Warrina Innisfail

Performance Report

Warrina St/ Tulip St
Goondi QLD 4860
Phone number: 07 4061 7177

**Commission ID:** 5076

**Provider name:** Warrina Innisfail

**Assessment Contact - Site date:** 31 May 2022 to 1 June 2022

**Date of Performance Report:** 19 July 2022

# Performance report prepared by

Tara Wurf, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** |  |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(e) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** |  |
| Requirement 2(3)(a) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Compliant |
| **Standard 7 Human resources** |  |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(c) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | Non-compliant |

# Detailed assessment

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 Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies areas in which improvements must be made to ensure the Quality Standards are complied with.

The following information has been taken into account in developing this 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, interviews with staff, consumers/representatives and others and the provider’s response received 20 April 2022 to a section 67 request for information
* the provider’s response to the Assessment Contact - Site report received 4 July 2022
* Performance Report dated 8 October 2021 following the site audit conducted 31 August 2021 to 2 September 2021
* other information and intelligence held by the Commission.

# STANDARD 1 Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect and can maintain my identity. I can make informed choices about my care and services and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

The Assessment Team did not assess all requirements of this Standard and therefore an overall summary and compliance rating for the Quality Standard are not provided.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

Consumers described feeling respected. They said staff are kind and caring and make them feel valued as individuals. Consumers provided examples of how staff deliver care and services in accordance with their preferences. Some consumers who had recently moved into the service reported being made to feel welcome by staff and settled into their new home.

Staff consistently spoke about consumers in a respectful manner. They demonstrated understanding of consumers’ backgrounds, personal circumstances and preferences, and how this influenced the care they provide on a day-to-day basis. Staff said they would raise concerns with registered staff and management if they thought a consumer’s dignity was not being respected.

The Assessment Team observed staff greeting consumers and visitors with familiarity and interacting with consumers in a dignified and respectful manner. Staff were also observed actively engaging with consumers whilst providing assistance during mealtime.

The service has organisational policies on cultural diversity available to guide staff practice and staff receive relevant training at orientation. The Charter of Aged Care Rights was displayed throughout the service.

Based on the information above, this requirement is compliant.

### Requirement 1(3)(e) Compliant

*Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.*

Overall, consumers felt they are provided with information to enable them to exercise choice, including in planning and delivery of their care and their participation in daily activities. Consumers said staff regularly remind them about daily activities and support them to attend. While one consumer with vision impairment would like to receive more regular general information, they said staff let them know what is happening at the service.

Staff and management described the various ways in which information is provided to consumers and their representatives. The service utilises written documents (such as menus, activity calendars and newsletters), informal discussions with consumers/representatives, formal case conferences, consumer meetings, noticeboards throughout the service and the service’s website.

Consumers and their representatives are provided with information when they enter the service to enable them and their representatives (where applicable) to make informed decisions about the way the consumer lives and to understand the care and service options available to them.

The Assessment Team observed hospitality staff communicating with consumers during a meal service and staff providing consumers with information about activities.

Based on the information above, this requirement is compliant.

# STANDARD 2 Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Assessment Team did not assess all requirements of this Standard and therefore an overall summary and compliance rating for the Quality Standard are not provided.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

*Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.*

Consumers reported they are involved in assessment and care planning and said the care and services they receive meets their needs.

Staff demonstrated understanding of the service’s assessment and care planning processes and described how they use assessment, planning and handover information to guide how they deliver safe and effective care. Registered staff said consumers are referred to specialist practitioners if required following assessment.

The quality manager described their process to review identified consumer risks and incidents, to identify trends, initiate referrals and ensure all those involved in the consumer’s care are consulted.

The service uses an electronic care management system (ECMS) to record consumers’ assessment and care and service plans. Consumer care planning documents reflected comprehensive assessment and care planning processes that identified consumer’s needs, goals and preferences, including any identified risks.

Assessments are completed on entry to the service and care and service plans are reviewed three-monthly or more frequently as consumer needs change. Registered staff complete assessments in partnership with consumers, representatives, medical officers, allied health professionals, and specialist health practitioners in wound care, diabetes and dementia care where necessary. Consumers’ progress notes are reviewed daily by the registered staff to identify any health-related issues or concerns for the consumer.

Consumer’s care and service plans were individualised and contained information about risks including in relation to falls, skin integrity weight loss, and complex care needs. Plans included strategies to minimise and manage risks. For example, care and service plans for consumers with:

* diabetes included a diabetic management plan that guides staff in monitoring glucose levels and directions for when levels are outside reportable range, including to contact the medical officer.
* complex behaviours included individualised strategies and evidence that strategies are reviewed following incidents.

Incidents are recorded and investigated, and care and service plans are reviewed and changed whenever a risk is identified.

The organisation has policies, procedures, guidelines and work instructions relating to assessment and planning to guide staff practice. A suite of evidence-based assessment tools is available for staff to use. Staff have access to training relevant to their position.

Actions have been taken to improve the performance of the service in this requirement, including in response to deficiencies identified during the site audit conducted 31 August 2021 to 2 September 2021. Improvements included:

* Implementation of a new electronic care management system, which includes a range of assessment and monitoring tools and charts. The system prompts staff to complete various tasks, such as wound monitoring. Staff have been trained in the use of the new system.
* Introduced various new roles/positions including:
* a quality manager that oversees the clinical governance framework for the service
* three care coordinators, who support assessment and care planning for consumers with complex clinical care needs, including diabetic management and wound management, and
* clinical coordinator roles that provide clinical support with assessment and care planning and identifying risks for consumers.
* The service’s updated the entry process for consumers to include assessment of risks associated with their care and support.

Based on the above, this requirement is now compliant.

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The Assessment Team did not assess all requirements in this Standard, therefore, a summary statement is not provided. However, a decision of non-compliance in one or more requirements results in non-compliance for the Quality Standard.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-compliant

*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.*

Consumers were satisfied with the care and service they receive and considered that their needs and preferences are met. Consumer’s care documentation (including assessments, care and service plans, progress notes) generally reflected individualised care that was safe, effective and tailored to the specific needs and preferences of the consumer, including for those consumers with complex care needs.

However, the service did not demonstrate clinical care delivery was safe and effective in relation to the management of restrictive practices, specifically chemical restraint. While the service’s policies and procedures in relation to restrictive practices and behaviour supports were aligned with current legislative requirements, staff did not demonstrate a shared understanding of what constitutes ‘chemical restraint’.

On commencement of the Assessment Contact, management did not supply accurate information regarding the number of consumers subject to chemical restraint. In relation to restrictive practices and psychotropic medication usage, the Assessment Team identified multiple consumers on the service’s psychotropic register prescribed psychotropic medications without a diagnosis to support the use of the medication. Those consumers were subject to restrictive practice without requisite legislative requirements being put in place.

Actions were taken to improve the performance of the service in this requirement in response to deficiencies identified during the site audit conducted 31 August 2021 to 2 September 2021 and included:

* updating the service’s restrictive practices policy and procedure to align with legislative requirements
* staff training in restrictive practices
* a review of consumer care plans and assessments, and completing behaviour support plans for all consumers
* modifying the service’s psychotropic register to align with the Commission’s psychotropic self-assessment tool
* attending quarterly Medication Advisory Committee and discussing psychotropic medication usage.

Despite these improvement actions, ongoing deficiencies in the service’s understanding and management of chemical restraint were identified in the Assessment Contact Report. In response, the approved provider identified further updates have been made to the service’s restrictive practice policy and procedure and additional education and training on chemical restraint for staff will be provided.

In light of the ongoing restrictive practice related deficiencies, this requirement is non-compliant.

### Requirement 3(3)(b) Compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

The service has a documented risk management framework for how risk is identified, managed and recorded. Policies are available to staff on high impact or high prevalence risks associated with the care of consumers.

Care planning documentation described the key risks for individual consumers and included assessments and strategies to monitor, manage and review the risks. Examples of risks included falls, unplanned weight loss, complex behaviours and infections. Documentation reflected the involvement of other health professionals (where appropriate).

Management described the high impact and high prevalence risks for consumers at the service. Staff provided information consistent with care planning documentation and described strategies used to minimise risks for individual consumers. They described how handover occurs at the beginning of each shift and consumers’ care needs and preferences and any relevant risks to the consumer are discussed.

Care staff were aware of how to report and document consumer incidents. Registered staff described how incidents are reviewed and how outcomes of any actions that required follow up are initiated.

Clinical incidents are recorded and are included in monthly clinical indicators. Monthly clinical indicator data is used to inform improvements for individual consumers.

Based on the above, this requirement is compliant.

# STANDARD 7 Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The Assessment Team did not assess all requirements of this Standard and therefore an overall summary and compliance rating for the Quality Standard are not provided.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Compliant

*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.*

Consumers and representatives were satisfied there are adequate staff to meet consumer needs and preferences. Consumers said they have access to clinical staff, care staff and other staff and were satisfied with staff responsiveness to their requests for assistance.

Clinical and care staff reported that while they were busy, they had sufficient time to meet consumers’ care and service needs and answer call bells in a timely manner. Hospitality and cleaning staff also said they have enough staff and time to complete their daily tasks.

Management said the service is sufficiently staffed and has a relatively low staff turnover rate. The service also has recruitment strategies to attract registered staff in the region, ongoing recruitment processes in place and a partnership with the local Registered Training Organisation for student placements.

Management monitors and reports monthly on call bell response times and investigates response times greater than 10 minutes.

Based on the information above, this requirement is compliant.

### Requirement 7(3)(c) Compliant

*The workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

Actions have been taken to improve the performance of the service in this requirement, including in response to deficiencies identified during the site audit conducted 31 August 2021 to 2 September 2021.

Consumers and representatives said they were satisfied with the overall skills, capability and knowledge of staff and other workforce members such as contracted allied health staff. Consumers/representatives said they were satisfied with the skills of staff who provide clinical care, such as medications and wound care. One representative expressed high levels of satisfaction with the staff and care provided to their loved one following a decline in the consumers’ health condition.

Staff said they complete orientation and mandatory training. Care staff said they feel confident in their role in providing care and services in accordance with their skills and qualifications. Hospitality and cleaning staff said they are satisfied with the support they receive from the service.

The service has processes to ensure staff have qualifications and registrations relevant to their role, position descriptions outlining their duties, and that staff in various roles complete relevant mandatory training and competencies. Overseas workers complete language and communication competencies prior to being employed at the service. Staff are supervised by more experienced staff initially and ongoing supervision of staff competency is monitored by clinical care coordinators.

Staff receive training in various topics relevant to their role and demonstrated knowledge of the topic areas, including the serious incident response scheme, restrictive practices, antimicrobial stewardship, medication, pain management and compulsory reporting.

The Assessment Contact Report identified some staff that had not completed relevant mandatory training requirements since December 2021 when the education coordinator position became vacant. This had been identified by the service’s human resource manager and included on the service’s plan for continuous improvement, along with anticipated dates for when training would be completed.

Whilst I note some staff were not current with their mandatory training, the service had identified the issue and documented a plan to address this prior to the assessment contact visit. The approved provider’s response to the Assessment Contact Report also stated that all staff had completed mandatory training. I have also placed weight on consumer/representative feedback that staff are knowledgeable and competent in their roles and staff feedback that they are confident in their roles and receive relevant training and support. Furthermore, the service has systems in place to ensure staff are suitably qualified for their roles. Therefore, I find this requirement is now compliant.

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

The Assessment Team did not assess all requirements in this Standard, therefore, a summary statement is not provided. However, a decision of non-compliance in one or more requirements results in non-compliance for the Quality Standard.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(c) Non-compliant

*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.*

Whilst the service has effective governance systems in place relating to finance and workforce, the organisation’s systems relating to information management, continuous improvement, regulatory compliance and feedback and complaints are ineffective.

#### Information management

Management advised the Assessment Team that the service’s information management systems are ineffective for the following reasons:

* information systems to record staff training had not been updated or monitored since December 2021
* the Chief Executive Officer was unable to locate information such as meeting minutes, audits, surveys and other governance-related information since May 2022
* trends are not identified and analysed to inform continuous improvement activities or staff education and training needs.

#### Continuous improvement

Whilst the service has a plan for continuous improvement in place, the Assessment Team identified 11 improvement initiatives documented relating to Quality Standards 7 and 8 dated 18 September 2021 that remained open, eight of which had passed their original due date for completion with no further information documented.

Governance systems have not ensured that improvement actions relating to chemical restraint, and Requirements 8(3)(c) and 8(3)(e) following the site audit conducted 31 August 2021 to 2 September 2021 were implemented, sustainable and/or effective in addressing the identified deficiencies.

#### Financial governance

The Assessment Contact Report included information provided by management that identified some financial concerns faced by the service as well as financial supports and reporting in place to provide financial governance and oversight at the service.

I have also considered additional information in the approved provider’s response to the Assessment Contact Report and am satisfied that the service has appropriate financial governance arrangements in place, including independent financial advisors and various financial reporting processes.

#### Workforce governance

I have considered information under this requirement and under Requirements 7(3)(a) and 7(3)(d) above. I am satisfied the service has effective workforce governance arrangements in place in relation in relation to ensuring the service’s workforce is sufficient and suitable to provide care and services to the consumers at the service.

#### Regulatory compliance

The organisation has a process to monitor law and regulations and to identify and communicate changes. Management demonstrated the effectiveness of this system by providing evidence of the implementation of an incident management systems and relevant staff training and vaccination programs for staff and consumers.

However, staff did not demonstrate a shared understanding of the legislative requirements regarding the categorisation and management of restrictive practices (chemical restraint). The systems in place to monitor the use of chemical restraint practices at the service (including a psychotropic register) were ineffective for the following reasons.

* Information in the psychotropic register was inaccurate and not reflective of the number of consumers subject to chemical restraint at the service.
* Several consumers subject to chemical restraint did not have current assessment, consent and authorisation documentation which complies with legislative requirements.
* The systems have not been effective in identifying staff knowledge deficiencies in relation what constitutes chemical restraint.

The evidence above has been considered further under Requirements 3(3)(a) and 8(3)(e).

#### Feedback and complaints

While the organisation has a complaints management system in place and complaints are reported to the Board, the Assessment Contact Report identified complaints raised by consumers’ representatives had not been recorded and feedback/complaints processes do not clearly link with quality improvement.

The approved provider’s response to the Assessment Contact Report identified improvement actions completed in response to deficiencies identified during the Site Audit conducted 31 August 2021 to 2 September 2021, including implementing a new electronic information management system. Additional improvement actions identified following the assessment contact visit included:

* implementing a plan to review information systems and updating the policy for information management
* updated governance terms of reference for the Board
* review of feedback and complaints policy and procedure
* reactivating staff meetings for non-care services
* implementing a process to ensure improvement data is analysed

Whilst improvement actions have been identified, at the time of the assessment contact, the organisation did not have effective governance systems in place at the service. Therefore, I find this requirement non-compliant.

### Requirement 8(3)(d) Compliant

*Effective risk management systems and practices, including but not limited to the following:*

1. *managing high impact or high prevalence risks associated with the care of consumers;*
2. *identifying and responding to abuse and neglect of consumers;*
3. *supporting consumers to live the best life they can*
4. *managing and preventing incidents, including the use of an incident management system.*

The organisation has a documented risk management and governance framework and relevant policies to guide management and staff. These frameworks and policies cover consumer safety, risk management, clinical safety and the escalation of critical incidents. Staff reported receiving relevant training on various tropics, demonstrated understanding of the policies and provided examples of their relevant to their work.

Actions have been taken to improve the performance of the service in this requirement, including in response to deficiencies identified during the site audit conducted 31 August 2021 to 2 September 2021. The service’s incident management system records incidents, incident investigations and incident outcomes. The system categorises incidents based on severity through a matrix. Critical incidents are escalated and reported, including to the Board.

The service has systems to monitor data on incidents, infections, mandatory reports and hazards. Management and staff were aware of these systems and how they are used to minimise risk.

Based on the above, this requirement is now compliant.

### Requirement 8(3)(e) Non-compliant

*Where clinical care is provided—a clinical governance framework, including but not limited to the following:*

1. *antimicrobial stewardship;*
2. *minimising the use of restraint;*
3. *open disclosure.*

The organisation has a documented clinical governance framework and policies relating to antimicrobial stewardship, restrictive practices and complaints including open disclosure. Management and staff have been trained in the framework and policies and could describe the intent and practical application of those policies to their work and roles.

Actions have been taken to improve the performance of the service in this requirement, including in response to deficiencies identified during the site audit conducted 31 August 2021 to 2 September 2021. For example:

* Engaged a quality manager to oversee the clinical governance framework, and three care coordinators to support consumers with complex clinical care needs, including diabetic management and wound management. A clinical coordinator has also been engaged and provides clinical support to registered and care staff.
* Staff meetings in 2022 included clinical education on topics such as medication, pain and psychotropic medications.
* Staff received training in serious incident response scheme, minimising restrictive practices and antimicrobial stewardship.

However, I have considered information detailed under Requirement 3(3)(a) under this requirement. In particular, information relating to the service’s failure to understand and manage restrictive practices, specifically chemical restraint.

Despite the organisation having updated the policies and procedures relevant to restrictive practices to align with legislative requirements, providing staff training, reviewing and updating consumer care documentation and modifying the service’s psychotropic register, clinical governance processes have failed to ensure that improvement actions implemented in relation to chemical restraint practices were effective in making the required improvements.

In response to the Assessment Contact report, the approved provider’s response identified further updates to the restrictive practice policy and procedure have been made and the organisation has committed to providing additional education and training to staff on what constitutes chemical restraint.

The deficiencies identified above demonstrate that whilst a clinical governance framework exists it has not been effective across all areas of clinical care, including in response to the ongoing restrictive practice related deficiencies. For this reason, I find this requirement non-compliant.

# 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) – Consumers receive safe and effective personal and/or clinical care, including in relation to the management of restrictive practices.
* Requirement 8(3)(c) – Effective organisation wide governance system are in place relating to information management, continuous improvement, regulatory compliance and feedback and complaints.
* Requirement 8(3)(e) – An effective clinical governance framework is in place that covers all areas of clinical care, including restrictive practices.