

**Performance Report**

**1800 951 822**

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| Name: | Scalabrini Village Nursing Home (Austral) |
| Commission ID: | 2656 |
| Address: | 65 Edmondson Avenue, AUSTRAL, New South Wales, 2171 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 20 November 2024 |
| Performance report date: | 20 December 2024 |
| Service included in this assessment: | Provider: 268 Scalabrini Village Ltd Service: 1014 Scalabrini Village Nursing Home (Austral) |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Scalabrini Village Nursing Home (Austral) (**the service**) has been prepared by Julia Durston, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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

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

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Assessment contact (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, older people/representatives and others.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements were assessed |
| **Standard 7** Human resources | **Not applicable as not all requirements were assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements were assessed** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Standard 2

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| Ongoing assessment and planning with consumers |  |
| Requirement 2(3)(a) | 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. | Compliant |

Findings

The service was previously found non-compliant in Requirement 2(3)(a) following a Site Audit from 2 April 2024 to 4 April 2024. The service did not demonstrate assessment and care planning considered all risks to consumers’ health and well-being, specifically in relation to consumers potentially subjected to environmental restrictive practice. Also, sampled consumers did not have the necessary assessments and consents in place required for environmental restraints.

During the Assessment Contact conducted on 20 November 2024, the Assessment Team found the service had implemented several actions to address the identified areas of non-compliance, including:

* Updating of the admission checklist to assess whether consumers are subject to restrictive practices.
* Assessing whether mobile consumers could use the door code to exit the building to identify those consumers subject to environmental restraint, and ensuring all restrictive practices consent forms were reviewed, updated and valid.
* Updating the consumer orientation checklist to include the exit codes for doors for consumers and representatives.

During the Assessment Contact, the Assessment Team found the service has returned to compliance in this requirement. Sampled consumers and representatives confirmed regular engagement during assessment and care planning, ensuring that consumers’ health and safety risks are thoroughly discussed and addressed. Staff demonstrated a clear understanding of the process for identifying and managing risks for sampled consumers. Review of sampled consumers’ care plans evidenced initial and ongoing care planning, including risks to the health safety and wellbeing of consumers and contained individualised management plans to mitigate each risk, developed in consultation with consumers and representatives. Sampled Consumers who were identified as being subject to forms of restraint have appropriate restrictive practice care plans, behaviour support plans and valid consents are in place. The service uses multidisciplinary team input when adjustments to consumer care needs change.

Based on the weight of the evidence provided, I am satisfied the service is compliant with requirement 2(3)(a).

# Standard 7

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

Findings

The service was previously found non-compliant in Requirement 7(3)(c) following a Site Audit from 2 April 2024 to 4 April 2024. The service did not demonstrate the workforce was fully competent and had the knowledge to perform their roles. While consumers and representatives considered members of the workforce to be skilled and competent, deficiencies in knowledge were identified in relation to restrictive practices. Management and staff were unable to demonstrate sufficient understanding around the identification of potential environmental restrictive practice regarding locked doors leading to areas within the service.

During the Assessment Contact conducted on 20 November 2024, the Assessment Team found the service had implemented several actions to address the identified areas of non-compliance, including implementation of a 5-day restrictive practices refresher training course to be completed by all staff by 19 November 2024.

During the Assessment Contact, the Assessment Team found the service demonstrated the workforce is competent. Employees have the skills and knowledge to effectively perform their roles, including in relation to restrictive practices. Staff confirmed they have recently undertaken training in and were able to clearly articulate what constitutes restrictive practice, including identification and consideration of the various types of restrictive practices. Staff were able to demonstrate their understanding of environmental restraint as a form of restrictive practice, risk assessments associated with validating the use of this practice, and interventions to minimise its use. Sampled consumers provided feedback that staff are competent and knowledgeable in their roles.

The service has an orientation program that includes mandatory online and in-person training and they receive ongoing assessments in the key competencies outlined in their position descriptions. There is a comprehensive learning matrix that records competency modules and assessments are being completed.

Based on the weight of the evidence provided, I am satisfied the service is compliant with requirement 7(3)(c).

# Standard 8

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| Organisational governance |  |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:1. antimicrobial stewardship;
2. minimising the use of restraint;
3. open disclosure.
 | Compliant |

**Findings**

The service was previously found non-compliant in Requirement 8(3)(e) following a Site Audit from 2 April 2024 to 4 April 2024. The organisation did not demonstrate effective clinical governance in relation to the identification of consumers subject to restrictive practices at the service; specifically environmental restrictive practice.

During the Assessment Contact conducted on 20 November 2024, the Assessment Team found the service had implemented several actions to address the identified area of non-compliance. In addition to the improvements noted in Requirements 2(3)(a) and 7(3)(c), management conducted and environmental review and made improvements, including, a site review was conducted to ensure where exit doors were secured after hours, they had keypads in place for independent egress. Keypads have been installed in the foyer of the service to provide free access through the external exit doors. The main entrance is open from 7:00 am to 7:00 pm, and 7:00 am to 8:00 pm in summer and consumers can access the front door using the keypad after hours. Consumers can access a side door near the main entrance at any time. There is signage directing people to this door. Staff are aware they need to assist any consumer unable to use the keypad independently. Consumers were informed of the keypads and access arrangements at resident and relatives meetings and by notices to all consumers. The registered nurse at night is stationed at the reception desk at the main entrance which allows them to monitor the front entrance.

During the Assessment Contact, the Assessment Team found the organisation demonstrated it has a clinical governance framework for the management and monitoring of the clinical and personal care provided by the service. The clinical governance framework includes an antimicrobial stewardship policy. Staff explained ways they minimise the use of antibiotics. Antimicrobial stewardship is also discussed at the quarterly medication advisory committee meetings. Staff have completed training in the use of restrictive practices and staff interviewed demonstrated an understanding of restrictive practices. Restrictive practice documentation showed restrictive practices are used in accordance with the organisation’s policy and legislative requirements, and management are working to minimise the use of restrictive practices. Staff have completed training in relation to open disclosure. Consumers and representatives interviewed confirmed there is open communication from the service whenever anything happens.

Based on the weight of the evidence provided, I am satisfied the service is compliant with Requirement 8(3)(e).

1. The preparation of the performance report is in accordance with section 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)