Flynn Lodge

Performance Report

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**Commission ID:** 6994

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

**Assessment Contact - Site date:** 15 July 2021 to 16 July 2021

**Date of Performance Report:** 30 September 2021

# Publication of report

This Performance Report **will 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

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| --- | --- |
| **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)(e) | Non-compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-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 Assessment Contact - Site; the Assessment Contact - Site 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 Contact - Site report received 11 August 2021.

# STANDARD 2 NON-COMPLIANTOngoing 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

At the Site Audit in August 2020, a decision was made that the service did not meet Requirements (3)(a), (3)(b) and (3)(e) within this Standard.

At this Assessment Contact the Assessment Team assessed Requirements (3)(a), (3)(b) and (3)(e) and recommended all three as not met.

The Assessment Team found most consumers were satisfied the service had identified their needs, goals and preferences, communicated such information to staff and were generally provided with the care they required. Staff interviewed exhibited some knowledge of consumers’ individualised risks and confirmed they had access to care planning documentation.

However, with assistance from translating services, the Assessment Team were informed by two consumers, the service had still not identified or addressed their preferences for pain management and representatives confirmed care and services had not been consistently reviewed following incidents.

Whilst the service had implemented some improvements, including full re-assessments and a review of all consumers’ care plans, the Assessment Team found the service had not utilised risk assessments and the care plans did not consistently guide staff. The Assessment Team identified care and services had not been reviewed for consumers in response to incidents or changes.

I have considered 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.

As three Requirements have been assessed as Non-compliant, the overall Standard has been assessed as Non-compliant.

## 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 reported the service had implemented some improvements in relation to this Requirement which included:

* the completion of risk assessments
* review of behaviours
* provision of staff training (in behaviour management and assessments such as smoking, alcohol consumption and risk assessments). Although the Assessment Team was not able to confirm if the staff who had attended were from Flynn Lodge
* a new smoking risk assessment had been initiated.

However, the Assessment Team found the service was unable to demonstrate assessment and planning processes, including risks to consumers’ health and well-being, consistently informed the delivery of safe and effective care and services. The Assessment Team provided the following information and evidence relevant to my finding:

In relation to Consumer A

* The consumer liked to consume alcohol and smoke cigarettes, had a diagnosis of dementia, had a cognitive impairment and was at risk of increased falls and seizures. The activities plan for risk activities for these activities was either not completed or had not been reviewed six monthly.
* Care documentation reviewed by the Assessment Team outlined specific risk management strategies, however information was not consistent in the documentation reviewed and/or from staff interviewed. For example:
* The risk management strategies, outlined in the activities plan for risk activities, included wearing a smoking apron and limiting the number of cigarettes provided (September 2020). The Assessment Team noted staff had documented the consumer refused the use of a smoking apron and other sections of the consumer’s care plan (dated May 2021) identified a reduced number of cigarettes to be provided. Two staff interviewed did not demonstrate an understanding of current limitations in respect to cigarettes, with one staff member reporting the consumer keeps their own cigarettes and lighter and can manage by themselves.

In relation to Consumer B

* The care plan identified smoking as a risk and recorded the consumer required distant supervision, kept their cigarettes and lighter as well as had a pendant if experiencing difficulty.
* Risks identified in relation smoking included past incidents of falling when trying to pick up cigarettes off the ground, a lack of insight into their own safety (due to a cognitive impairment), was not able to light or hold a cigarette and required supervision of staff.
* Risk management strategies noted by the Assessment Team did not reflect all relevant risks noted above.
* Although care staff reported the consumer was watched, they reported different information about the consumer’s abilities (compared to the above information) and said the consumer was able to smoke anytime, had their own lighter and cigarettes and looked after themselves.

In relation to Consumer C

* The Assessment Team found care documentation provided contradictory directions for meeting the consumer’s dietary needs. The written handover sheet documented the consumer required a diabetic soft diet and normal fluids. However,
* the care plan (dated July 2021) contained three subsections in which the texture of the meal was inconsistent varying from pureed to mince moist
* the dietary details assessment, nutrition assessment and poster displayed in the kitchen were also noted to contain conflicting information (with textures varying from mince moist to vitamised).
* The Assessment Team noted past recommendations for a vitamised or minced moist diet by the speech pathologist had been refused by the consumer in July/August 2020. A risk assessment form had not been completed, however the consumer and three care staff confirmed at the time of the Assessment Contact a vitamised/pureed diet was being provided.

In relation to Consumer D

* The Assessment Team also identified a fourth consumer (Consumer D who was insulin dependent) that was self-administrating their medication however an assessment had not been completed. I note information provided by the Approved Provider in its response showed the general practitioner was aware of the consumer self-administering. Although, no date was provided on the additional information submitted, the Approved Provider reported this had occurred in May 2021. In relation to this matter, I have not given significant weight to this information as there were no concerns identified in relation to the consumer’s capacity to manage their medications.

The Approved Provider’s response predominately did not refute the Assessment Team’s findings and included a written submission, action plan and clarifying information. It acknowledged the importance of effective assessment and planning to inform care and outlined consumers’ rights to dignity of risks and how it supported them to understand the risk and how to manage it. Its response identified:

* Risk assessments were undertaken routinely for consumers who were identified as having a potential risk and moving forward this would be a standard item at the local clinical governance meeting.
* In relation to the staff attendance at training, the Approved Provider confirmed the staff listed were from the service and improvements to the recording of this information (to identify work areas) would occur.
* In relation to smoking, there were four consumers at the service who smoked. The service had reviewed its records, all consumers have a smoking assessment, and these would be reviewed six monthly.

In relation to specific consumers, the Approved Provided identified the specific actions taken which included:

* For Consumer A, the risk assessment for alcohol consumption and smoking had been reviewed, signed off by the representative and consumer’s general practitioner including a right to take risk form. The consumer’s care plan had been updated to ensure consistency and the consumer’s alcohol, cigarettes and lighters were kept with the registered nurse.
* For Consumer B, the risk assessment for smoking and the right to take risk form had been revised and updated.
* For Consumer C, a record review had been conducted including consultation with the consumer and dietician. All documents were now consistent and a work instruction on documentation of nutritional preferences, assessment and notification has been developed, which will be informed planned education for registered nurse. It reported dietary information would be reviewed weekly for new consumers and those with changed dietary recommendations.

I acknowledge the Approved Provider’s response and the supporting documentation provided including actions that have been or are currently being undertaken. However, based on the Assessment Team’s report and the Approved Provider’s response, I find at the time of the Assessment Contact the service’s assessment and planning processes did not consistently consider risks or informed the delivery of safe and effective care and services. The Assessment Team found two consumers were identified risks had been identified, however management strategies were not consistently reflected in care documentation or always known by staff. Care plans, assessments and other documentation held by the service did not provide clear directives for staff and contained multiple conflicting directives, including for a consumer with a texture modified diet. While I noted progress has been made, the service will require a period of time to ensure these actions are fully implemented and embedded into practice.

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 noted some improvements had been implemented in relation to this Requirement which included:

* Accessing of an interpreter to speak to consumers and care plans updated to reflect their preferences for bush medicine and a healer.
* Employment of two Aboriginal Liaison Officers by the organisation.

However, the Assessment Team found the service was unable to demonstrate assessment and planning had consistently identified and addressed consumers’ current needs, goals and preferences. This was evidenced by:

The Assessment Team found that although two consumers’ pain was being managed through the use of massage and medication, both consumers’ preferences for how their pain was managed had not been addressed. The service was also not able to demonstrate they had utilised interpreting services to understand their needs, goals and preferences.

### In relation to Consumer E

The Assessment Team identified:

* Although the consumer’s preference for a Traditional Healer bush medicine to assist with pain relief had been identified, these had not yet been addressed or implemented.
* The consumer reported experiencing pain in their shoulder and arm. Although it was acknowledged the consumer experienced pain in their hip, the care plan (dated July 2021) and a staff member interviewed, did not refer to this area as a source of pain.
* An interpreter had not been accessed to understand the consumer’s needs, goals and preferences to support effective communication.
* The consumer’s food preferences for meat, bread and bullock had not been identified or considered.

In relation to Consumer C

The Assessment Team identified:

* The care plan (July 2021) showed the consumer had expressed a preference for pain to be reviewed by a Traditional Healer and for an interpreter to be used for care consultation. The Assessment Team however, noted the Traditional Healer had not yet occurred.
* In relation to dietary and individual preferences, the consumer reported they would like to eat kangaroo meat and beef as well as to chew tobacco. The Assessment Team found this was not identified in care planning or assessment documents.

Furthermore, the Assessment Team found goals recorded were not consistently consumer focused and interpreting services had not been accessed to support consumers.

* Four consumers’ goals were not consistently individualised, or consumer focused specifically in relation to staff assistance, privacy requirements and oral hygiene.
* Three consumers reported they had not been offered interpreting services and none of the 10 care, clinical and lifestyle staff had used or were aware of how to access interpreting services.

The Approved Provider’s response predominately did not refute the Assessment Team’s findings. Its response submitted further evidence of its consultation and co-design policy to support consumers where English was their second language. It did however outline the improvements the service was undertaking and its commitment to ensuring individualised care through effective assessment and care planning processes. Improvements and actions report as being completed or in progress included:

* Directions for how to contact a translator had been updated in the service’s flow chart. The Approved Provider outlined the difficulties in the recruitment and retention of First National Cultural Specialist (FNCS) as well as the challenges in accessing a traditional healer due to the need to comply with flu vaccinations. It reported it had been able to secure FNCS at a nearby service and would use the FNCS moving forward to provide translation services to consumers. In relation to the Traditional Healer, the service was working to find a suitable venue for consumers to attend off-site.
* In relation to Consumer E, it advised the consumer’s dietary preferences and had been updated in the care plan and handover sheet.
* A pain check program was implemented in July 2021, which would support the appropriate assessment and ongoing management of pain all consumers at the service.
* In relation to consumers’ goals, education would be conducted for all staff including clinical staff to support the development of consumer-focused goals.

I acknowledge the Approved Provider’s response and the supporting documentation provided including challenges experienced and improvements being made. However, based on the Assessment Team’s report and the Approved Provider’s response, I find at the time of the Assessment Contact, cultural preferences specifically relating to pain management for two consumers had not been implemented. Furthermore, processes to support consumer consultation and involvement via the use of an interpreter had not yet been implemented, dietary preferences had not been identified and goals were not consistently consumer focused. While I noted progress has been made, the service will require a period of time to ensure these actions are fully implemented and embedded into practice.

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)(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 noted some improvements had been implemented in relation to this Requirement which included:

* Following a past incident identified at the last visit, the staff member was counselled, an apology provided to the consumer and the consumer was provided with counselling support from an advocate. The Assessment Team noted the consumer was satisfied with the care and services provided and that the other consumer involved had since left the service.
* The service had revised its incident manual and compulsory reporting checklist to incorporate the Serious Incident Response Scheme (SIRS). Staff have undertaken training on behaviour management, incident reporting and elder abuse.

However, the Assessment Team found the service was unable to demonstrate care and services were reviewed when circumstances change, and incidents impacted on the needs, goals or preferences of consumers. This was evidenced by the following:

In relation to Consumer F

The service did not demonstrate care and services had been reviewed following an allegation of elder abuse in June 2021. The Assessment Team noted:

* The circumstances surrounding the allegation initially referred to a staff member, however subsequent information reported by the service indicated the possibility of a consumer.
* The incident report was lodged late and was incorrectly categorised. Progress notes indicated the alleged incident had not been investigated in a timely manner by clinical staff.
* The consumer was noted to have sustained bruises and a few days after the initial incident, behavioural charting noted the consumer was emotional on one occasion.
* An interview with the representative expressed concern about the feedback provided in relation to the incident, the consumer’s emotional well-being and reported the consumer had not been offered support following the incident or that a review of their care and services had occurred.
* Although initial follow up had occurred for the consumer in relation to their bruising, pain and initial well-being, the Assessment Team noted limited evidence to support that further reviews or strategies had been implemented. In addition, the Assessment Team noted the delay in the investigation process and this was still ongoing at the time of the Assessment Contact (one month).

In addition, the Assessment Team reviewed care documentation for three additional consumers which demonstrated the service had not consistently reviewed care and services following incidents:

In relation to Consumer G

The consumer had multiple behavioural incidents recorded in July 2021, impacting on other consumers and staff.

* The service did not demonstrate the consumer’s behavioural strategies had been reviewed in response to the incidents and effective strategies. Although the two care evaluations had been completed (March and July 2021), these indicated strategies were effective, despite charting identifying strategies trialled by staff had limited effect.
* A representative reported they had not been notified of behavioural incidents, despite staff reporting these had occurred. They raised the service had not openly reviewed the consumer’s care or suggested new behaviour management strategies following incidents.

The Assessment Team also identified two consumers that had experienced a near miss or unwitnessed falls and did not sight evidence of a review of their falls risk or follow up in relation to the incident.

* For Consumer H, they had a near missed fall on 15 July 2021 at night and found wedged between the wall and their bed. Given this had occurred during the Assessment Contact, I have not given significant weight to this and find the matters surrounding the incident more relevant in relation to Standard 3 Requirement (3)(a).
* For Consumer C, they sustained an unwitnessed fall in July 2021 and further evidence submitted by the Approved Provider identified the consumer’s falls risk assessment had been completed as part of the adverse event reporting process. Therefore, as this had been reviewed at the time, I have not relied on this information.

The Approved Provider’s response included a written submission as well as further evidence of actions taken, including an action plan. Its response clarified information regarding staff training, improvement actions being undertaken including in relation to identified consumers.

* In relation to staff training, confirmed that training as noted above had been completed by staff at the service. It further outlined it had subsequently provided SIRS training at the end of July 2021, additional elder abuse toolbox talks have been undertaken in August 2021 and posters encouraging staff and relatives to report elder abuse have been placed within the service.

In relation to Consumer F

* The Approved Provider asserts it had handled the alleged incident in accordance with the SIRS flow chart, categorised the type and considered its obligations had been met.
* A list of recommendations had been compiled and these would be monitored at the local and organisational clinical governance meetings.
* Full engagement with the family had occurred and sharing of the outcome of the investigation.

In relation to Consumer G

* Behavioural assessments were documented during the identified period in July 2021 and evidence of this provided. However, the assessment identified the consumer’s behaviours included moving furniture, voiding in inappropriate areas and undressing. I note triggers, or the cause was related to confusion or dementia and strategies had limited to no effect.
* Strategies by a dementia specialist have now been updated in the care plan, staff educated, and the behaviour management plan and handover sheets updated. The effectiveness of these strategies would be communicated through handover and documentation.

While I acknowledge the Approved Provider’s response clarified information in relation to two consumers, its response did not satisfy me that at the time of the Assessment Contact, it had consistently reviewed consumers’ care and services following incidents or changes. Two representatives did not indicate a review of care and services had occurred following behavioural incidents or an allegation of assault.

I note following an allegation of assault for one consumer, an investigation had not been conducted in a timely manner. Although the Approved Provider’s response outlined the recommendations being implemented in response to its investigation, relating to staff manual handling practice, skin care, staffing training in elder abuse and SIRS as well as dementia care, the Approved Provider did not adequately address the individual findings of the investigation nor specific strategies that were being implemented for the consumer to support them.

Furthermore, while behaviours were being documented and improvements actions have since been implemented including updating of the care plan, at the time ineffective strategies were not reviewed.

The service will require a period of time to embed these changes and demonstrate the overall effectiveness of its system.

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-COMPLIANTPersonal 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

At the Site Audit in August 2020, a decision was made that the service did not meet Requirement (3)(a) under this Standard.

At this Assessment Contact the Assessment Team assessed Requirement (3)(a) and recommended this Requirement as not met.

The Assessment Team found most consumers interviewed were satisfied they received the care they needed, however, three representatives expressed concern regarding the provision of personal care and behaviour management.

Staff interviewed exhibited knowledge of consumers’ personal and clinical care needs and could recite management strategies. Whilst the service had implemented some improvements, including full re-assessments and a review of all consumers care plans, care documentation viewed, however, demonstrated consumers’ behaviours, falls, diabetes and restraint had not consistently been managed in accordance with best practice and personal care was not consistently tailored to consumers' needs or optimises health and well-being.

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). I have provided reasons for my decision in the specific Requirement below.

As one of the Requirements have been assessed as Non-compliant, the overall Standard has been assessed as Non-compliant.

### 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 noted the service had implemented some improvements in relation to this Requirement which included the updating of diabetic management plans, provision of training to clinical staff and new flowchart developed on diabetes management to guide staff practice.

However, the service was not able to demonstrate each consumer received safe and effective personal and/or clinical care in relation to behaviour management, falls management and restraint. This is evidenced by the following:

In relation to restraint

The service did not demonstrate mechanical restraint was managed in accordance with best practice for Consumer H.

* An incident occurred on the evening of 15 July 2021 where the consumer was upside down and wedged between the bed and the wall. Although no injuries were reported at the time, staff confirmed the bed was lowered at night to prevent the consumer from getting out of bed.
* The consumer was identified as a high falls risk, required staff assistance with mobility and had a moderate to severe cognitive impairment. The Assessment Team observed the consumer’s bed was against the wall, sensor mat in place and the call bell had been detached.
* The Assessment Team identified staff were using a low low bed and pillow under the mattress at night to limit the consumer’s movement. While the service had a restraint policy and the low low bed was identified as a mechanical restraint, there was no restraint authorisation form and the resident risk activities/restraint review form had not completed. At the time of the visit, the service had not completed their incident investigation.

In relation to behaviour management

* For Consumer G, diagnosed with vascular dementia, displayed episodes of agitation and was verbally and physically aggressive towards others. The consumer was noted to have 12 incidents related to behaviours in a two-week period (July 2021). Incidents included wandering, disrobing and grabbing another consumer’s arm.
	+ Progress notes and incident reports demonstrated recommendations by a dementia specialist service (relating to pain and activities to engage) had not been implemented and interventions staff used were documented as ineffective.
	+ Care evaluation review in July 2021 documented behaviour management outcomes were effective and no new strategies implemented.
	+ A representative of another consumer raised concerns about Consumer G’s behaviours and reported a past incident where they had been pushed and at times was diverting consumers as they were the only one available.

In relation to personal care

Three of three representatives reported consumers were not consistently provided with personal care which was tailored to their needs or optimised their health and well-being. Examples included the provision of hygiene care to manage skin concerns with their scalp, a missing sensor mat, the potential risk of an asthma attack due to dust and inadequate cleaning, eyes were not cleaned, and the consumer not dressed in appropriate warm clothing.

In relation to falls management

The service had a head injury care pathway which guided staff practice, however, did not provide a falls management policy or procedure. The Assessment Team identified two consumers (Consumer C and Consumer F) who had experienced falls (June or July 2021) and had not been consistently identified as being reviewed post fall or full neurological observations completed.

* Consumer C experienced a fall in July 2021 sustaining a skin tear above the eye. Although wound care and pain relief provided, their neurological observations had not been obtained.
* Consumer F experienced an unwitnessed fall in June 2021. The medical officer was notified, and pain charting commenced. However, the Assessment Team noted only one set of neurological observations were completed and the consumer had not been reviewed by the physiotherapist until after the second fall which occurred eight days later.

At the time of the visit, management had self-identified areas of improvements with the falls pathway and neurological assessment was still under review by the clinical governance team.

In relation to diabetes management and wound management

The Assessment Team identified two consumers where staff had not consistently adhered to:

* The medical officer’s directives on four occasions, when blood glucose levels were above the recommended parameter on consecutive days. (Consumer D)
* The service’s wound management policy for recording measurements of a pressure injury. (Consumer I)

However, I note the medical officer had reviewed Consumer D at the end of May 2021, their insulin medication increased and BGLs were reported as stable. Following this review there was one incident of BGLs being above the specific parameter in early July 2021 where directives had not been followed, however no specific impact had been reported for the consumer. In relation to Consumer I, despite information and measurements of the wound not being recorded, the Assessment Team noted the wound was healing.

The Approved Provider’s response included the submission of further supporting documentation, an action plan and outlined improvements being made. Its response also included specific information about each of the identified consumers and actions taken.

In relation to restraint for Consumer H

* A risk assessment has been undertaken to review the risk of falling from bed at night and half hourly observations being completed.
* It reported the low low bed was used to reduce the risk of harm and the general practitioner and substitute decision maker has had the risk explained and written consent obtained for its use as well as for a sensor mat. It advised the practice of pillows under the mattress has been ceased.

In relation to falls management

* For Consumer C, regarding their falls risk, following an incident the service demonstrated its database included a falls risk assessment when a fall occurred. The service did not deem it appropriate for physiotherapy assessment.
* For Consumer F,
	+ its response outlined following the first fall, a referral had been made to the physiotherapist and the registered nurse conducted a full assessment including neurological observations with nil abnormalities observed. A set of observations had been taken for the second fall, however the consumer was not reviewed until nine days later (following the second fall) where additional strategies were implemented.
	+ Post fall protocol has been circulated for feedback from RNs and GPs.

In relation to behaviour management for Consumer G

* The dementia specialist report and recommendation has been uploaded and care plan updated.
* A box of distraction items placed in the consumer’s room and the activities plan updated.
* Staff have been educated on recommended strategies.
* Management were not aware of another consumer representatives’ feedback and reported a meeting would be arranged.

In relation to the three consumers were personal care concerns had been raised, the Approved Provider’s response reported the following actions:

* The consumer’s room cleaned, and cleaning audits reinstated.
* The sensor mat had been damaged and was being repaired. A replacement mat should be been implemented.
* Staff reminded of hygiene requirements for washing consumers’ hair, providing eye care and to engage with representatives about the effectiveness of hygiene care.

In relation to Consumer D, the Approved Provider identified the consumer was cognitively intact and managed their own medication. Training had been provided for registered nurses on diabetes management and blood glucose monitoring.

I acknowledge the Approved Provider’s response and the supporting documentation provided including improvements being made. However, based on the Assessment Team’s report and the Approved Provider’s response, I find at the time of the Assessment Contact, care provided had not been consistently delivered in a safe and effective manner that was best practice or optimised the consumers’ well-being. This is based on the following:

* With respects to restraint, I acknowledged a follow up risk assessment and consent had been obtained for the use of a low low bed as a form of restraint. While the Approved Provider’s response asserts this was to reduce harm, its response did not adequately demonstrate the risk associated with the bed against the wall had been considered including the detachment of the call bell from the wall to in order to prevent further incidents.
* In relation to post falls management, while a falls risk was undertaken at the time, the service did not adequately address whether staff had undertaken neurological observations following Consumer C’s fall. In addition, for the second consumer, there was a delay in the physiotherapist reviewing the consumer and management acknowledged improvements to its falls protocol and neurological assessment was still yet to be implemented.
* Furthermore, the service was not able to demonstrate behaviour management recommendations had been implemented to support effective behaviour management. The consumer’s behaviour was impacting on others and strategies implemented showed these were not effective.
* Three representatives expressed dissatisfaction with the management of consumers’ personal care and although had been raised and subsequent actions taken, these were not demonstrated to have been effectively implemented at the time of the visit.
* While practices were inconsistent in relation to diabetes management and wound recording, I note there was no impact reported.

While I acknowledge the actions and improvements being undertaken by the service, it will require a period of time to ensure practices are embedded and its systems demonstrate effectiveness.

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

# 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 the service effectively identifies risks to consumers’ health and well-being, complete appropriate assessments and implement management strategies to mitigate risks in consultation with consumers and/or representatives.
* Ensure staff have an understanding and access to information about consumers’ care strategies and preference.
* Identify each consumer’s preferences for care and the way they wish care and services are delivered including utilising translating services to support consumer involvement.
* Ensure the timely follow-up of incidents and review of care, including initiating assessments and providing further support to consumers where the need is identified.
* Ensure consumer care plans and documentation are updated and reflective of consumers’ current and assessed needs and preferences to enable staff to provide quality care and services.
* Ensure there are effective incident management systems to support timely review of care and services.

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

* Ensure both clinical and personal care is safe and effective, that is based on best practice and optimises their well-being.
* Ensure care delivery is monitored including representative and consumer satisfaction with care and services.
* Ensure care documentation supports and guides staff in the delivery of care.
* Ensure policies, procedures and guidelines in relation to clinical care are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation all aspects of care delivery.