Performance

Report

**1800 951 822**

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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: | 6 February 2023 to 8 February 2023 |
| Performance report date: | 14 March 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 Warrina Innisfail (**the service**) has been prepared by T Wurf, 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 2 March 2023
* the Performance Report dated 12 December 2022 following an assessment contact undertaken from 1 November 2022 to 2 November 2022
* the Assessment Contact Report for the assessment contact undertaken from 1 November 2022 to 2 November 2022
* other information and intelligence held by the Commission.

# 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.

* Requirement 2(3)(a) – Ensure that relevant risks to consumers are adequately assessed and are included in care planning documents, including for, but not limited to, consumers who have insulin-dependent diabetes and consumers who experience falls.
* Requirement 3(3)(e) – Ensure information about consumers’ conditions, needs and preferences are documented and communicated within the organisation.
* Requirement 4(3)(c) – Ensure consumers are provided with activities that are individualised, suitable and of interest to them, and they are supported to participate in the community, within and outside the service.
* Requirement 8(3)(c) – Ensure effective organisation-wide governance systems relating to information management, continuous improvement, regulatory compliance, and feedback and complaints.
* Requirement 8(3)(d) – Ensure effective risk management systems and practices, including, but not limited to, incident management.
* Requirement 8(3)(e) – Implement an effective clinical governance framework.

# 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 |

Findings

The performance report dated 12 December 2022 following an assessment contact undertaken from 1 to 2 November 2022 found the service non-compliant with requirement 2(3)(a) because risks to consumers’ health and well-being were not considered in assessment and planning processes, including for a consumer with multiple diagnoses and complex behaviours. Staff also reported they did not read consumer care documentation.

The Assessment Contact Report identified deficiencies in the service’s assessment and care planning, specifically related to consumers with insulin-dependent diabetes and a consumer who continued to experience falls.

The service had implemented some actions in response to the previous decision of non-compliance and to improve assessment and care planning processes, including establishing a ‘resident of the day’ and three-monthly care plan review processes, and improving staff access to consumer care documentation. However, the Assessment Contact Report identified:

* for three consumers, medical officer directives for the management of insulin-dependent diabetes were not included in care planning documents. Whilst the service updated the care planning documents for those consumers during the assessment contact, I am not satisfied the service’s processes for assessment and planning are effective; and
* a named consumer identified in the previous Assessment Contact Report (for the activity undertaken 1 to 2 November 2022) as a high-falls risk and who had experienced falls as a result of their vision impairment and environment still had not had their mobility care plan updated since February 2022, strategies to manage environmental risks of falling had not been considered (beyond relocating the consumer to another room), the consumer was not confident in the ability of staff to assist with mobilising, and the consumer continued to experience falls. I am not satisfied that appropriate assessment and planning to manage the risk of falling has been undertaken for this consumer.

The approved provider’s response accepted the findings in Assessment Contact Report. Therefore, based on the findings above, it is my decision requirement 2(3)(a) is non-compliant as relevant risks to consumers have not been adequately assessed and included in care planning documentation.

# 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 |
| 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. | 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 |

Findings

The performance report dated 12 December 2022 following an assessment contact undertaken from 1 to 2 November 2022 found the service non-compliant with requirements 3(3)(a), 3(3)(b), 3(3)(d) and 3(3)(e). Deficiencies related to management of:

* medication, falls, deterioration in health condition, and restrictive practices;
* high-impact risks associated with consumers’ falls, medication and end-of-life care;
* deterioration in consumers’ condition that was not acted upon in a timely manner; and
* information relating to consumer care not being documented or shared when required.

*Requirement 3(3)(a)*

The Assessment Contact Report identified actions implemented by the service to improve the service’s performance in this requirement. Actions included:

* reviewed consumers with complex and specialised care needs in October 2022;
* restructured the roles of the three clinical managers to include the clinical oversight of designated areas of the service, and appointed clinical champions in each area to support staff and clinical managers;
* implemented various review processes, including:
  + a ‘resident of the day’ process (commenced in November 2022), which includes comprehensive reviews of the consumer
  + annual case conferences (completed in January 2023);
* implemented clinical registers in November 2022 to assist clinical leaders and champions to manage and monitor consumers in their areas; and
* several actions to improve the management of restrictive practices, including reviewing consumers, training staff and implementing new monitoring and reporting systems.

The Assessment Contact Report identified that consumers and representatives were satisfied with the care consumers receive. Care documentation reviewed by the Assessment Team demonstrated appropriate identification, assessment, management and evaluation of consumers’ pain management, restrictive practices, and skin integrity. Where restrictive practices are used, assessments, authorisation, consent, and monitoring were demonstrated and behaviour support plans were in place. Staff described consumers’ individual care needs and confirmed they have easy access to care plans and consumer information.

The service collates information on incidents monthly and provides information to staff and organisational management. The service has policies and procedures in place that guide staff in providing best clinical practice.

I accept the improvements identified in the Assessment Contact Report, positive feedback from consumers and representatives, and broader evidence about the service’s management of areas of clinical care. Therefore, I have decided that requirement 3(3)(a) is compliant.

*Requirement 3(3)(b)*

The Assessment Contact Report identified actions implemented by the service to improve the service’s performance in this requirement. Actions included:

* reviewed consumers with complex and specialised care needs in October 2022;
* improved staff access to consumer care information, including behaviour support strategies to assist care and hospitality staff to support consumers with complex behaviours; and
* established weekly meetings with clinical leaders and clinical champions to discuss consumers and risk areas including falls, weight loss and behaviours.

The Assessment Contact Report identified that care planning documentation recorded risks to individual consumers, including in relation to falls, skin integrity, and changed behaviours, and included directives for staff to manage and monitor those consumers.

I accept the improvements identified in the Assessment Contact Report and documentary evidence about the service’s management of high impact, high prevalence risks to consumers. Therefore, I have decided that requirement 3(3)(b) is compliant.

*Requirement 3(3)(d)*

The Assessment Contact Report identified actions implemented by the service to improve the service’s performance in this requirement. Actions included:

* restructured the roles of the three clinical managers to include the clinical oversight of designated areas of the service, and appointed clinical champions in each area to support staff and clinical managers; and
* implemented a ‘resident of the day’ process (commenced in November 2022), which includes comprehensive reviews of the consumer.

Overall, consumers and representatives said staff respond promptly to consumers’ needs. Care planning documents reviewed by the Assessment Team demonstrated changes to a consumer’s health or condition were recognised and responded to, including for two consumers whose condition deteriorated and they were commenced on a palliative care pathway. Staff described the ways they recognise and respond to deterioration or change in a consumer’s condition.

Whilst I note that the above improvement actions are yet to be tested for effectiveness, I accept the findings outlined in the Assessment Contact Report, including positive feedback from consumers and representatives and evidence in care documentation that demonstrates deterioration and changes in a consumer’s health are recognised and responded to. Therefore, I have decided that requirement 3(3)(d) is compliant.

*Requirement 3(3)(e)*

The Assessment Contact Report identified deficiencies in the service’s process to document and communicate information, specifically related to the management of insulin-dependent diabetes and when a consumer is transferred to hospital. Whilst improvement actions to address previous non-compliance in this requirement were noted on the service’s plan for continuous improvement, no progress against those actions was documented. Management advised actions taken to improve the service’s performance in this requirement included:

* restructured the roles of the three clinical managers to include the clinical oversight of designated areas of the service, and appointed clinical champions in each area to support staff and clinical managers;
* rostering a registered nurse and enrolled nurse on evening and weekend shifts to increase clinical oversight;
* established weekly meetings with clinical leaders and clinical champions to discuss care planning, medication management and high impact/high prevalence risks; and
* implemented a register to record instances where clinical incidents have been documented but not escalated.

Despite these stated improvements, the Assessment Contact Report identified three consumers for whom medical officer directives for the management of insulin-dependent diabetes were not included in care planning documents. One of these named consumers experienced blood glucose levels outside acceptable parameters on 12 occasions over a two month period, which were not escalated for medical review as per the medical officer’s directives. Whilst the service updated the care planning documents for those consumers during the assessment contact, I am not satisfied the service has effective processes to ensure information about consumers’ needs are documented and communicated within the organisation. Additionally, another consumer’s care documentation did not record relevant information about that consumer’s transfer to hospital.

The approved provider’s response accepted the findings in Assessment Contact Report. Therefore, based on the findings above, it is my decision requirement 3(3)(e) is non-compliant as the service’s processes to ensure information about a consumer’s condition and needs are documented and communicated within the organisation are ineffective.

# 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. | 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)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

The performance report dated 12 December 2022 following an assessment contact undertaken from 1 to 2 November 2022 found the service non-compliant with requirements 4(3)(a), 4(3)(c), and 4(3)(f), based on:

* Consumers did not receive safe and effective support for daily living that optimises their health, well-being and quality of life.
* Consumers were not provided with activities that were suitable or of interest to them and were not supported to participate in the community either within or outside the service.
* Consumers were dissatisfied with meals.

*Requirement 4(3)(a)*

The Assessment Contact Report identified actions implemented or planned by the service to improve the service’s performance in this requirement. Actions included:

* implemented monthly consumer/representative meetings to determine activities of interest to the consumer cohort;
* sent letters to families requesting information about consumer preferences for activities and supports for daily living;
* commenced a ‘resident of the day’ process to determine individual preferences (action in progress); and
* recruiting for a lifestyle manager.

Consumers were satisfied they receive support for daily living that meets their needs and preferences. The Assessment Team observed consumers engaging with others, and participating in group and individual activities that those consumers confirmed were of interest to them.

Whilst I note that some of the above improvement actions are yet to be fully implemented and the effectiveness of other actions has not been tested, I accept the findings outlined in the Assessment Contact Report, including positive feedback from consumers and the Assessment Team’s observations. Therefore, I have decided that requirement 4(3)(a) is compliant.

*Requirement 4(3)(c)*

The Assessment Contact Report identified deficiencies in this requirement. For example:

* Consumers, representatives and management reported that the services and supports for daily living are not individualised to consumers’ needs or interests.
* Suitable activities are not available for consumers with physical and/or cognitive impairments.
* Lifestyle activities are not provided on weekends.
* Generally, consumer care documentation contains minimal information about preferred activities, social and personal relationships, and how consumers wish to participate in the community.

The approved provider’s response accepted the findings in Assessment Contact Report. Therefore, based on the findings above, it is my decision requirement 4(3)(c) is non-compliant as consumers are not provided with activities that are suitable or of interest to them and are not supported to participate in the community, either within or outside the service.

*Requirement 4(3)(f)*

The Assessment Contact Report identified several improvement actions completed or commenced to improve the service’s performance in this requirement. Completed actions included:

* employed a new head chef;
* changed the menu and engaged new suppliers of produce;
* meals are now prepared onsite; and
* established food focus groups with consumers.

Consumers reported they were satisfied with the new meals offered at the service and said that when there is a meal they don’t like, they are offered an alternative.

I accept the improvements identified in the Assessment Contact Report and I have given weight to the positive feedback from consumers about meals and options. Therefore, I have decided that requirement 4(3)(f) is 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

The performance report dated 12 December 2022 following an assessment contact undertaken from 1 to 2 November 2022 found the service non-compliant with requirements 8(3)(c), 8(3)(d) and 8(3)(e). Deficiencies related to:

* Ineffective organisational governance systems related to feedback and complaints, continuous improvement and regulatory compliance.
* Inconsistent management, escalation and reporting of serious incidents.
* Ineffective clinical governance framework which resulted in adverse outcomes for consumers.

*Requirement 8(3)(c)*

The Assessment Contact Report identified deficiencies with the service’s organisational governance systems and those actions implemented to improve documenting of complaints, review and documentation of consumers’ care, and monitoring incident reports have been ineffective. For example:

* Information management systems are ineffective. Care planning information was not accurate, current, or sufficient to guide the delivery of care. Staff were inaccurately recording information in progress notes. Information sharing between care and kitchen staff was ineffective. Sensitive and private information was not stored appropriately.
* Continuous improvement – processes to ensure the service’s plan for continuous improvement is current and maintained are ineffective. The service was unable to demonstrate how feedback and complaints are used to inform improvement activities.
* Feedback and complaints – complaints were inconsistently recorded in the service’s electronic complaints register. Consumers and representatives reported dissatisfaction with the service’s response to complaints.
* Regulatory compliance – whilst the service has commenced staff training in relation to the serious incident response scheme (SIRS) and staff demonstrated an understanding of SIRS, SIRS incidents were not consistently reported in line with legislative timeframes.

The approved provider’s response accepted the findings in Assessment Contact Report. Therefore, based on the findings above, it is my decision requirement 8(3)(c) is non-compliant as organisational governance systems are ineffective in relation to information management, continuous improvement, feedback and complaints and regulatory compliance.

*Requirement 8(3)(d)*

The Assessment Contact Report identified that whilst some improvement actions were implemented to address the previous decision of non-compliance (staff education and training, flow chart, and monitoring progress notes), these were ineffective and there are deficiencies in the service’s management and reporting of incidents. For example:

* staff do not consistently report serious incidents to management;
* incident reporting is incomplete, both in individual reports and the service’s SIRS register;
* incidents of abuse and neglect were not consistently reported within SIRS legislative timeframes;
* serious incidents documented in consumers’ progress notes were not routinely reported through the service’s incident reporting processes; and
* whilst the service has a process to monitor incident reporting via a weekly progress note checks, this process has been ineffective.

The approved provider’s response accepted the findings in Assessment Contact Report. Therefore, based on the findings above, it is my decision requirement 8(3)(d) is non-compliant as risk management systems and practices have been ineffective in managing and reporting incidents.

*Requirement 8(3)(e)*

The Assessment Contact Report identified that whilst the service is designing a new clinical governance framework, there are deficiencies in clinical governance. For example, inconsistent management of serious incidents and ineffective information management that has resulted in consumers’ clinical care information not being accurately documented and communicated to staff. These deficiencies have presented a risk of adverse clinical outcomes.

The approved provider’s response accepted the findings in Assessment Contact Report. Therefore, based on the findings above, it is my decision requirement 8(3)(e) is non-compliant as clinical governance systems have been ineffective in managing serious incidents and ensuring consumers’ clinical care information is accurate and communicated to staff.

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)