Performance

Report

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| Name of service: | Warrina Innisfail |
| Service address: | Warrina St/ Tulip St Goondi QLD 4860 |
| Commission ID: | 5076 |
| Approved provider: | Warrina Innisfail |
| Activity type: | Assessment Contact - Site |
| Activity date: | 1 November 2022 to 2 November 2022 |
| Performance report date: | 12 December 2022 |

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 Warrina Innisfail (**the service**) has been prepared by B   
Bassett, 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 29 November 2022.
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Non-compliant |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

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.

* The organisation must undertake initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning must have a focus on optimising consumer health and well-being in accordance with consumers’ needs, goals and preferences.
* The organisation must deliver safe and effective personal and clinical care in accordance with consumers’ needs, goals and preferences to optimise health and well-being.
* The organisation must effectively manage high impact and/or high prevalence risks associated with the care of consumers.
* Consumers are to receive services and support for daily living that optimise consumers’ independence, health, well-being and quality of life and receive a variety of meals of suitable quality and quantity.
* The organisation must have effective organisation wide governance systems, including effective risk management systems and practices and effective monitoring of restrictive practices.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | 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. | Non-compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| 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 Standard is Non-compliant as one of the five Requirements is Non-Compliant. Deficiencies relate to:

* Risks to consumers’ health and well-being were not considered in assessment and planning processes.

Consumers and representatives did not consider that assessment and planning informed the delivery of safe and effective care to consumers. The assessment and planning documentation for a consumer entering the service on a two-week respite recorded they had diagnoses of hypertension, dementia and depression. However, care planning documentation did not consider strategies or interventions to manage the consumer’s risks of anxiety and advanced dementia behaviours. Staff were not provided any documentation to guide them in managing the consumer’s risks to ensure the safe delivery of care and services.

Staff said they were guided by information shared by registered staff concerning consumers’ care and service needs as they were too busy to read care plans and they were unable to connect clinical assessments and interventions to impacts on consumers wellbeing.

Consumers and representatives confirmed they were provided information from the service to enable them to make informed decisions regarding their current needs, goals and preferences. Most consumer’s advance care planning and end of life (EOL) wishes were included in their documentation.

Overall, consumers and representatives said they were engaged as partners regarding planning of consumer care and services and could obtain a copy of their care plan whenever they wished. Care planning documentation identified consultation with consumers and their representatives and staff described how changes to care and services are recorded and communicated.

The Approved provider’s response to the site audit report acknowledged risk enablement was not documented or included in the care planning process. The Approved provider advised they will create a schedule for reviews with consumers and representatives to involve them in assessment and care planning and develop a comprehensive clinical care documents register to support staff to identify when assessments should be completed.

I acknowledge the commitment of the Approved provider to address the Non-compliance in Requirement 2(3)(a), however, rectification actions are going to take time to be implemented and assessed for their effectiveness, therefore it is my decision that Requirement 2(3)(a) is Non-compliant.

# 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. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Non-compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| 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 Standard is Non-compliant as four of the seven Requirements are Non-compliant. Deficiencies relate to:

* Consumers did not receive personal and clinical care that was safe, best practice and individualised, including in relation to management of medication, falls, deterioration in health condition, and restrictive practices.
* High impact and high prevalence risks were not managed effectively
* Deterioration in consumers’ condition was not acted upon in a timely manner.
* Information relating to consumer care was not documented or shared when required.

Requirement 3(3)(a) had previously been found to be non-compliant. Recent incidents evidence that some consumer’s care continued to be unsafe and was not right for them or reflect their individual needs. A consumer who passed away on the 2nd day of a two-week respite did not have their personal and clinical care needs adequately documented or reflected in the care provided by staff and management. The consumer was recorded as being observed ingesting unprescribed medications and was suspected of taking further unprescribed medications when empty packets were found in his room. Administration of medication processes were identified as being unsafe as a medication trolley was left unattended and it was reported the door to the medication room was left unlocked.

Another consumer was commenced on a palliative pathway without clinical indications to support this decision. The consumer was administered intravenous EOL medications, despite reporting to her representative and staff she was not experiencing pain and in the absence of clinical indicators. The medications were immediately ceased at the request of the consumer’s representative. Investigation of the incident by the Approved provider found the consumer’s mental status, physical function, capacity and condition had been inaccurately assessed. This consumer was also witnessed by their representative and staff being subjected to unauthorised physical restraint. High-impact or high-prevalence risks associated for some consumers were not managed effectively or responded to in a timely manner.

Consumers said they can wait long periods of time for toileting assistance and delays in medication delivery results in consumers feeling anxious or suffering side effects such as tremors.

Environmental restraints were not applied by the service in accordance with regulatory requirements. The Assessment Team identified 42 independently mobile consumers who were unable to access the main building without staff assistance. The consumers did not have authorisations for environmental restraint or an assessment of Behaviour Support Plan (BSP) identifying the reason for the restraint.

Review of care documentation and interviews with consumers representatives identified unauthorised use of chemical restraint on some consumers, and where consent was provided the risks, benefits and consequences of these restraints were not discussed.

Care planning documentation generally reflects the identification of, and response to, deterioration or changes in a consumer’s health. However, review of care documentation identified several instances where consumers’ deterioration was not effectively identified and/or responded to. Care planning documentation for 3 consumers did not contain adequate information to support effective and safe sharing of the consumer’s information in providing care. Appropriate referrals to other care services were not actioned in a timely manner.

For consumers sampled, care documentation reflected individualised preferences regarding EOL care and staff were able to describe supports provided to consumers nearing EOL.

Consumer care documentation evidenced referrals were made when required and the service uses alternate means to allow review and assessment by other providers.

The Approved provider has documented policies, procedures, and an outbreak management plan to guide staff in relation to antimicrobial stewardship, infection control and for the management of a COVID-19 outbreak. The Infection Prevention Control (IPC) Lead and staff were able to provide examples of practices to prevent and control infections and consumers and representatives expressed satisfaction in the service’s management of infection related risks

The Approved provider’s response acknowledged the deficits identified. The Approved provider committed to establishing a system wide clinical care management process to promote the safety, health and well-being of consumers. Actions identified by the Approved provider included strengthening the clinical staffing structure providing a clinical management and care pathway system that reduces reliance on individual registered staff, aligning clinical care practices with best practice models and providing increased education to staff in management of high impact and high prevalence risks.

The Approved provider also committed to comprehensive staff training regarding restrictive practice requirements, review of the care planning documentation of all consumers subject to restrictive practice and review of the service’s psychotropic register to identify any consumers subject to restrictive practice without the requisite legislative requirements being in place.

Incidents involving consumers are to be reviewed and analysed to address trends and applicability to care delivery and documentation of unplanned deterioration is to be improved to ensure effective responses.

While acknowledging the Approved provider’s undertaking to address the deficits identified by the Assessment Team, at the time of the site audit, Requirements 3(3)(a), 3(3)(b), 3(3)(d) and 3(3)(e) were non-compliant and my decision is that these Requirements are non-compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Non-compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Non-compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Non-compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

This Quality Standard is Non-compliant as three of the seven Requirements are Non-compliant. Deficiencies relate to:

* Consumers did not receive safe and effective support for daily living that optimises their health, well-being and quality of life.
* Consumers felt that they were not supported to participate in the life of the community both within and outside the service.
* Consumers expressed dissatisfied with their meals.

Some consumers and representatives expressed dissatisfaction with services and supports for daily living and said they did not receive safe and effective support for daily living activities that optimises their health, well-being or quality of life. Consumers said staff do not help them to go outside, choose activities or assist with meals when requested.

It was identified the consumer survey to assess the consumer’s satisfaction with the care and services provided has not been completed for the year 2022. The service has not assessed whether activities provided meet consumer’s needs, goals or preferences.

Services and supports for daily living do not assist consumers to participate in their community, have social and personal relationships or do the things of interest to them. The Assessment Team observed consumers in communal areas being left for long periods of time without staff assistance or engagement and staff said they offer consumers the option to sit in their room and watch TV or sit in the lounge room due to a lack of staff to provide other activities. A publishable version of the activity schedule was not available.

External consultants engaged by the Approved provider found the service does not provide enough activities for consumers living with dementia and consumers living with dementia were observed sitting in chairs for long periods of time and wandering the service in the absence of exercises or activities to stimulate them. In responding to this feedback, management said they have developed an activity schedule to be implemented on 4 November 2022. The new schedule was provided to the Assessment Team.

Most consumers and representatives sampled expressed dissatisfaction with meals. Feedback included criticisms that meals often lacked taste, portion sizes were too small, and foods were difficult to chew. Documentation showed consumers had raised numerous complaints in relation to food quality and quantity. The feedback register did not document outcomes of the service’s investigation into the complaints or actions taken to address these complaints.

The service was able to demonstrate that consumers receive support that is tailored to their emotional, spiritual and psychological well-being including documentation and acknowledgement of consumer’s cultural heritage and preference for their cares to be provided by female or male staff.

Representatives said they are kept informed of the consumer’s condition. Staff described process to ensure they are updated on any consumer’s changing condition, needs or preferences as they relate to services and supports for daily living.

The service was able to demonstrate timely and appropriate referrals are made to other providers of care and services, when required

Staff confirmed they have access to all equipment required to perform their role, said they had received training in manual handling and that they felt confident to use hoist equipment in a safe manner. Consumers confirmed they felt equipment provided was safe, clean and well maintained.

The Approved provider’s response acknowledged insufficient dementia specific activities for consumers and that consumers living with dementia are not provided access to outdoor areas on a regular basis. It was acknowledged there had been problems in providing consumers with a calendar of lifestyle activities. The Approved provider’s response advised they will engage with consumers and representatives regarding lifestyle activities, conduct a consumer survey and review the lifestyle program to develop a program that reflects consumers’ activities of choice. The Approved provider will also review the menu and ensure consumers are included in the menu design and that all future menus are reviewed by a Dietician prior to implementation.

The actions proposed by the Approved provider in relation to deficiencies in this Standard have not convinced me the service is providing safe and effective services and supports for daily living to meet consumer’s needs at this time. Therefore, it is my decision that Requirements 4(3)(a), 4(3)(c) and 4(3)(f) are non-compliant.

# 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. | Non-compliant |
| Requirement 8(3)(d) | 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. | Non-compliant |
| Requirement 8(3)(e) | 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. | Non-compliant |

Findings

This Standard is Non-compliant as three of the three Requirements assessed are Non-compliant. Deficiencies relate to:

* Ineffective organisation wide governance systems relating to information management, continuous improvement, regulatory compliance and feedback and complaints.
* Ineffective risk management systems and practices, including managing high impact of high prevalence risks associated with the care of consumers and managing and preventing incidents, including the use of an incident management system.
* Ineffective clinical governance framework regarding the minimisation of the use of restraint.

The Assessment Team identified deficits in organisational governance frameworks preventing effective oversight of information management, continuous improvement, regulatory compliance, complaints and feedback. Deficits in staff knowledge compromised the service’s effective application of its clinical governance framework and compliance with regulatory requirements, particularly regarding the application of restrictive practices and the escalation and reporting of serious incidents. Requirements 8(3)(c) and 8(3)(e) had previously been found to be non-compliant.

Whilst the service has established organisational governance policies, the Approved provider does not have effective processes to implement them. At the time of the site audit, the service was operating with two feedback registers and two plans for continuous improvement (PCI). In each instance, one was being maintained by the service and the other by external contractors. The information recorded in the documents was inconsistent and review of the service’s PCI did not include actions to improve the quality of care and services identified from feedback and complaints by consumers and representatives. Consumers and representatives sampled did not consider feedback and complaints were effectively reviewed and actioned by management. Consumer feedback surveys were not documented since March 2022. While consumer feedback is captured, information is not always shared, resulting in the service not recording, investigating or actioning consumer’s feedback and complaints. Management acknowledged the duplication of the registers and an inability to effectively track and trend feedback and complaints and continuous improvement actions across multiple sources. Management advised they would transfer the information in the service registers into those developed by the external contractors.

The Approved provider evidenced financial governance arrangements to support the changing needs of consumers and workforce governance arrangements to ensure the workforce is competent and enabled to deliver safe and quality care and services.

Review of documentation and interviews with staff identified gaps regarding the management, escalation and reporting of serious incidents where consumers may have been subject to abuse and/or neglect. Whilst the service maintains a Serious Incident Response Scheme (SIRS) register, some incidents reported to be notified by the service were not reflected in the service’s register. Incidents of a serious nature that may require notification to the Commission were not always identified and escalated to the appropriate party for notification. Staff did not demonstrate consistent understanding of regulatory requirements, resulting in incidents not being reported under SIRS.

Whilst the service has an established clinical governance framework, gaps in staff knowledge, clinical oversight and information management have resulted in adverse clinical outcomes for consumers. The Assessment Team identified a large number of consumers subject to environmental restraint that had not been identified by the Approved provider. Consumer representatives advised they had provided consent for the use of chemical restraint without the side effects of the medication used being discussed with them.

The Approved provider has committed to addressing the Non-compliances identified at the Site audit. Information systems will be streamlined and processes developed to educate staff regarding the correct storage of documents. The Approved provider response acknowledged systems have not been effective in identifying staff knowledge deficiencies in relation to chemical restrictive practice.

It is my decision governance systems will need time to be implemented and tested to ensure their effectiveness. Therefore, it is my decision Requirements 8(3)(c), 8(3)(d) and 8(3)(e) are non-compliant.

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)