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

**Assessment Contact - Site date:** 6 October 2020 to 7 October 2020

**Date of Performance Report:** 23 December 2020

# Publication of report

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

# Overall assessment of this Service

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| --- | --- |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(e) | Non-compliant |
| **Standard 3 Personal care and clinical care** |  |
| Requirement 3(3)(a) | Compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| **Standard 5 Organisation’s service environment** |  |
| Requirement 5(3)(b) | Compliant |
| **Standard 6 Feedback and complaints** |  |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** |  |
| Requirement 7(3)(d) | Compliant |
| **Standard 8 Organisational governance** |  |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | Compliant |

# Detailed assessment

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

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

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, staff and others
* the provider’s response to the Assessment Contact - Site report received 29 October 2020
* the Performance Report for the Site Audit conducted 18 February 2020 to 20 February 2020.

# STANDARD 2 NON-COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

The Assessment Team assessed Requirement (3)(e) in relation to Standard 2. All other Requirements in this Standard were not assessed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(e) in this Standard. This Requirement was found Non-compliant following a Site Audit conducted 18 February 2020 to 20 February 2020.

At the Site Audit, the Decision Maker found consumers’ care was not reviewed for effectiveness following incidents or changes in circumstances. The service was found, in some instances, to review consumers’ care following incidents, however, the process was not effective in reviewing current strategies, as strategies remained unchanged and incidents continued to occur.

Whilst the service has made some improvements in response to the Non-compliance identified at the Site Audit, the Assessment Team were not satisfied the service adequately demonstrated effective management processes for review of care and services when circumstances change, or incidents occur. The Assessment Team’s report specifically highlights one consumer who was not monitored or reassessed following an unexplained absence.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 2 Requirement (3)(e) and find the service Non-compliant with Requirement (3)(e). I have provided reasons for my decision in the specific Requirement below.

## Assessment of Standard 2 Requirements

### 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 did not adequately demonstrate care and services are reviewed regularly for effectiveness and when circumstances change or when incidents occur. The Assessment Team’s report specifically referenced a consumer with a cognitive impairment who was not sufficiently monitored or reassessed following an unexplained absence. This was evidenced by the following:

* The incident report included instructions for staff to monitor the consumer closely overnight. Progress notes did not evidence regular monitoring or further follow up of the consumer in the days following the incident. Additionally, there was no evidence behaviour assessments or monitoring charts were initiated.
* The behaviour care plan was updated with behaviour management strategies 18 days following the incident. Guidance for staff in relation to the consumer’s risk of absconding were not included.
* Management stated an Incident observation checklist is used following incidents. This checklist was not included in the consumer’s file.
* The incident report relating to the unexplained absence was incomplete, with a number of sections blank.
* Guidance for staff relating to behaviour management was not available on the organisation’s Policy and procedure matrix.

The approved provider’s response indicated they acknowledge and accept the Assessment Team’s findings. Additionally, the approved provider’s response included further clarification to the evidence documented in the Assessment Team’s report and a Plan for continuous improvement outlining actions closed, in progress and planned. In response to the Assessment Team’s report, the approved provider has implemented the following actions:

* Reviewed the consumer’s care plan and behaviour and risk assessments. These documents were not provided as part of the approved provider’s response.
* Developing guidance on how to manage consumers presenting with challenging behaviours, including a standard operating procedure for Missing persons and a behavioural management flowchart.

I acknowledge the approved provider’s commitment to address the issues identified in the Assessment Team’s report. However, based on the Assessment Team’s report and the approved provider’s response, I find at the time of the Assessment Contact an unexplained absence of a consumer was not appropriately managed. Progress notes indicated follow up and monitoring did not occur in the days following the incident. Whilst behaviour management strategies were added to the care plan, this was not actioned until 18 days following the incident and strategies to guide staff to minimise the consumer’s risk of absconding were not included.

For the reasons detailed above, I find the approved provider, in relation to Villa St Hilarion - Fulham Non-Compliant with Requirement (3)(e) in Standard 2.

# STANDARD 3 Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

The Assessment Team assessed Requirements (3)(a), (3)(b), (3)(d), (3)(e) and (3)(f) in relation to Standard 3. All other Requirements in this Standard were not assessed and, therefore, an overall rating of the Standard is not provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(a), (3)(b), (3)(d), (3)(e) and (3)(f) in this Standard. These Requirement were found Non-compliant following a Site Audit conducted 18 February 2020 to 20 February 2020.

At the Site Audit, in relation to Requirement 3(a) the Decision Maker found the service did not monitor consumers’ blood pressure in accordance with best practice or Medical officer directives, Medical officer directives were not consistently followed, and wound documentation did not support staff to ensure effective monitoring of clinical outcomes for consumers.

At the Site Audit, in relation to Requirement 3(d) the Decision Maker found 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.

In relation to Requirement (3)(e), the Decision Maker found at the time of the Site Audit, the service did not update consumer care plans to ensure effective communication concerning changes to consumers’ care needs following incidents of assault, where new strategies were identified to support each consumer in accordance with their individual needs.

At the Site Audit, in relation to Requirement (3)(f), the Decision Maker found the service was unable to demonstrate appropriate and timely referrals of consumers to individual, other organisations and providers of other care and services.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit in relation to Requirements (3)(a), (3)(d), (3)(e) and (3)(f) and have recommended these Requirements as met.

Whilst the service has made some improvements in response to the Non-compliance identified at the Site Audit in relation to Requirement (3)(b), the Assessment Team were not satisfied the service adequately demonstrated effective management processes in relation to high impact or high prevalence risks associated with the care of each consumer. The Assessment Team specifically highlighted issues relating to blood pressure monitoring and medication chart signature omission processes. The Assessment Team have recommended Requirement 3(b) as not met.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 3 Requirements (3)(a), (3)(b), (3)(d), (3)(e) and (3)(f) and find the service Compliant with these Requirements. I have provided reasons for my decision in the specific Requirements below.

### Assessment of Standard 3 Requirements

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

*Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:*

1. *is best practice; and*
2. *is tailored to their needs; and*
3. *optimises their health and well-being.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended this Requirement as met. The Assessment Team’s reports outlined the following actions and improvements implemented since Site Audit, including:

* Prescribed directives for blood pressure and blood glucose levels, including reportable ranges have been included in medication charts and electronic files.
* Risk management and escalation process is in place. Risks for consumers are being identified and escalated in response to incidents.
* Incidents are reported in line with legislative requirements.
* Files viewed for consumers highlighted in the Site Audit report demonstrated safe and effective personal and clinical care is being provided. One consumer’s pressure injury has resolved and documentation for another consumer demonstrated directives for reportable ranges of blood glucose levels are documented and all blood glucose levels recorded are within range.

In relation to Standard 3 Requirement (3)(a), documentation viewed, and information provided to the Assessment Team by consumers and staff through interviews demonstrated:

All consumers confirmed they receive personal and clinical care that is safe and right for them. Clinical staff described how personal care is tailored to meet the needs of consumers and care staff described care provided to sampled consumers which was in line with consumers’ needs and preferences.

Written materials, including policies and procedures which relate to best practice care delivery are available to guide staff practice. There are processes to ensure these documents are regularly reviewed and updated.

For the reasons detailed above, I find the approved provider, in relation to Villa St Hilarion - Fulham Compliant with Requirement (3)(a) in Standard 3.

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

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

The Assessment Team found the service did not demonstrate an effective process for management of high impact or high prevalence risks associated with the care of each consumer, specifically in relation to blood pressure management for three consumers and medication management for one consumer. The Assessment Team’s report indicates:

* Eight blood pressure readings outside of reportable range over a six month period for one consumer were not followed up or reported to the Medical officer.
* Progress notes indicate the consumer had four falls in a two month period.
* Progress notes indicate the Medical officer reviewed the consumer on three occasions over a 20 day period. The Medical officer noted low blood pressure readings and stated this was usual for the consumer.
* Blood pressure readings for two consumers were not taken in line with directives. One consumer’s blood pressure was not taken for two weeks and another consumer’s blood pressure was not taken on six occasions over a four month period. For one of these consumers, a reading outside of reportable range was not reported to the Medical officer.
* Medications were not signed as being administered for one consumer for two days in April (two medications) and once in September 2020 (one medication).
* The service does not have a formal process to guide staff in relation to missed signatures.
* The monthly medication audit conducted September 2020 did not identify issues with administration for the 13 medication charts reviewed.

The approved provider’s response included a Plan for continuous improvement and further clarifying information relating to two consumers highlighted in the Assessment Team’s report, including:

* In relation to the consumer with low blood pressure readings and falls, the response indicates the consumer was reviewed by the Medical officer on 10 occasions over a five month period. Four of these reviews related to blood pressure monitoring. Blood pressure monitoring for this consumer has been ceased.
* The approved provider’s response did not include any documentation relating to Medical officer reviews for this consumer.
* For one consumer, the response notes only one blood pressure reading was missed. The approved provider acknowledges a low blood pressure reading was not documented in the consumer’s progress notes.

The Plan for continuous improvement includes planned actions and demonstrates the approved provider is proactively addressing the issues identified in the Assessment Team’s report. Actions include:

* Development of guide relating to management of high risk relating to consumers, including medical incidents, such as medication chart signature omissions and falls management.
* Introduction of new medication charts to enable review of anomalies with blood pressures, blood sugar levels and missing signatures.
* Implementation of daily medication chart audits.

I acknowledge the approved provider’s commitment to address the issues identified in the Assessment Team’s report. Based on the Assessment Team’s report and the approved provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service is Compliant with this Requirement. The Assessment Team’s report indicated for one consumer, four falls were recorded, and blood pressure readings outside of reportable range were not followed up or reported to the Medical officer. In coming to my decision, I have placed weight on information documented in the Assessment Team’s report which indicated the consumer had been reviewed by the Medical officer on three occasions over a 20 day period in response to low blood pressure readings. Additionally, I have considered the approved provider’s response which included further clarification relating to this consumer, such as regular Medical officer reviews, including review of blood pressure. Blood pressure monitoring for this consumer has since been ceased.

Blood pressure readings for two consumers were noted in the Assessment Team’s report as not being taken in line with directives and a reading outside of reportable range not being reported to the Medical officer. The approved provider’s response included further clarification relating one of these consumers.

Three signature omissions were noted on one consumer’s medication chart. I have placed weight on the fact that the Assessment Team’s report does not indicate medications were not administered or indicate an impact for this consumer.

For the reasons detailed above, I find the approved provider, in relation to Villa St Hilarion - Fulham Compliant with Requirement (3)(b) in Standard 3

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

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

The Assessment Team’s reports provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended this Requirement as met. The Assessment Team’s reports outlined the following actions and improvements implemented, including:

* Developed a flowchart to guide referral of consumers with mental health issues, including referrals to services which do not require a referral from a Medical officer.
* Commenced regular multi-disciplinary meetings. An Italian speaking Psychologist has been employed and attends the meetings, undertakes mental health well-being assessments and provides direction for staff relating to follow-up care.
* Prescribed directives for blood pressure have been included in medication charts and electronic files.
* Care staff are no longer attending to consumers’ blood pressure monitoring.

In relation to Standard 3 Requirement (3)(d), documentation viewed, and information provided to the Assessment Team by consumers and staff through interviews demonstrated:

All consumers confirmed they were confident staff would recognise if their health declined and they would respond in a timely and appropriate manner. One consumer stated staff keep an eye on them, and they would get the doctor or send them to hospital “pretty quick” if they became unwell.

Care staff stated they report consumers’ deterioration in health to clinical staff. Clinical staff stated consumers are reviewed regularly and where changes to health are identified.

### For the reasons detailed above, I find the approved provider, in relation to Villa St Hilarion - Fulham Compliant with Requirement (3)(d) in Standard 3.

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

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

The Assessment Team’s reports provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended this Requirement as met. The Assessment Team’s reports outlined the following actions and improvements implemented since Site Audit, including:

* Updated the incident management policy to ensure incident escalation and follow up of consumers occurs in line with the new risk matrix. Development of Safe operating procedures relating to incident management.
* Implemented a Governance and risk committee meeting and reporting processes. Reports are tabled at Board meetings and include clinical incident data.

In relation to Standard 3 Requirement (3)(e), documentation viewed demonstrated care plans are reviewed in line with policies and procedures and include prompts for risk escalation. Staff have been provided training in relation to documentation, investigation of incidents and escalation processes.

For the reasons detailed above, I find the approved provider, in relation to Villa St Hilarion - Fulham Compliant with Requirement (3)(e) in Standard 3.

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

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

The Assessment Team’s reports provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended this Requirement as met. The Assessment Team’s reports outlined the following actions and improvements implemented since Site Audit, including:

* Developed a flowchart to guide referral of consumers with mental health issues.
* Commenced regular multi-disciplinary meetings. An Italian speaking Psychologist has been employed and attends the meetings, undertakes mental health well-being assessments and provides direction for staff relating to follow-up care.
* Training provided in relation to documentation and investigation of incidents and escalation processes, incident management and clinical documentation.

In relation to Standard 3 Requirement (3)(f), documentation viewed, and information provided to the Assessment Team by consumers and staff through interviews demonstrated:

Consumers provided examples of referrals to allied health professionals. Management described referral processes for two consumers for mental health reviews which had occurred in the past six months.

The organisation has policies and procedures relating to referral processes to guide staff practice. Documentation viewed by the Assessment Team demonstrated consumers are referred to providers of other care and services in a timely manner.

For the reasons detailed above, I find the approved provider, in relation to Villa St Hilarion - Fulham Compliant with Requirement (3)(f) in Standard 3.

# STANDARD 5 Organisation’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 assessed Requirement (3)(b) in relation to Standard 5. All other Requirements in this Standard were not assessed and, therefore, an overall assessment of the Standard is not provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(b) in this Standard. This Requirement was found Non-compliant following a Site Audit conducted 18 February 2020 to 20 February 2020.

At the Site Audit, the Decision Maker found the service had not implemented timely or effective strategies or processes to provide a living environment which promoted the safety of consumers. Specifically, the service had not ensured the outside areas were safe for consumers as the area was being accessed by vehicles. Additionally, the service had not implemented timely actions in response to ongoing incidents of theft from consumers’ rooms. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended this Requirement as met.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 5 Requirement (3)(b) and find the service Compliant with Requirement (3)(b). I have provided reasons for my decision in the specific Requirement below.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(b) 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’s reports provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended this Requirement as met. The Assessment Team’s reports outlined the following actions and improvements implemented since Site Audit, including:

* Establishing a designated parking and vehicle exclusion zone. The access area provides a pickup and drop off area and signage indicating no access for staff or visiting vehicles is posted. Bollards have also been installed.
* Provided a personal safe for each consumer and external security screen doors are being fitted to the independent living units.
* Establishing radio and closed circuit television enabling staff to visually identify and speak to people wishing to access the service. Additionally, all staff will be allocated swipe cards to access front and rear gates.
* In relation to Standard 5 Requirement (3)(b), documentation viewed, and information provided to the Assessment Team by consumers and staff through interviews demonstrated:
* All consumers sampled felt that they belong in the service and feel safe and comfortable in the service environment. They stated there had been no further reports of theft or concerns about intruders. Several consumers stated they are pleased with the extra security provided by the new security doors. All confirmed their units and the communal areas are well maintained and regularly cleaned.
* The Assessment Team observed the environment to be clean and well maintained and consumers were observed freely accessing both the internal and external areas of the service.

For the reasons detailed above, I find the approved provider, in relation to Villa St Hilarion - Fulham Compliant with Requirement (3)(b) in Standard 5.

# STANDARD 6 Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

The Assessment Team assessed Requirements (3)(c) and 3(d) in relation to Standard 6. All other Requirements in this Standard were not assessed and, therefore, an overall assessment of the Standard is not provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(c) and 3(d) in this Standard. These Requirements were found Non-compliant following a Site Audit conducted 18 February 2020 to 20 February 2020.

At the Site Audit, in relation to Requirement 3(c), the Decision Maker found the service did not have effective feedback and complaints processes for managing and resolving complaints. Consumers were not aware of outcomes of complaint investigations and documentation did not demonstrate actions or consultative processes undertaken. Additionally, the organisation’s open disclosure processes did not formally execute all elements of best practice, including formalisation of an apology.

In relation to Requirement 3(d), the Decision Maker found at the time of the Site Audit, the service did not have an effective feedback and complaints process for informing the governing body, the workforce and consumers about complaints management or complaints resolution for consumers. Additionally, the organisation did not demonstrate the use of complaints information to make improvements to safety and quality systems.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended these Requirements as met.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 6 Requirements (3)(c) and 3(d) and find the service Compliant with Requirements (3)(c) and 3(d). I have provided reasons for my decision in the specific Requirements below.

## Assessment of Standard 6 Requirements

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

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

The Assessment Team’s reports provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended this Requirement as met. The Assessment Team’s reports outlined the following actions and improvements implemented, including:

* Completed an investigation relating to potential theft. There have been no further incidents in relation to allegations of theft.
* Reviewed and/or updated open disclosure and feedback policies and the feedback form, developed a Standard operating procedure which clearly outlines sequence of actions to take, responsible role and timeline.
* Developed an Incident management policy outlining resolution process and open disclosure.

In relation to Standard 6 Requirement (3)(c), documentation viewed, and information provided to the Assessment Team by consumers and staff through interviews demonstrated:

All consumers stated they feel comfortable providing feedback. Some consumers provided examples of issues raised and stated issues are resolved.

Staff confirmed they have received training relating to feedback and complaints processes and provided examples of where they had supported consumers to provide feedback.

Documentation viewed by the Assessment Team demonstrated complaints are captured and actioned. A medication incident viewed demonstrated the service had notified the consumer and representative, open disclosure processes were applied, including consultation regarding actions taken to minimise the risk of the incident reoccurring.

### For the reasons detailed above, I find the approved provider, in relation to Villa St Hilarion - Fulham Compliant with Requirement (3)(c) in Standard 6.

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

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

The Assessment Team’s reports provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended this Requirement as met. The Assessment Team’s reports outlined the following actions and improvements implemented, including:

* Implemented a Governance and risk committee meeting where complaints are analysed and discussed within the service and the organisation.
* Implemented a Governance and risk committee report which is tabled at Board meetings. The report includes feedback and survey information. Feedback information is separated into complaint type to enable analysis and identification of trends.

In relation to Standard 6 Requirement (3)(d), documentation viewed, and information provided to the Assessment Team by consumers and staff through interviews demonstrated:

All consumers stated the service uses their feedback to improve care and services. Examples provided by consumers included issues relating to food being followed up by catering staff and installation of safes in their rooms to keep their valuables secured.

Documentation viewed by the Assessment Team demonstrated there are processes to ensure feedback is reviewed, analysed and trends identified. The service’s continuous improvement plan demonstrated feedback from consumers and representatives is used to improve quality of care and services.

For the reasons detailed above, I find the approved provider, in relation to Villa St Hilarion - Fulham Compliant with Requirement (3)(d) in Standard 6.

# STANDARD 7 Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

The Assessment Team assessed Requirement (3)(d) in relation to Standard 7. All other Requirements in this Standard were not assessed and, therefore, an overall assessment of the Standard is not provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(d) in this Standard. This Requirement was found Non-compliant following a Site Audit conducted 18 February 2020 to 20 February 2020.

At the Site Audit, in relation to Requirement (3)(d) the Decision Maker found 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 outcomes for consumers. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended this Requirement as met.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 7 Requirement (3)(d) and find the service Compliant with Requirement (3)(d). I have provided reasons for my decision in the specific Requirement below.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(d) Compliant

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

The Assessment Team’s reports provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended this Requirement as met. The Assessment Team’s reports outlined the following actions and improvements implemented, including:

* Care staff no longer undertake blood pressure monitoring.
* Updated recruitment documentation to include questions relating to risk management, incident management, elder abuse, open disclosure and mandatory reporting. Additional items have also been added to the Induction checklist.

In relation to Standard 7 Requirement (3)(d), documentation viewed, and information provided to the Assessment Team by consumers and staff through interviews demonstrated:

Consumers stated they were satisfied with the level of staff knowledge.

Care staff confirmed training, including mandatory components are provided. Management described how training needs are identified, including through review of incident data.

Training records indicated all staff have completed mandatory training requirements and there are processes to monitor staff training attendance, professional registrations and competencies. Onboarding documentation demonstrated staff recruited are competent and appropriately trained.

### For the reasons detailed above, I find the approved provider, in relation to Villa St Hilarion - Fulham Compliant with Requirement (3)(d) in Standard 7.

# STANDARD 8 Organisational 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 assessed Requirements (3)(c) and (3)(d) in relation to Standard 8. All other Requirements in this Standard were not assessed and, therefore, an overall assessment of the Standard is not provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(c) and (3)(d) in this Standard. These Requirements were found Non-compliant following a Site Audit conducted 18 February 2020 to 20 February 2020.

At the Site Audit, in relation to Requirement (3)(c) the Decision Maker found the service did not understand their compulsory reporting obligations and did not comply with relevant legislation relating to reporting and acting on allegations and suspicions of incidents of consumer sexual or physical assaults. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended this Requirement as met.

Whilst the service has made some improvements in response to the Non-compliance identified at the Site Audit in relation to Requirement (3)(d), the Assessment Team were not satisfied the service adequately demonstrated effective management processes in relation to high impact or high prevalence risks associated with the care of each consumer. The Assessment Team specifically highlighted issues relating to blood pressure monitoring and processes relating to medication signature omissions. The Assessment Team have recommended Requirement 3(d) as not met.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 8 Requirements (3)(c) and (3)(d) and find the service Compliant with Requirements (3)(c) and (3)(d). I have provided reasons for my decision in the specific Requirements below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(c) 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’s reports provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended this Requirement as met. The Assessment Team’s reports outlined the following actions and improvements implemented, including:

* Staff have received training related to mandatory reporting, including reportable assaults and unexplained absences.
* The reportable assaults register has been reviewed and updated. The consolidated register demonstrated staff are reporting and recording reportable assaults in line with legislative requirements and appropriate action is being taken.
* Implemented a Governance and risk committee meeting which includes mandatory reporting.

### In relation to Standard 8 Requirement (3)(c), documentation viewed by the Assessment Team demonstrated the service has effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. There are processes to monitor these areas.

For the reasons detailed above, I find the approved provider, in relation to Villa St Hilarion - Fulham Compliant with Requirement (3)(c) in Standard 8.

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

*Effective risk management systems and practices, including but not limited to the following:*

1. *managing high impact or high prevalence risks associated with the care of consumers;*
2. *identifying and responding to abuse and neglect of consumers;*
3. *supporting consumers to live the best life they can.*

The Assessment Team found the service did not demonstrate an effective risk management system and practices for high impact or high prevalence risks associated with the care of each consumer, specifically in relation to blood pressure and medication management. This was evidenced by the following:

* Staff were not following blood pressure monitoring directives for three consumers.
* The service did not identify three signature omissions on a consumer’s medication chart.
* The monthly medication audit conducted September 2020 did not identify issues with administration for the 13 medication charts reviewed.
* The Quality officer was not aware of the issues identified and additional monitoring processes had not been implemented.

The approved provider’s response included further clarifying information relating to two consumers highlighted in the Assessment Team’s report (refer to Requirement (3)(b)). Additionally, a Plan for continuous improvement includes planned actions and demonstrates the approved provider is proactively addressing the issues identified in the Assessment Team’s report. Actions include:

* Ensuring effective implementation of new medication charts and post incident follow-up.
* Scope of Standard 8 audit to focus on management of clinical and non-clinical incidents across the organisation.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit conducted 18 February to 20 February 2020, including:

* Development of a new incident form and policies and procedures relating to clinical and non-clinical incident management.
* Review of call bell monitoring and escalation processes.
* Reviewed the mandatory reporting register and implemented a Governance and risk committee report which includes reporting of incidents and allegations of assaults to the Board.

In relation to Standard 8 Requirement (3)(d), the Assessment Team’s report indicates:

* the organisation has a documented risk framework which describe how:
* high impact or high prevalence risks associated with the care of consumers are managed.
* the above and neglect of consumers is identified and responded to
* consumers are supported to live the best life they can.
* Staff said they had received training relating to the newly implemented incident report forms and described high impact or high prevalent risks for individual consumers. Staff were aware of their responsibilities, including legislative responsibilities in relation to reportable assaults.

I acknowledge the approved provider’s commitment to address the issues identified in the Assessment Team’s report. Based on the Assessment Team’s report and the approved provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service is Compliant with this Requirement. The Assessment Team’s report indicates blood pressure readings were not consistently being taken in line with Medical officer directives for three consumers. Additionally, three signature omissions were noted on one consumer’s medication chart. The organisation’s monitoring processes had not identified the gaps identified for the individual consumers highlighted in the Assessment Team’s report.

However, information in the Assessment Team’s report and the approved provider’s response indicates consumers’ blood pressures were adequately monitored by medical and/or clinical staff consistent with consumers’ clinical health status. In coming to my decision, I have considered information documented in the Assessment Team’s report which indicated one consumer had been regularly reviewed by the Medical officer in response to low blood pressure readings over a 20 day period and whilst medication signature omissions were identified for one consumer, the Assessment Team’s report does not indicate medications were not administered. Additionally, I have considered the approved provider’s response which included further clarification relating to blood pressure management for a consumer highlighted in the Assessment Team’s report.

For the reasons detailed above, I find the approved provider, in relation to Villa St Hilarion - Fulham Compliant with Requirement (3)(d) in Standard 8.

# 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 staff have the skills and knowledge to:
* Acknowledge and appropriately follow-up incidents, including initiating assessments and providing further support to and monitoring of consumers where the need is identified.
* Ensure consumer care plans are reviewed and updated following incidents ensuring information is reflective of consumers’ current and assessed needs and preferences.
* Ensure policies and procedures in relation to incident and behaviour management are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to behaviour and incident management.