaints | **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

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)(b) – the approved provider ensures effective management of high-impact or high prevalence risks associate with the care of each consumer, including for consumers who experience falls and for consumers who experience urinary tract infections.

# Standard 3

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| 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. | Non-compliant |

Findings

The service was found non-compliant in Requirement 3(3)(a) following a Site Audit conducted 17 May 2021 to 20 May 2021 due to gaps in wound management, pain management and appropriate supporting diagnosis for the use of psychotropic medication. The service has implemented continuous improvement actions in response to this non-compliance.

During the Assessment Contact undertaken between 22 November 2022 to 23 November 2022, the Assessment Team found that the service demonstrated continuous improvement that has been effective in ensuring consumer wounds are well managed. However, the Assessment Team identified some deficits in relation to chemical restrictive practice and the service’s assessment and management of consumer pain.

The Approved Provider responded with additional supporting evidence and a detailed plan for continuous improvement to address the identified deficits. The further evidence from the Approved Provider demonstrated the service has effective practices to identify and manage chemical restraint, and that where chemical restraint is used, it is with required consent and used as a last resort following the use of alternative strategies. The Approved Provider response also included information to show pain assessment and ongoing pain management for consumers. This includes the use of pharmacological and non-pharmacological treatments for pain management and regular engagement with medical officers, palliative care specialists and geriatricians to support individualised pain management for consumers. With these considerations I find the Approved Provider’s evidence to be more compelling in regards to compliance for this requirement and am satisfied that safe and effective personal care and clinical care are provided for each consumer. Therefore, I find the service compliant in Requirement 3(3)(a).

The service was found non-compliant in Requirement 3(3)(b) following a Site Audit conducted 17 May 2021 to 20 May 2021 due to gaps in medication management and behaviour management for consumers. The service has implemented continuous improvement actions in response to this non-compliance.

During the Assessment Contact undertaken between 22 November 2022 to 23 November 2022, the Assessment Team found that the service demonstrated continuous improvement by improving their approach to consumer medication management, monitoring and managing consumer health, and providing intervention and appropriate escalation when required. However, the Assessment Team identified some deficits with effective management of risks, in particular, related to falls and urinary tract infections.

The Approved Provider responded with additional supporting evidence and a detailed plan for continuous improvement to address the identified deficits. I acknowledge the Approved Provider have already addressed and clarified some of the identified deficits, however I find the Assessment Team’s findings to be more compelling in regard to compliance for this requirement. Further review is required in relation to the service’s processes for communicating the outcomes of assessments and reviews with consumers and their representatives to support informed decision making and choice related to health management strategies. Further consideration is required in relation to support and monitoring of each consumer with a focus on managing high impact or high prevalence risks.

Based on the information provided by the Assessment Team and the Approved Provider I find Requirement 3(3)(b) non-compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |

Findings

The service was found non-compliant in Requirement 4(3)(b) following a Site Audit conducted 17 May 2021 to 20 May 2021 due to gaps identified in providing consumers with services and support for daily living that promotes their emotional, spiritual, and psychological well-being. The service has implemented continuous improvement actions in response to this non-compliance.

During the Assessment Contact undertaken between 22 November 2022 to 23 November 2022, the Assessment Team found that the service demonstrated continuous improvement and were effectively promoting some consumer’s emotional, spiritual, and psychological well-being. The Assessment Team recommended non-compliance for this requirement as they reported that not all consumers’ needs are being met at the service.

The Approved Provider responded with additional supporting evidence and a detailed plan for continuous improvement to address the concerns. The Approved Provider supplied evidence that the service has implemented a trial program in partnership with NSW Health to effectively train volunteers to assist them to provide individual support for consumers living with dementia. Further, the service’s volunteer coordinator is engaging with the community visitor scheme to seek targeted cultural volunteers to support individual consumers at the service. The service demonstrated they are partnering with Meaningful Ageing Australia to provide contemporary training to staff in order to best support consumers. The Approved Provider also demonstrated that they have implemented a diversity and inclusion organisational working party who oversee an increased focused on culturally relevant activities and the delivery of a regular cultural activities calendar.

Further, the service highlighted their access to volunteers, pastoral care, therapy dogs, their implementation of a partners in care program, their increased number of electronic tablets available for consumers, and the increased choice of activities available to consumers including 1:1 support from Activity Officers.

With these considerations, I find the Approved Provider’s findings to be more compelling in regard to compliance for this requirement and am satisfied that the Approved Provider’s response demonstrates that the services and supports for daily living available for consumers promote their emotional, spiritual and psychological well-being. Therefore, I find the service compliant in Requirement 4(3)(b).

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The service was found non-compliant in Requirement 6(3)(c) following a Site Audit conducted 17 May 2021 to 20 May 2021 due to deficiencies identified in effective and timely actions in response to complaints and open disclosure principles.

During the Assessment Contact undertaken between 22 November 2022 to 23 November 2022, the Assessment Team recommended non-compliance in response to actioning and evaluating complaints and staff applying an open disclosure principle when things go wrong. The Approved Provider responded with additional supporting evidence and a detailed plan for continuous improvement to address the identified deficits. The service demonstrated that they have provided toolbox talks to staff focused on open disclosure and plan to maintain this topic for future training for all staff. The service demonstrated an effective complaint register in which actions taken to resolve complaints are appropriately recorded and consumer or representative satisfaction evaluations are documented. With these considerations, I find the Approved Provider’s findings to be more compelling in regard to compliance for this requirement and am satisfied that appropriate action is taken in response to complaints at the service and an open disclosure process is used when things go wrong. Therefore, I find the service compliant in Requirement 6(3)(c).

The service was found non-compliant in Requirement 6(3)(d) following a Site Audit conducted 17 May 2021 to 20 May 2021 as the service was unable to demonstrate that feedback and complaints are reviewed and used to improve the quality of care and services. The Assessment Team found that not all complaints were recorded in the feedback register.

During the Assessment Contact undertaken between 22 November 2022 to 23 November 2022, the Assessment Team identified some ongoing deficits in relation to complaints data management, specifically in relation to catering concerns raised by consumers. The Approved Provider responded with additional supporting evidence and provided a detailed plan for continuous improvement that addressed the identified deficits. The service demonstrated that they maintain a separate continuous improvement plan and feedback and complaints register for catering and highlighted that this was not reviewed by the Assessment Team as it was not specifically requested during the Assessment Contact.

With these considerations, I find the Approved Provider’s findings to be more compelling in regard to compliance for this requirement and am satisfied that the Approved Provider’s response demonstrates that feedback and complaints are reviewed and used to improve the quality of care and services. Therefore, I find the service compliant in Requirement 6(3)(d).

# Standard 7

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| Human resources | |  |
| 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 found non-compliant in Requirement 7(3)(e) following a Site Audit conducted 17 May 2021 to 20 May 2021 due to gaps identified with assessment, monitoring and review of the workforce. Staff could not recall when their last performance review had occurred, and not all staff felt supported to continuously improve in their work performance. The service has implemented continuous improvement actions in response to this non-compliance.

During the Assessment Contact undertaken between 22 November 2022 to 23 November 2022, the Assessment Team found that the service demonstrated staff appraisals are completed and the service has a current schedule to ensure compliance. The Assessment team observed that most staff have completed their appraisals. The Assessment Team recommended non-compliance in this requirement however due to the service’s inability to demonstrate that staff are effectively performance managed following an incident where they are required to undertake additional training.

The Approved Provider responded with additional supporting evidence and highlighted their actions to improve previous non-compliance in this requirement as detailed in their plan for continuous improvement that addressed the identified deficits. The service demonstrated effective performance management policies and procedures and provided their up to date staff appraisal spreadsheet.

With these considerations, I find the Approved Provider’s findings to be more compelling in regard to compliance for this requirement and am satisfied that assessment, monitoring and review of staff performance is undertaken regularly. Therefore, I find the service compliant in Requirement 7(3)(e).

# 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 |

Findings

The service was found non-compliant in Requirement 8(3)(c) following a Site Audit conducted 17 May 2021 to 20 May 2021 as the service was unable to demonstrate that the organisation’s governance systems were effective, specifically in relation to continuous improvement, workforce governance, regulatory compliance, and feedback and complaints. The service has implemented continuous improvement actions in response to this non-compliance.

During the Assessment Contact undertaken between 22 November 2022 to 23 November 2022, the Assessment Team found that the service demonstrated continuous improvement action and have been effective in some aspects of organisational governance, but not all.

The Assessment Team identified deficits in relation to information management, workforce governance and regulatory compliance. The Assessment Team reported that there are improvements required in the service’s current electronic record management systems including recording continuous improvement, staff training and incident management. Consumers, representatives and staff raised concerns with the Assessment Team about insufficient staffing levels and additional staff would improve care and services delivered to consumers. Management discussed how they are managing the challenges the organisation has in relation to staff retention, deployment of agency staff, and the ratio of registered and care staff. The Assessment Team reported that the organisation’s incident management system does not routinely include analysis of incidents to identify contributing factors and development of effective measures to prevent future incidents. Further, the Assessment Team identified several incidents that the service had not reported either as Priority 1 or Priority 2 under the Serious Incident Response Scheme (SIRS).

The Approved Provider responded with additional supporting evidence and a detailed plan for continuous improvement to address the identified deficits. The Approved Provider gave more detail on the organisational information management systems that are used in the service including the electronic clinical information systems. The Approved Provider demonstrated they are undertaking continuous improvement, and this is clearly documented through the service’s plan for continuous improvement. Organisational workforce governance arrangements are in place and used in the service to support the delivery of care and services. Further information was provided on the organisational regulatory compliance system and how this is used within the service. This includes the use of an incident management system. The Approved Provider clarified they do consider the required for reporting under the Serious Incident Response Scheme for incidents and incidents are reported in line with the requirements of the Scheme. With these considerations I find the Approved Provider’s evidence to be more compelling in regards to compliance for this requirement and am satisfied there is effective organisational wide governance systems operating at the service. Therefore, I find the service compliant in Requirement 8(3)(c).

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)