Performance

Report

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| Name: | The House of Saint Hilarion |
| Commission ID: | 6504 |
| Address: | 7 Kelly Avenue, SEATON, South Australia, 5023 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 4 July 2024 |
| Performance report date: | 11 July 2024 |
| Service included in this assessment: | Provider: 1421 The Society of St Hilarion Inc  Service: 4219 The House of Saint Hilarion |

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 The House of Saint Hilarion (**the service**) has been prepared by M Glenn, 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.

# 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, which was informed by a site assessment, observations at the service, review of documents and interviews with consumers/representatives, staff and management;
* the provider’s response received 9 July 2024 acknowledging the assessment team’s report; and
* a performance report dated 18 February 2024 for a site audit undertaken from 22 January 2024 to 25 January 2024.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not fully assessed |
| **Standard 3** Personal care and clinical care | **Not fully assessed** |
| **Standard 7** Human resources | **Not fully assessed** |
| **Standard 8** Organisational governance | **Not fully 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

**Requirement (3)(a)** was found non-compliant following a site audit undertaken in January 2024 as assessment and planning did not identify the use of environmental restraint for most mobile consumers, and risks associated with oral intake were not effectively captured. In response to the non-compliance, the provider implemented a range of improvement actions, including an escalation process to ensure food and fluid balance charting is completed, and gaps are identified; reviewing and implementing changes to environmental restraint processes; for those consumers identified as being subject to environmental restraint, conducting restrictive practice assessments and obtaining consents; and updating the security and door system to reflect consumer choice and independence.

At the assessment contact in July 2024, consumers and representatives were satisfied that assessment and care planning captures risks and informs the delivery of safe care and services. Care files for six consumers show initial and ongoing assessments, including validated assessment tools, are conducted to identify risks to consumers’ health and well-being, such as nutrition, weight loss, swallowing, falls, restrictive practice, skin integrity and pain, with strategies to mitigate risks communicated through individualised care plans. Documentation shows physical, environmental, mechanical, and chemical restraint is identified, assessed, reviewed, and monitored. Care files for three consumers subject to environmental restraint include risk assessments, documented discussions with representatives and informed consent, and corresponding behaviour support plans. Clinical and care staff described assessment and planning processes, how risk is identified and specific interventions for mitigating risks.

Based on the assessment team’s report, I find requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers compliant.

# Standard 3

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| Personal care and clinical care | |  |
| 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

**Requirement (3)(g)** was found non-compliant following a site audit undertaken in January 2024 as use of long-term antimicrobials were not regularly reviewed for effectiveness. In response to the non-compliance, the provider implemented a range of improvement actions, including, but not limited to, reviewing staff education and redistributing antimicrobial stewardship training modules; including consumers prescribed long-term antimicrobial therapy on a central register and ensuring they are monitored and reviewed on a regular basis; and increasing the working days of the infection prevention and control lead.

At the assessment contact in July 2024, consumers and representatives said the service minimises infection related risks, COVID-19 outbreaks are well managed, and they are kept informed. The service practices antimicrobial stewardship and takes action to reduce the risk of infection related risk through practices guided by policies and procedures. Consumers are screened regularly, pathology is collected prior to treating symptoms of infections, and infection-related risk mitigation strategies are implemented. A medication register includes consumers on antibiotics who are reviewed fortnightly by the clinical team, with regular discussions undertaken with the medical officer, pharmacists, consumers, and representatives with the aim to reduce antibiotic use. The antibiotic register totalled 14 consumers on antibiotics longer than four-weeks, with four prescriptions ceased during the last review. An infection prevention control lead is employed by the service and has oversight over infection related risk and outbreaks. Staff are aware of transmission-based precautions, described additional infection control strategies during outbreaks, and confirm they have received recent training in infection-related risks. Clinical staff are aware of antimicrobial stewardship principles, describing how they liaise with the medical officer to ensure pathology testing is conducted prior to antibiotic prescription. Management described, and observations of staff practice show the service is managing a current COVID-19 outbreak in accordance with the outbreak management plan.

Based on the assessment team’s report, I find requirement (3)(g) in Standard 3 Personal care and clinical care compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

**Requirements (3)(d) and (3)(e)** were found non-compliant following a site audit undertaken in January 2024 as completion of staff training, specifically mandatory and role specific modules, was not monitored; and performance appraisals were not completed in line with the organisation’s policy. In response to the non-compliance, the provider implemented a range of improvement actions, including, but not limited to, specific training reflective of the deficits identified at the site audit, including restrictive practice, antimicrobial stewardship, and culture and diversity; developing a more efficient performance appraisal template to effectively capture staff goals and performance; and implementing tracking and monitoring of performance appraisal completion, including increased accountability and reporting of completion rates to the governing body.

At the assessment contact in July 2024, most consumers and representatives were satisfied with staff knowledge, stating staff are competent in performing their roles. Selection, recruitment and onboarding processes ensure the workforce is equipped to undertake their roles and that appropriate knowledge and skills are maintained throughout their employment. Job specifications identify the expectations of staff, within the scope of their role, including maintaining the organisation’s values of respect, accountability and trust. A mandatory and annual training program includes a range of topics, including modules relating to the Quality Standards. This training is required for all staff, including the governing body. There are processes to monitor staff completion of mandatory training requirements. Care and clinical staff said they are provided training opportunities to perform their role and feel supported to seek guidance when required.

Staff performance is regularly assessed, monitored and reviewed. Probation reviews are conducted with new staff at three weeks, five weeks and three months, with a formal review at six months. After this, reviews are completed every two years, with informal performance discussions undertaken on an ad hoc basis. Staff performance is monitored on an ongoing basis through observations, incident data, and feedback and complaints, and there is a framework to address concerns relating to staff practice. All staff interviewed confirm they participate in performance reviews where they can discuss their performance and identify areas for additional training and support.

Based on the assessment team’s report, I find requirements (3)(d) and (3)(e) in Standard 7 Human resources compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | 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 |

Findings

**Requirements (3)(b) and (3)(c)** were found non-compliant following a site audit undertaken in January 2024 as reporting mechanisms to the governing body did not provide accurate information in relation to deficits in workforce governance, long term antimicrobials, and the prevalence of restrictive practices; and information management, workforce and regulatory compliance governance systems were not effective. In response to the non-compliance, the provider implemented a range of improvement actions, including, but not limited to, enhancing information in reports provided to the board; establishing a structured system to monitor, review and report on performance reviews; identifying and assessing consumers subject to environmental restraints; and updating the restrictive practices register.

At the assessment contact in July 2024, all consumers reported feeling safe and satisfied that the service is well run. The organisation is governed by a board comprising of members with varied levels of expertise, and the service is overseen by a director of care who reports to the chief executive officer and oversees the delivery of care and services. A quality care advisory body has been developed, holding monthly meetings. The chair of the board serves as a member of the quality care advisory body, facilitating communication between the board and the advisory body’s members. A comprehensive report covering clinical care, workforce details, feedback and complaints, incidents and mandatory reporting is created and presented to the board ahead of their monthly meetings.

Effective organisation wide governance systems are in place. Information management systems ensure staff have access to the necessary information to enable them to effectively perform their roles. A finance committee overseas financial governance, monitors and reviews financial performance, income, and expenditure, and provides monthly reports to the board. Members of the workforce have clearly defined responsibilities and accountabilities, detailed in position descriptions. Staff have clear reporting lines, with the director of care holding overall responsibility. The people and culture team is responsible for ensuring competencies, training and performance appraisals are conducted, with overall compliance reported to the board. The quality and safety team manage regulatory compliance. Subscriptions to peak regulatory bodies ensure timely access to relevant legislative changes, and there are processes to ensure significant changes are effectively and efficiently communicated to staff and consumers, as required. Procedures are in place to capture and manage feedback and complaints through to resolution, with ongoing review and analysis aimed at driving continuous improvement.

Based on the assessment team’s report, I find requirements (3)(b) and (3)(c) in Standard 8 Organisational governance compliant.

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)