Performance

Report

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| Name: | Warrigal Care Queanbeyan |
| Commission ID: | 0552 |
| Address: | 111 Campbell Street, QUEANBEYAN, New South Wales, 2620 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 17 July 2024 to 18 July 2024 |
| Performance report date: | 2 September 2024 |
| Service included in this assessment: | Provider: 468 Warrigal Care  Service: 5255 Warrigal Care Queanbeyan |

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 Queanbeyan (**the service**) has been prepared by Therese 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

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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 | **Not applicable as not all requirements have been assessed** |
| **Standard 4** Services and supports for daily living | **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** |

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 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |

Findings

Requirement 1(3)(a) was found non-compliant during a previous site audit, since that time the Approved Provider implemented actions to address the non-compliance, including all staff to complete the mandatory Code of Conduct training, all staff to attend a communication workshop and integrating Code of Conduct training into the onboarding program for all staff.

During the Assessment Contact conducted from 17 July 2024 to 18 July 2024 the Assessment Team found the service was treating consumers with dignity and respect with their identity, culture and diversity valued.

The organisation has documented processes which outline a consumer’s right to be treated with respect and dignity and policies to guide staff conduct accordingly. Care plans reflected the diversity of consumers, including information about their background, cultural and religious beliefs, and preferences. Staff were familiar with consumers’ backgrounds and spoke about consumers in a respectful manner. Language used throughout care plans and service documentation was noted to be respectful. Staff were observed engaging with consumers in a friendly, dignified, and respectful manner. Consumers and/or representatives confirmed they felt consumers are respected and valued as individuals by staff.

Information on the Charter of Aged Care Rights, dignity, respect, choice, and diversity are detailed in the consumer handbook and displayed throughout the service. Review of resident surveys, meeting minutes and training records confirmed consumers and/or representatives are satisfied with the care and services consumers receive. The organisation has policies and procedures in place that promote diversity and inclusion at all levels of care and services. Consumers and/or representative are confident staff support consumers to live their best life and respect consumer choices.

# 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

Requirement 2(3)(e) was found non-compliant during a previous site audit, since that time the Approved Provider implemented actions to address the non-compliance, including conducting an internal audit on care plan reviews and case conferencing and developing a table to ensure annual case conferences occurred.

During the Assessment Contact conducted from 17 July 2024 to 18 July 2024 the Assessment Team found the service demonstrated that care and services provided to consumers are reviewed ongoing, to ensure care and services are effective and reflective of the needs, goals, and preferences of each consumer.

Consumers and/or representatives stated they were informed of changes to care and services when they occurred and were provided with care plans that were updated in consultation with themselves and other relevant parties such as doctors, wound consultants, palliative care consultants, dietitians, and speech pathologists. This was confirmed by case conference records contained within consumer documentation. Clinical and care staff were able to describe how care is personalised for each consumer and how the needs of each consumer are identified and documented. Documentation reviewed indicates consumers are consistently assessed by clinical staff and changes in consumer health are being recognised, reviewed, documented, and escalated when appropriate.

# 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. | Compliant |

Findings

Requirement 3(3)(a) was found non-compliant during a previous site audit, since that time the Approved Provider implemented actions to address the non-compliance, including conducting an internal audit on pain charting and pain assessments, conducting an internal audit on wound charting, and implementing education for staff to address identified areas of concern.

During the Assessment Contact conducted from 17 July 2024 to 18 July 2024 the Assessment Team found each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care that is best practice, tailored to consumer needs and optimises their health and well-being.

Consumers and/or representatives provided positive feedback regarding personal and clinical care provided to consumers within the service. Clinical and care staff were able to demonstrate sound knowledge in personalised consumer needs and preferences. Documentation reviewed is consistently reflective of care being provided by staff.

Personal care preferences were tailored to consumer needs and documented within consumer files and care plans. Clinical and care staff were able to communicate in detail the preferences of each consumer, including their preferred time for showering, preferred clothing consumers wish to wear and personalised preferences such as personal placement of items when care is being provided.

In relation to skin integrity, risk assessments are completed within a timely manner to identify consumers who are at risk of pressure injuries, bruises, and other skin conditions. Head to toe skin assessments are conducted following a consumer’s return from hospital, with any changes including bruises, pressure injuries or skin tears being identified and documented on wound charts. Interventions such as the use of pressure relieving devices, skin moisturisation and pressure area care are recorded within a consumer’s care plan and within nursing progress notes.

Consumers confirmed care staff support them to maintain their skin integrity. Pressure reliving equipment is available to consumers, including air mattresses, electronic air chairs, footstools, booties, and pressure-relieving cushions. Consumers were observed to be using this equipment, and their use is recorded in consumer care plans.

In relation to wound care, the service has policies and procedures in place to guide staff in best clinical practice for wound management. Staff were knowledgeable in wound management procedures and the escalation of wounds when issues arise. Staff were aware of the referral process for an external wound consultant utilised by the service, and this was evident within consumer documentation. Clinical and service management described how wound management was part of their ongoing improvement plan with registered nurses and provided evidence of ongoing staff training.

The service has policies and procedures to guide staff in the management of diabetes, weight loss and nutrition and hydration. These policies outline the responsibilities of care and clinical staff in the management of consumers, including the monitoring, reporting, and escalating of a change in a consumer’s condition.

A review of consumer files reflected individualised diabetes action plans were in place for each consumer, including escalation protocols for out-of-range blood glucose levels. Clinical staff demonstrated a good understanding of personalised diabetes action plans and clinical documentation reflected these action plans were in use for consumers with unstable diabetes.

Pain management is taken into consideration for each consumer. Care staff described verbal and non-verbal signs of pain in detail and stated that if these signs were observed, concerns are escalated to the registered nurse for further review. Registered nurses described the process of pain assessment, use of validated pain assessment tools and their escalation protocols for consumers who experience changing or ongoing pain.

Feedback from consumers and/or representatives is reflected in the care documentation including discussions regarding the risks of pain medication usage. Clinical staff and service management described how pain management was part of their ongoing improvement plans, with registered nurses and care staff provided with ongoing education. Improvements within documentation of ongoing pain assessments, charting and evaluation of pain interventions was evident throughout consumer files for several consumers, with several consumers confirming they were not in pain.

Requirement 3(3)(b) was found non-compliant during a previous site audit, since that time the Approved Provider implemented actions to address the non-compliance, including reviewing all consumers with an increased clinical risk on a weekly basis and as needed and updating their high impact/high prevalence risk register accordingly.

During the Assessment Contact conducted from 17 July 2024 to 18 July 2024 the service was able to demonstrate their approach to the management of high impact/high prevalence risks was effective.

Clinical management identified their current focus within the high impact/high prevalence risk area was within behaviour management, medication management and falls prevention and management. They stated that weekly meetings occur to discuss and evaluate ongoing care and services for consumers who are identified as high risk. Falls prevention meetings occur monthly.

Consumers and/or representative feedback, observations and a review of care and service documentation was reflective of the service’s ongoing improvement in the management of these areas and its positive effect on consumer care and safety.

Clinical files and service documentation reflects consumers who experience responsive or challenging behaviours are assessed and monitored on a regular basis. Behaviour management strategies were observed to be personalised for each consumer. Behaviour support planning and behaviour charting is consistent and reflective of evaluation of each strategy used. Clinical, care and lifestyle staff were knowledgeable in each consumer’s needs and their personalised behaviour support plans and demonstrated this knowledge throughout the visit.

When an incident regarding challenging behaviours occurs, management demonstrated that incident review and escalation took place, as appropriate. This includes further education of staff; the revaluation of consumer behaviour plans and ongoing referrals to additional services such as Dementia Support Australia. Incident reporting, internally and under the Serious Incident Response Scheme when appropriate, was demonstrated throughout this visit.

A review of clinical meeting minutes and clinical service records, interviews with clinical and care staff members and observations of clinical staff attending medication rounding for consumers indicates medication management is appropriate and incidents related to medication management are minimised as per best practice standards.

Feedback from consumers and/or representatives were positive regarding medication management, and the Assessment Team were advised that communication regarding medications and any alterations regarding consumer medications is regular, thorough, and immediate.

A review of documentation for consumers with a high falls risk or a history of falls shows each consumer has a falls risk score and a falls risk assessment documented within their clinical file. The service has a falls management plan and with each fall that occurs, it was observed staff have appropriately assessed, managed, and escalated the incident according to the service’s policy and procedures. Assessments after a consumer experiences a fall are appropriate and timely. Consumers who have had a fall were escalated appropriately and referred to their medical officer and physiotherapist for review and reassessment. Further prevention strategies were documented. Consumer representatives were updated when an incident occurs and/or when a change in care was deemed necessary to aid in the prevention of falls.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

Requirement 4(3)(f) was found non-compliant during a previous site audit, since that time the Approved Provider implemented actions to address the non-compliance, including resuming with in-house catering services and discontinued the use of a contract catering service, and increased staff training related to meals and the dining experience.

During the Assessment Contact conducted from 17 July 2024 to 18 July 2024 the Assessment Team found the service demonstrated meals provided by the service are varied and of suitable quality and quantity.

Consumers and/or representatives were generally satisfied with the meals provided at the service. They stated the service provides a range of meals which are of suitable quality and quantity. The service has processes in place to include consumers in the development of the menu and to provide feedback on the quality of the food provided.

Texture modified meals are prepared and delivered frozen by an external organisation, all other meals are cooked fresh on site and seasonal fresh fruit is available. Consumers are offered an alternative hot meal option or sandwiches, soups and salads for main meals and kitchen staff can prepare alternatives if requested. Catering and care staff described specific dietary needs and preferences of consumers and explained how they cater to individual preferences and dietary requirements.

The service provides meals 24 hours a day to consumers. Staff advised a member of the kitchen staff is available until 8:00 pm and will prepare small meals such as toasted sandwiches, scrambled eggs or omelettes if requested. Staff confirmed they can access snacks and light meals such as sandwiches, salads, cheese and crackers, yoghurt, custard, fruit, and biscuits outside of kitchen operating hours.

A resident catering meeting is conducted monthly by the regional hospital manager and attended by the chef. This is an open forum for consumers to provide feedback in relation to the food and dining experience. Feedback is used to guide continuous improvement and menu development at the service. The kitchen and servery areas were observed to be clean and tidy with kitchen staff following food safety and infection control protocols, such as wearing gloves and hairnets.

# 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

Requirement 6(3)(c) was found non-compliant during a previous site audit, since that time the Approved Provider implemented actions to address the non-compliance, including training and education provided to staff on open disclosure, oversight on the feedback register by management to monitor complaint management.

During the Assessment Contact conducted from 17 July 2024 to 18 July 2024 the Assessment Team found the service demonstrated it has systems in place to effectively manage feedback and complaints.

Consumers and/or representatives are actively informed of the complaints process and actions implemented to address the complaint, ensuring consumers are satisfied and the compliant is resolved. Staff receive training to ensure open disclosure principles are maintained for all complaints received. An evaluation process and follow up is included as part of the response to all complaints.

Consumers and/or representatives reported they are satisfied with the outcomes when they had lodged a complaint with the service, and that staff actively apologise, and the investigation and resolution processes were managed effectively.

Review of the feedback register and documentation in relation to complaints show the service includes open disclosure principles in their actions and management of complaints. Staff described how they use open disclosure in their work and how to escalate complex discussions to management. Management advised open disclosure training is included in the onboarding program for all new staff and that they are continuously monitoring complaints submitted.

Requirement 6(3)(d) was found non-compliant during a previous site audit, since that time the Approved Provider implemented actions to address the non-compliance, including implementing a process where the call bells response times are reviewed daily and discusses with staff, and an increased oversight by management to ensure complaints are analysed and used to improve care and services.

During the Assessment Contact conducted from 17 July 2024 to 18 July 2024 the service demonstrated it has access to a robust organisational feedback system that enables management to address deficiencies through improvements and ensures continual improvement in care and services.

Consumers and/or representatives were satisfied with how the service implemented changes based on feedback and complaints. Staff were well-versed in the process of complaints and how they drive continuous improvement. Management advised they are actively reviewing complaints submitted and monitor systemic deficits that can be actioned through the continuous improvement plan.

Management review complaints submitted by consumers, through various methods including resident meetings, focus meetings and staff meetings. Consumer feedback confirmed satisfaction with the use of complaints to improve care and services, and review of the continuous improvement plan outlined various complaints driven changes in systems and processes to enhance the quality of care and services.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |

Findings

Requirement 7(3)(a) was found non-compliant during a previous site audit, since that time the Approved Provider implemented actions to address the non-compliance, including staff allocation to occur for each section allowing continuity of care, monitoring of staff performance, and increasing the workforce.

During the Assessment Contact conducted from 17 July 2024 to 18 July 2024 the service demonstrated it has systems in place to support and enable effective workforce deployment to meet consumer needs. Consumers and/or representatives stated there is enough staff to deliver safe and effective care and services that meets consumer needs and preferences. Staff feedback indicated there is enough staff to ensure positive outcomes in care and services for consumers. Observation confirmed there are adequate number and mix of staff across all sections of the service and that staff is knowledgeable in relation to the needs and preference of each consumer.

Review of care and service documentation and assessment tools showed the service actively ensures staff have the right skills, maintains continuity of care and provides education and information to support consumers. Management advised staff upskilling had recently been undertaken for various clinical topics including changed behaviours. Staff outlined the expectations in call bell response time and stated management have been active in monitoring and supporting staff to meet these expectations.

Requirement 7(3)(b) was found non-compliant during a previous site audit, since that time the Approved Provider implemented actions to address the non-compliance, including all staff to complete code of conduct training, all staff to attend a communication workshop, and ongoing monitoring of staff performance.

During the Assessment Contact conducted from 17 July 2024 to 18 July 2024 the service demonstrated it has systems in place to ensure workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. Observations and feedback from consumers and/or representatives showed the service has a workforce that is focused on positive interactions with consumers during the delivery of care and services. Staff were able to outline the various training they have received in developing their consumer interactions and what the expectations are under the Quality Standards. Review of documentation indicates staff are respectful in their reporting of care and services and promote person-centred care.

Consumers and/or representatives reported staff deliver care and services that is satisfactory and believe staff meet the needs of consumers in a safe and effective manner.

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)