Performance

Report

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| Name of service: | Kadimah Nursing Home |
| Service address: | 6 Cedar Street KILLARNEY QLD 4373 |
| Commission ID: | 5455 |
| Approved provider: | Killarney Memorial Aged Care Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 22 May 2023 to 23 May 2023 |
| Performance report date: | 21 June 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 Kadimah Nursing Home (**the service**) has been prepared by J. Earnshaw, 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
* other information and intelligence held by the Commission in relation to the service

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **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 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 |

Findings

The service was found non-compliant under this requirement following a Site Audit conducted 19 to 21 July 2022. Deficiencies related to the service being unable to demonstrate the monitoring of restrictive practices, consumers’ weight and fluid restriction needs. Consumers who were subject to restrictive practices did not have documented consent or risk assessments completed.

The assessment contact conducted 22 to 23 May 2023 found the service had taken action to improve performance under this requirement. The service demonstrated implemented interventions to ensure restrictive practises are monitored adequately including increased clinical oversight, staff training and the engagement of an external nurse consultant to complete quarterly reviews of clinical practice.

The service has undertaken a review of the psychotropic register and identified consumers who are subject to restrictive practice, for example, those consumers who are not provided with an access card have been identified as being subject to an environmental restrictive practice.

The service has commenced a weekly review of restrictive practices and care planning documentation relating to restrictive practices such as risk assessments and behaviour support plans are reviewed every 3 months and reviewed by the Medical Officer or as required if a consumer’s condition or circumstances change.

The service was able to demonstrate that medication reviews are completed for each consumer every 3 months by a pharmacist, reporting against polypharmacy risks and chemical restrictive practices.

The clinical management team complete weekly ‘resident of the day’ reviews to monitor clinical data such as weights and observations.

The service has implemented, under the Medical Officer’s guidance, as applicable, daily monitoring of consumers’ weight rather than restricting fluid. Weight monitoring outside of the monthly schedule, is added to the medication chart as a prompt for registered staff. Unplanned weight loss triggers a referral to a dietician and nutritional supplements/ foods and fluid charting are commenced.

Where restrictive practices are in place, assessments, informed consent from consumers and /or representatives and monitoring were demonstrated. Behaviour support plans are in place for consumers who are subject to restrictive practices. Review of documentation confirms consumers’ medication is reviewed regularly by the Medical Officer.

Representatives of consumers subject to restrictive practices reported that the service has communicated with them regarding the risks and benefits of the restrictive practice and to gain informed consent.

Care planning documentation for consumers demonstrated effective assessment, management and evaluation of restrictive practices, and monitoring of consumer weight and fluid intake.

In coming to my decision for this requirement, I have considered the information included in the assessment team report under this and other requirements alongside the approved provider’s compliance history and the demonstrated continuous improvement evidenced by the implementation of activities of improvement.

Therefore, I am satisfied that the service has addressed the deficiencies identified under this requirement, and find this Requirement compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |

Findings

The service was found non-compliant under this requirement following a Site Audit conducted 19 to 21 July 2022. Deficiencies related to the service being unable to demonstrate consumers had the freedom to access outdoor garden areas which also posed a falls risk. Consumers who choose to smoke were not adequately supervised by staff and the smoking area did not have emergency equipment available. The medication of consumers who self-medicate was not stored securely.

The assessment contact conducted 22 to 23 May 2023 found the service had taken action to improve performance under this requirement. Actions included:

* relocation of the smoking area to be closer to the main building, with emergency equipment and closed-circuit camera systems which alerts clinical staff when a consumer enters the smoking area.
* increased access to the outdoor areas which have been improved to address the previous falls risk.
* Some consumers were provided with access cards to move freely indoors and outdoors and other consumers were assessed for environmental restrictive practice.
* consumers who self-medicate are monitored and have been provided a locked drawer to store their medication.

The Assessment Team report provided information that consumers were observed moving freely throughout the service and accessing the outdoor spaces with footpaths that were observed to be clear of any obstacles.

The smoking area was observed to be clean and contained appropriate emergency equipment.

The Assessment Team observed staff to be assisting consumers to the smoking area and consumers accessing the smoking area independently.

Management advised the assessment Team, and observations confirmed, the service has a process to manage the self-administration of medication independently by some consumers.

In coming to my decision for this requirement, I have considered the information included in the assessment team report under this and other requirements alongside the approved provider’s compliance history and the demonstrated continuous improvement evidenced by the implementation of activities of improvement.

Therefore, I am satisfied that the service has addressed the deficiencies identified under this requirement and find this Requirement compliant.

# Standard 8

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| Organisational governance | |  |
| 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. | 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. | Compliant |

Findings

The service was found non-compliant under these requirements following a Site Audit conducted 19 to 21 July 2022. Deficiencies related to the service being unable to demonstrate adequate monitoring of safe self-administration of medication or sufficient weight and fluid management. For restrictive practices, assessments, informed consent from consumers/ representatives and monitoring were not demonstrated.

The assessment contact conducted 22 to 23 May 2023 found the service had taken action to improve performance under this requirement. Actions included:

The service has engaged an external nurse consultant and implemented a ‘resident of the day’ process to review care documentation and clinical data.

The service has restructured the service’s registered staff monthly meeting to include as standing agenda items: investigation of overdue documentation, review of consumers subject to restrictive practices, unplanned weight loss, medication management, audit and compliance reports.

The organisation’s monthly clinical governance meeting has been restructured to include a formal agenda covering topics such as internal clinical and risk audits, quality indicators, clinical data and trending. This information is shared with the Board.

Management undertakes a daily review of a clinical indicator checklist, with oversight by senior clinical staff and management to guide and monitor registered staff practise in the review and monitoring of specific tasks, such as consumer weight management, restrictive practice and wound care.

Consumers who self-manage medications have been issued with a secure storage unit for medications, are provided limited quantities of medication and are monitored by staff daily to ensure medications have been taken as prescribed.

The service conducts a weekly restrictive practice audit and has included restrictive practice as a standing agenda item at the service’s Board and internal clinical governance meetings.

The service has introduced mandatory training on restrictive practices for all staff annually and on commencement of employment. Management and senior clinical staff have been enrolled in a leadership program to build accountability and responsibility within their specific roles.

The service has engaged a pharmacist and geriatrician to review all medications every 3 months with specific focus on consumers subject to chemical restrictive practise and under behaviour management.

A memory support specific unit was introduced and consumers residing in this area of the service, who do not have access cards have been appropriately assessed for and have authorisation and consent for environmental restrictive practice.

The service demonstrated established governance frameworks, with policies and procedures that support the management of risks associated with the care of consumers, including identifying consumers with high impact and high prevalence risks. Clinical data including restrictive practices and weight management are reported, trended and analysed on a monthly basis. Staff demonstrated an understanding of consumers with high impact or high prevalence risks, including fluid restriction requirements and weight management processes.

The organisation has a documented clinical governance framework, that includes policies and processes that monitor how clinical risks are managed.

Staff demonstrated awareness of restrictive practices and consumers who self-manage medications, and procedures to ensure medication is stored safely and administered as required.

Regular quality meetings are conducted, and discussion includes, clinical risk, polypharmacy, clinical indicator data, and audit results.

In coming to my decision for these requirements, I have considered the information included in the assessment team report under this and other requirements alongside the approved provider’s compliance history and the demonstrated continuous improvement evidenced by the implementation of activities of improvement.

Therefore, I am satisfied that the service has addressed the deficiencies identified under these requirements and find these Requirements 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)