Kara House Nursing Home

Performance Report

47 Webb Street   
CLARE SA 5453  
Phone number: 08 8842 6565

**Commission ID:** 6016

**Provider name:** Yorke and Northern Local Health Network Incorporated

**Assessment Contact - Desk date:** 29 June 2020

**Date of Performance Report:** 21 July 2020

# Publication of report

This Performance Report **may 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 8 Organisational governance** | **Compliant** |
| Requirement 8(3)(d) | Compliant |

# Detailed assessment

This performance report details the Commission’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 - Desk; the Assessment Contact - Desk report was informed by review of documents and interviews with consumers, representatives, staff and management
* the provider’s response to the Assessment Contact - Desk report received 14 July 2020.

# STANDARD 8 COMPLIANT Organisational 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 Quality Standard is assessed as Compliant as one of the five specific Requirements has been assessed as Compliant. An overall assessment of all Requirements in this Standard was not completed.

The purpose of the Assessment Contact - Desk was to assess the performance of the service in relation to Requirement (3)(d) in this Standard. This Requirement was found Non-compliant following an Assessment Contact – Site conducted 23 February 2020.

The Assessment Team recommended Requirement (3)(d) in Standard 8 as met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 8 and find the service is Compliant with Requirement (3)(d).

At an Assessment Contact – Site conducted 23 February 2020, the Decision Maker found the service needed to ensure appropriate protections and safeguards around the delivery of care and services to respond effectively to incidents of abuse and to report these according to the law. This related to a male consumer, who did not have a diagnosis of dementia, allegedly displaying sexually inappropriate interactions towards the same female consumer on three occasions. The first incident occurred in September and was not reported until November 2019, placing the consumer at risk. A third incident occurred in January 2020.

In relation to Requirement (3)(d), the service has implemented a range of actions to address the deficiencies identified which I have detailed below.

## Assessment of Standard 8 Requirements

### 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.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the last Assessment Contact - Site, including:

* Additional on-line training has been provided to all staff in relation to:
* Preventing elder abuse
* Mandatory reporting and relevant obligations
* Incident reporting
* The use of the organisation’s electronic system for reporting incidents.
* Training relating to the Quality Standard 8 provided to staff to improve their understanding of what is expected.
* Additional face to face education provided to consolidate on line education and to ensure staff understanding of requirements.
* Education and training on how to conduct and implement audits effectively provided to relevant staff.
* Management stated the number of incident reports being completed has increased and quality of information documented on the reports has improved.
* Incident report data is being used to identify trends and behaviours of concern.
* Implemented daily ten by ten meetings to improve communication with staff in relation to incidents and behaviours of concern.
* A weekly Clinical risk meeting has been introduced with a focus on consumers at increased risk. Staff reported this has improved how clinical risks are addressed.
* Elder abuse has been included as a standing agenda item for meetings.
* Clinical risks identified for consumers named in the Assessment Team’s report have been addressed.

The approved provider’s response demonstrated they agreed with the Assessment Team’s findings.

In relation to Standard 8 Requirement (3)(d), information provided to the Assessment Team by management and staff through interviews demonstrated:

The organisation has a documented risk management framework, including policies describing how:

* high impact or high prevalence risks associated with the care of consumers is managed
* the abuse and neglect of consumers is identified and responded to
* consumers are supported to live the best life they can.

Staff interviewed were aware of these policies and described what they meant to them in practice. Staff had been educated about the policies and provided examples of their relevance to their work.

Incident reporting has improved and is now used to inform meetings and monthly clinical and key performance indicator reporting and analysis. Documentation viewed by the Assessment Team demonstrated incident reporting has resulted in identification of additional continuous improvement activities beyond improvements implemented to address the Non-compliance.

The organisation monitors the approved provider’s compliance with this Requirement through monthly reporting to the Board and performance discussions with management.

# 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, however, required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.