Performance

Report

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| Name: | Karingal Seymour |
| Commission ID: | 3050 |
| Address: | 3 Bretonneux Street, SEYMOUR, Victoria, 3660 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 6 February 2024 |
| Performance report date: | 29 February 2024 |
| Service included in this assessment: | Provider: 760 Seymour Elderly Citizens Hostel Inc  Service: 1809 Karingal Seymour |

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 Karingal Seymour (**the service**) has been prepared by L Glass, 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.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed. |
| **Standard 3** Personal care and clinical care | **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 2

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| Ongoing assessment and planning with consumers | |  |
| 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

The service was previously found non-compliant with requirement 2(3)(e). The service did not demonstrate incident data was regularly reviewed or there was guidance for staff to ensure consumers and consumer care plans are reviewed post falls. Initiatives implemented by the service to address the non-compliance have been successful, and this requirement is now recommended as met.

During the assessment contact, 6 February 2024 the service demonstrated a robust system and process to ensure consumer care plans are reviewed following fall and behaviour incidents. Consumers expressed their satisfaction with the way in which the service communicates with them to meet their current needs, goals and preferences. Staff demonstrated how consumer care is reviewed post fall and behaviour incidents. This aligned with organisation policy and related workforce training.

In relation to post falls and behaviour management, care files, clinical meeting minutes and data analysis demonstrated regular reviews occur, training is delivered, accessible policies and procedures are available to guide staff and reporting and improvement actions and outcomes occur. Consumer file review demonstrated assessments and reviews are completed and include allied health professionals when needed and reviews are discussed at the fortnightly clinical meeting. Consumers interviewed expressed satisfaction with the management of their care and how the staff communicated with them to ensure their needs, goals and preferences are met.

All consumer behaviour support plans (BSPs) have been reviewed and a schedule is in place for ongoing review. Several staff hold the BSP portfolio and demonstrated understanding of the services BSP review processes including how BSPs are reviewed in line with training, policy, procedure and consumer needs. Staff said they have allocated rostered time to undertake expectations to ensure delivery of care is meeting individual consumer’s needs, goals and preferences.

I have considered the Assessment Team’s report and the recommendation that requirement 2(3)(e) is met. I find the requirement 2(3)(e) 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. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

In relation to requirement 3(3)(a) the service was previously found non-compliant. The service did not consistently monitor consumers pain, record wound photograph/measurements or have adequate behaviour support plans (BSP) in place that included the use of chemical restraint. Initiatives implemented by the service to address the non-compliance have been successful, and this requirement is now recommended as met.

During the assessment contact, on 6 February 2024 the service demonstrated staff training has been delivered to address the deficits identified in relation to wound management. Staff ensure accurate information is reflected in consumer BSPs and pain charting strategies are implemented when as required analgesia is administered.

Consumers interviewed expressed satisfaction with the way in which wound, behaviour and pain are managed. Staff demonstrated requirements of wound, behaviour and pain management are in line with organisational policy and related training. In relation to wound, pain and behaviour management, care files, clinical meeting minutes and data analysis reflected regular reviews occur, training is delivered, accessible policies and procedures are available to guide staff and reporting and improvement actions/outcomes occur.

A review of consumer care files demonstrated each consumer had a wound and pain management plan in place. Wound charts consistently reflected photographs and wound measurements. Care file review of consumers with falls, behaviour, wounds and pain demonstrated consideration of pain and an associated pain management plan and charting. Pain information in consumer documentation confirmed non-pharmacological strategies are implemented when as required analgesia is being administered. Consumer BSPs are now regularly reviewed and include specific information regarding chemical restrictive practice. Auditing processes are in place to ensure a review for effectiveness of strategies occurs regularly.

In relation to requirement 3(3)(b) the service was previously found non-compliant. The service did not demonstrate falls management monitoring was in line with the service’s documented process. Documentation of complex indwelling catheter (IDC) care needs was inconsistent. Initiatives implemented by the service to address the non-compliance have been successful, and this requirement is now recommended as met.

During the assessment contact, the service demonstrated effective management of high impact or high prevalence risks associated with the management of falls and IDC care needs. Fall management was observed to be completed in line with the organisation's policy and procedures, and there was consistent documentation of complex IDC care needs. Consumers interviewed expressed their satisfaction with how falls and IDC care is managed. Staff described individual consumers risks and demonstrated understanding of the specific requirements for the management of falls and complex IDC care in line with organisational policy and related training.

I have considered the Assessment Team’s report and the recommendation that requirements 3(3)(a) and3(3)(b) are met. I find the requirements 3(3)(a) and 3(3)(b) 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. | 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. | 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

In relation to requirement 8(3)(c) the service was previously found non-compliant. The service did not demonstrate effective information management and continuous improvement systems were in place to support current and accurate care planning to guide staff in the delivery of care and services. The plan for continuous improvement (PCI) did not include outcomes, evaluations or fully implemented actions for some items. Initiatives implemented by the service to address the non-compliance have been successful and this requirement is now recommended as met.

During the assessment contact, on 6 February 2024 management demonstrated the organisation has effective systems and processes in place for the management and governance of all aspects of care and services. The organisation has appointed additional clinical staff to review all care assessments, staffing, and education. Staff confirmed they have access to resources and policies to guide them and ensure the care provided is safe and appropriate for individual consumers. By using internal audits, observations, care plan reviews, and incident reporting and investigations the service monitors and continuously improves the quality of care and workforce interactions. The service uses an electronic care planning system that includes essential information about each consumer’s condition, goals, and preferences. The system generates detailed handover sheets for nursing staff, care staff, and catering staff. Staff confirmed they had received training on the use of the electronic care planning system to ensure they could access and document information. A review of sampled consumers’ care plans showed their care planning information is current and accurate and guides the staff in the delivery of care and services.

Feedback from consumers and staff along with analysis of internal audit reports is used to identify trends, deficits, highlight areas of concern and inform the governing body. Management said strategies developed by the advisory or governing bodies to address these, inform the service’s PCI. The PCI is reviewed monthly as part of preparing a report for the Board. Review of the PCI noted all the PCI actions had outcomes, evaluations, and completion dates.

In relation to requirement 8(3)(d) the service was previously found non-compliant. The service did not demonstrate effective clinical oversight of high impact high prevalent risks, specifically falls, pain, and wound and Serious Incident Reporting Scheme (SIRS) incident management. Initiatives implemented by the service to address the non-compliance have been successful, and this requirement is now recommended as met.

During the assessment contact, management demonstrated the organisations risk management system is supported by policies and procedures to facilitate risk identification, risk minimisation, risk management, and response, to support the safety and well-being of consumers. High impact and high prevalence risks are initially identified through consumer assessment and monitored by clinical and care staff and other health specialist professionals as appropriate. All incidents are reported in the service’s electronic information management system and these, along with progress notes are reviewed each shift by the registered nurse in charge and again by the senior clinical manager to identify potential risks and reportable incidents for escalation and reporting to the SIRS. The service has an incident management system policy detailing incident management instruction, reporting obligations, and roles and responsibilities of staff members.

Training records showed and all staff interviewed confirmed they had received training in post falls management, proactive pain assessment and interventions and wound management. Staff demonstrated an understanding of reporting to the SIRS within the required timeframes and advised how they use targeted resources to assist in identifying if a SIRS is required. The service’s falls management policy and new post-fall management tool have been reviewed and updated. The service is also conducting regular toolbox meetings to discuss pain management, charting, and the appropriate use of medication. The service has updated its policy and falls tool and has added pain charting to its post falls management tool to capture the episodes of pain within the first 48 hours post-fall.

In relation to requirement 8(3)(e) the service was previously found non-compliant. The service did not demonstrate effective management and minimisation of the use of restraint. Initiatives implemented by the service to address the non-compliance have been successful and this requirement is now recommended as met.

During the assessment contact, the service demonstrated it has a clinical governance framework in place that provides an overarching monitoring system for clinical care. Staff have been given training in antimicrobial stewardship, open disclosure, restrictive practices, and minimising the use of restraints. There is a reporting structure in place to inform the Board about the monitoring systems for clinical care.

All BSPs have been reviewed and consumer profiles have been updated to capture accurate consumer information including individualised, detailed care recommendations. All the BSPs are now regularly reviewed and electronic alerts are activated if changes are made to a BSP. Staff demonstrated an understanding of restrictive practices and provided examples of how they minimise its use, including the use of non-pharmacological interventions before the administration of chemical restraints. A review of a range of clinical policies and procedures noted the service has policies available relating to antimicrobial stewardship, restrictive practices, and open disclosure.

I have considered the Assessment Team’s report and the recommendation that requirements 8(3)(c), 8(3)(d) and 8(3)(e) are met. I find the requirements 8(3)(c), 8(3)(d) and 8(3)(e) Compliant.

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