Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Keith & District Hospital Inc |
| Service address: | 35 Hill Avenue KEITH SA 5267 |
| Commission ID: | 6197 |
| Approved provider: | Keith & District Hospital Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 4 October 2022 to 5 October 2022 |
| Performance report date: | 8 November 2022 |

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 Keith & District Hospital Inc (**the service**) has been prepared by M Glenn, 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.

**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 consumers, representatives, staff and others;
* an Infection Control Monitoring checklist completed as part of the Assessment Contact;
* an email from the provider dated 17 October 2022 indicating a formal response to the Assessment Team’s report would not be provided; and
* the Performance report dated 18 June 2021 for the Site Audit conducted from 23 March 2021 to 25 March 2021.

# Assessment summary

|  |  |
| --- | --- |
| Standard 3 Personal care and clinical care | 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 | **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

|  |  |  |
| --- | --- | --- |
| 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 |
| 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

Requirements (3)(b) and (3)(g) were found Non-compliant following Site Audit undertaken from 23 March 2021 to 25 March 2021 where it was found the service was unable to demonstrate:

* Effective management of some high impact or high prevalence risks associated with the care of each consumer, incident reporting was not effective in recording all medication incidents, the new procedure for the use of restraint was not reflective of the current legislation and risks associated with the care of consumers was not consistently explained to consumer representatives; and
* A completed outbreak management plan was in place or that staff demonstrated consistent understanding of the use of personal protective equipment.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Implemented use of grip socks to prevent falls. All existing consumers received a complementary pair of socks, and all new consumers receive a pair on entry.
* Updated the Restrictive practice procedure to reflect current legislation and updated associated processes and work instructions to support implementation.
* Reviewed and updated incident reporting forms to ensure they support good reporting practice and collection of appropriate information.
* Training provided to relevant staff relating to suprapubic catheter care, incident management, investigation, open disclosure, restrictive practices, medications, falls, risk management and the outbreak management plan.
* All clinical, care and cleaning staff were reassessed for compliance with donning and doffing of personal protective equipment with reassessment to occur six-monthly for one year.
* Purpose-designed PPE stations placed at regular intervals around the service with infographic instructions displayed at point of use of PPE. Audits of PPE use are being conducted three-monthly for one year.
* The Outbreak management plan was reviewed and updated with ongoing weekly reviews occurring to ensure currency.
* Implemented antimicrobial stewardship procedures in accordance with quality standards requirements.

At the Assessment Contact, the Assessment Team found assessment and incident data is used to identify consumers with high impact or high prevalence risks, and tailored management strategies are developed. Where risks had been identified, care files demonstrated management strategies had been implemented, including additional monitoring, and referrals to Medical officers and/or Allied health specialists initiated. Care files sampled demonstrated appropriate management of risks relating to falls, behaviours and nutrition and hydration and records of incidents relating to falls, behaviour, bruising and medication errors showed actions taken to address risks. Staff were knowledgeable about sampled consumers and the strategies and interventions in place for risk prevention and management. Additionally, staff were aware of current restrictive practice procedures and care needs of consumers subject to chemical restraint. Consumers and representatives were satisfied with the care consumers receive, and representatives referred to management of specific risks related to falls, nutrition and behaviour.

The service has embedded infection prevention and control measures and antimicrobial stewardship principles into care and service delivery. The environment was observed to be clean and sanitiser and wipes were available in shared work spaces. Clinical staff described antimicrobial stewardship principles, such as the need to align correct antimicrobials with infection via pathology, and strategies they implement to minimise the need for antibiotics. Monitoring and trending of infections and antimicrobial use is conducted and reviewed at the monthly clinical meeting forums. An Infection Control Monitoring checklist, completed during the Assessment Contact, demonstrated COVID-19 preparedness, however, it is noted some aspects, such as an updated floor plan and processes for cohorting and clinical handover were updated during the Assessment Contact. Staff were wearing facemasks appropriately, practicing good hand hygiene and confirmed they had undertaken infection prevention and control and personal protective equipment (PPE) donning and doffing training. Nursing and care staff described their role in the event of an infectious outbreak and referenced the location of prepared outbreak trolleys, PPE stocks and the COVID-19 outbreak management plan. An immunisation program is in place for COVID-19 and influenza, and there are processes for routinely screening consumers, staff and visitors for COVID-19 or respiratory illness.

For the reasons detailed above, I find Requirements (3)(b) and (3)(g) in Standard 3 Personal care and clinical care Compliant.

# Standard 7

|  |  |  |
| --- | --- | --- |
| Human resources | |  |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |

Findings

Requirement (3)(c) was found Non-compliant following a Site Audit undertaken from 23 March 2021 to 25 March 2021 where it was found staff did not demonstrate consistent knowledge in relation to identification and communication of risks to consumers’ representatives, incident reporting processes, mandatory reporting, the correct use of personal protective equipment and antimicrobial stewardship. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to providing education to staff relating to elder abuse, mandatory reporting, the Serious Incident Response Scheme, cognitive impairment assessment, risk management, delirium screening, pressure injury prevention, wound assessment and documentation, pain, hydration and nutrition and dysphagia.

At the Assessment Contact, the Assessment Team were satisfied the workforce is competent, and members of the workforce have the qualifications and knowledge to effectively perform their roles. Qualifications are verified during recruitment processes, a range of training is provided and competency assessments are undertaken to ensure staff have the knowledge to perform their roles. Training records showed rostered staff to be up-to-date with mandatory training and staff have undertaken additional training on a range of topics in line with their role and duties. There are systems and processes to monitor ongoing compliance with completion of training, competency assessments, performance reviews and Health practitioner registration. Staff described undertaking mandatory online and practical education sessions and confirmed position descriptions and duty statements are accessible. Consumers and representatives were satisfied staff are competent, have the necessary skills to perform their roles and care is delivered safely and effectively. Three representatives of consumers living with dementia said staff know and understand how to engage with consumers who have cognitive impairment, including when responsive behaviours occur.

For the reasons detailed above, I find Requirement (3)(c) in Standard 7 Human resources to be Compliant.

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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

Requirements (3)(c), (3)(d) and (3)(e) were found Non-compliant following a Site Audit undertaken from 23 March 2021 to 25 March 2021 where it was found the service did not demonstrate:

* Effective governance with information management, regulatory compliance and workforce governance.
* Effective processes for the consistent identification and reporting for mandatory reporting
* Effective antimicrobial stewardship or management of chemical restraint.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Implemented an electronic information management system for consumer care and service assessment, care planning and incident reporting comprising of evidence-based assessment tools based on best practice and reflective of current aged care legislation and regulations. The system also ensures consolidation of incident data, inclusive of mandatory reporting incidents.
* Workforce governance systems are established, specifically in relation to staff compliance to legislative working requirements, such as police clearances, which are tracked and logged centrally.
* Reviewed the Behaviours of concern and restrictive practices in residential care procedure which is now reflective of legislative changes. The procedure outlines all types of restrictive practise. Education has been provided to all staff and is now part of the ongoing annual mandatory training modules.
* An antimicrobial stewardship policy is in place to guide staff in the ongoing monitoring of infections and use of antimicrobials are reported to clinical meeting forums and recorded in an antibiotic register.

At the Assessment Contact, the service demonstrated effective governance systems in relation to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. Consumers, representatives and staff confirmed the ease of access to relevant information to ensure safe and effective delivery of care and services and informed choice. An established continuous improvement framework reflecting the use of quality indicators, incident and feedback data assists the service and governing Board to review and tailor care and services to meet the needs of consumers. Board minutes included ongoing discussion of the service’s finances and ongoing viability, and monthly financial reports are tabled and discussed. A suite of policies and procedures and evidence-based assessment tools, reflective of current aged care regulation and legislation are available and are supported by position descriptions to guide the workforce in provision of care and services.

Effective risk management systems and practices are in place in relation to high impact or high prevalence risks, identification and response to abuse and neglect of consumers, management and prevention of incidents and supporting consumers to live the best life they can. All incidents of a mandatory reporting nature are logged within regulated timeframes and in line with the service’s policies and procedures. Reports of all mandatory reported incidents are developed monthly and reported to the Board. Quality indicators of care, including all incidents are tracked and reported monthly for further analysis and reviewed by the Board and clinical meting forums. Consumer choice to participate in risky activities are assessed using evidence-based assessment tools and in consultation with consumers and/or representatives. Clinical and care staff were knowledgeable of high impact or high prevalence risks, incident reporting processes and mandatory reporting obligations, in line with legislative requirements. Four representatives of consumers subject to restrictive practices said they are informed of all aspects of consumers’ care and alternative strategies used prior to the use of restrictive practice. They said they are informed of all incidents that occur, actions taken to prevent further reoccurrence and were satisfied with the outcomes of these discussions. Clinical and care staff demonstrated knowledge of high impact or high prevalence risks, incident reporting processes and mandatory reporting obligations in line with legislative requirements.

Effective clinical governance systems and processes were demonstrated, including in relation to antimicrobial stewardship, minimising use of restraint and open disclosure. Staff are guided by a Clinical governance framework, including a suite of policies and procedures. An antimicrobial stewardship procedure is in place and all infections are tracked and trended monthly. Reporting of infections and antibiotic use is undertaken through monthly clinical meting forums. A Behaviours of concern and restrictive practices in residential care procedure, reflective of current legislative requirements, guides clinical staff in the assessment of responsive behaviours and potential need for the use of restrictive practice management. Restraint assessments and consent forms are used to track restraint use and ongoing review through clinical meeting forums. An open disclosure procedure is in place and Board of director meeting minutes demonstrated discussion of incidents, including an apology (both written and verbal) to consumers’ representatives.

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