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: | Site Audit |
| Activity date: | 22 January 2024 to 25 January 2024 |
| Performance report date: | 18 February 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 Denise McDonald, 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 Site Audit 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 16 February 2024 which included a plan for continuous improvement, consumer’s care documentation, proposed training modules, amended position descriptions and revised assessment and care planning checklists.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

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.

* **Requirement 2(3)(a)**
  + The service ensures all consumers who may be considered at risk of inappropriate environmental restraint are assessed, and if restrained, consent is provided and behaviour support plans are in place.
  + The service ensures when consumers require oral intake assessment, staff monitor and collect sufficient information to inform those assessments.
  + **Requirement 3(3)(g)**
  + The service ensures processes are in place to monitor and review all consumers prescribed long term or preventative antimicrobials.
  + Antimicrobial stewardship is promoted to medical officers, consumers and their representatives.
* **Requirement 7(3)(d)** and **Requirement 7(3)(e)**
  + The service ensures all staff are provided with a training program which supports them to deliver the outcomes required by these standards and staff completion of training when scheduled is monitored.
  + The service ensures systems and processes are in place to routinely review each workforce members performance.
* **Requirement 8(3)(b)** and **Requirement 8(3)(c)**
  + The governing body ensures it is provided with the relevant information to ensure oversight and accountability for delivery of safe, quality and inclusive care and services.
  + The organisation ensures its agreed systems and processes to manage information, govern the workforce and ensure compliance with regulations are monitored and effective.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

This Quality Standard is assessed as Compliant as 6 of the 6 Requirements have been assessed as Compliant.

Consumers gave practical examples of how staff treat them with dignity and respect. Staff were observed to interact with consumers in a respectful and engaging manner. Staff demonstrated knowledge of consumers’ preferences, life history and spoke respectfully about consumers.

Consumers said a quiet/prayer room had been implemented in recognition of the way different consumers engaged with their faith. Staff understood consumer’s religious and cultural backgrounds and explained how this influenced the delivery of their care to ensure it was safe for them. Consumer’s spiritual, cultural preferences and language needs were reflected in care documentation.

Consumers said they had control over their care decisions, life choices and were supported to maintain important relationships. Staff demonstrated knowledge of consumers care decisions and how to support them to connect with others. Care documentation evidenced consumers had choice over care delivery, including which medical and allied health professionals, were involved in their care.

Staff demonstrated knowledge of processes to identify which consumers wished to engage in activities, which may place them at risk. Care documentation outlined strategies planned to promote consumer safety and supports required to assist them to live life as they chose. Consumers were observed accessing the community independently to reduce risk of social isolation.

Consumers and representatives confirmed they were kept up to date as information was provided to them in a variety of ways. Staff described how verbal and written information was adapted to meet the sensory and language needs of individual consumers. Activity calendars and menus were displayed to foster consumer choice and newsletters informed consumers of upcoming events.

Consumers were informed of their privacy rights upon entry, with policies and procedures guiding staff practice. Consumers gave practical examples of how staff respect their privacy. Staff were observed undertaking meetings in private spaces and locking computers when not in use to protect consumers personal information, however, some consumer information was visible as it was written on whiteboards hanging in communal areas. This is further considered under Requirement 8(3)(c).

# 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. | Not Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| 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 |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

The Quality Standard is assessed as non-compliant as one of the 5 specific Requirements have been assessed as non-compliant. In coming to my finding, I have considered the information contained within the Site Audit report and the provider’s response submitted on 16 February 2024.

In relation to Requirement 2(3)(a), the Site Audit report evidenced assessment and planning processes had not identified the risk of inappropriate environmental restrictive practice and risks associated with reduced oral intake were not able to be accurately assessed.

For environmental restrictive practices, the entry and exit point to the building, the grounds and the memory support unit (MSU), was secured by locking mechanisms which required a swipe card or code, to release the lock. For 104 consumers who were mobile and independent, they had not been provided with swipe cards and were reliant on staff to facilitate their entry and exit. Despite this, consumers had not been assessed for environmental restraint.

Staff said, and care documentation evidenced, environmental restraint assessments, and the subsequent obtaining of consent and behaviour support planning, was only completed for consumers, who exhibited exit seeking behaviours and were identified to be at risk if they left the MSU or service independently.

For reduced oral intake, clinical staff said, and care documentation evidenced, their ability to assess consumer’s nutrition and hydration needs were impacted as directives to record consumers food and fluid consumption were not always followed by care staff or they were not provided with sufficient information to inform whether changes were required to the consumer’s care strategies.

The providers response acknowledged these findings and submitted a plan for continuous improvement (PCI) outlining their actions taken, commenced, and forecast, to ensure risks of environmental restrictive practice were incorporated within their assessment and care planning processes and consumers oral intake was consistently monitored to inform assessment and to ensure effective care and services were able to be planned.

In response to environmental restraint, actions included assessing all existing consumers for restrictive practice, resulting in an additional 35 consumers being identified as having an environmental restraint. The restraint register, evidenced while the assessments were completed, consent for the restraint was still to be obtained for 5 consumers and the development of behaviour support plans, for all who are environmentally restrained, was identified as an ongoing activity.

Additionally, the assessment schedule, for new consumers has been amended to include assessment of environmental restrictive practices upon entry and clinical monitoring processes used to identify changes in consumer condition will also now consider if the change, requires environmental restrictive practices to be reassessed.

In response to oral intake assessments, staff were to be provided with additional training on the importance of monitoring of food and fluid consumption, daily clinical oversight to ensure completion of care documentation, when directed and an audit would be completed to ensure consistent and sufficient information was being documented to inform whether care and services were being effective.

While, I am satisfied the risk of inappropriate environmental restraint has been assessed for existing consumers, I am not persuaded behaviour support planning processes have been completed and deficits in oral intake assessment processes have been remediated. The PCI and supporting documentation, evidenced improvement actions were still being undertaken and were yet to be evaluated to demonstrate their effectiveness. I encourage the provider to embed these changes into their usual practice to ensure risk of environmental restrictive practice is considered and risks associated with reduced oral intake is effectively assessed.

Based on the detailed evidence above, I find Requirement 2(3)(a) is non-compliant.

In relation to the remaining 4 requirements of this Quality Standard, I find them compliant as:

Consumers and representatives confirmed they have been provided an opportunity to express consumer’s care goals, preferences and end of life wishes upon entry. Staff demonstrated knowledge of consumer’s mobility goals, personal hygiene preferences and care needs. Care documentation contained advance care directives, end of life plans and reflected the care needs, goals and preferences of consumers.

Consumers and representatives said they and those chosen by them, were included in care consultations. Staff confirmed consumers and their representatives were contacted during care evaluations and when changes to care were needed. Care documentation evidenced input from, and consultation with, consumers, representatives, medical officers and allied health professionals.

Consumers and representatives said they were advised of assessment outcomes during care consultations and were offered a copy of the care plan. Staff confirmed care plans were offered to consumers and their representatives. Care plans were observed to be readily accessible, at the point of care, as they were stored in consumer’s rooms.

Staff advised consumers care strategies were reviewed at 6 months following entry and then annually to ensure their effectiveness. Care documentation evidenced evaluations occurred as scheduled and in response to incidents or changes in consumer’s condition, however, as monitoring records were not consistently completed, staff advised their ability to evaluate the effectiveness of care was impacted. This is further considered under Requirement 2(3)(a).

# 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)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | 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 |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | 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. | Not Compliant |

Findings

The Quality Standard is assessed as non-compliant as one of the 7 specific Requirements have been assessed as non-compliant. In coming to my finding, I have considered the information contained within the Site Audit report and the provider’s response submitted on 16 February 2024.

In relation to Requirement 3(3)(g), the Site Audit report evidenced precautions to prevent and control the transmission of infection were successfully implemented and pathological testing was performed to inform antibiotic prescribing. However, when antimicrobials were prescribed long term or as a preventive measure, these were not reviewed to determine if their ongoing use was necessary, or they could be ceased.

Care documentation for 2 named consumers evidenced they had been prescribed antibiotics to prevent or minimise the likelihood of urinary tract infections for periods of more than 6 months. Staff confirmed they were aware of consumers who received antimicrobials for preventative measures and said processes to review its use were informal.

While processes were in place to monitor infection rates and care for consumers with active infections was discussed, these processes did not include review of the 14 consumers who were prescribed preventative antimicrobials as they were not identified on the report, used to inform those discussions.

Additionally, pharmacist reviews for long term preventative prescriptions were only undertaken if the medical officer requested it, otherwise decisions on re-prescribing were completed by the medical officer in consultation with family or nominated representatives.

The providers response acknowledged these findings and submitted a PCI outlining their actions taken, commenced, and forecast, to ensure risks of increasing antibiotic resistance was decreased by reducing the prevalence of long-term antibiotic use.

The actions included requiring staff to complete antimicrobial stewardship training annually, amending policies and procedures to provide clearer guidance to staff by defining long term use and enhancing clinical oversight and the responsibilities of the Infection control and prevention lead.

Additionally, medical officers were provided with correspondence highlighting the appropriateness of antibiotic use in a residential aged care setting, by the consultant pharmacist, and were asked to review all consumers prescribed long term and preventative antimicrobials to encourage reduction. I acknowledge medical officers have reviewed 4 consumers on long term antibiotic use, however, have continued the course of treatment, in consultation with representatives.

While I am satisfied some consumers on long term and/or preventative antibiotics have been reviewed, I consider the improvement actions described within the PCI and the providers response, are yet to demonstrate effective change in promoting antimicrobial stewardship.

I encourage the provider to continue to implement the planned improvement actions and embed these changes into their usual practice to ensure risk of increasing antimicrobial resistance is reduced.

Based on the detailed evidence above, I find Requirement 3(3)(g) is non-compliant.

In relation to the remaining 6 requirements of this Quality Standard, I find them compliant as:

Consumers and representatives said consumers received care which was aligned to their needs and supported their health and well-being. Staff demonstrated knowledge of consumer’s personal and clinical care needs, and described strategies used to ensure these needs were met. Policies and procedures guided staff in provision of safe, effective and best practice care, however, staff had not accurately identified consumers whose free movement was restricted, and they were environmentally restrained. This is further considered under Requirement 2(3)(a) as it relates to failure to identify risks to consumers and Requirement 8(3)(c) where it relates to governance systems being ineffective in ensuring regulatory compliance.

Consumers and representatives said high impact risks, such as falls were effectively managed for individual consumers. Staff demonstrated knowledge of high impact/high prevalence risks across the consumer cohort and monitored care documentation daily to ensure these risks were managed, however, strategies to ensure safe medication management had not been adopted. Consumers, at high risk of falls, were observed to have the required falls prevention equipment in place, however, consumers who had experienced unplanned weight loss were not being consistently monitored to enable effective assessment and to inform management strategies. This is further considered under Requirement 2(3)(a).

Staff described processes used during end of life care, included the involvement of family, health professionals and external organisations to ensure the comfort of consumers. Care documentation evidenced staff delivery of comfort measures was monitored, and consumers wishes were met, during end of life. Policies and procedures guided staff practice in providing end of life care.

Consumers and representatives said when consumers exhibited signs indicative of decline, staff implemented responsive actions. Staff demonstrated knowledge of signs and symptoms associated with decline and escalated these concerns, for action. Policies and procedures guided staff practice in detecting and responding to acute and gradual deterioration.

Consumers and representatives said information was communicated between staff and health professionals effectively. Staff confirmed visiting medical officers and allied health professionals communicated changes to consumer’s condition and needs through written and verbal means. Staff were observed exchanging information between shifts to ensure consumer needs were met.

Consumers and representatives said they were referred to medical officers and allied health professionals, when required. Staff demonstrated knowledge of referral processes and knew when to refer consumers. Care documentation reflected referrals were undertaken in a timely manner.

# 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)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

The Quality Standard is assessed as compliant as 7 of the 7 specific Requirements has been assessed as compliant.

Consumers said they were encouraged to undertake daily living tasks, such as doing the dishes and tidying up which promoted their well-being and independence. Staff demonstrated knowledge of the activity’s consumers wished to do independently such as organising taxis to attend community events. Care documentation evidenced consumers needs and preferences for activities of daily living were assessed and recorded.

Consumers said they were provided with reassurance and supported to undertake meaningful activities which promoted their emotional wellbeing. Staff confirmed providing consumers with one on one time when consumers said they felt low. Care documentation evidenced consumers faith-based practices were known and church services were facilitated.

Consumers gave practical examples of how they were supported to participate in activities held within the internal and external community, and confirmed staff assist them to stay in touch with their family and friends. Staff demonstrated knowledge of consumers activities of interest and relationships of importance to them. Consumers were observed receiving visitors and participating in a range of activities, including bus trips into the community.

Staff said they were kept informed of changes to consumers conditions and needs via handover and by accessing care documentation on the electronic care management system. Staff confirmed processes were in place to communicate changing needs and preferences between care and catering staff. Staff were observed handing over consumer information between shifts.

Consumers and representatives said consumers had been connected to volunteer agencies and had been referred to pet therapists. Staff provided examples of consumers being referred to others to support their social interaction needs. Policies and procedures guided staff on referral pathways and organisations available to support consumers daily living needs.

Consumers and representatives said the menu contained variety and there were options if consumers didn’t like the meal offered. Staff demonstrated knowledge of consumers food preferences and dietary needs. Catering documentation evidenced staff implemented safe food storage, preparation and service practices; and consumers had input into the development of the menu.

Consumers and representatives said they had access to clean mobility aids, and they were suitable for their needs. Maintenance documentation evidenced equipment was inspected routinely and repairs were undertaken promptly, when required. Equipment used for activities of daily living was observed to be clean and in good condition.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| 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 |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

The Quality Standard is assessed as compliant as 3 of the 3 specific Requirements has been assessed as compliant.

Consumers advised they felt at home and representatives said they were always made to feel welcome when they visit. Staff said consumers were encouraged to personalise their rooms and understood it to be the consumer’s home. Consumer’s rooms were observed to be decorated with their own belongings and navigational aids were easy to follow.

Consumers and representatives said the service was clean and they could freely access internal communal areas and external courtyards. Environmental monitoring documentation evidenced cleaning and preventative maintenance occurred as scheduled and any hazards were attended to in a timely manner. Consumers rooms and communal areas were observed to be clean, and consumers moved around as they wished, however, due to the security systems placed on entry/exit doors they were unable to access the community independently This is further considered under Requirement 8(3)(c) as it relates to a failure in governance systems to recognise this as an environmental restrictive practice.

Consumers advised the furniture within their rooms was comfortable, repairs were attended quickly, and fittings were in working order. Staff advised they clean equipment and furniture, shared by consumers, between uses and processes were in place to report if any maintenance was needed. Maintenance documentation evidenced equipment and fittings were regularly inspected to ensure they remained safe for consumer use.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| 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 |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

The Quality Standard is assessed as compliant as 4 of the 4 specific Requirements has been assessed as compliant.

Consumers said they felt comfortable making complaints and described various avenues available to them to give feedback, including verbally and in writing. Meeting minutes evidenced consumers were encouraged to give feedback across a range of topics. Feedback forms and electronic feedback kiosks were readily accessible to support consumers to raise any concerns.

Consumers said they were aware of advocacy services and written material had been translated into their preferred language. Staff advised many of them are bi-lingual which assists them to provide translation services and they have referred consumers to advocacy services. Posters, brochures, and pamphlets promoted consumer access to external complaints and advocacy services.

Consumers, who had made complaints, confirmed action was taken quickly and their concerns resolved. Management demonstrated knowledge of complaint resolution timeframes and confirmed open disclosure principles were embedded into complaints management processes. Complaints documentation evidenced response to complaints was prompt, apologies were given, and consumers were involved in complaint resolution.

Consumers and representatives said their feedback was used to improve the air quality within the MSU. Management advised consumer feedback and complaints were registered, trended and used to inform continuous improvement. Complaints documentation and improvement plans evidenced feedback was recorded, actions detailed with their completion monitored and evaluated.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| 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. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Not Compliant |

Findings

The Quality Standard is assessed as non-compliant as 3 of the 5 specific Requirements have been assessed as non-compliant. In coming to my finding, I have considered the information contained within the Site Audit report and the provider’s response submitted on 16 February 2024.

In relation to Requirement 7(3)(d), the Site Audit reported evidenced systems and processes had been ineffective in allocating and monitoring staff compliance with completion of specified training modules to ensure the outcomes required by the Quality Standards have been met. Additionally, when staff were known not to be completing oral intake monitoring correctly as considered under Requirement 2(3)(a), responsive training was not initiated.

Education monitoring records confirmed while staff had been allocated an annual training program, most staff had failed to complete the mandatory and role specific modules, potentially contributing to restrictive practices not being accurately identified and appropriate use of antibiotics not being promoted.

Staff responsible for monitoring training completion, disseminating overdue training alerts, enforcing non-compliance with training requirements, confirmed this was a low priority and these tasks were only completed on an ad hoc basis, however, they confirmed on occasion failure to complete training had led to staff being removed from the roster.

The providers response acknowledged these findings and submitted a PCI outlining their actions taken, commenced, and forecast, to ensure staff were trained across various topics, relevant to their roles and aligned to the Quality Standards.

The actions included increasing the number of staff within the people and culture team to ensure training completion is routinely monitored, revising the training program and designating annual, one-time and customised training to all members of the workforce, integrating training compliance into performance review processes and initiating performance management discussions when training compliance has not been achieved.

I consider the evidence brought forward in the Site Audit report was sufficient to determine while staff were offered training, this was not undertaken by staff and when staff were known to not be completing their duties correctly, this did not prompt additional training to be provided.

I acknowledge topics including restrictive practice, antimicrobial stewardship, nutrition and hydration have been allocated immediately for staff to complete and have been included in the revised education schedule, however, these improvement actions will take time to implement, embed into usual practice and demonstrate their effectiveness.

Based on the detailed evidence above, I find Requirement 7(3)(d) is non-compliant.

In relation to Requirement 7(3)(e), the Site Audit report evidenced staff performance had not been regularly reviewed as annual performance appraisals had not been completed as scheduled.

Management outlined staff performance was assessed and monitored through informal processes including obtaining feedback from consumers, representatives or staff and reviewing incidents. Management gave practical examples of where this information had led to performance management processes being initiated and changes were made to the role of the staff member as a result.

Personnel monitoring records evidenced 65% of staff had not completed their annual performance appraisal, however, due to a recent policy change in January 2024, from annual to biennial appraisals, this percentage reduced to 16%, equivalent to 11 staff who had not had their performance reviewed.

The providers response acknowledged these findings and submitted a plan for continuous improvement (PCI) outlining their actions taken, commenced, and forecast, to ensure performance appraisals occurred as scheduled.

The actions included scheduling appointments for the 11 staff to complete their outstanding review with their manager, further refining the new policies and procedures to guide staff and managers on when performance assessment and reviews were to occur and increasing monitoring processes to ensure compliance with review processes and timeframes.

While I am persuaded that the actions taken by the provider, will address the outstanding staff appraisals, I consider the other proposed actions will take time to implement and to demonstrate their effectiveness.

I encourage the provider to continue to implement the planned improvement actions and embed these changes into their usual practice to ensure the risk of workforce performance not being reviewed regularly is mitigated.

Based on the detailed evidence above, I find Requirement 7(3)(e) is non-compliant.

In relation to the remaining 3 requirements of this Quality Standard, I find them compliant as:

Consumers and representatives said staff attend to them quickly when they need their assistance. Management described staffing allocations are based on assessed consumer need and occupancy levels. Rostering documentation evidenced strategies were in place to cover planned and unplanned leave, with a pool of casual and agency staff available.

Consumers and representatives said the workforce knows them well and interacts with them as individuals. Staff were observed addressing consumers by their preferred name and being respectful during their interactions with consumers. Policies and procedures guided staff on expected behaviours when engaging with consumers.

Consumers and representatives felt staff were competent in their roles. Management described onboarding processes ensured staff have the appropriate knowledge and qualifications, with currency of registration and security checks monitored. Education records evidenced staff completed competency assessments for manual handling, administration of medication and handwashing.

# 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)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Not 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. | Not 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. | 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

The Quality Standard is assessed as non-compliant as 2 of the 5 specific Requirements have been assessed as non-compliant. In coming to my finding, I have considered the information contained within the Site Audit report and the provider’s response submitted on 16 February 2024.

In relation to Requirement 8(3)(b), the Site Audit report evidenced reporting to the governing body (the Board) did not provide them with pertinent and accurate information, relating to deficits in compliance with workforce governance, long-term antibiotic use and the prevalence of environmental restrictive practices, potentially leading to ineffective monitoring and oversight to ensure care was safe, effective and inclusive and prohibiting them from making decisions on or taking action to address the deficits.

The Site Audit reports evidenced deficits in restrictive practice assessment, management and responsive care planning, oral intake monitoring and lack of review for consumers on antibiotics without an active infection, which have led to findings of non-compliance in Requirements 2(3)(a) and Requirement 3(3)(g).

Additionally, non-compliance has been found in Requirement 7(3)(d) and Requirement 7(3)(e) as compliance with workforce performance reviews was not demonstrated and the completion of staff training to ensure the delivery of safe, quality and inclusive care and services, has had minimal oversight, including where only new staff were required to complete training on culturally safe care.

The providers response lacked commentary on these findings, however, the PCI submitted outlined their actions taken to improvement communication provided to the Board and enclosed a copy of a revised quarterly report which includes information regarding environmental restrictive practice, antimicrobial stewardship. However, workforce reporting addressed only the number of staff employed and industrial relations matters.

I consider the evidence brought forward in the Site Audit report was sufficient to determine non-compliance with this requirement as the organisation’s governing body was unaware of circumstances at the service and that organisational systems were not being effectively utilised or monitored. While, I have been provided with some evidence to support increased information will be provided to the Board, I was not provided with sufficient information to evidence how the board will improve the performance of the organisation against the Quality Standards.

Based on the detailed evidence above, I find Requirement 8(3)(b) is non-compliant.

In relation to Requirement 8(3)(c), the Site Audit report evidenced effective governance systems were in place for continuous improvement, financial management and feedback and complaints mechanisms but systems in place to ensure compliance with regulations, workforce responsibilities and management of information were not effective.

Regulatory compliance was not able to be demonstrated due to a lack of shared understanding with environmental restrictive practices and therefore, the requirements of the Quality of Care Principles 2014, had not been met, when restrictive practices had been applied to consumers, as the security system implemented, controlled entry and exit to the premises and prevented their free movement.

While information management policies committed to the protection, privacy and confidentiality of consumer personal information, this had not translated to practice with consumers information displayed on noticeboards visible to other consumers and their representatives. Additionally, staff reported they did not have access to the information needed to review and evaluate consumer when unplanned weight loss occurred.

In relation to workforce governance, policies and procedures were in place to direct how staff training and workforce performance was to be monitored and reviewed, however these had not been followed and when staff had been non-compliant with their workforce responsibilities, enforcement actions were not generally implemented.

The provider response lacked commentary on their overall governance systems, however, their PCI outlines the actions taken, planned and forecast to review, revise and implement new practices, provide staff with education and ratify new policies which supports the current systems were ineffective.

I acknowledge the provider is undertaking improvement actions for the deficits identified and these are yet to be fully implemented. I consider these actions will take time to embed within the organisation’s usual processes and would require evaluation to ensure their effectiveness and sustainability.

Based on the detailed evidence above, I find Requirement 8(3)(c) is non-compliant.

In relation to the remaining 3 requirements of this Quality Standard, I find them compliant as:

Consumers and representatives gave practical examples of their engagement contributing to the design and delivery of care and services; and confirmed the establishment of a consumer advisory committee, with meeting minutes, evidencing consumer input into service operations was supported. Management advised meetings, surveys and feedback forms ensured consumer suggestions were used to inform and evaluate service delivery.

A risk management framework, policies, and systems were in place to identify current and emerging risks, their potential consequences, to determine risk mitigation strategies and prevent abuse or harm to consumers. Board reports evidenced information on quality indicators, clinical risks and incidents, were escalated to oversight and manage emerging risks. Management and clinical staff described policies and procedures were in place to support consumers to engage with risk-based activities of their choosing; and to manage high impact and high prevalence risks, including falls, infection and unplanned weightloss, however, risk management systems had not identified the need to provide education to staff in response to a known deficit in oral intake monitoring practices. This is further considered under Requirement 7(3)(d).

A clinical governance framework was in place and included policies, procedures, service delivery practices, and staff training requirements across areas such as antimicrobial stewardship, restrictive practices, and open disclosure. While staff routinely implemented open disclosure in response to complaints or adverse events and they demonstrated knowledge of restrictive practices and antimicrobial stewardship, deficits were found in managements understanding of environmental restrictive practices leading to consumers not being assessed and regulatory compliance achieved as considered under Requirement 2(3)(a) and Requirement 8(3)(c). Additionally, antimicrobial stewardship was generally promoted, however, roles and responsibilities for reviewing consumers prescribed long-term or preventative antibiotics were not formalised or monitored. This is further considered under Requirement 3(3)(g).

1. The preparation of the performance report is in accordance with section 40Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)