Report on Provider Performance

Registered provider name	St Charbel's Care Centre Ltd
Provider's Australian Business Number (ABN)	45161404164
Registered provider ID (PRV)	5231
Aged residential care home (ARCH)	ARCH-04817
Name and address of care delivery location	St Charbel's Care Centre 2 Waterloo Road, Punchbowl Sydney NSW 2196
Date of activity	9 December 2025 – 10 December 2025
Date published	21 January 2026

History and purpose of monitoring inspection

St Charbel's Care Centre Ltd (St Charbel's Care Centre) is an aged residential care home with 75 allocated places. St Charbel's Care Centre has a history of non-compliance with the previous Aged Care Quality Standards (Quality Standards). While non-compliance under the requirements of the Quality Standards ceased on 1 November 2025 due to the commencement of the *Aged Care Act 2024* (the Act), the concerns identified also relate to current obligations a provider is required to meet under the Aged Care Act. Monitoring of these concerns by the Commission since 1 November 2025 has identified potential ongoing risk to older people.

An on-site monitoring inspection occurred at the provider on 9 and 10 December 2025 to determine if the risks to older people in the aged care service remained. The following concerns were monitored:

- Concerns in relation to effective assessment, provision and management of personal and clinical care including falls, wounds, pain, continence, fluid monitoring and deterioration.
- Concerns in relation to identification, assessment, management and oversight of restrictive practices and behaviour support.
- Concerns relating to effective organisational and clinical governance including incident management and oversight of staff practice/education.

Summarised compliance history

On 29 August 2024, the provider was found non-compliant with 39 requirements of the Quality Standards. A sanction was imposed on St Charbel's Care Centre on 5 November 2024 and a Notice of Requirement to Agree was issued on 5 November 2024. Ongoing monitoring by the Aged Care Quality and Safety Commission (the Commission) occurred.

On 18 June 2025 the provider was assessed as compliant in 26 requirements of the Quality Standards, however 13 requirements of the Quality Standards remained non-compliant.

A site visit on 17 September and 18 September 2025 identified ongoing concerns in clinical oversight, clinical monitoring, suitability of meals and governance.

Monitoring Inspection summary

The Monitoring Inspection was undertaken in accordance with the monitoring powers of Part 2 of *Regulatory Powers (Standard Provisions) Act 2014* as specified through Chapter 6 of the Act to monitor compliance with obligations.

There were 68 older people on site during the monitoring inspection.

During the monitoring inspection evidence was obtained by:

- interviewing management, staff and older persons
- reviewing documentation
- observing care delivery and the care environment.

Summary of Peformance

The Inspection Team found the registered provider is not meeting several obligations and conditions of registration under the Act, specifically:

- **Section 146** of the Act, compliance with Aged Care Quality Standards, specifically the following standards and outcomes:
    - Standard 2 – The Organisation:
        - 2.5 – Incident management
        - 2.9 – Human resource management
    - Standard 3 – Care and Service:
        - 3.1 Assessment and Planning
        - 3.2 Delivery of funded aged care services

- Standard 5 – Clinical Care:
  - 5.1 – Clinical governance
  - 5.3 – Safe and quality use of medicines
  - 5.5 – Safety of clinical care and services

- **Section 162** of the Act, compliance with requirements for restrictive practices, as the registered provider did not demonstrate consistent understanding of, and implementation of, requirements of Chapter 4, Part 9 of the *Aged Care Rules 2025* (Rules) for restrictive practices and behaviour support.

- **Section 164** of the Act, compliance with requirements for incident management systems, because the registered provider did not demonstrate meeting requirements as detailed in Chapter 4, Part 10, Division 1 of the Rules for incident management.

These Standards and Rules form part of the registered provider's conditions of registration and were not met. This report outlines a summary of aspects of the registered provider's performance relating to the above requirements of the Act.

Details of findings related to performance

Concern 1: in relation to effective assessment, provision and management of personal and clinical care including falls, wounds, pain, continence, fluid monitoring and deterioration.

Rationale

Under Section 146 of the Aged Care Act 2024, the registered provider must comply with the Aged Care Quality Standards:

- Standard 3.2 requires the provider to deliver services to individuals that meet their needs, goals and preferences and optimises their quality of life, reablement and maintenance of function.

- Standard 5.5 requires the provider to deliver safe and quality clinical care services and to reduce the risk of harm to individuals.

Findings

Wound care at St Charbel's Care Centre is not best practice and puts older people at risk of infection, pain and deterioration.

Basis for finding: One older person's wounds had deteriorated, and this was not identified until immediately prior to the monitoring inspection visit. Documentation of the condition of wounds each time they are attended is poor. In addition, photographs taken of wounds are not always clear which does not enable accurate monitoring of the progress of wounds. There was limited evidence to support monitoring of pain related to the wounds. There is

limited evidence to show wound care is being provided in accordance with the treatment plan. Discussion with the older person's family on the deterioration of the wound had not occurred.

Other older people's wounds which were reviewed by the Inspection Team did not show the level of deterioration experienced. The same deficiencies were identified in relation to lack of detailed monitoring documentation and clear photographs to enable monitoring of the healing process, lack of regular review of wounds and lack of pain monitoring.

Deterioration was not consistently identified by clinical staff and therefore the older person's changed needs were not well managed.

Basis for finding: For one older person, the Inspection Team could not locate any documentation in the clinical file regarding the identification of the deterioration. The Inspection Team asked management for any information regarding the clinical staff's identification of the deterioration or response to the older person's deterioration, but no information was provided. Information from an allied health provider was not included in the summary care plan to support care delivery. Staff were not familiar with all information relevant to the care of the older person.

Deficiencies in effective management of falls

Basis for finding: The Inspection Team identified for one older person post fall management was not comprehensive and there has been limited documentation to guide staff in relation to managing the older person's injuries and pain. Following an unwitnessed fall, neurological observations were not completed for one older person as required by the provider's policy. The treatment plan for injuries sustained in the fall was not followed. Pain monitoring did not occur and when completed recorded no pain despite feedback the older person was verbally and physically expressing pain with some movements. The incident report for the fall did not include a root cause analysis of the incident.

For another older person who experiences regular falls, no trend analysis has occurred to determine the reason for ongoing falls in particular timeframes. Incident reports do not demonstrate potential causal factors have been investigated. It was evident falls risk assessments were not consistently completed to identify the falls risk factors and to implement appropriate strategies to address the falls risk. The evidence does not support a structured approach was considered to consistently monitoring the older person's pain post fall.

Deficiencies in nutritionally adequate meals and weight loss management

Basis for finding: There is inadequate assessment and planning information to ensure dietary, mealtime and medication assistance is provided, placing older people with swallow difficulties at risk of choking. Some older people have experienced unplanned weight loss which was not responded to in a timely manner and/or recommended interventions have not been implemented.

There have been ongoing concerns around the knowledge of catering staff about ensuring older people received nutritionally sound meals, particularly in relation to the provision of nutritionally sound vegetarian meals. Some improvements in meal service had previously been observed. Deficiencies were again identified during this monitoring inspection particularly in relation to sufficient documentation to support catering and care staff implementing dietician recommendations. In addition, deficiencies in relation to the identification and response to weight loss were identified including an older person who has weight loss and dietician recommendations are not being followed.

Detailed person-centred information does not always guide the delivery of care and services

Basis for finding: Management had identified that there was currently no formal procedure for reviewing care plans in addition to assessment and planning processes not providing sufficient information to support the delivery of comprehensive person-centred care. One older person who has insulin dependent diabetes has very limited information about diabetic management in their care and services plan.

For one older person who is on palliative care, the palliative care plan does not reflect the outcomes of a palliative care consultation with the older person's family. The care plan does not provide guidance for staff on person-centred palliative care.

Overall, the evidence gathered by the Inspection Team demonstrates deficiencies in relation to effective assessment, provision and management of personal and clinical care continues to be evident at St Charbel's Care Centre and puts the safety of older people at risk.

Concern 2: in relation to identification, assessment, management and oversight in relation to restrictive practices and behaviour support.

Rationale

Under Section 146 of the Aged Care Act 2024, the registered provider must comply with the Aged Care Quality Standards:

- Standard 3.1 Assessment and planning requires that care and services plans must describe the current care needs, goals and preferences of individuals and include strategies for risk management and preventative care. The provider must ensure that care and services plans are regularly reviewed and are used by aged care workers to guide the delivery of funded aged care services.

- Standard 3.2 requires the provider to deliver services to individuals that meet their needs, goals and preferences and optimises their quality of life, reablement and maintenance of function.

- Standard 5.3 requires the provider to use medicines in a way that maximises benefits and minimises the risks of harm. The provider must ensure medicines are appropriately and safely administered, monitored and reviewed by registered health practitioners, considering the clinical needs and informed decisions of the individual.

- Standard 5.5 requires the provider to deliver safe and quality clinical care services and to reduce the risk of harm to individuals.

Under Section 162 of the Act, the registered provider must comply with requirements for restrictive practices, and demonstrate consistent understanding of, and implementation of, requirements of Chapter 4, Part 9 of the Rules for restrictive practices and behaviour support.

Findings

Insufficient identification of and response to changed behaviours

Basis for finding: Two older people who were identified in previous Commission activities as experiencing deficiencies in person-centred behaviour support and restrictive practices had their care reviewed. For one older person, the provider had not adequately identified and responded to the older person's behaviours requiring support or effectively supported the older person when experiencing a changed behaviour. The provider had not adequately reassessed their care needs in a timely manner to ensure chemical restraint is being used only to the extent necessary and in proportion to the risk of harm to the older person or others. While the older person had been referred to specialists and they were transferred to the hospital for further assessment of escalation in behaviours, there is limited evidence the provider continued to undertake comprehensive ongoing holistic assessments to understand underlying causes, contributing factors or potential triggers of the older person's behaviour changes.

The second older person frequently refuses personal care, displaying agitation and physical aggression towards staff. There is no evidence of assessments to understand why refusal is occurring. Information about the older person has not been used to develop individualised or proactive support strategies and triggers. Behaviour and pain charting is inconsistent and incomplete. There has not been timely monitoring, review and evaluation of behaviour

support strategies. There are no updates to the behaviour support plan after changes in the older person's condition. The older person is prescribed regular and as required psychotropic medication. There are inconsistencies in medication documentation. The risk of harm was not adequately assessed or articulated to justify chemical restraint as part of the older person's care.

For one older person who was subject of a serious incident response notification, strategies implemented at the time of the incident were not person-centred. There was a lack of ongoing assessment of the older person after the incident, or the review of relevant information such as potential triggers or individualised strategies to inform the review of the older person's behaviour support plan.

Understanding of responsibilities in relation to the use of restrictive practices not consistently demonstrated

Basis for finding: Assessment and care planning processes in relation to restrictive practices (specifically chemical and mechanical restraints) did not clearly identify or articulate the risk of harm to older persons or others. As a result, the provider could not demonstrate that restrictive practices (such as those outlined above) were used only when necessary and in proportion to the assessed risk of harm as a last resort, in the least restrictive form and for the shortest period of time. Older persons' behaviour support plans did not include the requirements that must be set out if restrictive practices have been assessed as necessary, to ensure it is a last resort, the least restrictive form and used for the shortest time possible.

For an older person, the assessment and consent for an extreme form of chemical restraint (injectable antipsychotic) was not supported by comprehensive holistic assessment, trialling of alternate strategies, and clear guidance for staff. There was no evidence that appropriate assessments were conducted, nor specific and detailed guidance developed on the circumstances under which the use of injectable medication would be clinically appropriate.

The provider has committed to an improvement plan to address deficiencies in relation to restrictive practices and behaviour support, with 3 key actions due to be completed by 31 December 2025. The Commission notes that previous action plans that have been proposed and implemented but have not been effective in mitigating risk to older persons.

Overall, the provider did not consistently demonstrate individualised, person-centred behaviour support. The provider has not sufficiently identified or responded to older persons changed behaviours, nor demonstrated that the support provided is person-centred or informed by comprehensive assessment, evaluation and planning processes. The provider has not routinely effectively supported older people during occurrences of changed behaviour or reassessed their care needs in a timely manner. The provider did not demonstrate compliance with legislative

requirements for behaviour support and restrictive practices, including obtaining informed consent for the use of a restrictive practice. Clinical staff at the provider did not identify deficiencies in individuals' assessments and care planning, including the absence of charting related to behaviour occurrences, the use of restrictive practices and assessment of potential unmet needs such as pain.

Concern 3: in relation to effective organisational and clinical governance including incident management and oversight of staff practice/education.

Rationale

Under Section 146 of the Act, the registered provider must comply with the Aged Care Quality Standards:

- Standard 2.5 requires the provider to use an incident management system to safeguard individuals and acknowledge, respond to, effectively manage and learn from incidents.
- Standard 2.9 requires the provider to deliver aged care services by aged care workers who are skilled and competent in their roles and have expertise and relevant experience, including providing aged care workers with training and supervision to enable them to effectively perform their roles.
- Standard 5.1 requires the governing body to integrate clinical governance into corporate governance to actively and continuously improve the safety and quality of clinical services individuals delivered to individuals.

The registered provider must also comply with:

- Section 162 of the Act, compliance with requirements for restrictive practices and implementation of, requirements of Chapter 4, Part 9 of the Rules for restrictive practices and behaviour support.
- Section 164 of the Act, compliance with requirements for incident management systems as detailed in Chapter 4, Part 10, Division 1 of the Rules for incident management.

Findings

Quality systems and processes were not demonstrated to be consistently effective to deliver robust clinical governance to enable the governing body to maintain oversight of all aspects of the providers obligations

> Basis for finding: Concerns about clinical governance resulting in unsatisfactory clinical care were first noted by the Commission in August 2024. There has been ongoing instability in the provider's clinical leadership team with 3 members of the team starting in the previous 3 weeks. Previous action plans that have been put in place have not been effective in

mitigating ongoing risk to older persons. Interviews with a board director, members of the provider's leadership team and a review of documentation regarding organisational and clinical governance/oversight, including oversight of staff practice/education demonstrates that the provider's systems and processes have not been effective in remediating concerns. The Inspection Team have identified deficits in relation to wounds and skin integrity, clinical deterioration, pain, weight, falls and incident management, behaviour support and restrictive practices during this monitoring inspection visit. The provider's policies for the delivery of care and services are largely generic and do not provide detailed guidance for management and staff which is tailored to the circumstances of St Charbel's Care Centre.

Management provided a range of audits that had been completed each month. Management was unable to provide the audit schedule when asked. Review of the provider's plan for continuous improvement showed some audits had identified deficiencies and documented appropriate actions, these were gaps that had previously been identified in prior Commission visits. This did not demonstrate confidence in the provider's systems and processes for monitoring and responding to key clinical risks in a timely manner.

A review of board meeting minutes and reports from the provider to their governing body identified restraint numbers are reported but the data does not identify that the provider or board have discussions about restraint. There were no systems in place to identify that older persons were subject to extreme forms of restraint – chemical restraint (injectable medication) and seclusion. Legislated requirements around behaviour support and restrictive practices were not followed.

While it was demonstrated some governing body actions have been undertaken, these were mostly process oriented and did not demonstrate robust involvement and actions by the governing body commensurate with the level of risk to older people living at St Charbel's Care Centre.

The provider did not consistently demonstrate effective oversight of incident management

Basis for finding: Management stated that from September 2025 they have implemented monthly trending and analysis of clinical indicator data at a leadership clinical meeting attended by the board director, facility manager and clinical care coordinators. This data is presented in a monthly clinical risk report. Review of this documentation identified limited analysis of the data to understand the root cause of incidents, raising concerns about management and staff skills, knowledge and understanding in relation data analysis. This included the identification of incidents which would require reporting under the Serious Incident Response Scheme and the inappropriate use of restrictive practices. Restrictive practices were used at St Charbel's Care Centre which were inconsistent with the requirements under the Rules. The provider did not demonstrate effective oversight to

monitor that staff are compliant in consistently identifying, managing and escalating incidents. There were discrepancies in data reported at St Charbel's Care Centre and at governing body level to ensure effective oversight at governing body level.

The provider did not consistently demonstrate effective oversight of staff education, onboarding and induction.

Basis for finding: There was no evidence of induction documentation for key staff including the care manager and clinical coordinators. Signed position descriptions for the leadership team including the facility manager and clinical care coordinators related to operating in a home care provider context and not for the residential aged care home context of St Charbel's Care Centre.

Overall, the provider did not consistently demonstrate sound governance, oversight and accountability to address the severity of ongoing risks to older persons. The provider's human resources and quality systems and processes were not demonstrated to be effective to deliver robust governance to enable the governing body to maintain oversight of all aspects of the provider's obligations. While the provider has committed to a plan to address the gaps, it remains a concern that other action plans have been proposed and implemented however they have not been effective in mitigating risk to older persons, and further monitoring is recommended.