Performance

Report

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| Name of service: | St Basil's Kensington |
| Service address: | 95-97 Todman Avenue KENSINGTON NSW 2033 |
| Commission ID: | 2285 |
| Approved provider: | St Basil's Homes |
| Activity type: | Assessment Contact - Site |
| Activity date: | 7 June 2023 to 9 June 2023 |
| Performance report date: | 26 July 2023 |

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 St Basil's Kensington (**the service**) has been prepared by M.Wyborn, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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 - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 13 July 2023.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

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

# 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 3**

* Ensure the service has an effective system for recording, monitoring and reviewing consumer assessment and care planning with a focus on high impact or high prevalence risks associated with the care of each consumer.
* Ensure the service is routinely reporting and investigating trends identified from the data gathered from quality safety risk meetings.
* Ensure the service is demonstrating that high impact and high prevalence risks associated with the care of consumers are effectively identified and managed, including medication management, consumer falls, and choking.

**Standard 8**

* Ensure the organisation’s suite of policies and procedures are reviewed.
* Provide ongoing education and training to staff on the suite of organisational policies.
* Ensure the service maintains an effective clinical governance framework to ensure safe and quality clinical care for consumers. This includes updated policies and staff education on minimising the use of restrictive practices, antimicrobial stewardship, and open disclosure.
* The organisation must ensure monitoring and oversight of the clinical care delivered at the service, and demonstrate that information and data is used to collate well-informed decisions.

# Standard 2

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

Findings

The service demonstrated that outcomes of consumer assessment and planning are effectively communicated and documented in individual consumer care and services plans, and these plans are readily available to consumers. Demonstrating effective continuous improvement since the last site audit in September 2022, the service has ensured that care plans are completed for all consumers, consumer case conferences are actioned in a timely manner, and the consumer handbook was updated and subsequently contains information relating to consumer care planning. The Assessment Team reviewed consumers identified in the previous performance assessment, and reported that all consumers still residing at the service had their issues addressed as part of the service’s continuous improvement actions.

Consumers and representatives advised that they are routinely involved in case conferences and consumer care plans are routinely provided to them. The Assessment Team observed that the service’s care plan review schedule and case conference schedule was up to date. The Assessment Team noted the consumers who did not have a care plan review or case conference were new to the service. The Assessment Team also reported that the service utilises an effective electronic documentation system to record and generate consumer care plans. Copies of the care plans were observed in consumer rooms, and care plans were readily available for consumers and representatives.

With these considerations, I find the service compliant in Requirement 2(3)(d).

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | 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. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(e) | 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. | Non-compliant |
| Requirement 3(3)(g) | 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. | Compliant |

Findings

The service was unable to demonstrate that consumers are routinely receiving care that is best practice, tailored to their needs and optimises their health and well-being. Consumers and representatives provided positive feedback about their clinical and personal care, however, some consumers subject to restrictive practices did not have appropriate consent forms or risk assessments completed, and some consumers with changed behaviours did not have their behaviours documented or managed appropriately. In their response to the Assessment Contact Report, the Approved Provider supplied relevant information in response to the consumers mentioned in the Report and provided a copy of the service’s plan for continuous improvement, however after considering the impact on each consumer, I find the Assessment Team’s findings to be more compelling in regard to consumer personal and clinical care and with these considerations, I find the service non-compliant in Requirement 3(3)(a).

The service was unable to demonstrate high impact, high prevalent risks associated with the care of each consumer are effectively managed and monitored. Care for consumers who experience falls and chronic wounds was in accordance with the organisation’s policies and procedures, however, there were deficits identified in the service’s systems for managing high impact and high prevalence risks and minimisation of infection related risks. The Assessment Team noted a high prevalence of changed behaviours leading to aggressive incidents not being managed effectively. In their response to the Assessment Contact Report, the Approved Provider highlighted the service’s reporting tool, incident analysis documents and risk identification tool, however after considering the impact on each consumer, I find the Assessment Team’s findings to be more compelling in regard to consumer personal and clinical care and with these considerations, I find the service non-compliant in Requirement 3(3)(b).

The service was unable to demonstrate that information about each consumer’s needs and preferences is documented and communicated within the organisation and where responsibility for care is shared. Information about each consumer’s current condition is not accurately and routinely documented in their care plan and the Assessment Team observed that consumer monitoring charts are completed on an inconsistent basis. Consumers who display behavioural concerns do not have relevant information about their behaviours, or appropriate strategies to manage them, included in their behaviour support plans. I find the Assessment Team’s findings to be more compelling in regard to personal and clinical care for consumers, and with these considerations, I find the service non-compliant in Requirement 3(3)(e).

The service has processes to minimise infection related risks and consumers and representatives provided positive feedback. The Assessment Team reported that the service continues to produce deficiencies in relation to staff proper use of personal protective equipment (PPE), documenting cleaning for slings, storage arrangements at the service, and rapid antigen testing processes and systems. In their response to the Assessment Contact Report, the Approved Provider highlighted their removal of items stored incorrectly, ensuring the sling register is maintained and up to date, and provided a summary training record related to infection prevention and control. After considering the impact on each consumer, I find the Approved Provider’s findings to be more compelling in regard to consumer personal and clinical care and with these considerations, I find the service compliant in Requirement 3(3)(g).

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | 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. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

The Assessment Team reported that the service was unable to demonstrate that each consumer receives effective services that meets their needs, goals and preferences. Further, the Assessment Team reported that meals provided at the service were not varied or of suitable quality or quantity. In their response to the Assessment Contact however, the Approved Provider supplied their plan for continuous improvement and highlighted the variety of activities available to consumers residing at the service, as well as the support provided by staff to assist consumers, including those that reside in the dementia support unit. The Approved Provider took immediate action to contact consumers and representatives of those mentioned in the Assessment Contact Report, and highlighted appropriate resolution to their concerns. The Approved Provider supplied evidence of purchase of new kitchen furniture and reinforced a variety of lifestyle activities that are of interest to consumers and that allow each consumer choice and control in relation to participation.

The Approved Provider supplied information to support their approach to encouraging feedback from consumers regarding meals at the time of the meal service. Consumers are offered other meal options if they present dissatisfaction with the meals provided. The Approved Provider explained in their response that the service undertakes food forums which include environmental factors such as dining ambience and consumer comfort.

After considering the Approved Provider’s response and the impact on each consumer, I find the Approved Provider’s findings to be more compelling in regard to services and supports for daily living, and with these considerations, I find the service compliant in Requirements 4(3)(a) and 4(3)(f).

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |

Findings

The Assessment Team reported that the service was unable to demonstrate a well maintained service environment that enables consumers to move freely at all times. The Assessment Team reported that two wheelchairs required tyre maintenance, a courtyard had damaged tiles, and the service was utilising spaces for storage that was ineffective. Further, the Assessment Team reported that access in and out of the service was somewhat restricted and on occasion, communal areas seemed crowded.

In their response to the Assessment Contact, the Approved Provider supplied their plan for continuous improvement and highlighted their immediate response to rectify the issues with the wheelchairs and have completed maintenance action in the service’s courtyard to ensure consumer safety. The Approved Provider highlighted their actions to ensure a home-like, safe and comfortable environment and reinforced their use of relevant signage throughout the service. In addition the service highlighted their provision for consumers to personalise their rooms and provided information regarding the service’s repaint plan. The service explained that their focus is to support consumers to access all areas of the service environment and explained that consumers who desire to enter and exit on a routine basis are provided to swipe cards. Consumers in the dementia support unit (DSU) are supported and their safety maintained by providing inside and outside access within the DSU environment.

After considering the Approved Provider’s response and the impact on each consumer, I find the Approved Provider’s findings to be more compelling in regard to the organisation’s service environment and with these considerations, I find the service compliant in Requirement 5(3)(b).

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |

Findings

The service demonstrated that consumers are made aware of and have access to advocacy and language services, and other methods for raising and resolving complaints. In response to the previous site audit in September 2022, the service took continuous improvement action to ensure that external complaints and advocacy brochures and posters were displayed throughout the service and in multiple languages reflecting individual consumer backgrounds. The service provided education sessions conducted by Senior Rights Service representatives to increase consumer and representative knowledge of available advocacy services and complaints process. The service also included consumer comments and complaints to the agenda at consumer and representative meetings, and information about the complaints process is now routinely included in each consumer newsletter.

The Assessment Team reported that staff appropriately described the process for assisting consumers to provide feedback or lodge a complaint, including the use of internal complaint mechanisms such as feedback forms or directing the consumer or representative to an advocacy service such as Older Person’s Advocacy Network (OPAN). The Assessment Team’s observation of consumer documents confirmed a representative from the Senior Rights Service conducted onsite education sessions in November 2022 informing staff and consumers on advocacy and related services.

The Assessment Team observed several brochures in different languages about reporting concerns and making a complaint in the service’s reception area, and the newsletter distributed to all consumers and representatives contains information on internal and external complaints processes and advocacy and language services. With these considerations, I find the service compliant in Requirement 6(3)(b).

The Assessment Team reported that the service continues to lack appropriate action in response to complaint management and to provide open disclosure when things go wrong. The Assessment Team reported ongoing complaints relating to laundry processes and missing clothing as well as existing complaints that are yet to be finalised. In their response to the Assessment Contact, the Approved Provider supplied their plan for continuous improvement and highlighted their immediate action to contact the consumers and representatives noted in the Assessment Contact Report. The Approved Provider highlighted improvements made at the service to ensure that complaints are managed effectively and to the satisfaction of consumers and representatives. These actions include a review of the service’s complaints process and clarification of roles and responsibility around management of complaints. Complaints were added as an ongoing agenda item at the governance meetings to allow for escalation to the executive and board. The service’s complaints register was added to the service’s quality audit schedule to be reviewed monthly to assist in ongoing identification and management of trends in complaints. An online platform for lodging complaints internally and directly to the executive team was implemented, and open disclosure training was provided to all staff and is now added to the corporate orientation agenda.

After considering the Approved Provider’s response and the impact on each consumer, I find the Approved Provider’s findings to be more compelling in regard to complaints management and open disclosure and with these considerations, I find the service compliant in Requirement 6(3)(c).

# 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 |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

The service demonstrated a competent workforce whose members have the qualifications and knowledge to effectively perform their roles. Since the site audit in September 2022, the service has undertaken a recruitment drive to reduce the number of agency staff employed and the organisation has increased its casual pool of staff used across all of its sites. Corporate orientation training is conducted monthly which provides an overview of the organisation and of the service to all newly commenced staff, including agency staff who are employed for at least 14 days. Further, the service routinely reviews its staff duty lists and provides focus and updates to all staff. The Assessment Team reported that all staff, including agency staff, have access to the service’s policies and procedures online, and staff interviewed by the Assessment Team understood where to locate the policies and procedures. With these considerations, I find the service compliant in Requirement 7(3)(c).

In the Assessment Contact Report, the Assessment Team recommended that service was unable to demonstrate that the workforce is trained and supported to deliver the outcomes required by the Aged Care Quality and Safety Standards. In their response to the Assessment Contact, the Approved Provider provided reference to reporting material that highlights relevant training to staff on mandatory topics as well as additional training provided to staff in response to educational needs at the service. The Approved Provider evidenced staff completion of training on open disclosure, consumer changing behaviours and serious incident notification requirements. The Approved Provider evidenced how they ensure that all staff maintain an appropriate training program and how management follow up with staff if identified not to have completed an education topic. After considering the Approved Provider’s response and the impact on each consumer, I find the Approved Provider’s findings to be more compelling in regard to human resources, and with these considerations, I find the service compliant in Requirement 7(3)(d).

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(c) | 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. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Non-compliant |
| 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. | Non-compliant |

Findings

The service effectively demonstrated that consumers are engaged in the development, delivery and evaluation of care and services. Consumer care plans are managed in consultation and case conference with consumers and representatives. The service provides appropriate feedback and complaints channels for consumers and representatives via resident meetings, and feedback and complaints forms. The Assessment Team identified consumer consultation in recent resident meetings on the service’s colour scheme options for the facility and an invitation to consumers seeking participation in food focus groups to be held with consumers, representatives and caters on a routine basis. Management advised that resident meetings are conducted in English and interpreted into Greek, and management advised that brochures are available providing information for consumers and representatives to internal and external complaints services and advocacy services. The Assessment Team observed complaints brochures including an Older Person Advocacy Network (OPAN) brochure on display at the entrance to the service. Management also advised that the service’s monthly newsletter is translated into Greek and this provides information about complaints and feedback. With these considerations, I find the service compliant in Requirement 8(3)(a).

In the Assessment Contact Report, the Assessment Team recommended that service was unable to demonstrate effective organisation wide governance systems. The Assessment Team reported inconsistent clinical documentation, relevant consumer information not routinely shared with others who have responsibility for the consumer, and inconsistent information in consumer care plans. Further, the Assessment Team reported deficiencies in the service’s recording of consumer incidents, reporting of incidents to the serious incident response scheme (SIRS) and undertaking effective interventions and applying strategies to ensure incidents do not reoccur. In their response to the Assessment Contact Report, the Approved Provider supplied their plan for continuous improvement and highlighted their incident management system and suite of policies and procedures, including those related to information management, regulatory compliance and feedback and complaints.

The Assessment Team was unable to evidence specific organisation wide governance systems lacking at the service and after considering the Approved Provider’s response and the impact on each consumer, I find the Approved Provider’s findings to be more compelling in regard to organisational governance, and with these considerations, I find the service compliant in Requirement 8(3)(c).

The Assessment Team reported that the organisation was unable to demonstrate effective risk management systems and practices, including management of high impact or high prevalence risks, or demonstrate an effective clinical governance framework to support effective antimicrobial stewardship. In their response to the Assessment Contact Report, the Approved Provider supplied their plan for continuous improvement, however, the Approved Provider was unable to demonstrate an effective incident management system including up to date risk management policies and procedures and an effective risk management framework. The organisation has a draft enterprise risk management plan and a draft clinical governance framework which still requires board approval. There are no other policies with regard to incident management apart from procedures for reporting of SIRS incidents and management of high impact and high prevalence risk policy.

In relation to clinical governance, the Assessment Team reported that the related organisational policies and procedures were in draft format. The clinical governance framework was due for review in July 2023, the antimicrobial stewardship policy was in draft. The organisation’s open disclosure policy and procedure, and restrictive practice prevention and management procedure were in date. There is no fully trained infection prevention and control lead at the service.

After considering the Approved Provider’s response and the impact on each consumer, I find the Assessment Team’s findings to be more compelling in regard to organisational governance, and with these considerations, I find the service non-compliant in Requirements 8(3)(d) and 8(3)(e).

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