Villa St Hilarion-Fulham

Performance Report

21 Farncomb Road
FULHAM SA 5024
Phone number: 08 8235 9055

**Commission ID:** 6145

**Provider name:** The Society of St Hilarion Inc

**Site Audit date:** 18 February 2020 to 20 February 2020

**Date of Performance Report:** 6 April 2020

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-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) | Non-compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Non-compliant |
| Requirement 3(3)(e) | Non-compliant |
| Requirement 3(3)(f) | Non-compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Non-Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Non-compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Non-compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Non-compliant |
| Requirement 6(3)(d) | Non-compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Non-compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | 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 Site Audit; the Site Audit 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 Site Audit report received 26 March 2020.

# STANDARD 1 COMPLIANTConsumer 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 Assessment Team found all sampled consumers confirmed they are treated with dignity and respect, can maintain their identity, make informed choices about their care and services and live the life they choose. Specific consumer feedback includes:

* All consumers stated they are treated with dignity and respect by all staff.
* All consumers were able to describe ways they feel supported to exercise choice and independence enabling them to maintain close relationships of choice.
* All consumers described how information provided to them assists them to make decisions.
* All consumers interviewed are satisfied their personal privacy is respected.

Staff interviewed spoke about consumers in a manner which demonstrated warmth and affection and an understanding of consumers’ personal experiences. Care staff demonstrated they are familiar with consumers’ backgrounds and how to provide care in accordance with consumers’ individual needs and preferences. Staff described how they support consumers to make decisions on a day-to-day basis. Staff were able to explain key risks for individual consumers, including how these risks are assessed and documented. Staff described various mechanisms used to keep consumers’ personal information private and confidential.

The Assessment Team reviewed care planning documentation which reflected things which are important to consumers, including spiritual and cultural needs. These documents reflect consultation with consumers during care plan review processes.

The Assessment Team observed staff interacting with consumers in a respectful and kind manner. They also observed leaflets, flyers, menus and lifestyle calendars available in multiple languages. The Assessment Team observed consumer records to be stored in a locked area of the service and all computers required password access.

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

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Compliant

*Each consumer is supported to exercise choice and independence, including to:*

1. *make decisions about their own care and the way care and services are delivered; and*
2. *make decisions about when family, friends, carers or others should be involved in their care; and*
3. *communicate their decisions; and*
4. *make connections with others and maintain relationships of choice, including intimate relationships.*

### Requirement 1(3)(d) Compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

### 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.*

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

# STANDARD 2 NON-COMPLIANTOngoing 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 Assessment Team found most sampled consumers confirmed they feel like partners in the ongoing assessment and planning of their care and services. Specific consumer feedback includes:

* Three consumers and/or representatives confirmed they have been involved in the assessment and planning phase of the development of the care plan.
	+ While two consumers and/or representatives stated they have not been involved in assessment and care planning processes, documentation demonstrates discussions of consumers’ care during care plan reviews.

Staff interviewed were able to describe how consumers’ care plans informs the delivery of safe and effective care. This includes information relating to consumers’ goals and preferences for end of life care.

The Assessment Team found a variety of health professionals are involved in the regular review of consumers’ care and include the consumer and/or representative. The care plan folder reflects the date of each care plan review, and who was involved in this process. All consumers have a care plan which is readily accessible to staff and consumers if they desire. Care plans were observed to be kept in a secure area of the nurses’ station.

The Assessment Team found Requirement (3)(a) in this Standard Non-compliant based on the service’s care planning documentation not consistently containing sufficient information to guide staff when changes occur in consumers’ health and well-being, and staff not consistently reassessing consumers for all potential risks following incidents. However, I find the service does have assessment and planning processes which considers risks to consumers’ health and well-being and find the service Compliant with Requirement (3)(a). See this Requirement below for reasons for my decision.

The Assessment Team found Requirement (3)(e) in this Standard Non-compliant. While the organisation has policies to guide staff in relation to assessment and care planning, these are not consistently followed when consumers’ circumstances change or after incidents. I find the service is Non-compliant with Requirement (3)(e) in this Standard because consumers’ care and services are not always reviewed following changes in consumers’ circumstances or after incidents. See this Requirement below for reasons for my decision.

The Quality Standard is assessed as Non-compliant as one of the five specific requirements has been assessed as Non-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 the service’s care planning documentation does not consistently contain sufficient information to guide staff when changes occur in consumers’ health and well-being, and staff do not consistently reassess consumers for all potential risks following incidents. The Assessment Team provided the following findings and evidence relevant to my decision:

* Care planning documents for a consumer did not contain information to guide staff in relation to declining mental health and suicidal ideation.
* Care planning documents for a consumer did not provide guidance for staff in relation to potential falls risk from episodes of low blood pressure.
* Staff do not consistently follow the service’s processes to reassess and review consumers’ potential and actual risks when incidents occur.

The approved provider submitted a response to the Assessment Team’s report and does not agree with the Assessment Team’s findings. The approved provider has provided additional information to support a finding of Compliance in relation to this Requirement. The approved provider asserts the following:

* In relation to the consumers with declining mental health and suicidal ideation, the service states the consumer moved into the service with known behaviours and continued to exhibit these behaviours while residing at the service. These behaviours are documented in the care plan.
	+ The consumer had a diagnosis of depressive anxiety prior to entry and had been on medication to manage the condition prior to moving into the service. The consumer’s condition has not escalated since entry and this was confirmed by the medical officer to the Assessment Team.
* In relation to a consumer whose care plan did not provide guidance for staff in relation to potential falls risk from episodes of low blood pressure, the service finds blood pressure was not a contributory factor to falls based on four falls occurring in the presence of staff members and the consumer’s poor eyesight and desire to maintain independence. A plan of care was reviewed after each incident and included review of falls prevention strategies.

Based on the Assessment Team’s report and the approved provider’s response, I find the service is Compliant with this Requirement. I find assessment and planning processes did initially identify the consumers’ behavioural, mental health or falls risks. However, when circumstances changed or when incidents occurred, the service did not recognise the need for a reassessment or did not effectively reassess the consumers’ needs to ensure strategies were meeting their needs and preferences. I find the Assessment Team’s evidence in this Requirement is more relevant to Requirement (3)(e) in this Standard and I have considered this evidence in that specific Requirement.

For the reasons detailed above I find The Society of St Hilarion Inc, in relation to Villa St Hilarion-Fulham, is Compliant in relation to Standard 2 Requirement (3)(a).

### 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.*

### 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.*

### 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.*

### Requirement 2(3)(e) Non-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 the service was unable to demonstrate review of care plans when circumstances change or when incidents have occurred. The Assessment Team provided the following findings and evidence relevant to my decision:

* In an approximate four-month period, numerous progress notes for a consumer demonstrated the consumer was distressed, crying, aggressive and wanting to go home. A depression assessment identified the consumer as having severe depression and progress notes identified the consumer was having suicidal thoughts. However, new strategies to manage the consumer’s condition and mental state were not implemented in response to these indicators of unmanaged behaviours or decline in mental health.
* In a two-year period, a consumer had left the service without supervision on six occasions. However, the service has not reviewed safety management strategies to prevent or minimise the re-occurrence of this type of incident.
* Documentation shows a consumer had seven falls in a 12-month period, with two falls resulting in injuries to the consumer. While the service reviewed the consumer’s falls prevention strategies after each fall, changes were not made to the strategies or additional strategies implemented to prevent the consumer from falling.
* Clinical staff interviewed were unable to describe why the consumer’s care plan and associated strategies had not been reviewed for effectiveness when incidents impacted on the consumer’s health, safety and well-being.

The approved provider submitted a response to the Assessment Team’s report and does not agree with the Assessment Team’s findings. The approved provider has provided additional information to support a finding of Compliance in relation to this Requirement. The approved provider asserts the following:

* The consumer with ongoing behavioural and/or mental health issues entered the service with a longstanding depression diagnosis and associated behaviours. The service asserts these were not new circumstances for the consumer and therefore there was no escalation in behaviours or changes in mental health status.
* In relation to the consumer who had left the service without supervision on six occasions, each incident was reported, documented and reviewed by senior clinical staff. Episodes were a year apart and the consumer was not found more than two metres outside the gate. The consumer has numerous safety interventions, and these appear effective.
* In relation to the consumer who has had seven falls in 12 months, the service states the consumer was reviewed after each fall and the care plan was assessed for any specific modifications or additional interventions. All safety requirements were adequate to minimising potential for falls.

Based on the Assessment Team’s report and the approved provider’s response I find the Service is Non-compliant with this Requirement. I find the Assessment Team’s evidence supports that consumers’ care is not reviewed for effectiveness following incidents or changes in circumstances. In relation to the consumer with unmanaged behaviours and/or mental health decline, while the service asserts the behavioural and mental health needs were identified on entry, I find the numerous progress notes over a four-month period, related to the consumer’s behaviours and mental status, were indicative of a change in the consumer’s mental health and cognitive function. Subsequently the consumer’s care should have been reviewed for effectiveness. Additionally, while in some instances the service is reviewing consumers’ care following incidents, this process is not effectively reviewing the current strategies, as strategies remain unchanged and incidents continue to occur.

For the reasons detailed above I find The Society of St Hilarion Inc, in relation to Villa St Hilarion-Fulham, is Non-Compliant in relation to Standard 2 Requirement (3)(e).

# STANDARD 3 NON-COMPLIANTPersonal 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 Assessment Team found most sampled consumers considered they receive personal and clinical care that is safe and right for them. Specific consumer feedback includes:

* Most consumers interviewed confirmed they receive the care they need.
* One representative was not satisfied with the clinical care provided to their family member.
* All consumers confirmed they have access to a doctor and allied health professionals when they need to.

The Assessment Team found the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved. Staff interviewed were able to describe how they provide care for consumers nearing the end of their life.

Clinical staff interviewed were able to describe ways they minimise the need for and the use of antibiotics to minimise infection related risks. Care staff interviewed were able to demonstrate an understanding of when they should use additional precautions in relation to personal protective equipment.

The Assessment Team found the service was Non-compliant in relation to Requirement (3)(a) because the service was unable to demonstrate each consumer gets safe and effective clinical care. I have found this Requirement Non-compliant and have provided reasons for my decision below.

The Assessment Team found the service was Non-compliant in relation to Requirement (3)(b) because the service was unable to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. I have found this Requirement Non-compliant and have provided reasons for my decision below.

The Assessment Team found the service was Non-compliant in relation to Requirement (3)(d) because the service was unable to demonstrate they consistently identify and respond to changes in consumers’ physical and mental health. I have found this Requirement Non-compliant and have provided reasons for my decision below.

The Assessment Team found the service was Non-compliant in relation to Requirement (3)(e) because the service was unable to demonstrate that following incident reporting for allegations of sexual and physical assault that actions implemented following these allegations were documented to enable clear communication within the organisation. I have found this Requirement Non-compliant and have provided reasons for my decision below.

The Assessment Team found the service was Non-compliant in relation to Requirement (3)(e) because the service was unable to demonstrate appropriate referrals to individuals, other organisations and providers of other care and services are attended in a timely manner. I have found this Requirement Non-compliant and have provided reasons for my decision below.

The Quality Standard is assessed as Non-compliant as five of the seven specific requirements have been assessed as Non-compliant.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-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 the service was unable to demonstrate each consumer gets safe and effective clinical care in accordance with best practice or which optimises each consumer’s health and well-being, specifically in relation to monitoring of blood pressure, implementation of medical officer directives, and completion of wound care documentation in accordance with the service’s policies and procedures. The Assessment Team provided the following findings and evidence relevant to my decision:

* Management and medication-credentialled care staff interviewed confirmed medication-credentialled care staff are responsible for undertaking blood pressure readings. However, these staff have not been provided with appropriate training and support to undertake this clinical role effectively.
* Clinical staff confirmed they are not reviewing blood pressure readings taken by medication-credentialled care staff on a daily basis, resulting in them omitting to recognise a number of ‘high’ blood pressures for multiple consumers.
* Documentation shows three consumers who have had blood pressure readings recorded outside optimal blood pressure ranges, have not been reviewed or managed in accordance with best practice to optimise each consumer’s health and well-being.
	+ One consumer had a medical officer directive for staff to monitor daily blood pressure readings, however, there was no optimal range recorded in medication charts, as per the service’s process, to support staff in recognising a suboptimal reading.
		- The consumer’s medication chart shows in a five-week period, 19 blood pressure readings were recorded outside of the optimal range and would be considered in a ‘high’ blood pressure range. However, these blood pressure readings were not escalated for clinical review.
		- On two occasions documentation indicates staff did refer ‘high’ blood pressure to the medical officer, however, medical officer notes do not indicate they reviewed the consumer’s ‘high’ blood pressure.
	+ A second consumer had a medical officer directive for staff to monitor daily blood pressure readings, however, there was no optimal range recorded to support staff in recognising a suboptimal reading.
		- For approximately one month, the consumer had daily blood pressure readings which would be considered ‘high’ which were not escalated for clinical review.
		- On one occasion the consumer had a significant ‘high’ blood pressure reading, however, this was not documented as being referred to the medical officer for review at the relevant time.
	+ A third consumer had three occasions of ‘high’ blood pressure which were not followed-up by clinical staff or medical officer.
* Documentation shows four consumers have not had their blood pressure monitored in accordance with medical officer directives.
* Documentation shows one consumer has not had their blood glucose levels monitored in accordance with their medical officer’s directives.
* Medication charts do not always contain indications for ‘as required’ medications in accordance with best practice guidelines.
* Alternatives strategies to the use antipsychotic medication has not always been trialled prior to the administration of a consumer on seven occasions in an approximate six-week period.
* Four consumers’ wound documentation shows staff are not adhering to the service’s wound management processes to document measures of all wounds.

The approved provider submitted a response to the Assessment Team’s report and have acknowledged the deficiencies identified by the Assessment Team. The approved provider has demonstrated a commitment and desire to rectify the deficiencies and have included compliance with this Requirement on the service’s continuous improvement plan. The approved provider has or plans to implement the following actions to ensure compliance with this Requirement:

* The service acknowledges that parameters for blood pressure monitoring were not always documented in medication charts, but this has now been corrected.
* The service acknowledges that use of medication-credentialled care staff to undertake blood pressure monitoring required changing. Subsequently, a directive both verbally and via email has been given to change this clinical responsibility from medication-credentialled care staff to clinical staff.
* The service acknowledges and recognises that there are inconsistencies in relation to blood glucose monitoring, supervision, urinalysis, maintenance of oxygen tubing, chemical restraint and medication charts and have included these areas on the service’s continuous improvement plan.

I acknowledge the service has been responsive to the deficiencies identified by the Assessment Team and had also initiated actions to improve the provision of clinical care. However, based on the Assessment Team’s report and the approved provider’s response, I find at the time of the site audit, the service did not monitor consumers’ blood pressure in accordance with best practice or medical officer directives, numerous medical officer directives were not always followed and wound documentation does not support staff to ensure effective monitoring of clinical outcomes for consumers. Deficiencies in these areas has impacted upon the delivery of safe and effective clinical care for consumers and has not promoted the delivery of best practice care or clinical care which is tailored to each consumer’s individual needs.

For the reasons detailed above I find The Society of St Hilarion Inc, in relation to Villa St Hilarion-Fulham, is Non-compliant in relation to Standard 3 Requirement (3)(a).

### Requirement 3(3)(b) Non-compliant

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

The Assessment Team found the service was unable to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. This is in specific reference to the service not adequately responding to four areas of risk; a consumer’s ongoing behavioural and/or mental health needs, a consumer’s repeated falls, consumers who require supervision found leaving their units unsupervised, and a consumer’s incremental weight loss. The Assessment Team provided the following findings and evidence relevant to my decision:

In relation to the consumer with ongoing behavioural and/or mental health needs:

* The service did not identify and respond appropriately, or in a timely manner, to a consumer’s ongoing behaviours, mental health decline or vocalisation of suicidal ideation.
	+ In an approximate four-month period, clinical staff did not effectively respond to progress notes indicating the consumer to have ongoing behaviours or ongoing indicators of a mental health decline. Progress notes in this period include:
		- Forty notes which show the consumer was crying, distressed or upset.
		- Seventeen notes which show the consumer was shouting.
		- Twelve notes which show the consumer was anxious.
		- Twenty-eight notes which show the consumer was stating they ‘wanted to go home’.
		- Seventeen notes which show physical aggression towards themselves or staff, including self-harming actions such as slapping their face and pulling their hair.
		- Fifteen notes which show the consumer was wandering or attempting to leave the service unsupervised.
	+ The medical officer reviewed the consumer approximately two months after the first signs of the above indicators and diagnosed the consumer with ‘major depression’ and commenced anti-depressant medication. However, the medical officer informed the Assessment Team the medication was not effective, and they were waiting for the consumer to “calm down maybe”.
	+ While the medical officer was aware the anti-depressant medication was not effective and a subsequent depression assessment (which showed the consumer as having severe depression) conducted by the service one month after the commencement of anti-depressant medications, no further changes were made by the medical officer. Additionally, no strategies were implemented by the service to address this ongoing and escalating health risk after the depression assessment in which they identified severe depression and suicidal ideation. The Assessment Team also identified two progress notes, one a month prior to the depression and assessment and another was on the day of the assessment which showed staff were aware of the consumer expressing thoughts of ending their life. One progress note stated the consumer said ‘I will kill myself’.
	+ Prior to the depression assessment identifying the consumer as having severe depression, the service did request the medical officer for an urgent referral to a geriatrician due to daily ‘ongoing anxiety, agitation, both physically and verbally abusive and threatening trying to hit staff and distressing other residents’. However, this referral was not actioned.
* The consumer’s representative was not satisfied the service effectively managed the consumer’s escalating distress or threats to end their life. The representative said they had heard the consumer make threats to their life and said the service were aware of the consumer having suicidal thoughts. The representative is concerned that the consumer was involved in an incident that was not accidental but rather an attempt by the consumer to end their life.

In relation to the consumer with repeated falls:

* Documentation shows a consumer had seven falls in a 12-month period, with two falls resulting in injuries to the consumer. While the service reviewed the consumer’s falls prevention strategies after each fall, changes were not made to the strategies or additional strategies implemented to prevent the consumer from falling.
* One falls prevention strategy for this consumer is to conduct hourly safety checks however, documentation does not support that these checks are being conducted.
	+ In an approximate one-week period, there were 35 occasions when the hourly check was not documented.
* Two staff interviewed said the consumer tries to mobilise on their own even though they require staff assistance and will try and sit down before they are correctly positioned over the chair. One staff member said it is difficult to attend to the consumer due to the layout of the home.
* Call bell data shows the consumer’s call bell is not always attended to within the service’s key performance indicator (KPI) of 12 minutes, with 28 call bells outside this time in a five-month period.

In relation to consumers who require supervision found leaving their units unsupervised:

* The service did not provide appropriate supervision of two consumers, in accordance with their care plans, to maintain their safety. The failure to provide adequate and appropriate supervision resulted in one consumer being involved in a significant incident causing them injury.
	+ In relation to the first consumer, the service had implemented preventative measures to monitor a consumer’s whereabouts and safety due to their potential to wander or leave the service unsupervised. The care plan directs staff to ‘escort to and from unit’ and a ‘door alarm’ to ensure staff are with the consumer when they are not in their unit.
		- An unwitnessed incident occurred where the consumer was hit by a waste disposal truck and the incident report indicates the consumer was not being supervised at the time of the incident.
		- Prior to the above incident, fifteen notes progress notes show the consumer was wandering or attempting to leave the service unsupervised.
	+ In relation to the second consumer, in a two-year period, the consumer has left the service without supervision on six occasions. However, the service has not reviewed safety management strategies to prevent or minimise the re-occurrence of this type of incident.
		- To alert staff to the consumer’s whereabout the care plan directs that the consumer is to have an alarm fitted to their door to alert staff if they are leaving their unit, are on hourly safety checks and must be escorted by staff to and from the unit.
		- The consumer’s hourly safety check chart shows in a 44-day period, staff completed the hourly checks on only 11 occasions.
		- Clinical staff indicated that the six incidents occurred because staff were not supervising the consumer and the consumer must have not been in their room prior to the incidents.
		- Staff interviewed said they are not always able to supervise the consumer if they are not in their room.

In relation to a consumer’s incremental weight loss:

* A consumer lost 4.3kgs in a 12-month period which has not been managed in accordance with the service’s weight loss management procedures.
	+ The consumer had several weight losses in the 12-month period, however, the consumer was not referred to a dietitian or interventions implemented to support the consumer’s nutritional status.
	+ The consumer’s nutritional risk assessment indicates the consumer is ‘low risk’ and the consumer indicated to the Assessment Team they are not concerned with their weight loss.

The approved provider submitted a response to the Assessment Team’s report and does not agree with the Assessment Team’s findings. The approved provider has provided additional information to support a finding of Compliance in relation to this Requirement. The approved provider asserts the following:

In relation to the consumer with ongoing behavioural and/or mental health needs:

* The consumer moved into the service with known behaviours and continued to exhibit these behaviours while residing at the service.
* A request for a geriatrician review was made to assist the consumer to settle into the service.
* The mental health coordinator assessed the situation and determined working with the family would assist the consumer to settle into the service.
* The service acknowledges the significant number of notes within the consumer’s records including incidents of crying, shouting and anxious thoughts and finds these notations are consistent with the consumer’s behaviour prior to moving into the service. Additionally, prior to moving into the service, the consumer had a diagnosis of depressive anxiety and had been on medication to manage this condition. The consumer’s condition has not escalated since entry and this was purportedly confirmed by the medical officer to the Assessment Team.

In relation to the consumer with repeated falls:

* The consumer was reviewed after each fall and the care plan was assessed for any specific modifications or additional interventions. All safety requirements were adequate to minimise potential for falls.
* The consumer’s blood pressure was not a contributory factor to the consumer’s falls as four of seven falls happened in the presence of staff and issues were attributed to vision impairment and insistence to maintain physical independence whenever possible.
* The approved provider accepts there is improvement required in relation to documenting safety checks to substantiate the effective implementation of fall prevention strategies.
* The service acknowledges there were 28 call bells outside the 12-minute KPI in a five-month period. However, they highlight this is 2.3 percent of all call bells in this period for this one consumer.

In relation to consumers who require supervision, found leaving their units unsupervised:

* In relation to the first consumer:
	+ The care plan directs staff to only implement behavioural management strategies when the consumer is ‘anxious, wandering or is verbally disruptive’. On the day of the incident where the consumer was hit by a waste disposal truck, these behaviours were not present, so staff did not fail to implement strategies.
	+ The service was unaware of any prior attempts to leave the service unsupervised.
* In relation to the second consumer:
	+ Each incident was reported, documented and reviewed by senior clinical staff. Episodes were a year apart and the consumer was not found more than two metres outside the gate.
	+ The consumer has numerous safety interventions, and these appear effective.

In relation to a consumer’s incremental weight loss:

* The service acknowledges the consumer’s weight loss should have been escalated to the medical officer for additional assessments and interventions. However, since the site audit, the medical officer has reviewed the consumer and finds based on the consumer’s health profile, this weight loss was beneficial.

Based on the Assessment Team’s report and the approved provider’s response I find this Requirement Non-compliant. The service has failed to effectively manage a consumer’s mental health condition and ongoing behaviours, has not effectively reviewed falls prevention strategies and have not effectively implemented monitoring strategies for consumers identified as potentially leaving the service unsupervised.

In relation to the consumer with unmanaged behaviours and mental health needs, while the approved provider states the consumer entered the service with a longstanding depression diagnosis and behaviours, the service did not implement effective strategies to manage the consumer’s ongoing mental health issues and behaviours. These behaviours were impacting on the well-being of the consumer and others and I find service failed to do all they could to manage, minimise or prevent the risk associated with this consumer’s care. I draw attention to aged care service providers’ responsibilities in accordance with these Standards, which includes a requirement to identify and manage behavioural and/or mental health at any point while the consumer is in their care, even if the behaviours and/or mental health issues were present before moving into the service. It is reasonable to expect that strategies used in the community or on entry to the service may need to be altered for consumers who move into residential aged living.

While the service developed a care plan to manage the consumer’s behaviours, the strategies were not effective in managing the consumer’s behaviours or alleviating mental health decline indicators, which included the consumer crying and being anxious. Clinical staff were concerned with the ineffectiveness of the behavioural management strategies and requested the medical officer to refer the consumer to a specialist. However, when this did not occur, staff did not follow-up or consider alternative specialist options available to them.

While the medical officer was aware of the consumer’s ongoing behaviours, severe depression and ineffectiveness of anti-depressant medication, no new interventions were implemented. Subsequent to this, the service identified the consumer had suicidal ideation, however, no strategies were implemented to manage the risk presented to the consumer in relation to their mental state.

I find the service had information to reasonably alert them to the consumer’s mental health decline and were aware of risks to the consumer’s health, safety and wellbeing but failed to implement effective strategies to manage the consumer’s behavioural and mental health issues.

In relation to the consumer with repeated falls, the approved provider and the Assessment Team both find the consumer was reviewed after each incident and interventions assessed for efficacy. However, the Assessment Team finds strategies were not changed or tailored following each incident and holistic consideration of reasons for the consumer’s fall were not considered. Based on the unchanged falls preventions strategies after seven falls in 12 months, I find it reasonable to conclude the service has not effectively reviewed the consumer’s fall prevention strategies or implemented new strategies to prevent or minimise risk associated with falls.

In relation to consumers who require supervision found leaving their units unsupervised, in relation to the first consumer, the approved provider asserts the care plan is only be implemented when the consumer is ‘anxious, wandering or is verbally disruptive’. However, I find it reasonable based on the care plan that staff should have been monitoring the consumer prior to the incident where the consumer was hit by a garbage disposal truck, in accordance with the care plan. In relation to the second consumer, while the approved provider finds the incidents were negated before the consumer was able to leave the vicinity of the service, I find the current management strategies are not effective as indicated by the ongoing incidents. While no harm to the consumer has resulted from these incidents, I reference the incident where a consumer, who was in the residential service grounds unsupervised, was hit by a vehicle. There is similar potential risk for this consumer if the care plan is not effectively implemented to manage this risk.

In relation to the consumer with gradual weight loss, while the medical officer has found this weight loss beneficial, I find the service has not followed their own procedures, to effectively monitor the consumer’s weight and potential risks of malnourishment and/or undernourishment prior to the site audit.

I find the service has not effectively managed risk related to the care of each consumer in accordance with consumers’ care plans, the service’s procedures or have not effectively identified or reassessed risks associated with their care, thereby failing to implement appropriate and effective interventions.

For the reasons detailed above I find The Society of St Hilarion Inc, in relation to Villa St Hilarion-Fulham, is Non-compliant in relation to Standard 3 Requirement (3)(b).

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

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

### Requirement 3(3)(d) Non-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 the service was unable to demonstrate they consistently identify and respond to changes in consumers’ physical and mental health, specifically in relation to responding to consumers’ ‘low’ and ‘high’ blood pressures and responding to a consumer’s mental health decline and ongoing behavioural issues. The Assessment Team provided the following findings and evidence relevant to my decision:

* In an approximate four-month period, clinical staff did not identify in a timely manner progress notes showing a deterioration in a consumer’s ongoing behaviours nor did they effectively respond to ongoing indicators of a mental health decline.
	+ Numerous progress notes demonstrated the consumer was distressed, crying, aggressive and wanting to go home.
	+ A depression assessment and progress notes identify the consumer was having suicidal thoughts.
	+ New strategies to manage the consumer’s condition and mental state were not implemented in response to these indicators of unmanaged behaviours or decline in mental health.
* The day after a consumer sustained a fall, progress notes show a consumer had episodes of significant ‘low’ blood pressure which were not escalated for immediate actions by clinical staff. The Assessment Team also found the consumer had multiple episodes of ‘low’ blood pressure noted in their medication chart which were not escalated to clinical staff for further action.
* Two consumers have had significant ‘high’ blood pressure readings without staff identifying the need to escalate these readings for review by clinical staff.

The approved provider submitted a response to the Assessment Team’s report and have acknowledged the deficiencies identified by the Assessment Team, with the exclusion of the consumer with ongoing behaviours and/or mental health decline. The approved provider has demonstrated a commitment and desire to rectify the deficiencies and have included compliance with this Requirement on the service’s continuous improvement plan. The approved provider has or plans to implement the following actions to ensure compliance with this Requirement:

* The service acknowledges that parameters for blood pressure monitoring were not always documented in medication charts, but this has now been corrected.
* The service acknowledges that use of medication-credentialled care staff to undertake blood pressure monitoring required changing. Subsequently, a directive both verbally and via email has been given to change this clinical responsibility from medication-credentialled care staff to clinical staff.

In relation to the consumer with unmanaged behaviours and mental health needs, while the approved provider states the consumer entered the service with a longstanding depression diagnosis and behaviours, the service did not recognise the consumer’s ongoing unmanaged behaviours or the deterioration in the consumer’s mental health, to the point where the consumer was expressing suicidal thoughts. While the service finds there was no escalation in behaviours or changes in mental health status, due to these being present prior to admission, I find it reasonable clinical staff should have recognised the numerous progress notes related to the consumer’s behaviours and mental status as being indicative of a deterioration in the consumer’s mental health and cognitive function, ultimately underpinned by unmet needs.

I acknowledge the service has been responsive to the deficiencies identified by the Assessment Team and had also initiated actions to improve staff responsiveness to identifying and actioning changes or deterioration to consumers’ conditions. However, based on the Assessment Team’s report and the approved provider’s response, I find at the time of the site audit, the service did not effectively recognise or respond in a timely manner to consumers’ suboptimal blood pressure readings, ongoing behavioural issues and/or mental health decline.

For the reasons detailed above I find The Society of St Hilarion Inc, in relation to Villa St Hilarion-Fulham, is Non-compliant in relation to Standard 3 Requirement (3)(d).

### Requirement 3(3)(e) Non-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 the service was unable to demonstrate that following incidents, changes to consumers’ needs and preferences were not documented in a manner to enable clear communication within the organisation. The Assessment Team provided the following findings and evidence relevant to my decision:

* Following an allegation by a consumer in relation to a sexual assault, management recorded actions that the consumer was only to have their care attended by two care staff and that no male care staff are to attend to the consumer. However, the consumer’s care plan does not contain these directives.
* Two incident reports in relation episodes of physical aggression between consumers shows that the consumer’s care plan was reviewed and amended with additional strategies, however, the care plan does not indicate any potential for physical aggression from this consumer.

The approved provider submitted a response to the Assessment Team’s report and have acknowledged the deficiencies identified by the Assessment Team. The approved provider has demonstrated a commitment and desire to rectify the deficiencies and have included compliance with this Requirement on the service’s continuous improvement plan. The approved provider has or plans to implement the following actions to ensure compliance with this Requirement:

* The service acknowledges there is improvement required in relation to implementing strategies after the review of incidents and had commenced improvements prior to the site audit.
* In relation to the consumer with two episodes of physical aggression, the service states there were inconsistencies with the witnessing and reporting of incidents and find improvements are required in relation to documentation, observation and appropriate reporting.

I acknowledge the service has been responsive to the deficiencies identified by the Assessment Team and had also initiated actions to improve documented information to reflect consumers’ needs and preferences, and to ensure this information is communicated effectively within the organisation. However, based on the Assessment Team’s report and the approved provider’s response, I find at the time of the site audit, the service did not update consumers’ care plans to ensure effective communication concerning changes to consumers’ care need following incidents of assault, where new strategies were identified to support each consumer in accordance with their individual needs.

For the reasons detailed above I find The Society of St Hilarion Inc, in relation to Villa St Hilarion-Fulham, is Non-compliant in relation to Standard 3 Requirement (3)(e).

### Requirement 3(3)(f) Non-compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

The Assessment Team found the service was unable to demonstrate appropriate referrals to individuals, other organisations and providers of other care and services is attended in a timely manner. Specifically, in relation to referring a consumer with ongoing behavioural issues and/or mental health concerns, consumers with blood pressure readings outside optimal ranges and a consumer with gradual weight loss to relevant health professionals to ensure appropriate and timely review. The Assessment Team provided the following findings and evidence relevant to my decision:

* Progress notes and staff interviews indicated a consumer’s behaviours had escalated and their mental health status was declining. Staff stated the consumer was ‘very distressed all the time’. Clinical staff requested the medical officer to make a referral to the geriatrician, however, no referral was initiated, and no other alternative external supports were considered.
	+ While the consumer was being overseen by the service’s mental health and wellbeing coordinator, there are no documented reviews by this specialist in relation to the consumers’ mental health decline.
	+ The consumer’s representative was not satisfied the service had referred the consumer to mental health supports in a timely manner.
	+ Clinical staff conducted a depression assessment which identified the consumer as having severe depression, however, staff did not refer the consumer to a specialist, even though the consumer had been on anti-depressant medication which had been ineffective.
* A consumer lost 4.3kgs in a 12-month period which has not been managed in accordance with the service’s weight loss management procedures.
	+ The consumer had several weight losses in the 12-month period, however, the consumer was not referred to a dietitian or interventions implemented to support the consumer’s nutritional status.
* Two consumers have had significant ‘high’ blood pressure readings without staff identifying the need to escalate these readings for review by clinical staff or the medical officer.

The approved provider submitted a response to the Assessment Team’s report and have acknowledged the deficiencies identified by the Assessment Team, with the exclusion of the consumer with ongoing behaviours and/or mental health decline. The approved provider has demonstrated a commitment and desire to rectify the deficiencies and have included compliance with this Requirement on the service’s continuous improvement plan. The approved provider has or plans to implement the following actions to ensure compliance with this Requirement:

* The service acknowledges that parameters for blood pressure monitoring were not always documented in medication charts, but this has now been corrected.
* The service acknowledges that use of medication-credentialled care staff to undertake blood pressure monitoring required changing. Subsequently, a directive both verbally and via email has been given to change this clinical responsibility from medication-credentialled care staff to clinical staff.
* The service acknowledges the consumer’s weight loss should have been escalated to the medical officer for additional assessments and interventions. However, since the site audit, the medical officer has reviewed the consumer and finds based on the consumer’s health profile, this weight loss was beneficial.

I acknowledge the service has been responsive to the deficiencies identified by the Assessment Team and had also initiated actions to improve referral processes. However, based on the Assessment Team’s report and the approved provider’s response, I find the service was unable to demonstrate appropriate and timely referral at the time of the site audit. In relation to the consumer with ongoing behavioural and mental health concerns, while the approved provider states the consumer entered the service with a longstanding depression diagnosis and behaviours which the medical officer was aware of and was being managed, clinical staff came to a conclusion that they required consultation from specialists as evidenced by their action to request a geriatrician referral. While the medical officer did not action this request to refer the consumer to a geriatrician, clinical staff did not seek other alternative services to assist in the management of the consumer’s behaviours and mental health. Additionally, the service undertook a depression risk assessment which identified that the consumer was severely depressed and had expressed suicidal thoughts. I find it reasonable based on this assessment and observations, and a recent finding the anti-depressant was ineffective, clinical staff should have referred the consumer to appropriate organisations and individuals to assist in identifying effective strategies to improve the consumer’s health and well-being.

For the reasons detailed above I find The Society of St Hilarion Inc, in relation to Villa St Hilarion-Fulham, is Non-compliant in relation to Standard 3 Requirement (3)(f).

### 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.*

# STANDARD 4 COMPLIANTServices and support for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

The Assessment Team found overall sampled consumers confirmed they get the services and supports for daily living that are important for their health and well-being and enable them to do the things they want to do. Specific consumer feedback includes:

* Consumers said they are satisfied with the services they receive which support their independence, well-being and quality of life.
* Consumers describe having friendships with consumers and feeling connected to people owing to being part of the service and having the confidence to form new friendships.
* Consumers said they mostly like the food and that it has improved through the introduction of a newly refurbished café on site.

Staff interviewed were aware of consumers’ choices and preferences relating to services and supports, such as church services, meals, lifestyle activities, exercises and preferences in relation to the care and services provided. Lifestyle staff confirmed they make referrals to external services based on consumers’ needs and provided examples of referrals to the community visitor’s scheme, visiting clothing and show services, and specific religious practitioners. Staff described how consumers’ food preferences are considered during the development of the seasonal menu. Lifestyle staff said there is enough suitable and well-maintained equipment available to assist them in delivering care and services.

The Assessment Team sampled consumers’ files and found care plans, progress notes and documentation show consumers are consulted about their care and service and what activities they would like to participate in and this information is reviewed quarterly or as required. It also showed that timely referrals to relevant services occur when changes to needs are identified.

The Assessment Team found the service Non-compliant in relation to Requirement (3)(b) in this Standard in specific reference to the service not identifying and responding appropriately to a consumer’s mental health decline and vocalisation of suicidal ideation, including not providing adequate supports for daily living and referrals to external support following a diagnosis of severe depression. I find the service is Compliant with this Requirement based on the Assessment Team’s report and evidence which shows referrals and supports for daily living are provided, and the evidence relating to Non-compliance more suitably relates to clinical referral and supports. See this Requirement below for reasons for my decision.

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

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Compliant

*Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.*

### Requirement 4(3)(b) Compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

The Assessment Team found the service did not identify and respond appropriately to a consumer’s mental health decline and vocalisation of suicidal ideation, including not providing adequate supports for daily living and referrals to external support following a diagnosis of severe depression. The Assessment Team provided the following findings and evidence relevant to my decision:

* A consumer’s representative was not satisfied the service provided adequate emotional support and supervision during the consumer’s depressive illness.
* In an approximate four-month period, clinical staff did not identify in a timely manner progress notes indicating a mental health decline.
	+ Numerous progress notes demonstrated the consumer was distressed, crying, aggressive and wanting to go home.
	+ A depression assessment and progress notes identify the consumer was having suicidal thoughts.
	+ New strategies to manage the consumer’s condition and mental state were not implemented in response to the decline in mental health.
* The service did not provide adequate emotional support to the consumer during a depressive illness or following the consumer’s allegation that they were sexually assaulted.

The approved provider submitted a response to the Assessment Team’s report and does not agree with the Assessment Team’s findings. The approved provider has provided additional information to support a finding of Compliance in relation to this Requirement. The approved provider asserts the following:

* In relation to the consumer with declining mental health and suicidal ideation, the consumer had a diagnosis of depressive anxiety prior to entry and had been on medication to manage this condition prior to moving into the service. The consumer’s condition has not escalated since entry and this was confirmed by the medical officer to the Assessment Team.
* Progress notes demonstrate the consumer was provided with emotional support on numerous occasions each day.
* Following the Assessment Team’s interview with the consumer, the service spoke with the consumer’s representative who stated they were happy with the care 95 percent of the time.

Based on the Assessment Team’s report and the approved provider’s response, I find the service is Compliant with this Requirement. I find the Assessment Team’s evidence and findings in relation to this Requirement are more relevant to Standard 3 Requirement (3)(b) and (d) and more suitably relates to clinical supports, rather than emotional, spiritual and psychological supports associated with daily living in this Standard. I have considered this evidence in Standard 3 Requirement (3)(b) and (d). In coming to my decision, I have also relied upon the Assessment Team’s evidence that staff were able to provide examples of emotional, spiritual and psychological support provided to consumers, including involvement of volunteers, one-to-one activities, community visitors scheme and both support for consumers to attend spiritual services both internally and externally. Additionally, consumers’ spiritual and cultural preferences are captured during entry to the service and lifestyle staff use this information to tailor support to consumers’ needs.

For the reasons detailed above I find The Society of St Hilarion Inc, in relation to Villa St Hilarion-Fulham, is Compliant in relation to Standard 4 Requirement (3)(b).

### Requirement 4(3)(c) Compliant

*Services and supports for daily living assist each consumer to:*

1. *participate in their community within and outside the organisation’s service environment; and*
2. *have social and personal relationships; and*
3. *do the things of interest to them.*

### Requirement 4(3)(d) Compliant

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

### Requirement 4(3)(e) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 4(3)(f) Compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 NON-COMPLIANTOrganisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

The Assessment Team found overall consumers indicated they feel they belong in the service and feel safe and comfortable in the service environment. Specific consumer feedback includes:

* Ten consumers interviewed in relation to the living environment indicated the gardens surrounding the central operating space are easy to find, level and well-maintained, with furniture placed in a manner which does not impede access. There is also shaded area in the outdoor area.
* Ten consumers interviewed confirmed maintenance issues are always immediately followed-up and staff are always helpful.
* Consumers confirmed their units are clean and well-maintained and did not indicate any issues with safety or privacy.

The Assessment Team observed staff and consumers interacting in the service’s newly built central operating space, and utilising multiple rooms within the service including the laundry, gym and activity spaces. The new shared spaces have rails, signage and are easy to navigate for those consumers with mobility and cognitive issues.

The Assessment Team found the organisation could demonstrate furniture, fittings and equipment to be safe, clean, well-maintained and suitable for consumers. Staff interviewed confirmed regular maintenance is undertaken by both internal personnel and external services and demonstrated the service responds to ad hoc maintenance requests.

The Assessment Team found the service did not always provide consumers with a safe environment, specifically in relation to the safety of consumers in areas where vehicles are moving and the security and safety of consumers’ belongings. I find that service in Non-compliant in relation to Requirement (3)(b) in this Standard, see this Requirement below for reasons for my decision.

The Quality Standard is assessed as Non-compliant as one of the three specific requirements has been assessed as Non-compliant.

## Assessment of Standard 5 Requirements*.*

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Non-compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

The Assessment Team found the organisation was unable to demonstrate that the service’s living environment is safe for consumers. The service has not responded in a timely manner to several incidents of theft of consumer’s property and/or unlawful intrusion or property damage. The service also failed to ensure corrective recommendations were effectively implemented following a finding the organisation breached Work Health and Safety legislative requirements. The Assessment Team provided the following findings and evidence relevant to my decision:

* Following an incident where a consumer was hit by a waste management truck in the residential area of the service, the external Work Health and Safety regulator found the organisation had breached its Work Health and Safety responsibilities. The regulator recommended exclusion zones for vehicles in areas where there is significant pedestrian movement and consideration of moving the waste bins. While the service has relocated the bins to an area where consumers cannot access, the Assessment Team observed management and staff vehicles entering and parking in the residential area of the service throughout the site audit.
* The Assessment Team identified on the service’s incident spreadsheet four incidents where four consumers have had their money and/or wallets stolen from their units. The incidents occurred across an approximate three-week period. However, management and staff confirmed minimal security measures have been implemented to reduce the risk of consumers having further money and/or items stolen from their units.
	+ The Assessment Team interviewed two of the four consumers who have had money stolen and they both indicated there has been no follow-up or review of incidents since they initially reported it.
	+ While the incident reports show consumers have been asked to only keep a small amount of money and to use the safe in their units, no other strategies have been implemented to increase safety and security at the service.
* The Assessment Team identified a local youth, who was known to the service, but was not connected in anyway to consumers, has been involved in a series of incidents with other youth, including intruding into the residential area and causing property damage over a week period. While management said a number of incident forms had been completed in relation the youth over the years, the behaviours of taunting staff and consumers had been normalised and accepted, resulting in the service failing to escalate the incidents to the executive team, causing a delay in actions to ensure the safety and comfort of the living environment.
	+ In response to the recent incidents, the service implemented preventative actions approximately 27 days after the initial incident.

The approved provider submitted a response to the Assessment Team’s report and have acknowledged the deficiencies identified by the Assessment Team. The approved provider has demonstrated a commitment and desire to rectify the deficiencies and have included compliance with this Requirement on the service’s continuous improvement plan. The approved provider has or plans to implement the following actions to ensure compliance with this Requirement:

* Following the incident where a consumer was hit by a waste disposal truck, the organisation immediately commenced an investigation and corrective actions and controls were implemented on the day of the incident to prevent unauthorised access to the residential area. The organisation also made a report to the external Work Health and Safety regulator. Consultation with key stakeholders in relation to traffic management has been completed and the service are in the process of developing designated staff parking zones, pick-up and drop-off zones and clear signage. Additionally, permanent bollards will be installed to prevent access to the residential area.
* The approved provider acknowledges the service did not follow-up the incidents of theft in a timely manner. The approved provider had initiated strategies prior to the site audit, including presentations by SA Police and Aged Rights Advocacy Service in relation to financial and personal safety, discussion at the weekly forum held with consumers and representatives, and offering consumers various options of storing personal property. However, since the site audit, the service is now offering all consumers a personal safe for every unit.
* The approved provider acknowledges the service requires improvement in relation to incident reporting, specifically in respect of the incidents involving youths accessing the site.

I acknowledge the service has been responsive to the deficiencies identified by the Assessment Team and had initiated some actions in response to the safety concerns of the residential service environment. However, based on the Assessment Team’s report and the approved provider’s response, I find at the time of the site audit, the service had not implemented timely or effective strategies and processes to provide a living environment which promoted the safety of consumers. Specifically, the service had not ensured the outside residential areas are safe for consumers because the area was still being accessed by vehicles, even though it was recommended an exclusion zone be implemented. Also, the service did not implement timely actions in response to ongoing incidents of theft from consumers’ rooms.

For the reasons detailed above I find The Society of St Hilarion Inc, in relation to Villa St Hilarion-Fulham, is Non-compliant in relation to Standard 5 Requirement (3)(b).

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 NON-COMPLIANTFeedback 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 Assessment Team found overall sampled consumers did consider they are encouraged and supported to give feedback and make complaints, and that appropriate action is taken. Specific consumer feedback includes:

* Consumers interviewed felt supported to make complaints or raise concerns and felt safe to do so.
	+ However, three consumers were not satisfied they had been communicated with about the outcome of one complaint each had raised.
* Some consumers were aware of alternative complaints avenues if they felt internal processes were inadequate.

Staff interviewed described how they would escalate concerns to clinical staff or management if required and all felt comfortable to communicate with management. Staff also described various advocacy and language services available to support consumers to raise concerns and provided specific examples in relation to accessing these services.

The Assessment Team observed pamphlets and posters in multiple languages on display and available to consumers and representatives at the service, in relation to external complaints and advocacy services.

The Assessment Team found that while the service supports consumers to raise concerns and provide feedback in relation to their care and services, the service was unable to demonstrate effective complaints resolution processes or that complaints are used to improve the quality of care and services. I find that service does not met Requirement (3)(c) and (d) in this Standard, see these Requirements below for reasons for my decision.

The Quality Standard is assessed as Non-compliant as two of the four specific requirements have been assessed as Non-compliant.

## 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.*

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

### Requirement 6(3)(c) Non-compliant

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

The Assessment Team found the organisation was unable to demonstrate that appropriate action is taken in response to complaints and that effective open disclosure processes are used when things go wrong. The Assessment Team provided the following findings and evidence relevant to my decision:

* Three consumers interviewed did not feel their concerns regarding the theft of money from their units were effectively managed and had not been informed of actions taken to address their concerns.
	+ Management stated they had understood they had provided feedback to consumers in relation to thefts of money but have acknowledged the feedback from the Assessment Team and will follow-up with relevant consumers.
* A consumer representative was not satisfied the service’s open disclosure practices included a formal apology in writing after their family member was involved in an incident which caused the consumer injury.
	+ Management stated they had offered the family an apology for the incident, however, management said they would formally write an apology letter to the family to support their closure following the incident.
* Complaints raised by consumers in relation to the same issue was closed before there had been adequate investigation or follow-up.

The approved provider submitted a response to the Assessment Team’s report and have acknowledged the deficiencies identified by the Assessment Team. The approved provider has demonstrated a commitment and desire to rectify the deficiencies and have included compliance with this Requirement on the service’s continuous improvement plan. The approved provider has or plans to implement the following actions to ensure compliance with this Requirement:

* The service states they had advised consumers in relation to thefts of money and reassured them of actions taken, however this was not adequately documented in records.
* While the organisation has an open disclosure policy and risk framework policy, the standard operating procedures in relation to risk management, and incident and feedback identification are being reviewed to assist staff with streamlining reporting to governance and risk management personnel to improve identification of trends.
	+ This process includes improving timely and appropriate feedback to consumers and adequate investigative and documentation processes.
* The service acknowledges there was no written apology sent to any of a consumers’ family member in relation to an incident involving the consumer, however, management were in daily contact with the family and were apologetic on a number of occasions. Since the site audit, the Chief Executive Officer has formally apologised in writing to the family.

I acknowledge that the service has been responsive to the deficiencies identified by the Assessment Team and had also initiated some actions in response to ensuring consumers are satisfied with the outcomes of their concerns. However, based on the Assessment Team’s report and the approved provider’s response, I find at the time of the site audit, the service did not have effective feedback and complaints processes for managing and resolving complaints. Consumers are not aware of outcomes of complaint investigations and documentation does not demonstrate actions or consultative processes undertaken. I also find that the organisation’s open disclosure processes did not formally execute all elements of best practice, including the formalisation of an apology.

For the reasons detailed above I find The Society of St Hilarion Inc, in relation to Villa St Hilarion-Fulham, is Non-compliant in relation to Standard 6 Requirement (3)(c).

### Requirement 6(3)(d) Non-compliant

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

The Assessment Team found the organisation was unable to demonstrate that feedback and complaints are reviewed and used to improve the quality of care and services. The Assessment Team provided the following findings and evidence relevant to my decision:

* Staff and management were unable to provide examples of feedback and complaints information being used to improve the quality of care and services.
* The service was unable to demonstrate it effectively manages all complaints or provides responses to consumers.
* The service does not have an effective complaints framework to monitor, analyse and report on complaints at the service.

The approved provider submitted a response to the Assessment Team’s report and have acknowledged the deficiencies identified by the Assessment Team. The approved provider has demonstrated a commitment and desire to rectify the deficiencies and have included compliance with this Requirement on the service’s continuous improvement plan. The approved provider has or plans to implement the following actions to ensure compliance with this Requirement:

* While the organisation has an open disclosure policy and risk framework policy, the standard operating procedures in relation to risk management, and incident and feedback identification are being reviewed to assist staff with streamlining reporting to governance and risk management governing personnel to improve identification of trends.
	+ This process includes improving timely and appropriate feedback to consumers and adequate investigative and documentation processes.

I acknowledge that the service has been responsive to the deficiencies identified by the Assessment Team and have initiated actions in response to ensure the service uses feedback and complaints processes to identify improvement opportunities to improve care and services. However, based on the Assessment Team’s report and the approved provider’s response, I find at the time of the site audit, the service did not have effective feedback and complaints processes for informing the governing body, the workforce and consumers about complaints management or complaints resolution for consumers. I also find that the organisation was unable to demonstrate the use of complaints information to make improvements to safety and quality systems.

For the reasons detailed above I find The Society of St Hilarion Inc, in relation to Villa St Hilarion-Fulham, is Non-compliant in relation to Standard 6 Requirement (3)(d).

# STANDARD 7 NON-COMPLIANTHuman 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 Assessment Team found overall sampled consumers indicated they get quality care and services when they need them and from people who are knowledgeable, capable and caring. Specific consumer and representative feedback include:

* Consumers and representatives interviewed indicated they are satisfied with the number of staff and said staff are kind, caring and available when consumers need them.
* Consumers described how they felt understood and respected by staff.
* Consumers indicated staff are appropriately skilled and able to cater to their needs, including being respectful and caring of individual identities and cultural needs.

Six staff interviewed indicated there are adequate numbers of staff and an appropriate skill mix to ensure consumers’ needs are met. Management described how observations of staff practice, performance appraisals, recruitment processes and regular training ensures staff are competent to perform their role. Staff described how the annual performance appraisal process involves them providing feedback in relation to a range of topics and are provided with opportunities to raise any issues or suggest training.

The Assessment Team reviewed rosters which demonstrated effective processes for filling planned and unplanned leave. The Assessment Team observed positive consumer and staff interactions during the site audit.

Management described how new staff have their performance reviewed at three points during the initial period of their employment. The Assessment viewed a care staff member’s performance appraisal which showed the service supported the staff member in adjusting and reviewing their employment to ensure they could undertake further training.

The Assessment Team found the service Non-compliant in relation to Requirement (3)(d) in this Standard in respect of the workforce not being sufficiently trained to ensure the effective clinical monitoring of consumers’ blood pressure. I find the service Non-compliant in relation to this Requirement, see this Requirement below for reasons for my decision.

The Quality Standard is assessed as Non-compliant as one of the five specific requirements has been assessed as Non-compliant.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Compliant

*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.*

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

### 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.*

### Requirement 7(3)(d) Non-compliant

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

The Assessment Team found the service was unable to demonstrate that medication-credentialled care staff are provided with appropriate and adequate training and support to effectively perform their roles and responsibilities required of them. The Assessment Team provided the following findings and evidence relevant to my decision:

* Management confirmed there are 13 medication-credentialled care staff who are currently required to monitor the blood pressures of consumers. However, these staff have not been provided with ongoing training in relation to monitoring consumers’ blood pressure.
* Management confirmed blood pressure monitoring training is not provided by the service and clinical staff are not effectively monitoring the outcomes of blood pressure monitoring. See Standard 3 Requirement (3)(a) for further evidence of inadequate blood pressure monitoring for individual consumers.
* Three medication-credentialled care staff said they had received blood pressure monitoring training when they commenced employment, however, had not participated in further training.
* Staff interviewed provided conflicting answers about optimal blood pressure ranges and/or when to report blood pressure readings to clinical staff.

The approved provider submitted a response to the Assessment Team’s report and have acknowledged the deficiencies identified by the Assessment Team. The approved provider has demonstrated a commitment and desire to rectify the deficiencies and have included compliance with this Requirement on the service’s continuous improvement plan. The approved provider has or plans to implement the following actions to ensure compliance with this Requirement:

* The service acknowledges that the use of medication-credentialled care staff to undertake blood pressure monitoring required changing. Subsequently, a directive both verbally and via email has been given to change this clinical responsibility to clinical staff.
* The service is developing a standard operation procedure to include a list of required duties and training resources are to be administered to ensure all staff are aware of these new responsibilities and procedures.
	+ Face-to-face and online mandatory training will include organisational wide requirements to understand the Quality Standards in detail.
	+ Training records are now recorded on the training platform and outcomes of the training are tested and assessed by relevant senior staff.

I acknowledge that the service has been responsive to the deficiencies identified by the Assessment Team and have initiated actions in response to ensure the service uses feedback and complaints processes to identify improvement opportunities to improve care and services. However, based on the Assessment Team’s report and the approved provider’s response, I find at the time of the site audit, medication-credentialled care staff were not provided with training and support in relation to blood pressure monitoring to protect consumers from clinical risk and ensure quality care outcomes for consumers.

For the reasons detailed above I find The Society of St Hilarion Inc, in relation to Villa St Hilarion-Fulham, is Non-compliant in relation to Standard 7 Requirement (3)(d).

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

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

# 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 Assessment Team found overall sampled consumers and representatives indicated the organisation is well run and they can partner in improving the delivery of care and services. Specific consumer and representative feedback include:

* Consumers and representatives said the service is well run and are satisfied it is meeting the needs of consumers.
* Consumers indicated they are supported to provide feedback through a range of mechanisms and can provide feedback in relation to services through discussions with staff.

The Assessment Team found the service involves consumers in the delivery and evaluation of care and services through care reviews, feedback processes, surveys and informal discussions.

Management indicated that the organisation’s policies and procedures were reviewed and discussed at board and other meetings within the last six months in response to the Quality Standards. They also provided the Assessment Team with a documented clinical governance framework, and policies relating to antimicrobial stewardship, minimising the use of restraint, and open disclosure.

The Assessment Team found the service Non-compliant in relation to Requirement (3)(c) in this Standard, specifically related to organisational governance systems not always being effective in respect of regulatory compliance. I find the Service Non-compliant in relation this Requirement, see below for reasons for my decision.

The Assessment Team found the service Non-compliant in relation to Requirement (3)(d) in this Standard, specifically related to ineffective risk escalation processes related to incidents. I find the Service Non-compliant in relation this Requirement, see below for reasons for my decision.

The Quality Standard is assessed as Non-compliant as two of the five specific requirements have been assessed as Non-compliant.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

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

### 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.*

### 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 the organisation was unable to demonstrate effective organisational wide governance systems, specifically in relation regulatory compliance. The Assessment Team provided the following findings and evidence relevant to my decision:

* Management were unable to demonstrate regulatory compliance systems and process to ensure the organisation is compliant with all relevant legislation and regulatory requirements. The service did not demonstrate an understanding of compulsory reporting requirements in relation to allegations or suspicions of consumer assault.
	+ A consumer made an allegation of sexual assault, however, management stated they believed the allegation was false so did not report this allegation in accordance with mandatory reporting legislative requirements.
	+ An incident report states that a consumer living with a cognitive impairment was observed to have their hand at the throat of another consumer. There was no documented follow-up of the incident, including the incident not documented on the service’s discretionary not to report assault log. There was no documented evidence the service met their obligations in relation to the use of their discretion not to report the suspicion of physical assault.

The approved provider submitted a response to the Assessment Team’s report and have acknowledged the deficiencies identified by the Assessment Team. The approved provider has demonstrated a commitment and desire to rectify the deficiencies and have included compliance with this Requirement on the service’s continuous improvement plan. The approved provider has or plans to implement the following actions to ensure compliance with this Requirement:

* The service acknowledges there is no documentation outlining why a discretion not to report or a mandatory report for the allegation of sexual assault was not included in the register.
	+ Since the site audit, the service has added the incident to the mandatory reporting register and reported the incident to the police.
	+ A new reportable assault flowchart and frequently asked questions information was sent to clinical managers and registered nurses.
	+ The service has drafted a number of standard operation procedures relating to critical incident reporting and identification prior to the site audit, however, were not completed prior to the audit.
* The service finds there were inconsistencies with the witnessing and reporting of the incident between two consumers involved in potential physical assault circumstance and are addressing attention to documentation, observation and appropriate reporting.

I acknowledge that the service has been responsive to the deficiencies identified by the Assessment Team and had also initiated actions to ensure compliance with relevant legislation. However, based on the Assessment Team’s report and the approved provider’s response, I find at the time of the site audit, the service did not understand their compulsory reporting obligations and did not comply with relevant legislation in relation to reporting and acting on allegations and suspicions of incidents of consumer sexual or physical assault.

For the reasons detailed above I find The Society of St Hilarion Inc, in relation to Villa St Hilarion-Fulham, is Non-compliant in relation to Standard 8 Requirement (3)(c).

### Requirement 8(3)(d) Non-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.*

The Assessment Team found the organisation was unable to demonstrate effective risk management and risk escalation systems and process which is not supporting the effective management of risks to consumers. Specifically in relation to staff not responding to allegations or suspicions of consumer sexual or physical assault in accordance with relevant legislation, lack of staff understanding in relation to when and who risk to consumers is to be communicated and ineffective review of incidents to ensure the service reduces or removes or minimises risks in a timeframe proportionate with the level of risk and impact to consumers. The Assessment Team provided the following findings and evidence relevant to my decision:

* Once an incident is registered in the service’s electronic management system, it is not always reviewed or analysed at the local site level for trends to be mapped for effective resolution of issues to improve care and services for consumers.
	+ Five staff and management stated the service failed to communicate potential risk to consumers to the executive team in relation to a series of connected incidents.
	+ The service was unable to demonstrate regular monitoring of call bells over the service’s KPI to understand impact to consumers.
* Clinical management did not demonstrate an understanding of the importance of reviewing incidents for trends to identify opportunities for continuous improvement and to reduce high impact risks.
* The service had identified the incident management policy to guide staff in relation to compulsory reporting of allegations and suspicions of consumer sexual or physical assault is inadequate and does not have clear guidelines in relation to roles and responsibilities:
	+ The Assessment Team noted two examples of incidents which has not been recorded as critical and should have been escalated and recorded on the mandatory reporting register.
* The executive management team were not informed about a series of critical incidents to ensure strategies in relation to incidents of intrusion were adequately responded to minimise risk to consumers.

The approved provider submitted a response to the Assessment Team’s report and have acknowledged the deficiencies identified by the Assessment Team. The approved provider has demonstrated a commitment and desire to rectify the deficiencies and have included compliance with this Requirement on the service’s continuous improvement plan. The approved provider has or plans to implement the following actions to ensure compliance with this Requirement:

* While the organisation has a risk management framework and policy, the approved provider acknowledges there is improvement to be made in the implementation and practice of this framework.
* The service has commenced drafting standard operating procedures in relation to incident reporting, and critical incident reporting and identification. An organisational incident matrix and associated training in and relevant to role are currently being developed.

I acknowledge that the service has been responsive to the deficiencies identified by the Assessment Team and had also initiated some actions in response to ensure incidents are appropriately escalated to relevant personnel. However, based on the Assessment Team’s report and the approved provider’s response, I find at the time of the site audit, the service did not have effective systems and processes to help them identify and assess risks to the health, safety and well-being of consumers. The service’s risk management system has not supported the effective identification and evaluation of incidents impacting on consumers’ health and well-being and has also failed to support the timely implementation of strategies in relation to the safety of residential service environment. The service’s escalation of incidents within the organisation has not been effective in informing relevant personnel to ensure proportionate and appropriate action is taken.

For the reasons detailed above I find The Society of St Hilarion Inc, in relation to Villa St Hilarion-Fulham, is Non-compliant in relation to Standard 8 Requirement (3)(d).

### Requirement 8(3)(e) 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.*

# 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 2 Requirement (3)(e)**
	+ Ensure clinical staff review current strategies for effectiveness, following changes in consumers’ circumstances or incidents.
	+ Ensure appropriate reassessment or updates to plans of care occur following changes in consumers’ circumstance or incidents.
* **Standard 3 Requirement (3)(a)(b)(d)(e) and (f)**
	+ Ensure staff undertaking clinical monitoring are provided with the appropriate training, support and supervision to effectively undertake their assigned responsibilities.
	+ Ensure care plans and clinical documentation contain directives and information to support best practice care.
	+ Ensure staff trial and document alternatives to chemical restraint prior to using medication.
	+ Ensure staff complete clinical documentation to support the effective monitoring and review of consumers’ health and care.
	+ Ensure adequate supervision and monitoring of implementation medical officer directives.
	+ Ensure clinical staff review current strategies for effectiveness, following changes in consumers’ circumstances or incidents.
	+ Ensure clinical staff regularly review progress notes to identify changes or escalation in relation to consumers’ health and commence appropriate assessment, referrals of changes to care.
	+ Ensure plans of care are updated to reflect required changes to care following incidents to meet consumers’ needs and preferences.
	+ Ensure referrals to appropriate specialists occur when staff cannot identify effective strategies or interventions to meet consumers’ needs.
* **Standard 5 Requirement (3)(b)**
	+ Ensure incidents relating to the safety and comfort of the living environment are escalated and actioned in a timely and appropriate manner.
	+ Ensure recommendations by regulatory and specialist bodies are effectively implemented in a timely manner.
* **Standard 6 Requirement (3)(c) and (d)**
	+ Ensure ongoing consultation with complainants, including discussion of possible solutions and outcomes to their complaints.
	+ Ensure documentation reflects all actions and consultation which occurs to resolve complaints.
	+ Ensure best practice and effective documentation is used in relation to open disclosure practices.
* **Standard 7 Requirement (3)(d)**
	+ Ensure staff undertaking clinical monitoring are provided with the appropriate training, support and supervision to effectively undertake their assigned responsibilities.
* **Standard 8 Requirement (3)(c) and (d)**
	+ Ensure staff understand their responsibilities in relation to compulsory reporting of alleged or suspicions of consumer assault.
	+ Ensure policies and procedures reflect legislative responsibilities in relation to compulsory reporting of alleged or suspicions of consumer assault.
	+ Ensure incidents are escalated within the organisation to relevant personnel to ensure appropriate and timely actions are taken.