St Basil's Aegean Village

Performance Report

10 Morton Road
CHRISTIE DOWNS SA 5164
Phone number: 08 7424 0950

**Commission ID:** 6151

**Provider name:** St Basil's Homes for the Aged in South Australia (Vasileias) Inc

**Assessment Contact - Site date:** 7 July 2022

**Date of Performance Report:** 27 July 2022

# Performance report prepared by

Janine Renna, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 8 Organisational governance** |  |
| Requirement 8(3)(e) | Compliant |

# Detailed assessment

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 Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others;
* the provider did not respond to the Assessment Contact - Site report; and
* the performance report dated 10 March 2022 for the Site Audit undertaken from 13 December 2021 to 15 December 2021.

# 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 Requirement (3)(e) in Standard 8 Organisational governance at the Assessment Contact. As no other Requirements were assessed at the Assessment Contact, an overall rating of the Standard has not been provided.

Requirement (3)(e) was found non-complaint following a Site Audit conducted from 13 December 2021 to 15 December 2021, where it was found the service was unable to demonstrate an effective clinical governance framework in relation to identification of restraint and ensuring regulatory obligations associated with the use of restraint had been met. The Assessment Team provided evidence of actions taken by the service in response to the non-compliance and have recommended the service meets this Requirement.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and based on this information, I find the service compliant with Requirement (3)(e) in Standard 8 Organisational governance. I have provided reasons for my finding under the specific Requirement below.

## Assessment of Standard 8 Requirements

### 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.*

This Requirement was found non-compliant following a Site Audit conducted from 13 December 2021 to 15 December 2021, where it was found the service was unable to demonstrate an effective clinical governance framework in relation to identification of restraint and ensuring regulatory obligations associated with the use of restraint had been met.

The Assessment Team’s report for the Assessment Contact conducted on 7 July 2022 described actions taken by the service in response to the non-compliance, which include, but are not limited to:

* reviewed and updated the organisation’s Clinical governance framework to ensure alignment with legislative requirements;
* updated policies and procedures in relation to chemical restraint;
* developed a psychotropic register and self-assessment to assist staff in identifying the use of restraint; and
* staff education and training.

The Assessment Team provided the following information and evidence collected through interviews and documentation, which are relevant to my finding in relation to this Requirement:

* Clinical audits are undertaken every 12 months and an audit action register is maintained to drive improvements in relation to identified gaps.
* The organisation maintains a high-risk report, which is reviewed at monthly clinical governance meetings. Strategies and mitigation measures are discussed, possible causes are identified, and trending is undertaken. Clinical governance meetings demonstrated discussion and reporting of infection control and antimicrobial stewardship.
* Procedures are in place to guide staff in relation to chemical restraint, including recognition, informed consent and physician oversight. Staff were aware of the procedures and provided examples of how they are applied and relevant to their role.
* Staff were knowledgeable about consumers subject to chemical restraint, including personalised strategies to trial before administering psychotropic medication, which were consistent with their care plans.
* Staff confirmed they have received training in relation to chemical restraint and behaviour management.

Based on the information summarised above, I find the service compliant with Requirement (3)(e) in Standard 8 Organisational governance.

# 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, however, required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.