Performance

Report

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| Name of service: | Karingal Seymour |
| Service address: | 3 Bretonneux Street SEYMOUR VIC 3660 |
| Commission ID: | 3050 |
| Approved provider: | Seymour Elderly Citizens Hostel Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 1 August 2023 |
| Performance report date: | 28 August 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 Karingal Seymour (**the service**) has been prepared by N Eastwood, 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 23 August 2023.

# 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 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **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)(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.
* 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.

* Requirement 3(3)(b) Effective management of high impact or high prevalence risks associated with the care of each consumer.
* Requirement 8(3)(c) Effective organisation wide governance systems relating to the following:

1. information management;
2. continuous improvement;

* 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 managing and preventing incidents, including the use of an incident management system.

* Requirement 8(3)(e) Where clinical care is provided—a clinical governance framework, including but not limited to the following:

1. minimising the use of restraint;

# 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. | Non-compliant |

Findings

The service was previously found non-compliant with this requirement following a Site Audit (the Site Audit) performed between 6 and 8 December 2022.

At the time of the Site Audit the service did not demonstrate incident data was regularly reviewed and or there was guidance for staff to ensure consumers and care plans were reviewed post falls.

The service has implemented actions in response to the identified non-compliance including development of a post fall review tool, fortnightly review of incidents at the clinical incident review and post fall physiotherapy reviews to commence in August 2023.

At the site visit of 1 August 2023, the service demonstrated some improvements, however the Assessment Team noted that care plans do not accurately reflect the consumer’s current health status or reflect recent changes to their care. Post incident review’s do not consistently consider alternative strategies for management or appear for review at the clinical review meeting. A review of post fall management plans does not support the ongoing assessment of pain and are not always completed. Where a consumer was identified as experiencing changed behaviours and was involved in an episode of aggression the service could not demonstrate evaluation of the current strategies for effectiveness was performed.

In response to the Assessment Team report the Approved Provider submitted a Plan for Continuous Improvement (PCI) which demonstrated actions to address this deficit including documentation review and updates as well as consideration of ongoing portfolio management. While I note the ongoing actions and reviews in place, further time and evaluation is required to ensure these actions are effective to ensure accurate documentation is in place to reflect changes to care needs.

As a result, and with consideration to the implemented actions and available information I find this requirement is not 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. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

The service was previously found non-compliant with requirements 3(3)(a), 3(3)(b), 3(3)(c), 3(3)(g) following a Site Audit (the Site Audit) performed between 6 and 8 December 2022.

At the time of the Site Audit the service did not demonstrate:

* best practice in relation to clinical care including wound management and restrictive practices, particularly the absence of behaviour support plans with individualised strategies in place for consumers subject to restrictive practices
* identification or implementation of strategies to address the weight loss or appropriate management of falls
* consumers who were nearing the end of life, had care provided in accordance with their needs and preferences
* best practice is implemented in relation to antibiotic use and staff did not demonstrate adequate knowledge of antimicrobial stewardship.

The service has implemented actions in response to the identified non-compliance including a range of education related to minimising restrictive practices, best practice wound management, a review and implementation of behaviour support plans for all consumer’s subject to restraint practices, update to the psychotropic self-assessment tool and a pharmacy review of consumers receiving psychotropic medication, implementation of post falls review process, engagement with a dietician, and further education to support antimicrobial stewardship and recognition of palliative progression.

At the site visit of 1 August 2023, the service demonstrated evidence of the actions implemented and progression toward addressing previously identified non-compliance.

Regarding requirement 3(3)(a) while there was evidence of implementation of several interventions the Assessment Team noted ongoing areas for improvement. Specifically, there were inconsistencies with recording photographs and wound measurements despite there being a process in place for a weekly wound review. There was also evidence that monitoring of consumer pain was not consistently occurring, including when the medical officer had given a directive for pain charting and Behaviour Support Plans did not always include detail related to the use of chemical restraint.

The Approved Provider submitted a Plan for Continuous Improvement (PCI) which reflected actions to ensure staff training requirements related to wound management are addressed. The PCI also indicates review and updates completed and ongoing to ensure accurate information is included in Behaviour Support plans. Pain charting strategies are to be implemented at the time of PRN analgesia administration and for consumers identified by the Assessment Team for further evaluation of pain relief methods.

Regarding requirement 3(3)(b) the Assessment Team noted improvements in relation to management of consumers with weight loss, now having access to a dietician who attends monthly. However, there were ongoing concerns related to falls management and consistency of monitoring in line with the service’s processes, additionally there was inconsistent documentation of attention to complex care needs for a consumer requiring indwelling catheter care.

The PCI submitted in response to the Assessment Teams observations reflected strategies to address indwelling catheter management and supporting documentation to be completed, as well as post fall and incident report training delivery.

While I acknowledge the ongoing and implemented actions the potential for impact to consumer care in the absence of improvement in these areas is significant. Further time to consolidate and evaluate the effectiveness of strategies to address the deficits in 3(3)(a) and 3(3)(b) are required. As a result, and with consideration to the implemented actions and available information I find 3(3)(a), 3(3)(b) continue to be non-compliant.

I am satisfied that requirement’s 3(3)(c) and 3(3)(g) are now compliant.

The service was able to demonstrate improvement in requirements 3(3)(c) and 3(3)(g) specifically related to implementing palliative care in a timely manner as well as communication with external palliative care providers and representatives. Advance Care Directives and end-of-life wishes documentation were easily accessible, with hard copies available in consumer files. The Assessment Team noted the provision of additional staff training and earlier implementation of end-of-life care pathway where a consumer is identified as requiring palliation. The service also demonstrated preparedness in the event of an infectious outbreak, and effective practices to support appropriate antimicrobial prescribing. The service screens all visitors and staff requiring a negative result from a rapid antigen test (RAT) before entering the service. The service has a nominated infection prevention and control (IPC) lead and consumers expressed satisfaction with actions taken to minimise the spread of infectious outbreaks. Staff described the process for the assessment of infection where a consumer has signs and symptoms of an infection and the ‘to dip or not to dip’ program for reducing antibiotic use for urinary tract infections.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

The service was previously found non-compliant with this requirement following a Site Audit performed between 6 and 8 December 2022 (the Site Audit).

At the time of the Site Audit the service was unable to demonstrate it was providing sufficient training related to the Serious Incident Response Scheme (SIRS) and the Age Care Standards, anti-microbial stewardship, high-impact, high-prevalence risks, or open disclosure.

The Assessment Team recommended requirement 7(3)(d) remained non-compliant due to the absence of supporting training documentation and evidence of knowledge deficits related to Serious Incident Response Scheme (SIRS) process and reporting. Notwithstanding the Assessment Teams observations, following consideration to the Approved Providers response I have come to a different view and consider this requirement is compliant.

The Assessment Team noted the actions implemented in response to the identified non-compliance and improvements in skills and knowledge related to palliative care, antimicrobial stewardship, and open disclosure. However, at the time of the site visit on 1 August 2023 staff demonstrated limited knowledge around SIRS processes and ongoing deficits related to clinical care reflected area for improvement in staff skills and training. Consumers and representatives confirmed they were satisfied with care and nursing staff are well trained and qualified. Management indicated significant work had been completed to close the ‘training gaps’ identified and confirmed with staff they are current with mandatory training requirements. A review of training records confirmed mandatory training had been completed and all staff were up to date on 30 June 2023.

The Approved Provider provided a response (the response) and a Plan for Continuous Improvement (PCI) which confirmed further education had been completed consistent with the mandatory education requirements. The PCI further reflects actions completed as well as planned and ongoing interventions related to mandatory training. The response included the mandatory training matrix and training calendar, while acknowledging that some of the reporting mechanisms may have been challenging to interpret. While noting the Assessment Teams observations surrounding clinical skills requiring improvement, the response and supporting PCI demonstrates there are active plans in place to support and continue staff training to ensure compliance with this requirement.

As a result, and with consideration to the implemented actions and available information I find this requirement is now compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| 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 service was previously found non-compliant with requirements 8(3)(b), 8(3)(c), 8(3)(d), 8(3)(e) following a Site Audit (the Site Audit) performed between 6 and 8 December 2022.

At the time of the Site Audit the service did not demonstrate:

* sufficient information was provided to the Board to make accurate judgements related to feedback trends, clinical incident trends and information relevant to continuous improvement activities
* systems to effectively manage information, support continuous improvement, govern its workforce, ensure it was compliant with regulations, or manage complaints.
* adequate risk managements systems in place to monitor high risk high prevalence risks, and incident reporting
* clinical staff had an adequate understanding of key clinical concepts including anti-microbial stewardship, minimising the use of restraint, and open disclosure.

The service has implemented several effective actions in response to the identified non-compliance including a restructure of reporting at Board level to accurately reflect quarterly feedback and clinical trends, reporting of all clinical incidents and continuous improvement activity, Board level training and engagement activities with consumers, representatives, and staff. Antimicrobial stewardship and open disclosure actions have been effective however further actions are required to support appropriate use of restraint and open disclosure. Actions identified in the continuous improvement plan have been recorded as implemented however noted to be ineffective, specifically those related to clinical care which continue to be non-compliant.

Regarding requirement 8(3)(c) management reported that the service has made improvements as per the continuous plan of improvement. At the Assessment Contact on 1 August 2023, the Assessment Team noted that although actions have been implemented, not all have been effective in practice. A review of care plans found that care planning information is not always current or accurate to guide staff practice in the delivery of care and services. Management indicated the Plan for Continuous Improvement (PCI) is reviewed monthly as part of preparing papers for the Board. However, the Assessment Team noted the current PCI template provided by management did not include outcomes and evaluations for some actions. Management confirm that a number of internal audits and data analysis are now completed to ensure staff compliance with updated policies and procedures. These are conducted in medication management, information management, direct care, housekeeping, consumer files, quality of life and the consumer experience. The Assessment Team noted some improvements with this requirement, however, not all planed actions were fully implemented, and management confirmed further education is required.

Regarding requirement 8(3)(d) although the service demonstrated a range of actions implemented to rectify the non-compliance, the Assessment Team noted deficits continue to occur in clinical care. The service was unable to demonstrate that their risk management framework provides effective clinical oversight of high-impact or high-prevalence risks particularly related to post falls management, proactive pain assessment and intervention, consistency in wound management documentation, staff knowledge of Serious Incident Response Scheme (SIRS) role or evidence of effective reporting of SIRS incidents.

Regarding requirement 8(3)(e) some actions in response to the non-compliance identified at the Site Audit have been effective related to antimicrobial stewardship and open disclosure. However, the Assessment Team noted the service did not demonstrate effective management and minimising of the use of restraint. Staff described the process for minimising the use of antibiotics and how open disclosure relates to their role but were not able to describe the service’s process for minimising the use of restraint which could be attributed to the incomplete information included in behaviour support plans.

The Approved Provider submitted a Plan for Continuous Improvement (PCI) in response to the Assessment Team report, a number of actions are identified to support the progression toward a return to compliance with requirements 8(3)(c), 8(3)(d), and 8(3)(e). While I note that these are interrelated with the identified deficits in other requirements and are consistent with items to ensure oversight of the effective actions proposed, the associated risk to consumers continues to significant if not addressed effectively. Additional time to evaluate and ensure all actions are sustained in practice is required. As a result, and with consideration to the implemented actions and available information I find requirements 8(3)(c), 8(3)(d), 8(3)(e) continue to be non-compliant.

I am satisfied that requirement 8(3)(b) is now compliant.

Consumers indicate they felt the service was well run. Management confirm the Board were now well informed to be able to make decisions. Staff report receiving communication via newsletters and emails and are confident they are well informed about what was happening. Management demonstrated to the Assessment Team the improvements made in reporting to the Board, there are now monthly and quarterly inclusions that were not previously provided such as infection rates and use of anti-microbials, wounds by category, psychotropic self-assessment tool, quality indicators, SIRS and AN-ACC. There is a newsletter provided to consumers which includes contribution by the Board and a review of the continuous improvement plan confirmed all improvements for reporting to the Board had been actioned by the end of March 2023.

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)