Performance

Report

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| Name of service: | Karinya Residential Care |
| Service address: | 50 Felspar Street NARROGIN WA 6312 |
| Commission ID: | 7222 |
| Approved provider: | Narrogin Cottage Homes Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 28 August 2023 to 29 August 2023 |
| Performance report date: | 16 October 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 Karinya Residential Care (**the service**) has been prepared by R, Beaman, 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 19 September 2023; and
* the Performance Report dated 23 November 2022 for a Site Audit undertaken from 27 September 2022 to 29 September 2022.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **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.

Standard 3 Requirement (3)(a)

* Ensure each consumer receives safe and effective personal care and clinical care.

Standard 8 Requirements (3)(d) and (3)(e)

* Ensure the organisation’s risk management framework is effective, specifically in relation to enabling consumers to take risks in safe manner to live their best life, and the incident management system is effective in preventing further incidents from occurring.
* Ensure the organisation’s clinical governance framework is effective, specifically in relation to minimising the use of restraint.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |

Findings

This Requirement was found non-compliant following a Site Audit undertaken from 27 September 2022 to 29 September 2022 where the service did not demonstrate consumers were treated with dignity and respect by staff, specifically in relation to the delivery of personal care and communication. Since the Site Audit visit, the service has implemented various improvement actions, including development of a Diversity policy and staff education in relation to the organisation’s Code of Conduct.

At the Assessment Contact from 28 August 2023 to 29 August 2023, consumers and/or their representative’s confirmed consumers were treated with dignity and respect. Consumers were satisfied with staff behaviour and confirmed they delivered care in a way that maintained their dignity and respected their culture, and diversity. Staff were observed treating consumers with dignity and respect throughout the Assessment Contact visit.

Based on the Assessment Team’s report, I find Requirement (3)(a) in Standard 1 Consumer dignity and choice 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 |

Findings

This Requirement was found non-compliant following a Site Audit undertaken from 27 September 2022 to 29 September 2022 where the service did not demonstrate personal and clinical care was safe or effective, specifically in relation to pain and medication management or that care was tailored to each consumer’s needs. Since the Site Audit visit, the service has implemented various improvement actions, including all medication scripts are obtained prior to the consumer being admitted to the service, reviewing, and updating each consumers’ preferences for personal hygiene care, and an increase in medication competent staff.

At the Assessment Contact from 28 August 2023 to 29 August 2023, the Assessment Team was not satisfied each consumer receives safe and effective personal and clinical care, specifically in relation to medication management, restrictive practices and delivering care in line with best practice. The Assessment Team’s report included the following information and evidence gathered through documentation, interviews, and observations relevant to my finding:

* Three consumers (Consumers A, B and C) are administered psychotropic medications as a strategy for behaviour management. All three consumers are considered to have a chemical restraint in place.
* In relation to Consumer A, the service does not evaluate or analyse whether the psychotropic medication used to manage adverse behaviours is effective and what non-pharmacological strategies can be used for Consumer A prior to medication administration.
  + Consumer A’s representative confirmed Consumer A had been receiving psychotropic medications for a long period of time and had never had discussions about minimising them.
* Consumer B was prescribed an as required dose of anti-psychotic medication as a behaviour management strategy. Consumer B was referred to and reviewed by a Mental Health specialist in June 2023 with recommendations to change the as required dose to regular commencing on a smaller dose with instructions to increase to if needed.
  + Documentation confirmed Consumer B was commenced on the higher dose of the medication without any trials prior to the medication increase. The effectiveness of the medication change was not monitored, and the service did not identify Consumer B’s medication was not being administered in line with recommendations.
* In relation to Consumer C, the service did not trial any non-pharmacological interventions prior to administration of antipsychotic medication to manage Consumer C’s behaviours in June 2023. During June 2023, the medication was increased on three occasions. Clinical staff were not able explain why the increase in mediations occurred and there was no information to show other interventions were trialled to demonstrate the medication was administered as last resort. Documentation showed in August 2023, the antipsychotic medication was ceased as Consumer C was allergic.
* Staff did not follow organisations policies and procedures and undertake neurological observations as required for two consumers who sustained unwitnessed falls.

The provider acknowledged the findings in the Assessment Team’s report and provided a plan for continuous improvement with actions implemented and planned to rectify the deficits identified. Those actions included, but are not limited to:

* Developing protocols to ensure all staff in the relevant areas are informed of at-risk consumers.
* Ensuring Behaviour Support Plans are developed, and staff are informed of those.
* Education for all staff in relation to restrictive practices, including the need for accurate and timely documentation and assessment of actions.

I acknowledge the provider’s response and the actions they have taken since the Site Audit and have planned to implement to rectify the deficits in this Requirement. However, I find the service did not ensure each consumer received safe and effective clinical care specifically in relation to the use of restrictive practices including chemical and mechanical restraint nor did staff undertake appropriate post falls management processes for consumers who sustained unwitnessed falls. In coming to my finding, I have relied on the evidence included in the Assessment Team’s report that shows for Consumer A, non-pharmacological strategies were not trialled prior to administration of medication, which is considered a chemical restraint, nor did staff evaluate the effectiveness of the medication on Consumer A’s behaviours. I have considered for Consumer B, evidence in the Assessment Team’s report shows staff did not trial alternative strategies prior to the change in medication from as required to regular, staff did not follow the recommendations by the Mental Health specialist and administered the higher dose of medication prior to trialling the lower dose, nor did staff monitor the effectiveness of the medication after administration. I have also considered evidence that shows for Consumer C, non-pharmacological strategies were not trialled prior to the increase in dose of an antipsychotic medication which was considered a chemical restraint. Furthermore, I have considered the evidence that shows two consumers did not have neurological observations undertaken in line with the organisations policies and procedures following unwitnessed falls.

I acknowledge the actions the provider has taken since the Site Audit and those they have included in their response that are planned to address the deficits identified in this Requirement. However, I find those actions will need more time to be fully embedded and have efficacy across this Requirement.

Based on the information above, I find Requirement (3)(a) in Standard 3 Personal care and clinical care non-compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(c) | Furniture, fittings, and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

This Requirement was found non-compliant following a Site Audit undertaken from 27 September 2022 to 29 September 2022 where the service did not demonstrate furniture, fittings and equipment were safe, clean, or well maintained. Since the Site Audit visit, the service has implemented various improvement actions, including improvements made to consumer bathrooms to ensure safety, and bathroom flooring being replaced to prevent the occurrence of mould.

At the Assessment Contact from 28 August 2023 to 29 August 2023, consumers and representatives confirmed furniture, fittings and equipment used is safe, clean well-maintained and suitable for consumer use. Maintenance staff were observed tending to issues that required fixing to enhance the service’s fittings. Consumers were satisfied any issues they raise requiring fixing are done so in a timely manner.

Based on the Assessment Team’s report, I find Requirement (3)(c) in Standard 5 Organisation’s service environment compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Requirements (3)(c) and (3)(d) were found non-compliant following a Site Audit undertaken from 27 September 2022 to 29 September 2022 where the service did not demonstrate appropriate action was taken or used open disclosure in response to feedback, including complaints. The service also did not demonstrate feedback and complaints were used to improve care and services. Since the Site Audit, the service has implemented various actions to rectify the deficits identified, including developing a new Open Disclosure policy and education for staff in relation to open disclosure and the complaints process.

At the Assessment Contact undertaken from 28 August 2023 to 29 August 2023, consumers and representatives were satisfied their feedback, including complaints are actioned in a timely manner and outcomes are to consumer satisfaction. Consumers and representatives confirmed open disclosure was used in response to any complaints or incidents that occurred.

Staff demonstrated understanding of the feedback process and could describe ways in which feedback is used for improving care and services and examples of when they have used open disclosure. Management provided examples of how they have used feedback, including complaints to make improvements to care and the service environment.

Based on the Assessment Team’s report, I find Requirements (3)(c) and (3)(d) in Standard 6 Feedback and complaints 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. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirements (3)(a), (3)(d) and (3)(e) were found non-compliant following a Site Audit undertaken from 27 September 2022 to 29 September 2022 as the service did not have a sufficient mix and number of staff to deliver safe and quality care, specifically in relation to personal care, continence care and lifestyle support. The service also did not demonstrate staff were trained and equipped to deliver care and services nor was staff performance monitored effectively. Since the Site Audit, the service has implemented various actions to rectify the deficits identified, including the recruitment of a new care manager, engagement of agency registered staff, wellness officer and the creation of a senior carer’s role. The service has also reviewed training and provided further education on medication, Code of Conduct, Serious Incident Response Scheme (SIRS) and restrictive practices, along with implementing staff performance management with the new care manager role.

At the Assessment Contact undertaken from 28 August 2023 to 29 August 2023, consumers and representatives were satisfied with the mix and number of staff to deliver care and services and confirmed consumers did not have to wait long for assistance when they requested it. Consumers confirmed they felt staff were well trained and knew what they were doing and how to deliver care in a way that meets their needs. Consumers and representatives were satisfied with staff performance and felt if there were any issues these would be appropriately actioned by management.

Clinical and care staff confirmed they had access to mandatory and ad hoc training resources and received regular training at the service in various forms, including tool-box sessions, online or facilitated workshops. Management confirmed they use observations of staff performance, feedback from staff, consumers, and representatives to guide the training schedule.

Documentation confirmed there is a process undertaken to complete performance appraisals with staff both formal and informally. There is a system in place to alert management to staff who are needing to complete mandatory and other training. Management also has a system and process in place to ensure there are enough staff allocated with the right mix based on consumer needs.

Based on the Assessment Team’s report, I find Requirements (3)(a), (3)(d), and (3)(e) in Standard 7 Human resources compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| 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. | 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

All five Requirements in this Standard were found non-compliant following a Site Audit undertaken from 27 September 2022 to 29 September 2022 where the service did not demonstrate it engaged consumers in the development of care and services, resident relative meetings were not being held, took appropriate action or used open disclosure in response to feedback, including complaints, and the governing body was not aware of the Quality Standards or that the policies they had in place to guide staff practice were out dated. The service did not demonstrate it had an effective risk management, organisational or clinical governance frameworks in place.

Since the Site Audit, the service has implemented various actions to rectify the deficits identified, including re-establishing the resident relative meetings, upskilling of Board members in understating the Quality Standards, further education on accurate documentation, risk management, managing and preventing incidents and restrictive practices and open disclosure. The service has also implemented a new risk register and reviewed and updated the restrictive practice policy.

At the Assessment Contact undertaken from 28 August 2023 to 29 August 2023, the Assessment Team were not satisfied the risk management system or clinical governance frameworks were effective, the risk management system supported consumers to live the best life they can, or clinical governance was effective in minimising the use of restraint.

**Requirement (3)(d)**

The Assessment Team’s report provides the following information and evidence gathered through documentation and interviews relevant to my finding:

* Two consumers who wished to take risks have documentation identifying what the risk is and acknowledgment from the consumers and/or their representative it is a risk activity. However, for both consumers there were no strategies in place to mitigate the risks and ensure consumers’ safety when undertaking their activity of choice.
* Whilst incidents are recorded, escalated, and investigated the incident management system has not identified investigations are completed. Four incidents sampled for one consumer showed staff did not investigate possible factors that contributed to the consumer’s incidents, and they did not identify strategies to prevent recurrence or ensure consumer safety.

The provider acknowledged the findings in the Assessment Team’s report and provided a plan for continuous improvement with actions implemented and planned to rectify the deficits identified with the risk management system. Those actions included, but are not limited to:

* Put in place a process for registered staff to complete incident forms and undertake investigations and escalate to care manager when further investigation is required.
* An updated Negotiated Risk form has been implemented and instructions to prompt registered staff to complete appropriately.

I acknowledge the provider’s response and the actions they have taken since the Site Audit and have planned to implement to rectify the deficits in this Requirement. However, I find the risk management framework is not effective, specifically in relation to consumers wishing to take risks and the incident management system. In coming to my finding, I have considered information in the Assessment Team’s report that shows two consumers who were wishing to undertake activities of risk did not have effective strategies in place to mitigate the risks and ensure consumers’ safety, and the governance systems in place did not identify this. I have also considered evidence that shows the incident management system, specifically in relation to investigations are not being completed fully to identify what factors contributed to incidents to prevent recurrence and enable the development of effective mitigation strategies.

I acknowledge the actions the provider has planned and/or has already taken in response to the deficits identified and find they will need time to be fully embedded to achieve efficacy in this Requirement.

Based on the information above, I find Requirement (3)(d) in Standard 8 Organisational governance is non-compliant.

**Requirement (3)(e)**

The Assessment Team’s report provides the following information and evidence gathered through documentation, interviews, and observation relevant to my finding:

* Five consumer care files identified by the service as subject to chemical restraint did not have individualised Behaviour Support Plans (BSP).
* BSPs did not include personalised strategies to manage changed behaviours or alternative strategies trialled for consumers where psychotropic medications were administered to manage behaviours.
* Where psychotropic medications are administered in an as required dose, staff did not consistently record the strategies trialled prior to administration or the effectiveness of the medication.
* One consumer was not considered by the service as having a mechanical restraint in place when they were recorded as wearing a dignity suit for the management of behaviours. The consumer was observed wearing the dignity suit, staff confirmed they wore the suit day and night and the consumer’s representative confirmed knowledge of the suit. The service did not have a restraint authorisation in place, any assessments in relation to behaviours and restrictive practices for the consumer or information about the restraint included in the BSP.
* One consumer has been administered an as required dose of antipsychotic psychotropic medication on multiple occasions between May 2023 and August 2023 to manage their behaviour without strategies trialled prior to use documented, and no valid informed consent, including discussion of risks for the administration of the medication.

The provider acknowledged the findings in the Assessment Team’s report and provided a plan for continuous improvement with actions implemented and planned to rectify the deficits identified with the risk management system. Those actions included, but are not limited to:

* Clinical Guideline manual being developed to ensure all staff have access to relevant information.
* All policies relating to Clinical Governance being reviewed.

I acknowledge the actions the provider has taken since the Site Audit and actions planned included in the provider’s response to rectify the deficits identified in this Requirement. However, I find the clinical governance framework is not effective, specifically in relation to minimisation of restraint. In coming to my finding, I have considered the information and evidence included in the Assessment Team’s report which shows for five consumers, there was no personalised BSPs with tailored strategies to manage behaviours or evidence alternative strategies were trialled prior to show medication was administered as a last resort. I have also considered evidence that shows staff, or the service did not recognise one consumer was subject to a mechanical restraint through the application of a dignity suit of which staff confirmed the consumer remains in day and night with no information provided to indicate it was released for any period of time. Furthermore, the service did not demonstrate informed consent was obtained for the consumer nor was it obtained for another consumer who was subject to chemical restraint.

In coming to my finding, I have placed weight on the information included in the Assessment Team’s report and find the clinical governance framework has systemic issues in relation to minimising the use of restraint, it did not identify where consumers subject to chemical restraint did not have all required documentation in place, where consumers have a mechanical restraint in place it did not identify this and, as such show that it was last resort or alternative trialled. Furthermore, the clinical governance framework did not identify when informed consent was not obtained prior to chemical restraint being put in place.

I acknowledge the provider has implemented and planned actions to address the deficits identified in relation to minimising the use of restraint. However, I find these will need time to be fully embedded to have efficacy in relation to the clinical governance framework.

Based on the information above, I find Requirement (3)(e) in Standard 8 Organisational governance non-compliant.

In relation to Requirements **(3)(a), (3)(b) and (3)(c),** consumers and representatives confirmed they are engaged in the development and delivery of care and services in various ways, including providing feedback through surveys and resident and relative meetings. Consumers and representatives were satisfied with the way the service is run and consumers felt safe living at the service.

The service has oversight by a Board who is provided performance reports, including incidents and complaints monthly which are then discussed at monthly Board meetings. The organisation has a process for continuous improvement and uses consumer feedback to drive improvements in care and services. The organisation has governance systems in place for workforce, feedback, regulatory compliance and financial that are effective. Staff demonstrated understanding the services organisation governance processes and provided examples of how consumers are supported to engage in those processes.

For the reasons detailed above, I find Requirements (3)(a), (3)(b) and (3)(c) in Standard 8 Organisational governance 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)