Performance

Report

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| Name: | Kalyna Care |
| Commission ID: | 3162 |
| Address: | 344 Taylors Road, DELAHEY, Victoria, 3037 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 17 July 2024 to 18 July 2024 |
| Performance report date: | 15 August 2024 |
| Service included in this assessment: | Provider: 933 Ukrainian Elderly People's Home  Service: 1921 Kalyna Care |

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 Kalyna Care (**the service**) has been prepared by J Cayabyab, 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 (performance assessment) – 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 9 August 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 7** Human resources | **Not Compliant** |
| **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

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 7(3)(a) – The Approved Provider must demonstrate staffing levels and mix is planned to ensure delivery of safe and effective care and services to consumers. The service should ensure accurate reporting of mandatory care minutes requirements.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

The Assessment Team Report recommended the service is non-compliant with Requirement 3(3)(b). With consideration to the available information and the Approved Provider response, I have come to a different view.

The Assessment Team Report identified deficiencies related to effective monitoring and management of high impact high prevalence risks associated to consumers including restrictive practices, changed behaviours, pain, falls, and continence care. The Assessment Team reported that the service did not demonstrate a shared understanding of restrictive practices including the effective identification, monitoring, and management of consumers subject to seclusion and the completion of informed consent for consumers subject to chemical restrictive practices.

The Approved Provider submitted a response to the Assessment Team Report which provided further information and evidence around the concerns related to restrictive practices and complex clinical care. The response included documented evidence of consultation undertaken with relevant consumers and representatives, as well as efforts made to strengthen staff performance management and staff education. The Approved Provider’s response also highlighted their continuous improvement efforts to strengthen incident reporting and investigation including mandatory incident reporting for inappropriate use of seclusion, and the service undertook relevant review and update of other documentation for continuous improvement.

I acknowledge the Approved Provider’s actions related to management of pain, falls, changed behaviour, and continence care and am reassured there are effective systems in place to support these aspects of care for each consumer.

I note the identified deficits related to potential use of seclusion strategies for changed behaviour. I acknowledge that this was identified by the Assessment Team and the service immediately addressed concerns at the time of the Assessment Team attendance at the service. I also note the Approved Provider’s response around elements of seclusion for the consumer mentioned in the Assessment Team Report, highlighting that there is evidence that the Approved Provider has conducted adequate assessments in consultation with the representative following the Assessment Team attendance and now comply with their obligations to the criteria related to environmental restrictive practices.

As a result, I am satisfied this Requirement is Compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | 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. | Not Compliant |

Findings

The Assessment Team Report recommended the service is non-compliant with Requirement 7(3)(a).

Deficiencies identified related to management understanding of the mandatory care minutes reporting requirements, and staff shortages, with examples of this negatively impacting on the delivery of care and services for consumers.

The Approved Provider submitted a response to the Assessment Team Report with further information and context around the identified deficiencies. The Approved Provider acknowledged the concerns raised in relation to key personnel demonstrating an understanding gap of the mandatory care minutes requirements and provided evidence of education completed by the service. In relation to the staffing deficiencies, the response included specific actions including implementation of the daily roster register to identify unplanned leave, roster monitoring system for every shift to monitor staff coverage in each area, transition of casual staff to permanent employment, and increased recruitment drive which has provided full shift coverage for the service.

I acknowledge the Approved Provider’s actions related to staff knowledge gap on the mandatory care minutes requirements and I am reassured that the education undertaken by the key personnel will support the service for the appropriate reporting of their care minutes requirements.

I note however that the deficits related to staff shortages including significant number of unfilled shifts and unplanned leave with clinical staff has impacted clinical care for consumers as evidenced in this Requirement and Requirement 3(3)(b). I also acknowledge the actions taken by the service around recruitment and the additional measures implemented to ensure adequate staff coverage every shift. In coming to my decision, I have weighed the evidence including the Approved Provider response and the Assessment Team Report. I have considered consumer and representative feedback in relation to the impact of insufficient staffing in their care, staff interview and documentation review confirming staff shortages and unfilled shifts not being replaced, and the Assessment Team’s observation during the site visit. I am of the view that there is ongoing concern, and the implementation of remediation actions will require further time to ensure the measures are embedded into practice and evaluated for effectiveness. As a result, I find Requirement 7(3)(a) is Not Compliant.

# Standard 8

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| Organisational governance | |  |
| 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 organisation has established a clinical governance framework which provides guidance to staff and the service when providing care and services to consumers. The organisation also evidenced reporting mechanism and systems that demonstrate effective oversight of clinical governance. Monthly reports are provided to the board including, clinical management, incidents, trend analysis, feedback, infections and audit results. The organisation demonstrated appropriate staff education related to relevant policies and procedures including minimising the use of restrictive practices, promoting antimicrobial stewardship, and practicing open disclosure. The Assessment Team reported that staff demonstrated appropriate knowledge and application of these topics. In relation to deficiencies identified related to restrictive practices, I have considered this information under Requirement 3(3)(b).

It is my decision Requirement 8(3)(e) is Compliant.

1. The preparation of the performance report is in accordance with section 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)