Flynn Lodge

Performance Report

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**Commission ID:** 6994

**Provider name:** Australian Regional and Remote Community Services Limited

**Site Audit date:** 18 August 2020 to 20 August 2020

**Date of Performance Report:** 2 December 2020

# Publication of report

This Performance Report **may be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Non-compliant |
| Requirement 2(3)(b) | Non-compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Non-compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | Compliant |

# Detailed assessment

This performance report details the Commission’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies areas in which improvements must be made to ensure the Quality Standards are complied with.

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff and others
* the provider’s response to the Site Audit report received 22 September 2020.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

The Quality Standard is assessed as Compliant as six of the six specific Requirements have been assessed as Compliant.

The Assessment Team found all sampled consumers interviewed confirmed they are treated with dignity and respect, can maintain their identity, make informed choices about their care and services and live the life they choose. The following examples were provided by consumers during interviews with the Assessment Team:

* staff make them feel respected and valued by the way they interact and care for them.
* staff listen to them, try to do what they ask of them and regular staff often know their preferences and needs.
* they are supported to exercise choice and independence
* are provided with information to assist them in making choices about their care and lifestyle.
* they received an information pack detailing information about the organisation and the services available when they entered the service.
* personal privacy is respected when staff deliver care and services.

Initial and ongoing assessment processes assist to identify each consumer’s cultural, emotional, spiritual, and cultural needs and background. Information gathered is used to developed detailed individualised care and lifestyle plans which assist staff to deliver care and services in line with consumers’ needs and preferences.

The organisation has a Reconciliation Action Plan (RAP) Engagement and Indigenous Participation Team and management described how this will support the service to meet the needs of their Aboriginal consumers. An Aboriginal liaison officer has also been appointed by the organisation and will provide cultural, emotional and spiritual support to the Aboriginal and Torres Strait Islander consumers, assist them to connect with their families and arrange visits to community.

Care documentation viewed by the Assessment Team demonstrated the service supports consumers to exercise choice and independence in a variety of ways. Care plans include details of significant others, nominated representatives and consumer goals, including maintaining their independence and how the consumer would like this to occur. Additionally, progress notes demonstrated consultation with representatives occurs. Staff described how they support consumers to have independence and self-determination and maintain relationships with those people who are important to them.

Consumers confirmed they are assisted to live their best life. Risk assessments are conducted, and strategies implemented to ensure consumers are able to undertake these activities safely.

Consumers are provided with an information pack on entry which includes rights and responsibilities, privacy and consent, advocacy, complaints and compliments, admission fees, care provision and safety. Interpretation sheets have been created for use with non-English-speaking Aboriginal consumers and referrals to the Aboriginal liaison officer can be made if requested.

Staff demonstrated an awareness of consumers’ privacy preferences and provided examples of how they support them. The Assessment Team observed staff to be respectful of consumers’ privacy whilst in their rooms, knocking on doors prior to entering, greeting and speaking respectfully to consumers and using their preferred names. Consumer information is securely stored.

The Assessment Team found the organisation has monitoring processes in relation to Standard 1 to ensure a culture of inclusion and respect for consumers; supports for consumers to exercise choice and independence and consumers’ privacy is respected.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Compliant

*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.*

### Requirement 1(3)(d) Compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

### Requirement 1(3)(e) Compliant

*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.*

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected, and personal information is kept confidential.*

# STANDARD 2 NON-COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Quality Standard is assessed as Non-compliant as three of the five specific Requirements have been assessed as Non-compliant.

The Assessment Team found overall, consumers considered that they feel like partners in the ongoing assessment and planning of their care and services. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* consumers or a person of their choosing, are involved in care planning and have a say in the delivery of care and services.
* confirmed they are informed about the outcomes of assessment and planning, including on entry, at care plan reviews and following incidents.
* two consumers reported their pain management needs have been identified, however, goals and preferences relating to management strategies had not been identified.
* representatives reported they did not have a physical copy of the care plan but believed they could request it if desired.

Initial and ongoing assessment processes, including consultation with consumers and/or representatives assist the service to identify each consumer’s care needs and preferences. Care plans are developed from information gathered. Care plans viewed by the Assessment Team were current and reflective of consumers’ assessed needs. Staff interviewed were knowledgeable about care planning and assessment processes, and confirmed care plans and assessment documents are readily accessible and provided enough information to provide care and services to consumers in line with their needs and preferences.

There are processes to identify and review consumers’ end of life planning and advanced care planning. Advanced care plans and end of life wishes were noted by the Assessment Team in most care files viewed. Management stated those without this documentation had chosen not to complete it, however, all consumers are gently invited to complete one at each care plan review. Consumers receiving palliative care have a palliative care plan in place, which is been signed by the Medical officer and the consumer and/or their representative. The palliative care plan includes goals and interventions, including specific wishes, family involvement, religious and cultural needs, pain management and skin integrity. Staff demonstrated an awareness of consumers receiving palliative care and could identify where they would acquire information pertaining to their needs, goals and preferences.

Care files viewed by the Assessment Team demonstrated involvement of consumers and/or representatives in assessment and care planning review processes on entry and at six-month reviews. Additionally, representatives had been informed where incidents and changes to consumers’ health status had occurred.

The Assessment Team were not satisfied care plans are consistently updated to reflect consumers’ current needs, goals and preferences or individualised management strategies are developed, including risks to health and well-being and behaviours. Not all consumers had their goals and preferences in relation to pain management identified and one consumer’s emotional needs had not been identified or reassessed following an incident.

The Assessment Team have recommended Requirements (3)(a), (3)(b) and (3)(e) not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response and find the service Non-compliant with Requirements (3)(a), (3)(b) and (3)(e). I have provided reasons for my decision in the specific Requirements below.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Non-compliant

*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.*

The Assessment Team were not satisfied risks to consumers’ health and well-being are consistently identified or information relating to risks inform the delivery of care and services. This was evidenced by the following:

* Risk assessments relating to consumption of alcohol had not been completed for two consumers. Risks associated with the consumption of alcohol were not discussed with the consumers and staff were not informed of possible risks or strategies to reduce or manage the risks. Both consumers have a diagnosis of Dementia.
* A risk assessment for a consumer who chooses to smoke did not consider the storage of smoking devices as a risk and did not have strategies to manage and reduce known risks associated with smoking, including the consumer’s known risk of falls. Staff were not managing the risks in line with the care plan, including provision of appropriate supervision and equipment.
* Not all behaviours documented in progress notes or described by staff in interviews were reflected in care plan for one consumer. Behaviours of refusal of blood glucose monitoring and inappropriate sexualised behaviours were not documented in the care plan and there were no recorded strategies to inform staff on how to manage the behaviours.

The approved provider acknowledged the deficits identified by The Assessment Team and agreed improvements need to be made. The approved provider’s response included actions taken and planned actions, including supporting documentation, in relation to the Assessment Team’s report, including:

* Risk assessments have been updated for alcohol consumption for two consumers.
* A risk assessment has been updated relating to the consumer keeping a lighter and risks associated with falls and smoking have been reviewed, the consumer and guardian have signed a Right to take risks form.
* The consumer with risks relating to behaviours has been reviewed by behaviour specialists and the Medical officer and new strategies have been documented and implemented to reduce and prevent ongoing behaviours related to refusal of blood glucose monitoring and sexualised behaviour. Staff training on behaviour management is planned.
* Risk assessment and management education, including in relation to alcohol and smoking provided to 11 clinical and care staff in September 2020.
* A new smoking risk assessment initiated.
* Risk reviews are in process of being conducted and/or revised for all consumers. The gap analysis and action plan will be followed up at the monthly Clinical governance meetings and is expected to be finalised in October 2020.

I acknowledge the approved provider’s response and the supporting documentation provided. However, based on the Assessment Team’s report and the approved provider’s response, I find at the time of the Site Audit the service’s assessment and planning processes did not consistently consider risks to consumers’ health and well-being or inform the delivery of safe and effective care and services. Risks relating to four consumers had not been appropriately identified and assessed and management strategies had not been developed to guide staff to ensure safe and appropriate delivery of care to consumers.

For the reasons detailed above, I find the approved provider, in relation to Flynn Lodge, Non-compliant with Requirement (3)(a) in Standard 2.

### Requirement 2(3)(b) Non-compliant

*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.*

The Assessment Team were not satisfied assessment and planning processes identified and addressed consumers’ goals and preferences, specifically in relation to cultural healing practices for Aboriginal consumers. This was evidenced by the following:

* Two Aboriginal consumers reported that whilst their need for pain management had been identified, the service had not identified or sought to understand their individual goals and preferences for management of pain. Additionally, an interpreter was not utilised to gain an understanding of their needs, goals and preferences. Specifically, in relation to preference for bush medicine and consultation with a traditional healer.

The approved provider acknowledged the deficits identified by the Assessment Team and agreed improvements need to be made. The approved provider’s response included actions taken and supporting documentation in relation to the Assessment Team’s report, including:

* A translator has been used to speak to both consumers and care plans updated to record consumers’ preferences for a healer and use of bush medicine. Additionally, appointments with a traditional healer will be arranged for both consumers.
* Introduced availability of an interpreting service for all consumers of non-English speaking backgrounds on entry and when decision-making is required.
* Allocated time for the Aboriginal liaison officer to talk to indigenous consumers and discuss and translate their individual needs and preferences.

I acknowledge the approved provider’s response and the supporting documentation provided. However, based on the Assessment Team’s report and the approved provider’s response, I find at the time of the Site Audit cultural preferences, specifically relating to pain management for two Aboriginal consumers had not been identified or implemented. Whilst both consumers stated their pain was being managed by the service with Western medicine, their preference for the use of traditional bush medicine had not been discussed with them.

For the reasons detailed above, I find the approved provider, in relation to Flynn Lodge, Non-compliant with Requirement (3)(b) in Standard 2.

### Requirement 2(3)(c) Compliant

*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.*

### Requirement 2(3)(d) Compliant

*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.*

### Requirement 2(3)(e) Non-compliant

*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.*

The Assessment Team were not satisfied care and services were consistently reviewed following incidents which impacted the needs, goals or preferences of consumers. This was evidenced by the following:

* A female consumer described to the Assessment Team an alleged sexual assault on her by a male consumer in August 2020. The Assessment Team’s report indicates the male consumer had performed this inappropriate behaviour in front of the consumer. The consumer stated the incident had brought back memories of an assault and had left them feeling anxious and upset. Whilst the consumer had discussed the incident with clinical management, no further follow up or support had been provided and the incident was not documented in the consumer’s file.
* The male consumer’s behaviour assessment and care plan had not been updated or reviewed since the alleged incident and the care plan did not identify propensity to exhibit sexualised or inappropriate behaviour.

The approved provider acknowledged the deficits identified by the Assessment Team and agreed improvements need to be made. The approved provider’s response included actions taken and supporting documentation in relation to the Assessment Team’s report, including:

* Counselling has been undertaken with the clinical staff member and an apology provided to the female consumer.
* A Resident advocate has met with the consumer to provide peer support and ongoing counselling has been provided
* Observations of the male consumer undertaken with no sexualised behaviours observed during the monitoring period.
* Revision of the incident management manual circulated and sections relating to reportable abuse highlighted.

I acknowledge the approved provider’s response and the supporting documentation provided. However, based on the Assessment Team’s report and the approved provider’s response, I find at the time of the Site Audit, following an incident which impacted on a consumer’s emotional well-being the incident was not sufficiently acknowledged, additional support provided, or the incident investigated. Additionally, information relating to the incident had not been recorded in either consumers’ file or follow up actioned.

For the reasons detailed above, I find the approved provider, in relation to Flynn Lodge, Non-compliant with Requirement (3)(e) in Standard 2.

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The Quality Standard is assessed as Non-compliant as one of the seven specific Requirements have been assessed as Non-compliant.

The Assessment Team found overall, sampled consumers considered that they receive personal care and clinical care that is safe and right for them. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* consumers get the care they need and were satisfied with the care provided.
* confirmed consumers have access to Medical officers and/or allied health professionals as and when they need it.
* one representative stated the service did not always provide adequate denture care for consumers and described occasions when dentures were found to be unclean and not correctly fitted during mealtimes.

The service has a range of policies and procedures relating to best practice care delivery, including in relation to skin integrity, pain, palliative care and restraint. A range of validated risk assessment tools are used with information gathered assisting to develop strategies and care plans.

Consumer files sampled demonstrated a range of monitoring tools and assessments are completed on entry and on an ongoing basis and are used to identify and evaluate changes to consumers’ health, condition and abilities. Where changes to consumers’ health are identified, additional charting and monitoring processes are implemented and referrals to Medical officers and/or allied health specialists initiated.

Clinical staff described processes for referrals to Medical officers and allied health specialists, including the use of a communication book to monitor who has been reviewed, who requires follow up and who is awaiting a review.

Staff described how input from other health professionals informs care and services. Care files sampled demonstrated regular assessments are conducted by allied health professionals, including Physiotherapists, Podiatrists, Speech and language therapists and Dietitians, and strategies are implemented to guide staff in the delivery of consumers’ care and services.

Consumer files viewed demonstrated deterioration or a change in consumers’ physical health is identified in a timely manner, assessed, reviewed and monitored, including in response to falls, wounds, pain and choking.

The service has processes to identify each consumer’s needs, goals and preferences in relation to end of life. Care, clinical and lifestyle staff were knowledgeable about consumers receiving palliative care and described how the delivery of care and services is altered during end of life. Staff also discussed how they ensure care is provided in a way which promotes privacy, dignity and respect.

Clinical and care staff demonstrated some knowledge of infection control principles and the Assessment Team observed public posters and strategies, such as hand sanitiser stations, screening and temperature testing of visitors and staff for minimising the spread of infection, including COVID-19.

The Assessment Team were not satisfied comprehensive diabetic directives to ensure safe and effective clinical care were in place for diabetic consumers. Additionally, the Assessment Team identified staff did not consistently comply with the required actions when blood glucose levels were recorded out of range.

The Assessment Team were not satisfied the service adequately demonstrated effective management of weight loss or that information about consumers’ condition, needs and preferences had been documented and communicated with members of staff.

The Assessment Team have recommended Requirements (3)(a), (3)(b) and (3)(e) not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response and find the service Non-compliant with Requirement (3)(a) and Compliant with Requirements (3)(b) and (3)(e). I have provided reasons for my decision in the specific Requirements below

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-compliant

*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.*

The Assessment Team were not satisfied service adequately demonstrated that Diabetic directives contained sufficient information for staff to guide the provision of safe and effective clinical care. This was evidenced by the following:

* Diabetic management plans for two consumers included directives for staff to take when blood glucose levels were below desired range. However, directives for when levels were above desired range were not documented. For one of these consumers, no further action was taken when a repeat blood glucose level reading was noted as high.
* Blood glucose levels recorded below desired range were not consistently followed up in line with Medical officer directives or the service’s processes.
* A Diabetic management plan for one consumer indicates frequency of blood glucose level readings, desired range of levels and when to notify the Medical officer. However, no further actions are documented.

The approved provider acknowledged improvements need to be made. The approved provider’s response included actions taken in relation to the Assessment Team’s report and supporting documentation, including:

* Revised and updated Diabetes plans to include additional actions to be taken.
* A Diabetes toolbox session has been held with staff.
* Developed a new flowchart to provide guidance to staff on diabetes management.

I acknowledge the approved provider’s response, including the supporting documentation provided. However, based on the Assessment Team’s report and the approved provider’s response, I find at the time of the Site Audit, Diabetes management plans did not provide sufficient information to guide staff in the delivery of safe and effective clinical care to consumers. A repeat blood glucose level reading was recorded as high for one consumer, however, further follow-up was not initiated. Additionally, where directives were documented, information provided by the Assessment Team demonstrates these were not consistently followed.

For the reasons detailed above, I find the approved provider, in relation to Flynn Lodge, Non-compliant with Requirement (3)(a) in Standard 3.

### Requirement 3(3)(b) Compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

The Assessment Team were not satisfied the service adequately demonstrated effective management of high-impact or high-prevalence risks associated with the care of each consumer. This was evidenced by the following:

In relation to weight management:

* One consumer had a weight loss of 6.1kgs in an eight month period with a loss of 3.3kgs recorded in a one month period. A nutritional assessment completed in July 2020 did not detail issues with weight loss.

In relation to falls management:

* One consumer, identified as a high falls risk, requires staff to remind them to use a four-wheel-walker (4WW) and requires one staff assist with transfers. The consumer was observed by the Assessment Team mobilising independently without the 4WW. Care staff present observed the consumer, however, did not remind them to use the 4WW.
* The consumer has had two falls since entering the service, the last in April 2020.

In relation to behaviour management:

* One consumer reported the service was not effectively managing another consumer’s behaviours. The consumer said this had been occurring for a period of three weeks. The care plan demonstrated behaviours had been identified and interventions recommended. However, the Assessment Team noted it was unclear if any action had been undertaken to address the consumer’s inappropriate behaviours.

The approved providers’ response acknowledges documentation could have been improved and there could have been some improvements to how the consumer’s weight loss was communicated with the family. However, the approved provider respectfully disagreed with the Assessment Team’s recommendation and provided the following information:

In relation to weight loss:

* The consumer was identified with swallowing difficulties in June 2017, referred to a Speech pathologist and placed on a modified diet, including high calorie yoghurts. A further review occurred in April 2018 in response to weight loss and additional supplements added to the diet plan.
* In July 2020 when weight loss of over 3kg was recorded, a further Speech pathology and Nutritional assessment were undertaken.

In relation to behaviour management:

* A comprehensive care plan specifically addressing the behaviour issues is in place and staff have been instructed to vigilantly monitor the consumer’s interactions with others.

In relation to falls management:

* The approved provider did not respond the information in the Assessment Team’s report.

Based on the Assessment Team’s report and the approved provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service is Compliant with this Requirement. I acknowledge the Assessment Team’s report indicates some gaps in relation to management of high impact or high prevalence risks to consumers. However, the Assessment Team’s report does not indicate these gaps have impacted on consumers. The approved provider’s response demonstrates appropriate actions to manage a consumer’s weight loss have been implemented, including referrals to allied health professionals.

One consumer, identified as a high falls risk, was observed walking without their walking frame and staff present did not remind them to use the frame. The Assessment Team’s report notes the consumer has had two falls since entering the service with the last occurring in April 2020.

In relation to behaviour management, the Assessment Team’s report indicates the consumer’s care plan demonstrates behaviours are identified and interventions documented. The approved provider’s response notes since the consistent application of behaviour strategies there has been a decrease in reported episodes of physical aggression for this consumer.

For the reasons detailed above, I find the approved provider, in relation to Flynn Lodge, Compliant with Requirement (3)(b) in Standard 3.

### Requirement 3(3)(c) Compliant

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved.*

### Requirement 3(3)(d) Compliant

*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.*

### Requirement 3(3)(e) Compliant

*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.*

The Assessment Team were not satisfied the service was able to demonstrate that information about the consumer’s condition, needs and preferences is effectively communicated within the organisation. This was evidenced by the following:

* The Assessment Team were informed by consumers, staff and the consumer’s representative, two consumers had periodically engaged in a relationship whilst at the service. The female consumer’s representatives had been informed and consented for the relationship to continue provided staff did not perceive the consumer to be coerced.
* The female consumer’s representative stated, following a fall resulting in a fracture they met with management and requested the care plan be altered to reflect changes in management, including not leaving the consumers unsupervised and conducting close (30 minute) monitoring of the female consumer. The Assessment Team could not find evidence that the consumer’s current condition, needs and preferences had been documented in either consumers’ care plans and the service could not demonstrate the revised needs and preferences requested by the consumer’s representatives had been communicated to staff.

The approved provider’s response acknowledges documentation could have been improved in this case. However, the approved provider respectfully disagreed with the Assessment Team’s recommendation and provided the following information:

* Although the consumer had a diagnosis of dementia, it was clear the consumer enjoyed the male consumer’s company and sought them out for companionship. Risks relating to these encounters were discussed with all staff and representatives, and risk assessments completed.
* Following a fall, the representative requested the consumers continue to socialise, but no longer be permitted to be intimate. Since readmission to the service, the consumer has been unwell and limited by their mobility. The instruction was explained to the male consumer and they appeared to understand the concerns. The male consumer continued to visit the consumer, and no evidence of intimacy was noted.

Whilst the approved provider did not agree with the Assessment Team’s findings of not met, the approved provider’s response includes actions the organisation has taken or plan to undertake in relation to the Assessment Team’s report, including:

* Provision of education and support to staff in relation to sexuality of older people and in particular, those with dementia.

Based on the Assessment Team’s report and the approved provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service is Compliant with this Requirement. Whilst documentation did not include the representative’s request for close monitoring of the female consumer to ensure both consumers were not left unsupervised, the approved provider’s response indicates communication in relation to the representative’s wishes were relayed to the male consumer. The male consumer continued to visit the consumer, however, there was no indication intimate encounters occurred. Additionally, the consumer’s care plan had been updated to include strategies targeted to meet their current needs.

For the reasons detailed above, I find the approved provider, in relation to Flynn Lodge, Compliant with Requirement (3)(e) in Standard 3.

### Requirement 3(3)(f) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 3(3)(g) Compliant

*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.*

# STANDARD 4 COMPLIANT Services and support for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

The Quality Standard is assessed as Compliant as seven of the seven specific Requirements have been assessed as Compliant.

The Assessment Team found most sampled consumers considered that they get the services and supports for daily living that are important for their health and well-being and enable them to do the things they want to do. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* consumers are supported to do things of interest to them and to keep in touch with people of significance.
* the service enables consumers to develop and engage in individual interests and hobbies.
* two consumers reported they would like further support and services to meet their cultural goals and preferences, such as visits from an Aboriginal healer.
* satisfied with the quality and quantity of the meals.

Initial and ongoing assessment processes identify each consumer’s emotional, spiritual, cultural and social needs. Care plans are developed from the information gathered and identify consumers’ specific interests and preferences, however, the Assessment Team noted some care plan information was standardised. Lifestyle staff described likes, dislikes, interests and hobbies for sampled consumers in line with care plan information.

A monthly activities schedule is developed in response to consumers’ assessed needs, survey results and feedback. Consumer attendance is monitored which allows identification of consumers at risk of isolation. A member of staff who can converse with some of the Aboriginal consumers is utilised to understand their needs. Specific activities to support Aboriginal consumers are organised, such as providing resources for paintings and recognising significant cultural days.

Care plans identify people who are important to consumers, confidants, relationships and affiliations with external organisations. Staff demonstrated knowledge of sampled consumers, identifying who was important to them, how they support them to participate in the community and maintain relationships with people important to them. Consumer files demonstrated timely and appropriate referrals are initiated, including to Aboriginal liaison services when the need arises.

A monthly menu is developed by a visiting Dietitian every three months and distributed to consumers. All consumers were satisfied with the quality and quantity of meals provided and confirmed kitchen staff cater to their individual needs and preferences. Three representatives stated the quality of the food has improved as a result of feedback and action taken by management. Information relating to consumers’ dietary needs and preferences, including allergies, texture, likes and dislikes, is obtained on entry and reviewed every six months or when needs change.

## The Assessment Team found the organisation has monitoring processes in place in relation to Standard 4 to ensure safe and effective services and supports for daily living are provided that optimise consumers’ independence, health, well-being and quality of life.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Compliant

*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.*

### Requirement 4(3)(b) Compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

### Requirement 4(3)(c) Compliant

*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.*

### Requirement 4(3)(d) Compliant

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 4(3)(e) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 4(3)(f) Compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

The Quality Standard is assessed as Compliant as three of the three specific Requirements have been assessed as Compliant.

The Assessment Team found most consumers sampled considered that the belong in the service and feel safe and comfortable in the service environment. The following examples were provided by consumers during interviews with the Assessment Team:

* confirmed the service is comfortable, clean and well maintained.
* feel at home at the service, can decorate rooms to their liking and enjoy having family come and visit. However, since COVID-19, they have not been able to see family as often as they would like.
* two female consumers stated they did not feel safe due to a male consumer’s behaviours.

The Assessment Team observed the service to be calm, inclusive and homely. Consumer rooms and the living environment are spacious, and consumers can move around freely and interact with others. Pictures, signage and posters are at eye level and there is adequate lighting. The service environment is safe and uncluttered, and furnishings and fittings were noted to be clean and well maintained.

Consumers have access to shared communal areas which include a dining/activities and lounge area. Outdoor areas are well maintained, and consumers can freely access these areas. Some consumer rooms have doors leading to the front garden area and consumers were observed watering the plants.

Staff described how they identify and report hazards, incidents and maintenance requests. An electronic maintenance log is maintained and includes scheduled and reactive maintenance tasks and highlights any outstanding issues. Contracted services are also utilised.

## The Assessment Team found the organisation has monitoring processes in place in relation to Standard 5 to ensure a safe and comfortable service environment is provided that promotes consumers’ independence, function and enjoyment.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 COMPLIANT Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

The Quality Standard is assessed as Compliant as four of the four specific Requirements have been assessed as Compliant.

The Assessment Team found that overall consumers considered they are encouraged and supported to give feedback and make complaints, and appropriate action is taken. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* they feel comfortable to make complaints and know how to suggest improvements.
* supported to provide feedback and make complaints when they need to.
* changes are made as a result of complaints and feedback, and management work closely with them to ensure feedback is actioned promptly.
* the service seeks feedback through multiple avenues, including resident meetings, surveys, room visits and through Service improvement request forms, and concerns are addressed.

Consumers and representatives are provided with information relating to internal and external complaints mechanisms, advocacy and language services on entry. Information in relation to complaints processes and advocacy is also displayed and accessible to consumers and representatives within the service.

Consumers stated they are supported to provide feedback and raise concerns either directly with staff, by completing Service improvement requests or raising issues through Resident meeting forums. Suggestion boxes and Service improvement request forms were observed around the service and easily accessible. Staff describe how they respond to issues or concerns raised by consumers and/or representatives, including assisting consumers to complete and lodge Service improvement forms.

Documentation viewed and feedback from most consumers and representatives demonstrated complaints raised are acknowledged, appropriate action taken, and feedback provided to the complainant. One representative described how their complaints had been addressed, including meeting with management and agreed strategies to be implemented. The representative stated improvements to the quality of meals had resulted.

There are processes to ensure complaints are reviewed and used to improve the quality of care and services. Two representatives stated they are more confident in recent times with the complaints process as they are seeing action is being taken and management are doing their best to address their concerns.

The service has policies and procedures to support staff to identify and action feedback and in relation to responsibilities around open disclosure. Management described how consumer complaints are addressed, including using an open disclosure approach.

The Assessment Team found the organisation has monitoring processes in relation to Standard 6 to ensure input and feedback from consumers, carers, the workforce and others is sought by the service and used to inform continuous improvements for individual consumers and the organisation.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

### Requirement 6(3)(d) Compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

# STANDARD 7 COMPLIANT Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The Quality Standard is assessed as Compliant as five of the five specific requirements have been assessed as Compliant.

The Assessment Team found that most sampled consumers considered they get quality care and services when they need them and from people who are knowledgeable, capable and caring. The following examples were provided by consumers during interviews with the Assessment Team:

* staff are kind, caring and treat them well.
* staff are “110%” and give all they can to help everyone.
* interactions with staff are positive and staff and management are respectful.
* one consumer and one representative stated they are not confident management staff know what they are doing.
* six of seven representatives said there is not adequate staff resulting in continence needs not being met and consumers having to wait for assistance with meals.

There are processes to ensure the workforce is planned and the number and skills mix enables the delivery of quality care and services. Staffing shortfalls are filled by the organisation’s own staff. Management described how staffing levels had been reviewed in response to falls incident data. Documentation viewed by the Assessment Team demonstrated management are proactively sourcing staff.

The Assessment Team observed staff interactions with consumers to be kind and caring. Most consumers said the workforce interacts with them in a kind and caring manner and are respectful of their identify, culture and diversity.

The workforce have the skills and knowledge to effectively perform their roles. The workforce is recruited based on their qualifications and/or experience of the role. Induction processes include mandatory training topics and a buddy shift process. There are processes to identify staff training requirements and an annual training schedule is maintained. Training records viewed by the Assessment Team demonstrated all staff have completed mandatory training modules.

The organisation conducts regular assessment, monitoring and review of the performance of each member of the workforce. A probationary and annual performance management process is in place which assists in identifying training needs to ensure the delivery of safe and quality care and services. Records viewed by the Assessment Team demonstrated all staff have completed a performance review.

The Assessment Team found the organisation has monitoring processes in place in relation to Standard 7 to ensure the workforce is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Compliant

*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.*

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

### Requirement 7(3)(c) Compliant

*The workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

### Requirement 7(3)(d) Compliant

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

### Requirement 7(3)(e) Compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

# STANDARD 8 COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

The Quality Standard is assessed as Compliant as five of the five specific requirements have been assessed as Compliant.

The Assessment Team found most sampled consumers considered that the organisation is well run, and they can partner in improving the delivery of care and services. The following examples were provided by consumers during interviews with the Assessment Team:

* confirmed the service is well run.
* they are involved in the development, delivery and evaluation of care and services.
* one representative stated they were worried the service was not sufficiently monitoring two consumers who are in a relationship to prevent further risks from reoccurring.

The organisation has a governance structure to support all aspects of the organisation, including information management, continuous improvement, financial governance, workforce and clinical governance and feedback and complaints. There are processes to ensure these areas are monitored and reported at various service and organisational meeting forums and to the Board.

However, the Assessment Team were not satisfied the service met their responsibilities or demonstrated they managed incidents, in line with legislative and regulatory requirements.

There are processes to ensure consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. Monthly consumer and representative meetings provide opportunities for consumers to provide feedback and discuss issues.

The organisation has policies and procedures to guide staff practice in relation to antimicrobial stewardship, minimising use of restraint and open disclosure. Staff interviewed demonstrated an awareness of these policies and described how they implement these within the scope of their roles.

The Assessment Team found the organisation has monitoring processes in place in relation to Standard 8 to ensure the organisation’s governing body is accountable for the delivery of safe and quality care and services.

The Assessment Team have recommended Requirement (3)(c) not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response and find the service Compliant with Requirement (3)(c). I have provided reasons for my decision in the specific Requirements below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

### Requirement 8(3)(b) Compliant

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

### Requirement 8(3)(c) Compliant

*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.*

The organisation demonstrated effective organisation wide governance systems relating to information management, continuous improvement, workforce governance, regulatory compliance, and feedback and complaints. However, the Assessment Team were not satisfied the service met their responsibilities or demonstrated they managed incidents, in line with legislative and regulatory requirements. This was evidenced by the following:

### In relation to discretion not to report

* In April 2020, the consumer’s representative was informed by senior clinical staff that staff had found two consumers, both with a diagnosis of Dementia, to be having intimate relations in the male consumer’s room.
* An incident form for the female consumer shows follow up with the representative, education to staff on sexuality and intimacy and a direction to staff to monitor both consumers.
* An incident report for the male consumer dated April 2020 includes instruction for staff to conduct behaviour charting and frequent visual checks for both consumers.
* In July 2020, the consumers were found to be having intimate relations in a consumer’s room. The service did not record this in the mandatory reporting register.

### In relation to reporting alleged sexual assaults

A consumer described to the Assessment Team an alleged sexual assault which occurred two days prior.

* A male consumer approached them and started displaying inappropriate sexual behaviour in front of them. The consumer said they reported this to senior clinical staff who have not provided them with guidance or feedback. The consumer’s care file did not contain any documentation relating to the incident or discussion with the senior clinical staff.
* The senior clinical staff member stated action had not been taken as they felt the consumer had imagined it.

The approved provider’s response indicates the organisation strongly disagrees with the Assessment Team’s recommendation and provided the following information:

##### In relation to discretion not to report:

* Both consumers had a caring relationship prior to the discovery of their intimate encounter which was known to the staff and the consumers’ representatives who visited. Neither consumer was distressed by the encounter and representatives of both consumers were immediately contacted and gave consent for the intimate relationship to continue.

##### In relation to reporting alleged sexual assaults:

* Whist the incident and subsequent initial handling was deeply regrettable, there was no sexual contact and, as such we do not have a mandatory requirement to report the allegation to the Police or Aged Care Quality and Safety commission.

Whilst the approved provider did not agree with the Assessment Team’s findings of not met, the approved provider’s response includes actions the organisation has taken or plan to undertake in relation to the Assessment Team’s report, including:

* Incident management training, in particular elder abuse and reportable incidents is now part of the initial orientation package and six monthly.
* An electronic incident management system was implemented in September 2020 and will ensure documentation of reportable assaults is consistent.

Based on the Assessment Team’s report and the approved provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service is Compliant with this Requirement. In relation to discretion not to report, both consumers were consenting and as noted in the approved provider’s response, both had a caring relationship prior to the discovery of their intimate encounter which was known to the staff and the consumers’ representatives who visited. Additionally, as noted in Standard 3 Requirement 3(e) of the Assessment Team’s report,the two consumers had periodically engaged in a relationship whilst at the service and the female consumer’s representatives had been informed and consented for the relationship to continue provided staff did not perceive the consumer to be coerced.

In relation to reporting alleged sexual assaults, the incident described in the Assessment Team’s report does not meet mandatory reporting requirements and, therefore, management had no obligation to report. However, the approved provider acknowledged the initial handling of the incident was not appropriate and have since implemented improvements to address the issues documented in the Assessment Team’s report. Information in the Assessment Team’s report, relating to this incident has been considered under Standard 2 Requirement 3(e) which has been found Non-compliant.

For the reasons detailed above, I find the approved provider, in relation to Flynn Lodge, Compliant with Requirement (3)(c) in Standard 8.

### Requirement 8(3)(d) Compliant

*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.*

### Requirement 8(3)(e) Compliant

*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.*

# Areas for improvement

Areas have been identified in which improvements must be made to ensure compliance with the Quality Standards. This is based on non-compliance with the Quality Standards as described in this performance report.

**Standard 2 Requirements (3)(a), (3)(b) and (3)(e)**

* Ensure staff have the skills and knowledge to:
  + Identify risks to consumers’ health and wellbeing, complete appropriate assessments and implement management strategies to mitigate risks in consultation with consumers and/or representatives.
  + Identify each consumer’s preferences for care and the way they wish care and services are delivered.
  + Acknowledge and appropriately follow-up incidents, including initiating assessments and providing further support to consumers where the need is identified.
* Ensure consumer care plans are updated and reflective of consumers’ current and assessed needs and preferences to enable staff to provide quality care and services.
* Ensure policies and procedures in relation to assessment, care planning and review are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to assessment, care planning and review.

**Standard 3 Requirement (3)(a)**

* Ensure staff have the skills and knowledge to:
  + monitor consumers’ blood glucose levels in line with Medical officer directives and implement appropriate monitoring strategies, in line with directives, where readings are outside of acceptable ranges.
* Ensure policies, procedures and guidelines in relation to diabetes management are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to diabetes management.