McNamara Lodge

Performance Report

41 Portrush Parade, MEADOW SPRINGS
MANDURAH WA 6210
Phone number: 08 9582 5300

**Commission ID:** 7259

**Provider name:** Air Force Association (Western Australian Division) Incorporated

**Assessment Contact - Site date:** 9 July 2020 to 10 July 2020

**Date of Performance Report:** 11 September 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

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| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(e) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| **Standard 3 Personal care and clinical care** | **Compliant** |
| Requirement 3(3)(f) | Compliant |
| **Standard 4 Services and supports for daily living** | **Compliant** |
| Requirement 4(3)(f) | Compliant |
| **Standard 6 Feedback and complaints** | **Compliant** |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Compliant |
| **Standard 8 Organisational governance** | **Compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | 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 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 27 July 2020.

# STANDARD 1 COMPLIANTConsumer 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 three of the six specific Requirements has been assessed as Compliant. An overall assessment of all Requirements in this Standard was not completed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(a), (3)(c) and (3)(e) in this Standard. These Requirements were found Non-compliant following a Site Audit conducted on 3 December 2019 to 5 December 2019. The Decision Maker found the following:

* The organisation did not demonstrate all consumers were treated with dignity and respect, with their identity, culture and diversity valued.
* The service does not support each consumer to exercise choice and independence regarding making decisions about their own care and the way services are delivered, communicate their decisions about their care and services they receive or make connections with others and maintain relationships.
* The organisation did not provide each consumer with information that was current, timely or communicated in a way that was clear, easy to understand and/or enables them to exercise choice.

Following the Assessment Contact conducted on 9 July 2020, the Assessment Team recommended Requirements (3)(a), (3)(c) and (3)(e) in Standard 1 as met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 1 and find the service is Compliant with Requirements (3)(a), (3)(c) and (3)(e).

The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

## 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.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Assessment Contact, including:

* Staff have been provided with additional training regarding the Aged Care Quality Standards.

The approved provider’s response stated they agreed with the Assessment Team’s findings.

In relation to Standard 1 Requirement (3)(a), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Consumers and representatives said staff encourage them to share information regarding their personal preferences to ensure the care provided individualised with their preferences respected.
* A consumer with limited vision said staff will knock on the door and announce themselves as they enter the room, so they are aware of who is entering the room.
* A consumer said they are provided with a menu to enable them to choose their daily meals. Staff knock on the door and introduce themselves when they enter and assist them to the dining room. They also explain what is on the plate and where the meal is located.
* One representative said they can continue to care for a consumer by providing assistance during meals. While staff are able to provide this assistance, staff encourage the representative to continue to be involved in the ongoing care of the consumer.
* Care staff said information on consumers’ specific needs or preferences are shared at handover, and they are encouraged to discuss with each consumer or representative their individual needs and preferences. Electronic tablets are available and if staff are unfamiliar with consumers’ preferences, they can review their care plan. Staff described the strategies used for individual consumers with specific care needs.
* Staff spoke about consumers in a way that indicated respect and said that it was the role of carers to provide safe and comfortable care in accordance with each consumer’s preferences.
* The Assessment Team observed staff interacting respectfully with consumers, encouraging them to participate in activities, acknowledging and chatting when passing consumers in the corridor and seeking permission prior to attending to tasks, such as personal care assistance. This included observing staff assisting visually impaired consumers at mealtimes.
* The Assessment Team viewed care plan documentation which had been reviewed and updated following feedback from consumers’ family members during the initial admission and review processes.

For the reasons detailed above, I find the approved provider, in relation to McNamara Lodge, does comply with Requirement (3)(a) of Standard 1.

### 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.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Assessment Contact, including:

* Staff have been provided with training on the Aged Care Quality Standards.
* Staff and consumers have been advised of the process regarding consumers and/or representatives accessing and having input into the care planning process.
* Resources have been produced and provided to all consumers regarding the concepts of care planning, assessment processes and outcomes.

The approved provider’s response stated they agreed with the Assessment Team’s findings.

In relation to Standard 1 Requirement (3)(c), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Consumers said staff ask them about their preferences when providing care and said family and friends can visit regularly. Consumers said staff encourage and support them to visit and spend time with other members of their family who also reside at the service.
* One consumer said staff provide them with an opportunity to do things for themselves. The consumer said therapy staff meet with them to discuss the activities available and to identify any activities that may be of interest to them. Staff provide assistance to them to attend the activities.
* Representatives said they are provided with information and have opportunities to meet with clinical staff to discuss consumers’ care plans or changes in consumers’ conditions. Representatives also said that as the care needs of consumers fluctuate, staff are flexible when providing care provided to them.
* Representatives said during the COVID-19 outbreak, management and staff have continued to provide them with information and seek feedback to ensure consumers remain connected to things which are important to them, such as family, religion and their culture.
* Care staff said care plans are available to guide staff in the provision of care to consumers. Staff said they provide care to consumers in line with their preferences. Staff provided examples of how they assist consumers to make choices, including providing consumers with clear and accurate information and options to inform their choice. This includes respecting the consumers’ preference for female carers and reminding consumers on the times for activities.
* Catering staff said consumers are provided with a daily menu which includes alternative meals for lunch and dinner. While consumers pre-order their meals, they are able to change their mind at the time of serving and any requests are accommodated by staff.
* Consumers are invited to discuss individual preferences with staff during initial assessments and on an on-going basis. Where consumers are unable to advise of their preferences, staff ask their representatives to assist by providing information. This assists staff in tailoring care and services to the consumers’ individual preferences.
* Consumers and their representatives are invited to a meeting approximately six weeks after admission to the service, where they discuss their care plan to ensure it reflects their preferences. Care plans are reviewed in consultation with the consumer and/or their representative at least annually.
* The service has processes to document existing Enduring Power of Guardianship directives, and consumers are invited to complete Advanced Care Directives to identify when others should be involved in their care and treatment decisions.

For the reasons detailed above, I find the approved provider, in relation to McNamara Lodge, does comply with Requirement (3)(c) of Standard 1.

### 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.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Assessment Contact, including:

* Noticeboards have been placed throughout the service and display the activity planner and other information relevant to consumers and visitors.
* Staff have been provided with education regarding sensory loss, including visual impairment and hearing loss.
* The service has reviewed the process for the management of consumers’ hearing aids to improve cleaning and battery function.

The approved provider’s response stated they agreed with the Assessment Team’s findings.

In relation to Standard 1 Requirement (3)(e), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Consumers sampled said they are provided with a menu to assist them to choose their meal when ordering the day prior to serving. This information is also available on the whiteboard in the dining room to remind them of what is being served on the day.
* Consumers and representatives said the weekly activities schedule is posted on the noticeboard. Staff also remind consumers of the activities on the day.
* Representatives said staff regularly provide them with information regarding changes to their family member’s care plan and they can request formal meetings with clinical or allied health staff. Staff are always happy to answer questions or to refer representatives to other staff members if they are unable to answer the question.
* Representatives said there is a noticeboard in each area of the service which has information relevant to consumers and representatives and a variety of brochures are available in the reception area.
* All representatives said they have been kept well informed about the visitor restrictions, ongoing care of consumers and updated during the COVID-19 outbreak.
* Management said formal care planning conferences are arranged post admission and annually, or more often if required.
* Care staff said they are informed about changes in consumers’ needs and preferences during handover, toolbox education sessions, through memoranda and ongoing verbal communication.
* Lifestyle staff said they spend time with consumers with visual impairment to ensure they are aware of the activities available.
* A review of care plans and assessment documentation by the Assessment Team showed consumers’ communication needs, including any sensor impairments, are assessed following admission. Strategies to assist consumers with identified deficits are documented in the individualised care plans.
* The Assessment Team observed a range of documentation in the foyer and on noticeboards throughout the service, including the current activities calendar and the Charter of Aged Care Rights.

For the reasons detailed above, I find the approved provider, in relation to McNamara Lodge, does comply with Requirement (3)(e) of Standard 1.

# STANDARD 2 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

The Quality Standard is assessed as Compliant as two of the five specific Requirements has been assessed as Compliant. An overall assessment of all Requirements in this Standard was not completed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(c) and (3)(d) in this Standard. These Requirements were found Non-compliant following a Site Audit conducted on 3 December 2019 to 5 December 2019. The Decision Maker found the following:

* The service did not demonstrate that the organisation’s assessment and planning processes are based on ongoing partnership with the consumer or their nominated representative,
* The service did not demonstrate that the planning of care is effectively communicated to the consumer or their nominated representative or care and service plans are readily available to them.

Following the Assessment Contact conducted on 9 July 2020, the Assessment Team recommended Requirements (3)(c) and (3)(d) in Standard 2 as met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 2 and find the service is Compliant with Requirements (3)(c) and (3)(d).

The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

## Assessment of Standard 2 Requirements

### 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.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Assessment Contact, including:

* Clarification with clinical staff regarding their roles and expectations.
* Training to be arranged for clinical staff regarding clinical assessment, deterioration, management and referral.

The approved provider’s response stated they agreed with the Assessment Team’s recommendation.

In relation to Standard 2 Requirement (3)(c), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Consumers sampled said staff include their preferences in their care plans and this has made a difference with staff providing ongoing care.
* Representatives said that while they have not had an opportunity to fully discuss information regarding consumers due to the visiting restrictions related to COVID-19, the management team is approachable, and they are confident consumers’ preferred care choices are respected. One representative said they meet with staff daily to discuss ongoing changes to the consumer and that any changes in care strategies have been included in the care plan and discussed with staff.
* The Clinical Nurse Manager said initial and ongoing assessments are completed in accordance with the service’s policies and procedures. This includes assessments completed over the initial period with a multi-disciplinary team before the care plan is developed. An identified change to a consumer’s health status triggers a re-assessment completed by the registered nursing staff.
* The Clinical Nurse Manager said care plans are provided to the consumer and their representative to review once they are completed. During COVID-19, representatives have been invited to read the care plan which is sent via email for comment.
* Allied health staff said that following assessments being undertaken to identify consumers’ needs and preferences, a care plan is developed. Care plans are discussed with the consumer and their representative as appropriate.
* Staff confirmed the development of care plans is completed in consultation with consumers and/or their representatives. Staff said they are encouraged to get to know consumers and to share information, as appropriate, with members of the team.
* As part of the organisation’s policy, all consumers and their appointed representative can review care documentation on request, with senior staff available to assist with the review process.
* A multi-disciplinary team meeting is held weekly to discuss clinical incidents, changes in consumers’ condition, behaviours, or preferences. The Clinical Nurse Manager is responsible for ensuring information is shared with registered and care staff and that information is included in the consumer’s care plan.

For the reasons detailed above, I find the approved provider, in relation to McNamara Lodge, does comply with Requirement (3)(c) of Standard 2.

### 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.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Assessment Contact, including:

* The ‘Case Conference’ form on the service’s electronic care management system has been amended to ensure care plans are discussed and attendees are offered a copy of the care plan.
* Resources are to be produced by the organisation regarding the basic concepts of care planning, assessment processes and outcomes.
* To increase staff awareness regarding care planning and consumer input and access, toolbox training sessions on care planning have been created, in line with role specifics.
* Electronic tablets have been installed in corridors to increase staff access to the electronic care management system at the point of care.

The approved provider’s response stated they agreed with the Assessment Team’s findings.

In relation to Standard 2 Requirement (3)(c), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Three sampled consumers said staff provide the care that is recorded on their care plan, but they can change their mind. When this occurs, staff pass the information on to others.
* Representatives said they are satisfied with the care and services provided to consumers and staff keep them fully informed of any incidents or changes to the consumers’ care. As part of the admission process, one representative said they are asked to provide information on the consumer’s health and well-being and are satisfied this information informed the care the consumer is receiving.
* Staff said they have access to care plans for all consumers via the service’s electronic care management system. Information is provided at handover at the commencement of each shift on changes in consumers’ needs, incidents, appointments or special requests. Staff confirmed assessment and planning is completed on admission and there is an interim care plan to refer to while other comprehensive assessments are being completed. Staff provided examples and said they are asked to record information to inform the assessments.
* The Clinical Nurse Manager said the plan of care is discussed with all consumers and/or their representatives and consumers may request to review their care plan at any time. Care plan information is available to all staff via the electronic care management system.
* The Assessment Team viewed care planning documentation which confirmed care plan information is discussed with consumers and their representatives on admission and regularly, or when the consumer’s condition changes. Care plans were noted to include identified activities of risk, including strategies to reduce risk, and are reviewed when a consumer’s condition changes. Care plans included specialised health care needs and information to guide staff.
* Care plans included strategies for the management of skin integrity, pain management and the use of specialised equipment for consumers with low vision.
* Progress notes and incident reports confirmed family members are contacted when an incident occurs.
* As part of the organisation’s policy, all consumers and their appointed representative can review care documentation on request.

For the reasons detailed above, I find the approved provider, in relation to McNamara Lodge, does comply with Requirement (3)(d) of Standard 2.

# STANDARD 3 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

The Quality Standard is assessed as Compliant as one of the seven specific Requirements has been assessed as Compliant. An overall assessment of all Requirements in this Standard was not completed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(f) in this Standard. This Requirement was found Non-compliant following a Site Audit conducted on 3 December 2019 to 5 December 2019. The Decision Maker found the organisation was unable to demonstrate that referral to appropriate specialists occurs in a timely manner.

Following the Assessment Contact conducted on 9 July 2020, the Assessment Team recommended Requirement (3)(f) in Standard 3 as met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 3 and find the service is Compliant with Requirement (3)(f).

The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

### Assessment of Standard 3 Requirements

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

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

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Assessment Contact, including:

* Clarification with clinical staff regarding their roles and expectations.
* Training to be arranged for clinical staff regarding clinical assessment, deterioration, management and referral.
* The organisation to develop a referral agencies list.

The approved provider’s response stated they agreed with the Assessment Team’s findings.

In relation to Standard 3 Requirement (3)(f), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Two consumers said the podiatrist visits them regularly and they are referred to a physiotherapist or occupational therapist if there are changes in their care needs.
* Two representatives said consumers have been referred to external services, including a dietitian and speech pathologist. The representatives said they have been informed of the outcome with the recommendations by the specialist services being implemented as required.
* The Clinical Nurse Manager said they regularly undertake referrals to other allied health services when specific issues related to a consumer are identified.
* Allied health staff said all consumers who have a fall or have demonstrated a deterioration in their physical condition are reviewed.
* The Assessment Team viewed three consumer files which included assessments, care plans, progress notes and family conferences. These documents confirmed ongoing communication between the clinical team, consumers and their representatives as well as with internal and external service providers.
* The organisation has policies and procedures regarding referrals to other services. Contracts and brokerage agreements are in place with external providers as required.
* The service trends, analyses and responds to high impact or high prevalence risks by reporting each incident. Clinical indicator data is discussed at the multi-disciplinary team members to assist with the identification of improvement opportunities.

For the reasons detailed above, I find the approved provider, in relation to McNamara Lodge, does comply with Requirement (3)(f) of Standard 3.

# STANDARD 4 COMPLIANTServices 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 one of the seven specific Requirements has been assessed as Compliant. An overall assessment of all Requirements in this Standard was not completed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(f) in this Standard. This Requirement was found Non-compliant following a Site Audit conducted on 3 December 2019 to 5 December 2019. The Decision Maker found not all consumers were satisfied that the meals were varied, of a suitable quality or to their liking.

Following the Assessment Contact conducted on 9 July 2020, the Assessment Team recommended Requirement (3)(f) in Standard 4 as met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 4 and find the service is Compliant with Requirement (3)(f).

The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

## Assessment of Standard 4 Requirements

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

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

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Assessment Contact, including:

* The service is continuing to develop and monitor processes to ensure meals are varied and of suitable quality and quantity, including:
	+ Implementing a formal written process to inform hospitality management of changes to consumer dietary needs.
	+ Implementing meal choice processes the day before rather than a month before.
	+ Encouraging consumers to provide feedback on the meal service.
	+ Re-commencing the food focus groups and having face to face meetings between staff and consumers to discuss the menu as it changed in line with the seasonal menu change.

The approved provider’s response stated they agreed with the Assessment Team’s findings.

In relation to Standard 4 Requirement (3)(f), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Consumers sampled said there has been an improvement in the meals over recent months and they like the meal choice process which has changed to ordering the day before rather than a month before.
* The Food and Beverage Manager said there have been changes implemented. These include:
	+ The implementation of a new menu in January 2020.
	+ The Food and Beverage Manager and the chefs discuss complaints received regarding food.
	+ Menus are now displayed in a better format with food descriptions to provide consumers with more information about what is included in each meal.
	+ The service has a ‘food taster’ to provide feedback to the Food and Beverage Manager.
	+ Communication has improved regarding changes to consumer dietary needs and the Food and Beverage Manager maintains a spreadsheet containing this information.
	+ The food focus group has re-commenced with up to 10-12 consumers attending meetings regularly. Feedback from consumers indicates they are happier with choosing their meals the day before rather than a month before.
	+ There are additional sandwiches and salads available in the fridges, along with fruit, yoghurt and custard for consumers who feel hungry outside of normal mealtimes.
* Staff explained the dietary needs and preferences for consumers and said the dietary requirements list was available on the ‘tea trolley’. Staff said they refer to the list to ensure each consumer is provided with the appropriate meals and drinks. Staff provided information on how often menus are changed and the new daily selection process and said this change has been positive and consumers are welcoming the change.
* The service has implemented new processes where staff hand-write the daily menu on the whiteboard in the dining room and provide photographs and recipes for consumers to review when they are selecting the following day’s meals.
* The service has implemented new feedback processes in the kitchen. The process includes feedback being reviewed and actioned by the Facility Manager and the Food and Beverage Manager.
* The Assessment Team viewed care plan documentation which reflected the dietary needs and preferences of consumers.
* The Assessment Team observed the main kitchen and the serveries to be clean and tidy. Staff were observed providing the lunch time meal to consumers in one of the dining areas.
* The food survey and audit results showed high consumer satisfaction with meals; however, the Assessment Team noted the service evaluation of the results indicates there is still room for improvement.
* Minutes of meetings showed the service actively encourages feedback from consumers about food and meals.

For the reasons detailed above, I find the approved provider, in relation to McNamara Lodge, does comply with Requirement (3)(f) of Standard 4.

# STANDARD 6 COMPLIANTFeedback 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 two of the four specific Requirements has been assessed as Compliant. An overall assessment of all Requirements in this Standard was not completed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(c) and (3)(d) in this Standard. These Requirements were found Non-compliant following a Site Audit conducted on 3 December 2019 to 5 December 2019. The Decision Maker found as follows:

* The service had not acted appropriately to address the complaints made by consumers regarding meal provision, did not demonstrate effective and timely responses to information to improve the hospitality services and did not provide evidence of consumer consultation.
* The service was unable to demonstrate that feedback and complaints are reviewed and used to improve the quality of care and services.

Following the Assessment Contact conducted on 9 July 2020, the Assessment Team recommended Requirements (3)(c) and (3)(d) in Standard 6 as met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 6 and find the service is Compliant with Requirements (3)(c) and (3)(d).

The service has implemented a range of actions to address the deficiencies identified which I have detailed below

## Assessment of Standard 6 Requirements

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

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

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Assessment Contact, including:

* The service is continuing to develop and monitor processes to ensure appropriate action is taken in response to complaints. For example:
	+ Re-commencing the food focus group to obtain feedback from consumers about meals and to address and respond to that feedback.
	+ Developing new menus in response to feedback from consumers.
	+ Implementing processes to assist vision impaired consumers to review menu choices.

The approved provider’s response stated they agreed with the Assessment Team’s findings.

In relation to Standard 6 Requirement (3)(c), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Two consumers said the Facility Manager or Nurse in charge respond to their requests in a timely manner.
* Two representatives said if they have any concerns, they discuss the issue with the Registered Nurse in the first instance and their concerns are generally resolved.
* One representative said the service apologised to them following an incident between consumers and discussed the processes implemented.
* Management and staff explained ‘Open Disclosure’ and when this would be used.
* Management said, and documentation confirmed, consumers are invited to provide feedback about meals. The Facility Manager works with the Food and Beverage Manager and chefs to act on feedback provided and an ‘Open Disclosure’ process is used when things go wrong.
* Staff interviewed were able to explain how the organisation follows up when a concern or complaint is raised by a consumer and provided the Assessment Team with examples.
* The organisation has ‘Open Disclosure’ information included in various manuals, policies and guidance materials which were reviewed in January 2020. Posters were observed in the staff room.
* The Assessment Team viewed information which showed the service is receiving, assessing, actioning and evaluating feedback on a regular basis.
* Minutes of the staff meeting held on 25 February 2020 indicate that ‘Open Disclosure’ and feedback as well as information obtained from the service’s feedback forms was discussed with staff.
* Refer to information in Standard 4 Requirement (3)(f) regarding specific information on the improvements made in relation to the provision of meals.

For the reasons detailed above, I find the approved provider, in relation to McNamara Lodge, does comply with Requirement (3)(c) of Standard 6.

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

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

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Assessment Contact, including:

* The service is continuing to develop and monitor processes to feedback and complaints are reviewed and used to improve the quality of care and services. For example:
	+ Re-commencing the food focus group to obtain feedback from consumers about meals and to address and respond to that feedback.
	+ Developing new menus in response to feedback from consumers.
	+ Implementing processes to assist vision impaired consumers to review menu choices.

The approved provider’s response stated they agreed with the Assessment Team’s findings.

In relation to Standard 6 Requirement (3)(d), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Two consumers with vision impairment said staff are aware of the difficulties they have due to poor vision and have assisted them by implementing agreed strategies.
* Management described the main areas of a complaint and what has, or is proposed, to be done to address the concerns. For example, management said there had been complaints from families regarding the implementation issues with a new swipe card processes during the COVID-19 outbreak. The service had identified the lessons learned and reported to the Executive of the organisation. Management said the service had provided letters of apology to family members.
* The service has a Plan for Continuous Improvement which is used to respond to and act upon complaints and issues.
* The Assessment Team noted the service documents complaints and how it addresses the complaints raised.
* The organisation has updated policies to include information about ‘Open Disclosure’.
* All staff attend orientation on commencement which includes training on responding to complaints and dealing with difficult situations. Information on the complaints processes and ‘Open Disclosure’ is available to staff.
* Information on complaint numbers is displayed on the noticeboard in the staff room every month. Comments, complaints and suggestions is a standing item on meeting agendas.
* All comments, complaints and suggestions are captured on a spreadsheet and collated monthly. The service has implemented a process to strengthen trend analysis with the implementation of a revised monthly quality meeting format and process.

For the reasons detailed above, I find the approved provider, in relation to McNamara Lodge, does comply with Requirement (3)(d) of Standard 6.

# STANDARD 7 COMPLIANTHuman 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 three of the five specific Requirements has been assessed as Compliant. An overall assessment of all Requirements in this Standard was not completed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(a), (3)(c) and (3)(d) in this Standard. These Requirements were found Non-compliant following a Site Audit conducted on 3 December 2019 to 5 December 2019. The Decision Maker found as follows:

* The organisation was unable to demonstrate effective workforce planning to ensure the number of staff deployed enables the delivery and management of quality services.
* The organisation did not demonstrate the workforce is competent or that the members of the workforce have the qualifications and knowledge to effectively perform their roles.
* The workforce was not appropriately trained, equipped or supported to deliver the outcomes required by the Quality Standards.

Following the Assessment Contact conducted on 9 July 2020, the Assessment Team recommended Requirements (3)(a), (3)(c) and (3)(d) in Standard 7 as met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 7 and find the service is Compliant with Requirements (3)(a), (3)(c) and (3)(d).

The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

## 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.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Assessment Contact, including:

* The service is continuing to develop, monitor and consult with consumers and/or representatives and staff to ensure the number and mix of members of the workforce enables the delivery and management of safe and quality care. For example:
	+ The service completed workflow studies in February 2020.
	+ The service has reviewed maintenance and administration staff job descriptions.
	+ The service has created a communication and distributed it to consumers and staff about student placements and the value of their contribution.

The approved provider’s response stated they agreed with the Assessment Team’s findings.

In relation to Standard 7 Requirement (3)(a), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Consumers and representatives interviewed said there are enough staff to support the consumers. They said staff can be busy at times during the day but generally are available to assist when needed.
* One representative said the consumer takes a long time to complete a meal; however, staff do not rush them, and the consumer’s weight has remained stable.
* To address staff concerns about having limited time, management said electronic tablets have been installed throughout the service to make it easier and quicker for staff to access care plans and consumer information. Staff said they find the electronic tablets are useful and it is easing their workload.
* In January 2020 the service employed an occupational therapist in a leadership role to review the activities program. This is to ensure the program is linked to consumer interests and preferences and offers activities that meet the diverse needs of the consumers.
* The service has changed how staffing is allocated and for two wings the afternoon shift has five staff working as a team with a nurse co-ordinating the team. The service is planning on expanding this approach across the different wings.
* Time and motion studies were completed in February 2020 to identify where improvements could be made for staff workloads. Consumer needs are used to ensure appropriate staffing allocations and the service now allocates staff to individual consumers.

For the reasons detailed above, I find the approved provider, in relation to McNamara Lodge, does comply with Requirement (3)(a) of Standard 7.

### 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.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Assessment Contact, including:

* The service is continuing to develop and monitor processes to ensure the workforce is competent and staff have the qualifications and knowledge to effectively perform their roles. For example, the service conducts regular toolbox training sessions to provide staff with up-to-date knowledge.

The approved provider’s response stated they agreed with the Assessment Team’s findings.

In relation to Standard 7 Requirement (3)(c), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Consumers interviewed said staff are skilled enough to meet their care needs. Three consumers said they know the care they need and ensure they get the assistance they need.
* Two representatives said nursing staff monitor staff to ensure staff know what they are doing and that everything is completed.
* Management said they ensure staff are provided with appropriate training to undertake their roles. Staff have regular toolbox sessions and training sessions.
* Staff confirmed they receive regular training and have on-line access to the training modules. Staff said there is a regular performance appraisal process and staff are encouraged to identify areas where they would like some additional education and support. Staff also stated they are required to undertake mandatory competency training annually.
* The Clinical Nurse Manager said they provide ongoing support to clinical and care staff and spend time observing staff to confirm they are meeting the requirements of their role.
* The organisation has a mandatory training program which is managed from the organisation’s central office. The service arranges and manages toolbox sessions and specific education as needed.

For the reasons detailed above, I find the approved provider, in relation to McNamara Lodge, does comply with Requirement (3)(c) of Standard 7.

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

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

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Assessment Contact, including:

* The service is continuing to develop and monitor processes to ensure the workforce is trained and supported to deliver the outcomes required by the Quality Standards. For example:
	+ The organisation reviewed the on-line ‘Customer Service’ training in January/February 2020 to ensure it was in line with the Quality Standards.
	+ Staff were surveyed to identify more suitable times for toolbox training.
	+ The organisation has a process for monitoring staff medication competency which includes face-to-face theoretical training, on-site training and observation. The service conducts mandatory annual medication competency reviews.
	+ All Registered Nurses in the service have completed oxygen management training and have been deemed competent.

The approved provider’s response stated they agreed with the Assessment Team’s findings.

In relation to Standard 7 Requirement (3)(d), a sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Consumers and representatives interviewed said staff have the required training and background to deliver appropriate care and services to consumers. One consumer said staff are aware of how to care for their oxygen equipment and ensure it is clean and cared for as required.
* Two representatives said staff are aware of consumers’ needs when using specialised equipment, including customised chairs and lifting equipment, and ensure consumers are safe and comfortable.
* Management said that if any feedback from consumers or performance issues identify staff require additional training, the service will arrange staff to complete the additional training. This could include specific training modules on-line, reminders and training at staff meetings, toolbox sessions and information provided in the staff room for staff to review.
* Staff said they are provided with training on the Quality Standards. This includes scheduled training, on-the-job training and toolbox sessions.
* The organisation provides mandatory training which includes fire, manual handling and food safety. The organisation maintains a monitoring dashboard to show the organisation and service-specific compliance with mandatory training.
* The organisation has processes for identifying staff training needs and these needs are reflected in the training schedule. Management said the outcomes of the Site Audit in December 2019 had resulted in additional training for clinical staff on oxygen management.

For the reasons detailed above, I find the approved provider, in relation to McNamara Lodge, does comply with Requirement (3)(d) of Standard 7.

# STANDARD 8 COMPLIANTOrganisational 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 four of the five specific Requirements has been assessed as Compliant. An overall assessment of all Requirements in this Standard was not completed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(a), (3)(b), (3)(c) and (3)(e) in this Standard. These Requirements were found Non-compliant following a Site Audit conducted on 3 December 2019 to 5 December 2019. The Decision Maker found as follows:

* The organisation did not demonstrate they have an implemented governance structure which includes a clinical governance framework or a risk management framework.
* The organisation did not demonstrate they have implemented policies which align with the Aged Care Quality Standards supporting all aspects of the organisation, including information management, continuous improvement, financial governance, workforce and clinical governance, regulatory compliance, and feedback and complaints.
* The organisation was unable to demonstrate the clinical governance processes ensured that a minimisation of restraint approach has been used in accordance with the *Quality of Care Principles 2014*.

Following the Assessment Contact conducted on 9 July 2020, the Assessment Team recommended Requirements (3)(a), (3)(b), (3)(c) and (3)(e) in Standard 8 as met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 8 and find the service is Compliant with Requirements (3)(a), (3)(b), (3)(c) and (3)(e).

The service has implemented a range of actions to address the deficiencies identified which I have detailed 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.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Assessment Contact, including:

* The service is continuing to develop and monitor processes to enable consumers to engage in the development and delivery of care and services. For example:
	+ Re-commencing a food focus group.
	+ Implementing improved processes to provide feedback about meals and dietary requirements to the Food and Beverage Manager.
	+ Inviting consumers to be part of a video series showing good customer service.
	+ Inviting consumers and representatives to have input into reviewing and developing policies and procedures. One representative has expressed an interest in being involved.
	+ The living environment refurbishment will continue, with consumers invited to provide feedback. For example, the colours consumers would like for the chairs in the main foyer.

The approved provider’s response stated they agreed with the Assessment Team’s findings.

In relation to Standard 8 Requirement (3)(a), information provided to the Assessment Team by management, staff and consumers demonstrated:

* Overall consumers said the organisation is well run and they can partner in improving the delivery of care and services.
* Consumers and representatives said the food focus group has re-commenced and consumers have an opportunity to provide feedback to the service about meal service. Consumers said they have noticed an improvement in the meals.
* Consumers said the management of the service appears to be working well together.
* Management said, and documentation confirmed, consumers are invited to provide feedback about meals. The Food and Beverage Manager and chefs review the feedback and provide information to the Facility Manager regarding any concerns raised and actions taken.

For the reasons detailed above, I find the approved provider, in relation to McNamara Lodge, does comply with Requirement (3)(a) of Standard 8.

### 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.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Assessment Contact, including:

* The organisation is continuing to develop and monitor processes to ensure the governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. For example:
	+ Updating policies and procedures to meet the Aged Care Quality Standards and providing the updated documents to the service and uploading them onto the on-line central system for access by staff.
	+ Updating the clinical data spreadsheet to support identification of chemical restraint and to ensure accurate collection of data.
	+ Completed the risk management policy to ensure a comprehensive risk management framework.
	+ Ongoing high-level meetings to discuss risk management.

The approved provider’s response stated they agreed with the Assessment Team’s findings.

In relation to Standard 8 Requirement (3)(b), information provided to the Assessment Team by management and staff demonstrated:

* The service has implemented a new swipe access system to ensure secure access to the service, following complaints about families being unable to access the service following a change to their swipe card access. The service has developed a ‘lessons learned’ report for Board consideration, based on consumer and/or representative feedback. The Board intends to use the lessons learned to ensure implementation and ongoing use of similar swipe access systems is improved.
* The organisation has employed a quality expert whose role includes ensuring appropriate support to the service on audits, data analysis and continuous improvement processes.

For the reasons detailed above, I find the approved provider, in relation to McNamara Lodge, does comply with Requirement (3)(b) of Standard 8.

### 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 Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Assessment Contact, including:

* The organisation is continuing to develop and monitor processes to ensure the effective organisation-wide governance systems relating to information management, continuous improvement, including a risk management framework, regulatory compliance, and feedback and complaints. For example:
	+ The organisation has updated all policies and procedures in line with the Aged Care Quality Standards.
	+ The service has implemented additional feedback and complaint mechanisms to encourage feedback from consumers and representatives.

The approved provider’s response stated they agreed with the Assessment Team’s findings.

In relation to Standard 8 Requirement (3)(c), the following information was provided to the Assessment Team by management and staff and demonstrated:

**Information management:**

* Staff said they have ready access to the information they require. Staff said the new electronic tablets available throughout the service are beneficial in assisting them to access up-to-date information about consumers.
* Staff said they receive regular information from management through memoranda and staff meetings.
* Management and staff said the service has improved their handover documentation.

**Continuous improvement:**

* Opportunities for continuous improvement are identified through feedback and audit processes and recorded on the service’s Plan for Continuous Improvement.
* The organisation has updated all policies and procedures in line with the Aged Care Quality Standards.
* Management provided examples of how the Board is provided with updates and information about the service’s continuous improvement processes.

**Financial governance:**

* The service’s budget is set by the Board and there is an opportunity to use additional funding, if necessary.
* The organisation undergoes external auditing processes.

**Workforce governance**:

* The organisation has reviewed job descriptions to ensure clear responsibilities and accountabilities are known.
* Refer to Standard 7 for information about improvements made regarding workforce management at the service.

**Regulatory compliance:**

* The organisation has mandatory reporting processes and the service maintains a register.
* The organisation subscribes to various aged care information sources and information about changes to the aged care legislation is communicated to the service and staff. Additional training is provided to staff where required.

**Feedback and complaints:**

* The organisation has appropriate feedback and complaint mechanisms. The service uses feedback and complaints to improve the services and care provided to consumers.
* Refer to Standard 6 regarding processes in place for the management of complaints at the service.

For the reasons detailed above, I find the approved provider, in relation to McNamara Lodge, does comply with Requirement (3)(c) of Standard 8.

### 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.*

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the service’s last assessment and have recommended this Requirement as met. The Assessment Team’s report outlined the following actions and improvements implemented since the Assessment Contact, including:

* The organisation is continuing to develop and monitor processes to ensure the implementation of a clinical governance framework, an organisational approach to open disclosure and ensure the organisation’s approach to restraint remains aligned to current legislative requirements. For example:
	+ The organisation has updated its ‘Restraint Minimisation and Usage’ policy, including flowcharts, in line with the Aged Care Quality Standards.
	+ All consumers prescribed psychotropic medications for behaviour management have been reviewed by a general practitioner, with clear rationale for prescribing the medication. Letters and consent forms have been sent to consumers and next of kin, with a process in place to obtain consent for the use of all psychotropic medications.

The approved provider’s response stated they agreed with the Assessment Team’s findings.

In relation to Standard 8 Requirement (3)(e), information provided to the Assessment Team by management and staff demonstrated:

* The organisation has a documented clinical governance framework which includes antimicrobial stewardship, minimising the use of restraint and open disclosure. Management said the clinical governance framework is now complete and was promoted at the February 2020 organisational level clinical care meeting and at the service-based clinical meeting in March 2020.
* The organisation provided the Assessment Team with a documented clinical governance framework, a policy relating to antimicrobial stewardship, a policy relating to minimisation of restraint and an open disclosure policy referenced in various organisational guidance, manuals and policies.
* Staff said they have had education on the policies and were able to provide examples of their relevance to their work. Registered Nurses explained how the ‘Restraint Minimisation and Usage’ policy has been implemented with flowcharts developed to guide staff on physical, chemical and environmental restraint.
* Management said the organisational level ‘Division Council’ agenda now includes updated about opportunities for improvement.

For the reasons detailed above, I find the approved provider, in relation to McNamara Lodge, does comply with Requirement (3)(e) of Standard 8.

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is, however, required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.