Performance

Report

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| Name of service: | Warrigal Care Coniston |
| Service address: | 91 Bridge Street CONISTON NSW 2500 |
| Commission ID: | 2543 |
| Approved provider: | Warrigal Care |
| Activity type: | Assessment Contact - Site |
| Activity date: | 15 March 2023 |
| Performance report date: | 8 April 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 Coniston (**the service**) has been prepared by Melissa Buhagiar, 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 conducted 15 March 2023, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider did not respond to the Assessment Team’s report.
* the following information given to the Commission, or to the assessment team for the Assessment Contact - Site of the service: Directions Notice issued 13 July 2022 following Site Audit conducted 24-26 May 2022, Performance Report dated 30 June 2022 following Site Audit conducted 24-26 May 2022, Site Audit Report for the Site Audit conducted 24-26 May 2022.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | **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)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

This requirement was found non-compliant following a site audit from 24 May 2022 to 26 May 2022. Care and services were not reviewed for two consumers who returned to the service from hospital. Skin assessments were not completed when the consumers returned to the service despite both consumers experiencing changes to their skin integrity.

In response, to the findings of non-compliance identified at the site audit, the service has implemented a number of actions.

The service has implemented a new checklist to be completed when a consumer returns from hospital. Registered nurses have been educated on the use of the checklist and confirmed that this process has been embedded into their practices at the service. Dates of when each item is completed, and notes are part of the checklist.

All registered nurses and team leaders were educated on 20 July 2022 regarding the need for a skin assessment to be attended and documented when a consumer returns from hospital or extended leave. The registered nurse is then to follow the policies and procedures for any skin impairment by completing a skin injury report, and attending wound assessments, wound charting and pain assessment as required. Pain assessment is an item on the return from hospital checklist.

Staff and management interviewed explained the review process at the service. The organisation’s policy states that care plans are reviewed on a three-monthly basis. Prompts within the electronic care management system alert staff to upcoming or overdue interventions, reviews, and assessments. There are return from hospital processes in place to review care and services to reflect any change in the needs, goals, or preferences of the consumer. Consumer care plans sampled; showed that care planning was reviewed regularly and when required.

The Assessment Team interviewed the service’s physiotherapist who advised that any changes in circumstances where consumer’s needs, goals and preferences change, trigger a referral and review. The registered nurses are informed of any changes to care strategies. The registered nurse updates the care plan and directives are given to staff.

The Assessment Team reviewed six consumers care plans sampled had been reviewed three monthly or following a change in consumer’s needs.

I find that the approved provider is compliant with requirement 2(3)(e).

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

This requirement was found non-compliant following a site audit from 24 May 2022 to 26 May 2022. The service was unable to demonstrate that staff practices support effective infection control processes including hand washing. Mandatory training relating to infection control were not competed.

In response, to the findings of non-compliance identified at the site audit, the service has implemented a number of actions, including staff hand washing competencies and Infection Control Observational Audits with identification of any breaches for action.

The Assessment Team reviewed training records that showed not all staff have completed mandatory training in relation to infection control. However, management said this is due to new staff commencing and some staff that are now due to complete the training after falling overdue within the last month.

Management advised that the IPC lead had recently left the service in December 2022 and have recently appointed a new IPC lead who is now responsible, as well as the manager to ensure all training is completed and up to date. The service is creating and implementing a training schedule to ensure the service will always be 100% compliant with all infection control training.

The training schedule will include weekly training reports to identify staff that are non-compliant or staff that are due for training 11 months since their last date of training. Staff will be notified and scheduled to attend the training on a specific date with management and the IPC lead overseeing the schedules and non-compliance.

Management described how they use monitoring tools, monthly and quarterly reporting to maintain oversight and benchmark antibiotic usage against national standards and other services within the organisation. Management advised that antibiotics are typically commenced following a confirmed pathology result to ensure its appropriateness and a microbial report assessment form is completed.

The Assessment Team reviewed care plans for 3 consumers that had recently been administered antibiotics or had been suspected of having an infection and confirmed that infection and microbial report assessment forms had been completed.

The Assessment Team interviewed staff who provided examples of practices to prevent and control infections such as hand hygiene, encouraging fluids, the use of personal protective equipment (PPE) and obtaining pathology results prior to commencing antibiotics.

The service has policies and procedures to support the minimisation of infection related risks and promotion of antimicrobial stewardship.

The Assessment Team reviewed regular IPC audit reports completed monthly by the services IPC lead.

The Assessment Team spoke with consumers and representatives who said the service is clean and they have observed staff using PPE and one consumer representative said they observe staff washing their hands.

The Assessment Team observed visitors going through a thorough screening process prior to entering the service, this process included rapid antigen testing, temperature checks and a questionnaire and declaration. All visitors, and staff were observed to be wearing surgical masks at the service. Clinical and care staff using masks, hand hygiene and when required gloves when providing personal care to consumers. However, one care staff was observed assisting a consumer with their lunch, then proceeded to answer a telephone call hand it to another consumer, then return to the consumer they were assisting without washing their hands. This was raised with management who said they would carry out infection control and handwashing training with the staff member immediately.

I have found the approved provider is compliant with Requirement 3(3)(g).

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