St Basil's Homes for the Aged in Victoria

Performance Report

24 Lorne Street
FAWKNER VIC 3060
Phone number: 03 9358 4444

**Commission ID:** 3150

**Provider name:** St Basil's Homes for the Aged in Victoria

**Assessment Contact - Site date:** 1 July 2021 to 5 July 2021

**Date of Performance Report:** 10 August 2021

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** |  |
| Requirement 1(3)(e) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** |  |
| Requirement 3(3)(a) | Compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 6 Feedback and complaints** |  |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** |  |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(e) |  Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Non-compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) |  Non-compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) |  Non-compliant |

# Detailed assessment

This performance report details the Commission’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies areas in which improvements must be made to ensure the Quality Standards are complied with.

The following information has been taken into account in developing this 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 Contact - Site report received 30 July 2021.

# STANDARD 1 Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

The approved provider was found Non-compliant in relation to one requirement under this Quality Standard at the previous assessment visit.

The Assessment Team assessed this requirement and found it Compliant.

An overall rating for this Quality Standard is not provided as not all requirements were assessed.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(e) Compliant

*Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.*

The Assessment Team found that the approved provider has addressed the deficits identified in the previous visit. The service now has a range of ways to provide information to each consumer and/or their representative that is current, accurate and easy to understand. While monthly ‘resident and relative’ (resident forum) meetings are yet to occur on a regular basis, consumers/representatives said they are provided with the information they need. Staff were able to describe various ways information is provided to consumers/representatives to enable them to exercise choice.

An advocacy meeting was held with representatives via electronic platform in February 2021. A ‘resident and relative’ (resident forum) meeting was held April 2021. More recently meetings have been cancelled due to COVID-19 restrictions Management advised they are currently considering how to best facilitate ‘resident and relative’ (resident forum) meetings due to the cultural diversity of their cohort of consumers. The Board is planning to provide a monthly Board newsletter to representatives.

The Assessment Team observed information such as the activity program, the menu, external complaints, feedback forms, advocacy, hearing and interpreter services displayed in various areas of the service. Information is displayed in English and other languages appropriate to the service’s cohort of consumers. The Assessment Team observed photographs of a range of meals displayed to support consumers choice.

The service has updated the resident handbook to include information about the Board, the Charter of Aged Care Rights, resident and relative meetings, case conferences, feedback forms, the Aged Care Quality and Safety Commission contact details and the Quality Standards. Information in relation to advocacy, language and hearing services were added to the handbook during the performance assessment. Currently the ‘resident handbook’ is available in English. The service is seeking to find a provider to translate this document.

Each consumer and/or their representative has been provided a copy of the Charter of Aged Care Rights in their preferred language. This information was also explained by staff.

The Approved provider did not submit a response to this requirement.

I have reviewed all of the information provided and find this requirement is Compliant as the approved provider was able to demonstrate that each consumer is provided with current, accurate and timely information in a manner that they can understand and supports them to exercise choice.

# STANDARD 2 COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The approved provider was found Non-compliant in relation to five requirements under this Quality Standard at the previous assessment visit.

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – reviewing their care planning documents in detail, asking consumers about how they are involved in care planning, and interviewing staff about how they use care planning documents and review them on an ongoing basis.

Overall sampled consumers and representatives considered that they feel like partners in the ongoing assessment and planning of care and services and are very satisfied with the process of consultation about consumers’ care and services.

Care planning documents provided evidence of comprehensive assessment and care planning information for consumers. Care documents contained consumers’ goals, health risks and individual preferences. Assessment and care planning documents also reflect input from consumers and/or their representatives as well as other health professionals involved in the care of the consumer. Staff demonstrated an understanding of each consumer’s needs and goals consistent with care planning documentation. Assessment and care planning documentation is reviewed regularly and when circumstances change.

Clinical staff provide consumers or their representative with an opportunity to discuss outcomes of assessment and planning at every monthly resident of the day review. Consumers and representatives have access to consumers’ care plans.

The Quality Standard is assessed as Compliant as five of the five specific requirements have been assessed as Compliant.

## Assessment of Standard 2 Requirements*.*

### Requirement 2(3)(a) Compliant

*Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.*

The Assessment Team found that the care documentation shows care planning includes relevant assessment and risk identification. Staff know consumers’ risks and described strategies to ensure their safe and effective care. The service monitors consumers’ identified clinical risks such as falls, behaviours, infections, wounds and pressure injuries via a newly implemented electronic risk management system. Care plan documentation reflects the outcome of risk assessments undertaken in relation to pain, falls, skin integrity and specialised care needs. These are updated as these risks change or in response to the investigation of any incident or feedback.

Members of the multi-disciplinary team as well as other health professionals said they are consulted for their input as required. Care staff are involved in the assessment processes. Care planning documentation is kept current and any changes to care are available to care staff and other health professionals.

The service has draft policies and procedures in place that guide staff in the assessment and care planning process.

The Approved provider did not submit a response to this requirement.

I have reviewed all of the information provided and find this requirement is Compliant as the approved provider was able to demonstrate that consumers are assessed for risk and that this information informs individualised care plan interventions for each consumer.

### Requirement 2(3)(b) Compliant

*Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.*

The Assessment Team found that consumers’ needs, goals and preferences are considered in the care planning process. All consumers and representatives interviewed provided positive feedback about the degree of interest demonstrated by staff when consulting them about their preferences.

Staff demonstrated an understanding of consumers’ needs and goals which was consistent with care planning documentation. Consumers’ care plans are personalised and outline preferences for showering times and frequency during the week, clothing preferences and individualised goals. Consumers’ care documents demonstrated that advance care planning is discussed with them and/or their representative according to the personal wishes of the consumer. Details of advanced care directives are included in an end of life care plan as well as the handover sheet. Staff use a culturally specific approach that enables open communication, including an option to decline any conversations regarding end of life care.

The service has a draft policy which guides staff in assisting consumers and their representatives with advance care planning.

The Approved provider did not submit a response to this requirement.

I have reviewed all of the information provided and find this requirement is Compliant as the approved provider was able to demonstrate that assessment and care planning identifies and addresses consumers’ current needs and preferences, including end of life planning if the consumer wishes this to occur.

### Requirement 2(3)(c) Compliant

*The organisation demonstrates that assessment and planning:*

1. *is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and*
2. *includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.*

The Assessment Team found that assessment and care planning documents reflect input from consumers and/or their representatives as well as specialists involved in the care of the consumer. These include geriatricians, general practitioners, allied health team, external experts and the leisure and lifestyle team. Consumers and representatives are very satisfied with the process of consultation about consumers’ care and services and spoke positively about how staff respect choices and decisions about who they want involved in their care. Communication with the consumer and/or their representative is documented throughout the initial assessment and care planning process on entry to the service.

The Approved provider did not submit a response to this requirement.

I have reviewed all of the information provided and find this requirement is Compliant as the approved provider was able to demonstrate that assessment and care planning is based on ongoing partnership with consumers and includes other service providers as required.

### Requirement 2(3)(d) Compliant

*The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.*

The Assessment Team found that clinical staff provide consumers or their representative with an opportunity to discuss outcomes of assessment and planning with every resident of the day review. Representatives confirmed that staff are responsive in discussions about the consumer’s care and that they have access to care plans. Care staff have ready access to consumers’ care plans to facilitate service delivery. The service has a draft policy in place to guide staff practice in relation to representative involvement and consultation

The Approved provider did not submit a response to this requirement.

I have reviewed all of the information provided and find this requirement is Compliant as the approved provider was able to demonstrate that the outcomes of assessment and planning are communicated to consumers/representatives and that care plans are readily accessible to consumers/representatives.

### Requirement 2(3)(e) Compliant

*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.*

The Assessment Team found that consumers’ assessment and care planning documentation is reviewed regularly and when circumstances change. Consumers’ files demonstrate that assessment and care plans were reviewed every month, when consumers’ preferences have changed or following any incidents. Documentation of each incident includes details of the follow-up investigation and management overview. The general practitioner and other relevant health professionals are informed and where appropriate the consumer is reassessed for any changes to documented care interventions. Clinical staff described the incident management process including communication with representatives when required. The service has policies and procedures in draft form to guide staff practice in relation to review of care and services.

The Approved provider did not submit a response to this requirement.

I have reviewed all of the information provided and find this requirement is Compliant as the approved provider was able to demonstrate that consumers’ care and services are reviewed regularly for effectivities and are also reviewed when consumers’ circumstances change.

# STANDARD 3 Personal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The approved provider was found Non-compliant in relation to five requirements under this Quality Standard at the previous assessment visit.

To understand the consumer’s experience and how the organisation understands and applies the requirements within this Standard, the Assessment Team sampled the experience of consumers – their care plans and assessments were reviewed and staff were asked about how they ensure the delivery of safe and effective care for consumers. The team also examined relevant documents.

Consumers and representatives interviewed said care is safe and meets consumers’ needs. Staff interviews, and clinical documentation demonstrate individualised care that is safe, effective and tailored to the specific needs and preferences of the consumer. This includes best practice management of skin integrity, pain, restraint and behaviours to optimise health and well-being.

Consumers’ clinical needs are identified, assessed and individualised interventions developed and implemented to manage pain, skin integrity and wounds and behaviours. Potential clinical risks such as falls are also identified, assessed and managed effectively. Consumers with complex care needs such as diabetes management, stoma care, fluid balance monitoring requirements and swallowing difficulties are managed.

Staff provided feedback about how to identify and monitor deterioration and consumers’ overall feedback was that staff would know what to do in the event their health needs changed.

The service has effective processes to document and communicate information about consumers’ condition, needs and preferences including verbal and written handover. Clinical staff, allied health professionals and care staff confirmed they are provided with and have access to the information they need.

All staff demonstrated an effective understanding, application and monitoring of infection control practices. Observations indicated consistent application and usage of PPE as required. Consumers’ infections are identified and managed. Antibiotic prescription is minimised.

Five requirements under this Quality Standard have been assessed and found Compliant.

An overall rating for this Quality Standard is not provided as not all requirements were assessed.

### Assessment of Standard 3 Requirements*.*

### Requirement 3(3)(a) Compliant

*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.*

The Assessment Team found that consumers and representatives interviewed said care is safe and meets consumers’ needs. Staff interviews, and clinical documentation demonstrates individualised and safe care is provided. This includes best practice management of skin integrity, pain, behaviours and restrictive practices to optimise health and well-being. Clinical staff demonstrated a sound understanding of how to identify which consumers were subject to restrictive practices. They demonstrated minimal and effective use of as required (PRN) psychotropic medication as well as behaviour management strategies and referrals that aligned with best practice. This was supported by review of consumers’ clinical files.

Pain charting is commenced following consumers’ incidents or injury as appropriate, and at other times as required. Care plans shows non-pharmacological strategies are implemented including access to allied health for pain management as required. The monitoring of 'as needed' pain medication is documented for effectiveness in progress notes and on medication charts. Pain assessment and management is an ongoing focus for the service, with a recent internal audit identifying which pain assessment tool was most appropriate to use for individual consumers and ensuring all consumers have current pain issues documented. Consumer files reviewed demonstrated appropriate assessment and management of pain.

Strategies to maintain consumers’ skin integrity are documented. Appropriate equipment is in use. Incidents are documented when skin integrity is compromised. Monitoring occurs as required to ensure healing of wounds.

The service has draft clinical policies and procedures as well as behavioural management flow charts in place to guide staff practice.

The Approved provider did not submit a response to this requirement.

I have reviewed all of the information provided and find this requirement is Compliant as the approved provider was able to demonstrate that each consumer gets safe and effective clinical and personal care.

### Requirement 3(3)(b) Compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

The Assessment Team found that potential clinical risks such as falls are identified, assessed and managed effectively. Two consumers who recently experienced falls were appropriately managed and monitored. These consumers were reviewed by their general practitioner and falls prevention interventions were reviewed by a physiotherapist following the falls. Relevant care plans have been reviewed.

While two consumers with stomas have current assessments and care plans relating to the management of the stoma, the Assessment Team found that the service does not have emergency management directions for stomas. It was also noted that whilst the service had draft forms of some clinical policies and procedures to support staff practice, there was no policy pertaining to management of a suprapubic catheter. Management acknowledged the importance of implementing such guidance for staff.

Two consumers who are currently on fluid balance monitoring had appropriate documentation completed as per medical directives. Staff demonstrated and understanding of the symptoms and management of fluid overload.

Two consumers living with type two diabetes mellitus have current management plans and appropriate monitoring documentation recorded.

Two consumers with swallowing difficulties have current assessments and interventions in place as directed by the speech pathologist. Staff demonstrated an understanding of the safety requirements for these consumers.

The Approved provider did not submit a response to this requirement.

I have reviewed all of the information provided and find on balance that this requirement is Compliant. While the Assessment Team identified some gaps in the policy guidance for staff in relation to stoma care and emergency management, these issues will be considered under Standard 8 requirement (3) (e). Overall the approved provider was able to demonstrate effective management of risk associated with the care of each consumer.

### Requirement 3(3)(d) Compliant

*Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.*

The Assessment Team found that staff were able to provide feedback on how to identify and monitor consumers’ deterioration and appropriate escalation. Consumers and representatives interviewed said staff would know what to do in the event their health needs changed. Consumers’ files demonstrated appropriate management of clinical deterioration including timely medical referral and regular monitoring and recording of required observations.

The Approved provider did not submit a response to this requirement.

I have reviewed all of the information provided and find this requirement is Compliant as the approved provider was able to demonstrate that staff recognise and respond to consumers’ deterioration in a timely manner.

### Requirement 3(3)(e) Compliant

*Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.*

The Assessment Team found that the service has effective processes to document and communicate information about consumers’ condition, needs and preferences including verbal and written handover. Clinical staff, allied health professionals and care staff are provided with and have access to the information they need. Consumer documentation including care plans, progress notes and written handover, supports the effective and safe sharing of consumers’ information. Details of information exchanged to other care professionals is easily accessible in consumers’ files. Notes on reviews and assessments completed are also available. The Assessment Team observed current handover sheets that contain information about consumers’ care needs including allergy and risk information, mobility and dietary requirements. Over the three days of the assessment contact, new copies of the handover sheet were provided to staff every day, evidencing constant updates by clinical staff

The Approved provider did not submit a response to this requirement.

I have reviewed all of the information provided and find this requirement is Compliant as the approved provider was able to demonstrate that information about consumers’ conditions, needs and preference is documented and communicated.

### Requirement 3(3)(g) Compliant

*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.*

The Assessment Team found that the service has a range of systems and processes to minimise infection such as an infection, prevention and control lead, risk screening of staff and visitors on entry, and influenza and COVID-19 vaccination programs for consumers and staff. Monitoring systems such as reporting of infections, collation and analysis of infection data are developing and being embedded within staff practice. The service’s policies and procedures to guide staff practice are yet to be ratified by the service’s Board. The service’s infection, prevention, control lead has completed all required training. Their role was initially related to COVID-19 and it has now expanded to include aspects of the environment, antimicrobial stewardship and staff education. Infections and prescribed antibiotics are recorded within the service’s electronic care planning system with data collated monthly for trending and analysis. Infection prevention and control summary reports for May and June 2021 included a clinical review of each consumer’s infection, in most cases an evaluation and a broader summary. Vaccination registers are maintained for consumer and staff.

Staff have received PPE training and the Assessment Team observed staff using required PPE appropriately. Sufficient supplies of PPE were observed within reach of staff.

The Approved provider did not submit a response to this requirement.

I have reviewed all of the information provided and find this requirement is Compliant as the Approved provider was able to demonstrate processes and practices have been implemented to minimise infection related risks.

# STANDARD 6 Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

The approved provider was found Non-compliant in relation to three requirements under this Quality Standard at the previous assessment visit.

The Assessment Team assessed the three Non-compliant requirements and found them Compliant.

An overall rating for this Quality Standard is not provided as not all requirements were assessed.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

The Assessment Team found that the service has implemented a range of systems and process to encourage and support stakeholders to provide feedback. Consumers/representatives interviewed confirmed they feel safe to raise feedback and described how they had done so either via telephone or face to face. Staff described ways they support consumers to raise feedback. The service’s management and Board members described historical and cultural challenges to stakeholders providing feedback and described further actions they plan implement encourage and support feedback. Feedback forms are currently available in English and Greek and displayed in various areas of the service. The service’s resident handbook and agreement include information about providing feedback to the service including the Aged Care Quality and Safety Commission contact details. The Assessment Team observed advocacy, hearing and interpreter service information displayed in various areas of the service. Information is displayed in English and other languages appropriate to the service’s cohort of consumers.

The Approved provider did not submit a response to this requirement.

I have reviewed all of the information provided and find this requirement is Compliant as the Approved provider was able to demonstrate improvements have been made to encourage and support consumers and their families to provide feedback and make complaints.

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

The Assessment Team found that consumers and representatives are satisfied that appropriate actions are taken in response to complaints. Staff have completed some training in and demonstrated a basic understanding of open disclosure. The Assessment Team sampled complaints (feedback) recorded on the service’s complaints register and found appropriate action has been taken. Whilst management reported an open disclosure process is applied documentation did not consistently support this had occurred

The service has draft policies and procedures to guide complaints management and open disclosure. These are yet to be ratified by the service’s Board.

The Approved provider did not submit a response to this requirement.

I have reviewed all of the information provided and find this requirement is Compliant. While specific processes in relation to open disclosure are still being implemented the approved provider was able to demonstrate previous deficits have been addressed and that appropriate action is taken in response to complaints.

### Requirement 6(3)(d) Compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

The Assessment Team found that the service now maintains a feedback and complaints register. Consumers and representatives interviewed expressed satisfaction with changes made at the service as a result of their feedback. While the the service currently does not trend feedback due to low volume of feedback provided, management provided examples of improvements implemented based on feedback. These include improvements to texture modified meals and to the laundry service. The facility manager’s monthly report to the Board includes a summary of feedback and complaints.

The Approved provider did not submit a response to this requirement.

I have reviewed all of the information provided and find this requirement is Compliant. The Approved provider was able to demonstrate that previous deficits have been acted on and processes have been implemented to enable consumer feedback and complaints to be used to improve the quality and care of services.

# STANDARD 7 Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The approved provider was found Non-compliant in relation to two requirements under this Quality Standard at the previous assessment visit.

The Assessment Team assessed the two Non-compliant requirements and found them Compliant.

An overall rating for this Quality Standard is not provided as not all requirements were assessed.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(c) Compliant

*The workforce* *is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

The Assessment Team found that the service demonstrated processes to record and monitor staff qualifications, practitioner registrations and criminal history checks. The service has implemented a range systems and staff have completed training to support and improve the knowledge and competency in relation to assessment and care planning and the provision of clinical and personal care as required under Standards 2 and 3. Whilst a new suite of competencies have been developed for a variety of knowledge areas these have not yet been implemented. Position descriptions are undergoing a final review prior to implementation. The service is yet to determine the best ongoing training processes/platform for their cohort of staff.

Overall sampled consumers considered that they receive personal care and clinical care that is safe and right for them. Consumers and representatives feel safe to raise concerns with staff and did not report any concerns with staff skills and knowledge.

The Assessment Team verified that the following actions have been undertaken to address previous deficits. This include the appointment of a human resource manager, the identification of staff training needs through feedback. training, competencies, incident information and observations and the provision of required training and associated language/ literacy support. The facility manger has informally met with the majority of staff to gain an understanding of their experience and identify opportunities to develop staff in various roles needing to be filled. Clinical staff demonstrated a sound understanding of how to identify consumers subject to restrictive practices. They were able to demonstrate minimal and effective use of as required (PRN) psychotropic medication as well as behaviour management strategies and referrals that aligned with best practice.

The service maintains a training matrix and records training which has been provided and the number of staff who attended. The matrix shows training has been provided to address previously identified defects in staff knowledge including medication safety, diabetes management, comprehensive health assessment of the older person and clinical deterioration. In addition to existing competencies such as hand hygiene, donning and doffing of PPE and medication the service has developed a suit of competencies to be implemented. These include wound management, pressure area care and diabetes learning and assessment packages.

The service has a register of staff qualifications, nursing registrations and criminal history checks.

The Approved provider did not submit a response to this requirement.

I have reviewed all of the information provided and find this requirement is Compliant. The Approved provider was able to demonstrate that previous deficits have been acted on and processes implemented to ensure the workforce is competent and members of the workforce have the qualifications and knowledge to effectively perform their roles.

### Requirement 7(3)(e) Compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

The Assessment Team found that whilst the service has a performance appraisal tool, this has not yet been used to assess, monitor and review the performance of each staff member. The service did not advise an expected timeframe for their performance appraisal process to be commenced and/or completed. The service’s performance management policy and procedure is in draft format and has not yet been reviewed by the human resources manager nor approved by the service’s Board.

The facility manager described performance management processes currently being applied to a registered staff member in response to allegations of historical unnecessary use of force and unauthorised use of restrictive practices. These allegations have been recorded on the service’s SIRS register and reported to the Commission.

The Approved provider’s response confirms that the service’s performance appraisal tool has not yet been implemented. The response notes that a decision was made by the Board to commence formal staff appraisal processes in August 2021, to give staff returning to their roles time to adjust to the changes being implemented at the service. The response notes that through this time senior staff have managed staff performance through observation, incidents and complaints. The response also confirms that performance management and disciplinary action has been undertaken in relation to two staff members through this period. The response notes that since the assessment contact the performance management policy has been ratified by the Board and is being implement within the service. A performance appraisal schedule for 2021 was provided.

I have reviewed all the information provided and on balance I am satisfied that this requirement is Compliant. While the approved provider had not implemented the service’s formal staff appraisal process at the time of the assessment contact, mangers at the service were able to demonstrate that staff performance was being monitored and reviewed and action taken where necessary. The approved provider also provided information demonstrating that the formal staff appraisal process has commenced.

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

The approved provider was found Non-compliant in relation to five of the five specific requirements under this Quality Standard at the previous assessment visit.

The service has commenced to actively seek engagement with stakeholders in the design and delivery of care and services. The Assessment Team notes these activities are mostly in the development phase, not yet implemented or results not yet collated and evaluated.

The Board has undertaken a range of training to understand their accountability for the delivery of care and services. A range of systems and processes such as subcommittees and reporting are in the development and implementation phase.

Whist the service showed improvements with governance systems a number of critical systems such as policies and procedures and monitoring process (meetings, audits and reporting) are not yet fully implemented and embedded into practice therefore have not yet been evaluated for effectiveness.

The service has a range of process to assess, plan, monitor and report high impact or high prevalence risks associated with the care of consumers.

While the service provided a documented clinical governance framework, a policy relating to antimicrobial stewardship, a policy relating to minimising the use of restrictive practice and an open disclosure policy, these documents are in draft form and yet to be ratified by the service’s Board. Other governance systems such as audits and industry benchmarking, committees, reporting, corrective action processes are either yet to be implemented and/or in the development/implantation phase therefore have not evaluated for effectiveness

The Assessment Team assessed the five requirements and found three requirements Non-compliant.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Non-compliant

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

The Assessment Team found that the service has commenced to actively seek engagement with stakeholders in the design and delivery of care and services. The Assessment Team notes these activities are mostly in the development phase, not yet implemented or results not yet collated and evaluated.

The Board has implemented a ‘consumer support network’ subcommittee. The recorded membership of this subcommittee includes a Board member, facility manager, two consumers and three representatives, with different representatives to be invited time to time to ensure a variety of stakeholder engagement. Suggestions from this committee have included a theatre, a library and a café. A library has been set up in one wing, larger projects are to be considered as part of the Board’s strategic planning process. The Board also has plans to increase consumer access to the Board, with the implementation of a roster of Board members to visit the service and engage and seek consumer feedback. A proposed broader consumer engagement group has not yet gained support. A representative’s suggestion to change the name of the service’s wings has not yet been acted on.

On the 16 June 2021 the service emailed stakeholders their annual survey which seeks their feedback on care and services. Results are pending.

The Approved provider did not submit a response to this requirement.

I have reviewed all of the information provided and have come to a different view to the Assessment Team. I find this requirement is Non-compliant. While the Approved provider was able to demonstrate that actions have commenced to address previously identified deficits, I am not satisfied that the changes to improve consumer engagement in the development, delivery and evaluation of care and services are fully implemented. The proposed actions while take time to be embedded and for outcomes to be demonstrated.

### Requirement 8(3)(b) Compliant

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

The Assessment Team found that the Board has undertaken a range of training to understand their accountability for the delivery of care and services. A number of systems and processes such as subcommittees and reporting are in the development and implementation phase. The current Board is made up of seven members with a range of skills and experience. Board subcommittee members have skills related to aged care, medicine and nursing. Subcommittees are tasked with making recommendation to the Board on specific areas. A new financial auditor has been contracted and cyber and other security measures improved.

Current Board members have undertaken a range of internal training. Topics covered include aged care quality standards, basic governance, governance policies, clinical governance, risk management and roles and duties of Board members. Training for the Board has also been facilitated by the Australian Institute of Company Directors.

The Board satisfies itself that the Quality Standards are being met through the ongoing employment of a nurse advisor, ongoing development of the Board and subcommittees, having the right people in the right roles at the service level, appropriate reporting from the service and the development of policies and procedures.

The Approved provider did not submit a response to this requirement.

I have reviewed all of the information provided and find this requirement is Compliant. While actions are not yet fully embedded, the Approved provider was able to demonstrate that previous deficits have been acted on to ensure a governing body that promotes a culture of safe and quality care and services that is accountable for their delivery.

### Requirement 8(3)(c) Non-compliant

*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.*

The Assessment Team found that while the service showed improvements with governance systems a number of critical systems such as policies and procedures, monitoring process and continuous improvement processes are not yet fully implemented and embedded into practice therefore have not yet been evaluated for effectiveness.

Opportunities for continuous improvement are identified by feedback, suggestions, incidents, reviews, collation and analysis of clinical data, meetings, observations and through changes in regulatory requirements. While the service has a range of meetings and a meeting calendar the Assessment Team noted some meetings (medication advisory committee, nurse and consumer) are still in their development phase. The service has held one medication advisory committee meeting in the last six months. The medication advisory committee meeting minutes do not reflect reported deficits in supply pharmacy service and contain limited information about requirements regarding the use of psychotropic medications. There was no reference to other relevant issues.

The service is planning to implement a suite of audits and industry benchmarking) in late July 2021 to seek opportunities for continuous improvement and satisfies itself the Quality Standards are being met.

The service maintains an electronic continuous improvement plan. A number of planned actions in response to identified non-compliance with the Quality Standards. Evaluation of improvements completed have not been consistently recorded. Members of the service’s Board advised they plan to implement a new process which will demonstrate effectiveness of actions implemented. This process it yet to be implemented.

Improvements have been made to the service’s clinical documentation system including an enhancement of the security of these information management systems.

The service is process of implementing budgets for various areas of the service. The service has implemented a credit card system for small purchases and developed a guiding policy for financial delegations.

Workforce governance processes are being established and are the role of the recently appointed human resource manager.

The service has a documented serious incident management - serious incident response scheme reporting (SIRS) policy which has been approved by the service’s senior leadership and clinical risk and governance committee however, no approval date has been recorded. Other related policies such as open disclosure, incidents and incident management and reporting are in draft form and do not always contain appropriate information to guide staff practice.

The service has a consolidated register which reflects incidents which have been reported as per regulatory requirements and includes follow up actions. Management know the incident management system is working as evidenced by staff reporting incidents including reporting of historical incidents.

Training documents show 69 of 87 staff have completed SIRS training with a further session planned in September 2021.

Governance processes in relation to feedback and complaints are being implemented.

The response submitted by the Approved provider acknowledges that governance systems are not fully implemented, particularly in relation to policies and procedures, internal auditing and meeting accountabilities and responsibilities. The response notes that these processes and related practices will require time to be embedded. The response states that Board approval of key policies and procedures commenced in July 2021 and that the meeting schedule has been reviewed and aligned to Board and Board sub-committees. The response notes that all aspects of the plan for continuous improvement are reviewed monthly and changes are made to reflect the status or each action. The response also notes that the 2021/22 facility budget is in place with regular expenditure reporting to the Board, that an organisational structure has been created and all roles filled including a full quota of registered nurses and care staff. All staff have now completed SIRS training.

I have considered all the evidence provided and on balance I find this requirement Non-compliant. While the Approved provider has commenced actions to address the governance deficits previously identified, policies and procedures to guide staff practice have not yet been endorsed, internal auditing has yet to commence, and committees are not yet fully functioning to meet relevant responsibilities and accountabilities.

### Requirement 8(3)(d) Compliant

*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.*

The Assessment Team found that the service has a range of process to assess, plan, monitor and report high impact or high prevalence risks associated with the care of consumers.

The service’s incident management system (IMS) includes an electronic reporting system for clinical incidents within which details of the follow-up investigation(s) and management review are recorded. The general practitioner and other relevant health professionals are informed and where appropriate the consumer is reassessed for any changes to documented care interventions as evidenced in Standards 2 and 3. Staff are aware of their reporting and escalation responsibilities depending on their role.

The service has a range of process to assess, plan, monitor and report high impact or high prevalence risks associated with the care of consumers. These include risk assessments, a risk profile on handover, a register of consumers prescribed psychotropic medications, an infection register, a whiteboard in the nurse’s station that outlines risks for consumers, stop and watch process and huddles.

Commencing July 2021 senior nurses have been allocated portfolios which align with the national quality indicator program and other high impact or high prevalence risks such as infection. A clinical care manager explained how staff are developing their knowledge in relation to allocated portfolios, reporting expectations and how staff are provided with feedback on their reports to aid their development. Tools to aid reporting are also being developed.

The service has draft policies and procedures regarding elder abuse which are yet to be ratified by the Board. Eighty-five of 87 staff have completed online elder abuse training. Staff described appropriate actions they would take if they observed and or suspected elder abuse.

The Approved provider did not submit a response to this requirement.

I have reviewed all of the information provided and find this requirement is Compliant. While actions are not yet fully embedded, the Approved provider was able to demonstrate that previous deficits have been acted on to ensure effective risk management systems and practices are in place.

### Requirement 8(3)(e) Non-compliant

*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.*

The Assessment Team found that while the service provided a documented clinical governance framework, a policy relating to antimicrobial stewardship, a policy relating to minimising the use of restrictive practice and an open disclosure policy, these documents are in draft form and yet to be ratified by the service’s Board. The Assessment Team noted policies did not always contain contemporary and/or critical information to guide staff practice. Other governance systems such as internal auditing and industry benchmarking, committees, reporting and corrective action processes are either yet to be implemented, or are in the development phase therefore have not evaluated for effectiveness.

The service is planning to implement a suite of audits and industry benchmarking in late July 2021. The service is planning to implement a corrective action report and register. Meetings such as nurse, medication advisory committee and consumer are yet to be consistently held and yield outcomes.

A Board member and management acknowledged the need for further review of the service’s medication, falls management, incident reporting, complaint, information management (storage), restrictive practices and restrictive interventions policies to ensure clear guidance for staff. The timeframe for this review was August 2021. The Assessment Team also noted that the antimicrobial stewardship policy, the infection prevention and control policy and the open disclosure policy all require review to ensure they reflect current best practice. Policies and procedures have primarily been developed internally or provided by a related aged care residential service.

In relation to antimicrobial stewardship:

Clinical staff demonstrated an understanding of safe medication practices that aligned with best practice principles. Whilst they were aware that there was a policy available in draft form, they were unaware of the specific content of the policy.

In relation to restrictive practice:

Clinical staff demonstrated a sound knowledge and implementation of best practice principles relating to restrictive practices. Care staff were able to demonstrate understanding of chemical restraint being utilised as a last resort for consumers and successful behaviour management interventions that were effective in managing behaviours of concern. They were also able to describe escalation to a registered nurse when required. The draft restrictive practice policy requires review and updating.

In relation to open disclosure

While senior nursing staff and management demonstrated and understanding of open disclosure and how they apply this in their day to day work they acknowledged their documentation does not reflect guiding principles of open disclosure. Care staff interviewed did not always demonstrate an understanding open disclosure or how they may apply this in there day to day work. The draft open disclosure policy requires review

Training records show 62 of 67 required staff have completed online open disclosure training. Further training is scheduled September 2021.

The Approved provider response notes that the clinical governance framework has been in place since February 2021 and has been used to guide improvements. Further education and planning in relation to the clinical governed framework is planned for August 2021. Internal auditing commenced in July 2021. The response also notes that key policies including the complaints management, open disclosure, medication management and infection prevention and control are currently being reviewed. The falls management and restrictive practices policies have also been updated. The response notes that registered nurse portfolio roles and relevant meetings will include ongoing policy review.

I have considered all the evidence provided and on balance I find this requirement Non-compliant. While the Approved provider has commenced actions to address the clinical governance deficits previously identified, governance processes including policies and procedures to guide staff practice particularly in relation to antimicrobial stewardship, restrictive practices and open disclosure have been reviewed and updated since the assessment contact and monitoring processes are not yet fully implemented to ensure ongoing compliance.

# 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.

* Implement planned actions to ensure consumer engagement in the development, delivery and evaluation of care and services.
* Implement planned governance systems including organisational and service delivery policies and procedures and monitoring process (committees, audits and reporting). Ensure the organisation’s continuous improvement process is used to monitor, identify, act on and evaluate improvement opportunities across all areas of the service.
* Ensure the service’s clinical governance framework is fully implemented including antimicrobial stewardship and open disclosure processes.