Performance

Report

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| Name: | St Basil's Kensington |
| Commission ID: | 2285 |
| Address: | 95-97 Todman Avenue, KENSINGTON, New South Wales, 2033 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 30 January 2024 to 31 January 2024 |
| Performance report date: | 1 March 2024 |
| Service included in this assessment: | Provider: 736 St Basil's Homes  Service: 739 St Basil's Kensington |

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 Therese Solomon, 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 (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Applicable As Not All Requirements Assessed |
| **Standard 8** Organisational governance | **Not Applicable As Not All Requirements 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 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. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | 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. | Compliant |

Findings

Requirement 3(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Consumers and/or representatives provided mostly positive feedback about the personal and clinical care of consumers. Review of the care of consumers shows personal and clinical care is safe and effective across domains of care, including management of skin integrity, pain, incidents, and the provision of behaviour support.

The service has a behaviour support strategy meeting weekly, and a report is generated by the care manager to reflect all consumer behaviours documented by staff during the week. Care and service reviews for consumers who have changed behaviours shows behaviour support is provided.

While there was some negative feedback from one consumer in relation to their personal care, the feedback from consumers and/or representatives was mostly positive. Review of consumer care and service records showed the service is managing consumer skin integrity and wounds effectively, however documentation is minimal in relation to wound evaluation and description. This has been identified and acknowledged by the service and education has commenced with further education organised for staff. Safe and effective care is being provided for consumers in other areas such as pain management, incident management and the provision of behaviour support.

Requirement 3(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated they have effective processes in place to manage high-impact and high-prevalence risks associated with the care of each consumer. The process includes a high-impact high prevalence risk list generated by the care manager weekly which flags the top ten consumers at higher risk and consumers with increasing risk. For example, consumers experiencing new pain, wounds, infections, weight loss and all falls and incidents. The list supports a handover sheet which is documented on by the registered nurses each shift. The service has a nurse practitioner support program, and the information in the list is emailed to the nurse practitioner. The nurse practitioner reviews and comments on each consumer, this is documented in the consumer’s progress notes and followed up at twice weekly senior clinical staff meetings.

While the right consistency of food as assessed by a speech pathologist was not consistently provided for one consumer, increasing the risk of choking, the service has identified and escalated this and increased monitoring to minimise the risk. Overall, the service provided examples and explained the processes being followed to effectively identify, manage, and monitor high-impact and high-prevalence risks associated with the care of the consumers.

Requirement 3(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Observation of the handover process by the Assessment Team showed staff are provided with information about the condition, needs and preferences of the consumers they are caring for at the service. Staff are provided with shift charts which show them charting requirements for each consumer, for example, food and fluid charts, behaviour charts, sight charts and a weekly environmental restraint chart. Acute changes and care requirement charts are added for changed conditions, for example, post-falls and for vital signs and pain. There was ample evidence of documentation in progress notes to show effective communication with other providers of care, including dietician and speech pathologist.

While the Assessment Team identified some gaps and inconsistent information in care plans, information is well documented about the condition and care needs of consumers in the clinical information systems overall. Staff were able to describe and provide the appropriate care and services required. Information has been communicated to other providers of care and their information is documented in consumer care and service records.

# Standard 8

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| Organisational governance | |  |
| 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. | 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. | Compliant |

Findings

Requirement 8(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation has a documented risk management framework, which was approved by the governing body in October 2023, and has current policies and procedures. Organisational management outlined the Board’s responsibilities for risk management, and the information which the Board requests and is provided with to exercise direction and control. Documentation and other information gathered about a sample of the commitments made for organisational risk management shows that overall, they are being met. Documentation and other information gathered about the four sub-requirements of this Requirement, and in relation to the planned closure of the service, shows related risk management.

Commitments of the board in the risk management framework include having a risk register and regularly reviewing reports of the organisational risk profile. Review of recent reports to the Board and minutes of Board and Board sub-committee meetings show this occurs. Organisational management, who prepare the reports and attend those meetings, confirmed it occurs. Links are evident between results outlined relating to specific sub-requirements and the organisational risk register, showing risk management is ongoing.

In relation to high-impact and high-prevalence risks associated with the care of consumers, internal and external quality audits are being undertaken and there is data collection, analysis, benchmarking and/or trending in relation to clinical performance indicators, incidents and feedback and complaints. Results are discussed and action plans developed at service level with input from relevant organisational supports, such as the quality manager. Reports are prepared for and tabled at Board sub-committee and Board meetings. Clinical risks and risk management is discussed in detail at the quality improvement, clinical risk, and at Board meetings.

In relation to identifying and responding to the abuse and neglect of consumers and the incident management system, review of documentation relating to incidents – including some recent Serious Incident Response Scheme incidents – shows investigation occurs and there is related follow-up, such as actions to prevent recurrence for individuals and systemic improvements. There is a first party review of individual incidents by one of the service managers and a second party review by the organisational quality manager. Information about the incidents, reviews and outcomes are reported to the executive and Board. Review of Board and Board sub-committee meeting minutes shows the board scrutinises the information and, in some cases, requests further information for effective oversight.

The Assessment Team identified areas for improvement related to the risk register, however the provider had already identified this and had implemented actions to address the deficits.

Requirement 8(3)(e) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation has a documented clinical governance framework approved by the Board in October 2023 and current policies and procedures. Organisational management outlined the Board’s responsibilities for safe and quality care, and the information the Board requests and is provided with to exercise direction and control. Documentation and other information gathered about the commitments made for organisational clinical governance shows they are being met in practice. Documentation and other information gathered about the sub-requirements of this Requirement shows effective clinical governance.

The clinical governance framework includes a commitment to systematic monitoring of safety and quality performance, and a commitment that the Board receives reports and monitors progress on safety and quality performance and outcomes. Review of documentation and interviews with organisational and service management shows that data and information about clinical performance and effectiveness is being collated, analysed, benchmarked and/or trended, and reported on routinely and as needed. Discussions take place at service level meetings where action plans are developed, if needed. This information is used to inform reporting to the executive and Board. Minutes of recent Board sub-committee and board meetings shows the reports about safety and quality performance and outcomes are being reviewed by the board.

In relation to antimicrobial stewardship, there are regular reviews and audits of service performance with results discussed at service-level meetings. Review of related documentation shows a focus on encouraging doctors to order pathology testing for consumers, where appropriate, and to review results prior to prescribing antimicrobials. Data, analysis, and trends in infection rates are regularly reported on, including to the Board, with analysis showing attention is also paid to appropriate antimicrobial use.

In relation to minimising the use of restraint, service management had data and information readily available about the types and reasons for use of restrictive practices with consumers showing ongoing oversight. Organisational management had identified some concerns related to the use of antipsychotics and consumer diagnosis. Management explained work has been undertaken to understand the identified concerns, which found some incorrect reporting had occurred as well as a high number of complex care consumers. Information gathered by the Assessment Team in relation to individual consumers and oversight of restrictive practice usage, shows work to minimise the use. For example, increased use of a nurse practitioner and Dementia Services Australia for consumer behaviour support. Information about use of restrictive practices with consumers is being routinely provided to the Board for review.

In relation to open disclosure, review of management of individual complaints and Serious Incident Response Scheme incidents showed open disclosure is being practised and consumers and representatives confirmed this. The management team have been involved in open disclosure meetings with consumers and/or their representatives. Reports to a Board sub-committee and to the Board include information about complaints and Serious Incident Response Scheme incidents, and they have sufficient detail to enable the Board to understand if open disclosure is being practised.

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)