Royal Freemasons Sale

Performance Report

28 Surkitt Boulevard
SALE VIC 3850
Phone number: 03 5149 3100

**Commission ID:** 4566

**Provider name:** Royal Freemasons Ltd

**Site Audit date:** 3 March 2021 to 5 March 2021

**Date of Performance Report:** 27 May 2021

# Publication of report

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

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant**  |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Non-compliant |
| Requirement 2(3)(d) | Non-compliant |
| Requirement 2(3)(e) | Non-compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(c) | Non-compliant |
| Requirement 3(3)(d) | Non-compliant |
| Requirement 3(3)(e) | Non-compliant |
| Requirement 3(3)(f) | Non-compliant |
| Requirement 3(3)(g) | Non-compliant |
| **Standard 4 Services and supports for daily living** | **Non-compliant** |
| Requirement 4(3)(a) | Non-compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Non-compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Non-compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Non-compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Non-compliant |
| Requirement 6(3)(d) | Non-compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Non-compliant |
| Requirement 7(3)(d) | Non-compliant |
| Requirement 7(3)(e) | Non-compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Non-compliant |
| Requirement 8(3)(b) | Non-compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | 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 Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the Site Audit report received 8 April 2021.
* Information provided by the Intake and Complaints Resolution Group of the Aged Care Quality and Safety Commission.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

Most sampled consumers considered that they are treated with dignity and respect, can maintain their identity, make informed choices about their care and services and live the life they choose. Most of the consumers reported the regular staff treat them with respect and dignity with feedback indicating agency staff are less caring and respectful. Consumers said staff value them as individuals.

Consumers and representatives said their culture was respected and provided examples of ways in which their culture, values and diversity were respected. Consumers described ways they were able to make and communicate decisions about their care and were able to choose who is involved in their care.

Consumers said staff understand what is important to them and support them to make decisions about taking risks in day to day life. All consumers said they were able to make choices with the way information is communicated and presented to them.

All of the consumers and representatives said their privacy was important to them and respected.

Staff are familiar with consumers' backgrounds and preferences for their care. Care planning documents were detailed and specific to each consumers’ background. Staff were observed interacting with consumers respectfully.

Staff were able to demonstrate the way culturally safe care is provided to the consumers at an individual level. Overall, care planning documents were specific in references to consumers' cultural needs.

Staff described ways each individual consumer is supported and displayed the ability to communicate with consumers and representatives effectively and openly to provide a choice in the level of care provided.

Staff were able to describe the steps taken to support consumers taking risks, managing the risk and assisting consumers to make informed decisions. Care plans reflected consumers' choice in relation to taking risk.

Staff provided multiple ways of presenting information to the consumers which included mainly verbal communication. Staff were observed presenting consumers with information to make appropriate decisions. Staff understood the importance of privacy.

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

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

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

*Each consumer is supported to exercise choice and independence, including to:*

1. *make decisions about their own care and the way care and services are delivered; and*
2. *make decisions about when family, friends, carers or others should be involved in their care; and*
3. *communicate their decisions; and*
4. *make connections with others and maintain relationships of choice, including intimate relationships.*

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

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

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

*Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.*

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

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

# STANDARD 2 NON-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

Overall sampled consumers did not consider that they feel like partners in the ongoing assessment and planning of their care and services.

Consumers and representatives said their care and services are generally known and planned around what is preferred. Care plans reflect consumers’ current goals, needs and preferences. Overall consumers were unable to describe any further involvement in care planning or assessment processes following admission.

Overall consumers and representatives interviewed said they were not aware they had a care plan, have not been offered a copy or not aware they could ask for this.

Care plan development is timely following consumers’ admission and includes comprehensive assessment including consideration of risks to the consumer’s health and well-being. Care plans contain language that is easy for consumers to understand and are accessible to staff. Care plans are not consistently reviewed after incidents or when circumstances change. Care plans sampled show ad hoc evidence of review. Ongoing review of care plans is not effectively monitored and does not demonstrate a risk-based approach.

Not all representatives were advised of an incident or the injuries sustained as a result of an incident.

Staff described people of importance to the consumer. Staff described how other service providers contribute to the consumer’s care and the development of a tailored care plan but stated that consumers and their representatives are not yet involved on an ongoing basis.

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

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) 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.*

### Requirement 2(3)(b) 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.*

### Requirement 2(3)(c) Non-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 provided information that while processes for consultation with consumers and their representatives are in place, these are not consistently used to ensure ongoing partnership in assessment, care planning and review of consumers’ needs. While some consumers and representatives were able to describe consultation taking place, others reported that this does not occur for them. Staff described people of importance to the consumer but said they are not consistently involved in assessment and care planning.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including training records, information sheets, toolbox session information, policies and meeting agenda and minutes.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). Care plan reviews are conducted monthly during the resident of the day process, third monthly during the full consumer care plan review or if care needs change for the consumer due to improvement or deterioration must be discussed with the consumer and/or representative and documented as part of the assessment and care plan process. The care plan assessments 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;

Consumers care plans were discussed in the Resident and Relative meeting and consultation is in progress to ensure all consumers and representatives have access and input in their care. This should allows the consumer to prescribe their own care.

Dementia and cognitive Impaired consumers are involved, and copies of care plans were provided to all representatives and the Approved Provider is in the process of updating all care plans so it reflects the care provided. A family and consumer information session will be held in the Shields wing where care plans, environmental and chemical restraints will be discussed.

The Approved provider has held meetings with registered and enrolled nurses covering a range of topics including medication administration and safe medication management, Standard 2 ongoing assessment and planning, the Aged Care Quality Standards, Serious Incident Reporting Scheme (SIRS), risk management procedure, infection control procedure, open disclosure, and deterioration of a consumer.

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined.

I find at the time of the Site Audit the Approved Provider did not demonstrate that assessment and planning 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 did not include other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.

I find this Requirement is non-compliant.

### Requirement 2(3)(d) Non-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 provided information that overall consumers and representatives interviewed said they were not aware they had a care plan, have not been offered a copy or not aware they could ask for one. The consumer welcome handbook does not reference care plans and consumers' ability to access these. Care plans contain language that is easy for consumers to understand and are accessible to staff.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including training records, information sheets, toolbox session information, policies and meeting agenda and minutes.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). The Approved Provider has engaged two Managers of Clinical Practice to provide leadership and guidance to the registered staff and assist with mentoring new staff working at the service. The care for the consumer’s wellbeing is now documented in the electronic care system. A number of care plans were provided to representatives to take home and read through them and make changes then follow up with a meeting with the Managers of Clinical Practice. Care plan reviews are in process with the support service to provide clinical support.

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined.

I find at the time of the Site Audit the Approved Provider did not demonstrate 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.

I find this Requirement is non-compliant.

### 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 provided information that Care plans are not consistently reviewed after incidents or when circumstances change. Care plans sampled show ad hoc evidence of review. Consumers and representatives were unaware of a process to regularly review the effectiveness of their care. Ongoing review of care plans is not effectively monitored and does not demonstrate a risk-based approach.

For the named consumers reviews had not occurred upon return to the service from hospital, post falls, or post behavioural incidents.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including training records, information sheets, toolbox session information, revised procedures, and meeting agenda and minutes.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). A family and consumer information session will be held in the Shields wing where care plans, environmental and chemical restraints are to be discussed. Registered and Enrolled nurse meetings and educations sessions have been conducted topics covered included Standard 2 ongoing assessment and planning, Aged Care Quality Standards, Serious Incident Reporting Scheme (SIRS), risk management procedure, lifestyle program procedure and open disclosure.

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined.

I find at the time of the Site Audit the Approved Provider did not demonstrate 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.

I find this Requirement is non-compliant.

# 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

Consumers and representatives are not consulted and informed of psychotropic medication usage. Consumers described ways in which they did not feel the personal and clinical care they receive is effective. Representatives said staff did not responded promptly to concerns that their relatives were unwell. Consumers and representatives said that communication regarding their family members internally and with medical practitioners was not effective and reliable. Consumers and representatives provided mixed levels of satisfaction with their access to medical professionals and other organisations.

Where psychotropic medications are prescribed, the process for prescription, assessment, authorisation and consent, monitoring and review did not occur according to regulatory requirements.

Staff identified consumers with high impact or high risk management requirements. Incident documentation review indicates pain management, prevention of wounds and management of skin integrity is not fully effective. The prevention and management of falls is not effective.

Not all consumer files sampled contained documentation in the form of a completed advanced care directive form or care plan. Staff interviews, and observation confirm end of life needs are generally met in line with consumer wishes and comfort is maintained.

Care planning documents and/or progress notes did not adequately reflect identification of, and response to, deterioration in health condition.

Staff described how information about consumers may be shared externally by a number of means with no clear process to ensure communications have been received or acted upon. Care documents including progress notes did not provide adequate information to support effective and safe sharing of the consumer’s care needs.

Consumer documentation reviewed indicate referrals to health professionals occur. However, follow up of review by allied health and medical practitioners does not occur consistently.

Whilst the service has processes to minimise infection related risks, the service was unable to demonstrate practices to promote appropriate antibiotic prescribing.

The Quality Standard is assessed as Non-compliant as seven of the seven specific requirements have 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 provided information that consumers and representatives are not consulted and informed of psychotropic medication usage. Consumers described ways in which they did not feel the personal and clinical care they receive is effective. Where psychotropic medications are prescribed, the process for prescription, assessment, authorisation and consent, monitoring and review did not occur according to regulatory requirements.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including training records, information sheets, education session information and meeting minutes.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). Registered and Enrolled nurse meetings and educations sessions have been conducted topics covered included Standard 2 ongoing assessment and planning, Aged Care Quality Standards, Serious Incident Reporting Scheme, risk management procedure, lifestyle program procedure and open disclosure.

A medication advisory committee meeting is scheduled to discuss the psychotropic usage at the service, and other related medication incidents. The residential care manager is in the process of contacting all the consumer representatives to discuss medication usage

The psychotropic register has been reviewed and is now current, and a review of consumers in the Shield wing of the service will be undertaken with strategies to reduce/ eliminate unnecessary the use of psychotropic medications.

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined.

I find at the time of the Site Audit the Approved Provider did not demonstrate each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice; and is tailored to their needs; and optimises their health and well-being.

I find this Requirement is non-compliant.

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

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

The Assessment Team provided information that there is not effective management of high impact or high prevalence risks to consumers. The prevention and management of consumer falls is not consistently effectively managed. Medication incident monitoring and review is not effective

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including training records, information sheets, education session information and meeting minutes.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). Falls education has been provided to staff. A meeting with the external physiotherapy and occupational therapy group is planned for a discussion about out of date care plans, as well as exercise and balance exercise groups. Incident and risk management education has been provided. Medication Incidents will be discussed in medication advisory committee meetings and route cause analysis is to be done. Staff are completing medication management education, with competency assessments to follow.

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined.

I find at the time of the Site Audit the Approved Provider did not demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer.

I find this Requirement is non-compliant.

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

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

The Assessment Team provided information that staff interview and observation confirm end of life needs are identified in line with consumer wishes and comfort is maintained. Document review indicates end of life assessment and care planning is not always commenced. However, where an advanced care directive care plan was entered, there were consistent entries regarding end of life wishes with personal goals listed as well as consideration of the need for emotional support for family, religious/ cultural support, pain management and care needs. For a named consumer, end of life wishes was not implemented as per the consumers wishes.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including training records, information sheets, toolbox session information and meeting minutes.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). The Approved Provider advised that consumer advance care plans are current in the residents’ Gallery. In the admission pack the care directive will be provided to ensure consumers and family can document their wishes before coming into the service. In case conferences the directives get discussed and updated as required. A family and consumer information session will be held in the Shields wing where care plans, environmental and chemical restraints will be discussed.

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined. I also note at the time of the site audit, there were several consumers without an end of life plan, or documented end of life wishes.

I find at the time of the Site Audit the Approved Provider did not demonstrate the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved.

I find this Requirement is non-compliant.

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

*Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.*

The Assessment Team provided information that care planning documents and/or progress notes did not adequately reflect identification of, and response to, deterioration in health condition. While staff were able to describe how they monitor consumers and would escalate concerns, they could not provide example of where this had happened. Representatives said staff did not responded promptly to concerns that their consumers were unwell.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including training records, information sheets, toolbox session information, a deterioration policy and procedure and meeting minutes.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). An education session was provided on recognition of a deteriorating consumer. Education sessions will be repeated until all registered nurses have attended and being deemed competent. Behaviour Management and change of consumers’ cognitive status will be presented in partnership with an external dementia advisory service.

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined.

I find at the time of the Site Audit the Approved Provider did not demonstrate deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.

I find this Requirement is non-compliant.

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

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

The Assessment Team provided information that consumers and representatives said that communication regarding their family members internally and with medical practitioners was not effective and reliable. Staff described how information about consumers may be shared externally, with no clear process to ensure communications have been received or acted upon. Care documents including progress notes did not provide adequate information to support effective and safe sharing of the consumer’s care needs.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including training records, information sheets, toolbox session information, examples of consultation with consumers/representatives and meeting minutes.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). An education session was provided on recognition of a deteriorating consumer. A family and consumer information session will be held in the Shields wing where care plans, environmental and chemical restraints will be discussed. Documentation on consultation with families will be more evident in the progress notes.

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined. I also note that the Approved Provider response did not address how improvements with external stakeholders such as medical officers would occur.

I find at the time of the Site Audit the Approved Provider did not demonstrate information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.

I find this Requirement is non-compliant.

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

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

The Assessment Team provided information that consumer documentation reviewed indicate referrals to health professionals occur. However, timely follow up and review by allied health and medical practitioners does not occur consistently Consumers and representatives provided mixed levels of satisfaction with their access to medical professionals and other organisations.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including meeting agenda and minutes and examples of recent dietitian and speech pathologist reviews.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvemen. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). An external dementia advisory service is involved in Shields wing to create a more appropriate environment for consumers. A full-time physiotherapy is on site. Evidence of podiatrists, speech pathologist and dietician reviews evident in care plans.

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined. I also note that the Approved Provider response did not address how improvements to communication with medical officers would occur.

I find at the time of the Site Audit the Approved Provider did not demonstrate timely and appropriate referrals to individuals, other organisations and providers of other care and services.

I find this Requirement is non-compliant.

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

*Minimisation of infection related risks through implementing:*

1. *standard and transmission based precautions to prevent and control infection; and*
2. *practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.*

The Assessment Team provided information that the service was unable to demonstrate practices to promote appropriate antibiotic prescription. The service has process for the management of standard and transmission-based precautions. Staff demonstrated knowledge and understanding of infection control practices to reduce the spread of infection however, practical application of antimicrobial stewardship theory was not evident.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including training records, information sheets, infection control audit tools, toolbox session information and meeting minutes.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). Antimicrobial stewardship will be tabled on the next medication advisory committee meeting and registered nurse meeting. Upcoming education will be inclusive of Anti-Microbial stewardship.

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined.

I find at the time of the Site Audit the Approved Provider was able to demonstrate that minimisation of infection related risks through implementing standard and transmission-based precautions to prevent and control infection are generally established; practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics have not been effectively established.

I find this Requirement is non-compliant.

# STANDARD 4 NON-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

Most sampled consumers did not consider that they get the services and supports for daily living that are important for their health and well-being and that enable them to do the things they want to do. Consumers and representatives interviewed provided feedback there is a lack of stimulating activity and gave examples of care and services which did not meet their needs, goals or preferences, and of how this limited their participation and wellbeing. Most consumers reported little interest in the group activities offered and described them as under stimulating. Representatives described a lack of stimulation and activities of interest for consumers who required more assistance. Engagement of consumers living with dementia in Shields wing, the memory support unit, is not demonstrated.

Most consumers reported how their spiritual and emotional wellbeing is supported at the service. Consumers said that their family and friends were welcome at the service, and that they were able to maintain connections with the people who are important to them. Most consumers expressed that information regarding their condition and assistance required is well communicated between staff and to external organisations.

All consumers and representatives provided feedback that meals were not of suitable quality and variety, that the service runs out of food items and that they are not offered substantial choices.

Most consumers reported that their equipment is safe, clean and well maintained. Maintenance logs demonstrated issues reported regarding equipment were resolved promptly.

Staff were able to describe consumer’s important relationships and how they like to spend time with those people, consumer’s interests and previous links to the community, but insufficient staffing and the small capacity of the bus were factors which limit consumer participation.

Most staff said they are confident that they knew how to support consumer’s needs and preferences because the information the care plans and on handover is accurate, up to date and reliable.

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

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Non-compliant

*Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.*

The Assessment Team provided information that consumers and representatives interviewed provided feedback that there is a lack of stimulating activity and gave examples of care and services which did not meet their needs, goals or preferences, and of how this limited their participation and wellbeing. Some staff and management said that consumers in Shields were not offered a range of activities. Engagement of consumers living with dementia in Shields, the memory support unit, is not demonstrated.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including training records, information sheets, lifestyle audit, new lifestyle calendar and meeting agenda and minutes.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). A family and consumer information session will be held in the Shields wing where care plans, environmental and Chemical restraints will be discussed. An external dementia advisory service has been contacted with education and information sessions arranged. The service has engaged in a lifestyle assistant that will be in rostered in Shields wing from 10.00am until 4.30pm. The Shields wing will have their own activities program and will be conducted. A lifestyle audit will be completed in partnership with their families and activities will be tailored to the consumers need

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, including the additional support being provided to Shields wing, the effectiveness and sustainability of improvements is yet to be determined.

I find at the time of the Site Audit the Approved Provider did not demonstrate each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.

I find this Requirement is non-compliant.

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

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

### Requirement 4(3)(c) Non-compliant

*Services and supports for daily living assist each consumer to:*

1. *participate in their community within and outside the organisation’s service environment; and*
2. *have social and personal relationships; and*
3. *do the things of interest to them.*

The Assessment Team provided information that most consumers reported little interest in the group activities offered and described them as under stimulating. Representatives described a of lack of stimulation and activities of interest for consumers who required more assistance. Access to the community is currently limited by the size capacity of the services’ bus. Care planning documents provided relevant information regarding consumers social and personal relationships, significant life events and community connections, and the meaning of these experiences to the consumer. No activities were observed in Shields wing throughout the visit. Consumers said that their family and friends were welcome at the service, and that they were able to maintain connections with the people who are important to them.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including training records, information sheets, lifestyle audit, new lifestyle calendar and meeting agenda minutes. The Approved Provider also noted that Covid-19 has restricted community involvement but activities like shopping, going out for meals, Church and entrainment are evident in the lifestyle calendar.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards).

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined. I accept that Covid-19 has impacted on the services’ ability to undertake community-based activities, however I also note the consumer feedback in relation to their dissatisfaction with the ability participate in their community within and outside the organisation’s service environment. I do note that consumers advised they have social and personal relationships maintained.

I find at the time of the Site Audit the Approved Provider did not demonstrate Services and supports for daily living assist each consumer to participate in their community within and outside the organisation’s service environment; and do the things of interest to them.

I find this Requirement is non-compliant.

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

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

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

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

### Requirement 4(3)(f) Non-compliant

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

The Assessment Team provided information that all consumers and representatives interviewed provided feedback that meals were not of suitable quality and variety, that the service runs out of food items and that they are not offered substantial choices. Consumers or representatives also advised that food preferences are not always respected, and consumers and representatives are purchasing additional food to supplement consumers diets.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including a copy of the new menu and a report on consumer weights.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). Food focus meetings are continuing. complaints forms have decreased with food complaints since the Site Audit, consumers have been informed there is more choices on the menu and the menu has changed which is more tailored to consumers choices.

Dietary assessments are now updated with consumers choices and dignity of risks are in progress for consumers that do not want to follow the advice of health care professionals All care plans are now reflective of consumers choices however will be an ongoing process as part of resident of the day. Weights for the month of April stabilised with unplanned weight loss is below benchmark levels.

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined. I note from the Assessment Teams report that a new chef manager had recently commenced at the service and food focus meetings had been introduced, as well as the chef meeting with some consumers to address concerns in meals. However, I note the ongoing consumer and representative dissatisfaction with meals and that the improvement activities had not yet been effective in meeting consumers needs and preferences.

I find at the time of the Site Audit the Approved Provider did not demonstrate with the meals are provided, they are varied and of suitable quality and quantity.

I find this Requirement is non-compliant.

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

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

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

Overall sampled consumers considered that they feel they belong in the service and feel safe and comfortable in the service environment.

The service environment is welcoming and has a large reception area and a café at the entrance frequented by consumers. Communal areas and the café were observed to be used by consumers and visitors throughout the visit. Consumers and representatives said the service environment is welcoming.

The service was safe, clean and well maintained indoors. Outdoor areas had a central shaded area with a table and seating. Maintenance staff described a regular schedule of maintenance and maintenance logs demonstrated this.

Furniture, fittings and equipment were clean and well maintained. Consumers interviewed who use mobility aids or supportive equipment said they felt safe and staff knew how to use equipment. Staff are aware of how to use equipment and how to report maintenance issues.

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

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

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

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

# STANDARD 6 NON-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

Overall sampled consumers did not consider that appropriate action is taken when they make complaints. They said they are encouraged and supported to give feedback and make complaints. All consumers and representatives interviewed said they feel comfortable to raise a complaint or concern with the staff and management.

All consumers interviewed reported they are able to advocate for themselves and this is either verbally, written or through a representative. Most consumers and representatives interviewed did not provide positive feedback regarding open disclosure and said their issues were not resolved. Most of the consumers and representatives interviewed explained they do not have confidence in management to make improvements to the quality of their care and services.

Staff described how they support consumers to make complaints and the process involved. The service’s policy and procedure documents state all procedures and avenues for feedback and complaints.

The staff identified the advocacy and language services available to consumers. Information is available to inform and supports the provision of feedback confidentially internally or externally as preferred.

Staff members interviewed were not able to demonstrate open disclosure and could not explain how it improved the care towards consumers. The documentation and follow up of complaints are not effective and does not support resolution and open disclosure. Policies and procedures are in place and outline the focus on a transparent approach.

Staff provided examples of how the complaints and feedback process is actioned. The continuous improvement and complaints registers indicated complaints have not been used to identify and action improvements.

The Quality Standard is assessed as Non-compliant as two of the four specific requirements have been assessed as Non-compliant.

## Assessment of Standard 6 Requirements

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

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

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

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

### Requirement 6(3)(c) Non-compliant

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

The Assessment Team provided information that most consumers and representatives interviewed did not provide positive feedback regarding open disclosure and said their issues were not resolved. Staff members interviewed were not able to demonstrate open disclosure and could not explain how it improved the care towards consumers. The documentation and follow up of complaints are not effective, does not support resolution and open disclosure. Policies and procedures are in place and outline the focus on a transparent approach.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including training records, an open disclosure policy and procedure, feedback and complaints registers and meeting minutes. The Approved Provider advised that feedback has increased on the feedback register and follow up with complaints is evident. All Commission complaints are now closed and regular follow up with consumers and families are evident. Registered and Enrolled nurses have had open disclosure training.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). Regular feedback is being sought from consumers in the forms of surveys (lifestyle) and food focus meetings. Care plans are given to consumers to read through however a number have declined as they feel they are “independent” and do not have insight in their care

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities and education that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined.

I find at the time of the Site Audit the Approved Provider did not demonstrate appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

I find this Requirement is non-compliant.

### Requirement 6(3)(d) Non-compliant

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

The Assessment Team provided information that most of the consumers and representatives interviewed explained they do not have confidence in management to make improvements to the quality of their care and services. Staff provided examples of how the complaints and feedback process is actioned. The continuous improvement and complaints registers indicated complaints have not been used to identify and action improvements.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including training records, an open disclosure policy and procedure, feedback and complaints registers and meeting minutes. The Approved Provider advised that feedback has increased this month on the feedback register and follow up with complaints is evident. All Commission complaints are now closed and regular follow up with consumers and families are evident.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards).

Feedback and complaint registers are in place. The service has provided training to staff on complaints management. Feedback forms are in place, follow up and open disclosure being practiced. All Commission complaints are closed.

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined.

I find at the time of the Site Audit the Approved Provider did not demonstrate feedback and complaints are reviewed and used to improve the quality of care and services.

I find this Requirement is non-compliant.

# STANDARD 7 NON-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

Most sampled consumers did not consider there are enough staff and said they generally get quality care and services. Most consumers and representatives asked interviewed in relation to their care said they do not think there is enough staff.

Consumers and representatives said they find regular staff kind and caring with agency staff less caring and more task focussed. Most consumers and representatives said regular staff know what they are doing with agency staff not knowing their needs well. Interactions between consumers, representatives and staff were observed to be kind, caring, cheerful and respectful. Staff from a range of cultures are employed.

Staff said there are not enough staff and agency staff are not well trained. There has been a change in key management to support clinical oversight, including two new Managers of Clinical Practises employed and additional lifestyle staff have been appointed.

Management said they have identified a range of education required by staff. Significant education needs have been identified through self-assessment processes indicating performance improvements are required. The monitoring of mandatory education is not effective. The orientation of agency staff is not effective.

Where staff members' performance did not meet expectations, documentation did not indicate effective or timely recording of performance related issues and discussion of these, impacting on consumer safety.

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

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Non-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 provided information that most consumers and representatives interviewed in relation to their care said they do not think there is enough staff. Staff said there are not enough staff and agency staff are not well trained. There has been a change in key management to support clinical oversight. Lifestyle hours have reduced. Call bell usage and response times have increased.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including call bell records and falls data. The Approved Provider advised that lifestyle hours had not decreased, however the Co-ordinator was on leave and had resigned in March 2021.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). The Approved Provider advised that in relation to recruitment the service has employed 15 new team members, with a change in clinical leadership in late February 2021. This involve two new Managers of Clinical Practises and the service is divided in two sections to support clinical oversight and compliance. An eight-hour orientation day has commenced in March 2021 to ensure effective on boarding. The service is currently advertising for a lifestyle co-ordinator. A Fulltime lifestyle assistant is now appointed in Shields wing to ensure a dementia specific program is deployed.

Falls education has been completed for all team members. Safe medication practices is redone by all medication endorsed team members, Call bell monitoring is established and feedback given to staff. Also call bells are now monitored against falls, and falls have decreased.

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined. I also note the level of consumer and representative dissatisfaction with staffing levels.

I find at the time of the Site Audit the Approved Provider did not demonstrate 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.

I find this Requirement is non-compliant.

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

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

### Requirement 7(3)(c) Non-compliant

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

The Assessment Team provided information that most consumers and representatives said regular staff know what they are doing with agency staff not knowing their needs well. The workforce is recruited to specific roles requiring qualification, credentialing or competency. Staff said agency staff do not always know what they are doing. Staff are not competent to administer medications safely. The competence of the previous facility manager and manager of clinical practice was not monitored.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including agency orientation documentation.

The service has an infection control lead now qualified and appointed at the service. The Approved Provider states the workforce is competent and all registered staff hold registration with The Australian Health Practitioner Regulation Agency. Agency staff members are now orientated to the site and a register is kept by Managers of Clinical Practises to ensure the service orientate all agency staff. On boarding education that includes: safe medication management, elder Abuse, work health and safety and safe practices, person centred care & consumer directed care, manual handling, infection control, handwashing, and fire training. The current Manager and both the Managers of Clinical Practises have completed safe medication practices training.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). A residential support partner will be added to the service full time. Recruitment is underway to support quality, clinical and income.

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined.

I find at the time of the Site Audit the Approved Provider did not demonstrate the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

I find this Requirement is non-compliant.

### Requirement 7(3)(d) Non-compliant

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

The Assessment Team provided information that most consumers and representatives said regular staff know what they are doing with agency staff not knowing as much. Management have identified a range of education required by staff. Significant education needs have been identified through self-assessment processes indicating performance improvements are required. The monitoring of mandatory education is not effective. The orientation of agency staff is not effective.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including agency orientation documentation. The Approved Provider advised 20 new staff members were recently orientated. On-board processes are established and monitored buddy shifts in place for new team members. An agency orientation spreadsheet has been created and managed by Managers of Clinical Practises.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). The service currently recruiting for a residential support person and a residential support person from another service operated by the Approved Provider is helping with education. All Mandatory education is now monitored.

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined. I note positions are still being recruited.

I find at the time of the Site Audit the Approved Provider did not demonstrate the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

I find this Requirement is non-compliant.

### Requirement 7(3)(e) Non-compliant

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

The Assessment Team provided information that where staff members' performance did not meet expectations, documentation did not indicate effective or timely recording of performance related issues and discussion of these. Reporting of nursing practice has occurred.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including a performance appraisal letter and performance management policy.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). Performance reviews of all staff members will be conducted in April/May 2021. Self-assessment of performance is made available to all staff and they will book in a time with their managers. Education to key staff members on doing file notes and following the performance Management process are completed.

Risk management and elimination education has commenced and was due for completion by April 2021 to ensure an early detection, recognition and elimination of risks to consumers.

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined.

I find at the time of the Site Audit the Approved Provider did not demonstrate regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

I find this Requirement is non-compliant.

# STANDARD 8 NON-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

Most sampled consumers generally considered that the organisation is well run. However, consumers and representatives provided feedback indicating there is not enough staff, there are poor meals and open disclosure could improve. Representatives complained about the lack of follow up in relation to account enquiries. Consumers are not supported to engage in the development, delivery and evaluation of care and services. Re-establishment of a consumer engagement panel is planned.

The governing body does not effectively promote a culture of safe, inclusive and quality care. The monitoring of monthly reports was not effective with current trends and data not informing the Board.

Stakeholders have access to relevant information. A methodical approach to identification of required improvements, ongoing monitoring, review and service improvement is not evident. Representatives and consumers were not advised in advance of the pending performance assessment. Workforce governance is not effective. The monitoring and trending of feedback and complaints is not effective with reporting to the Board not reflecting the extent of complaints.

There is a risk framework identifying high impact and high prevalence risks and abuse or neglect of consumers. Reporting to the Board does not identify trends in an effective and timely manner to support risk management. The monitoring of incident reporting and recording in the mandatory reporting register was not effective. Oversight of outbreak management planning was not effective. Support for consumers to live the best life they can is not effectively monitored.

There is a clinical governance framework established with reporting and monitoring occurring. Staff did not demonstrate understanding of documentation and psychotropic medication review requirements to ensure usage is minimised and safe. Governance of psychotropic medication usage and chemical restraint is not effective. Staff did not identify locked courtyard doors as a restrictive practice. Management has not demonstrated open disclosure occurs in response to complaints or where incidents may/have caused harm to consumers.

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

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Non-compliant

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

The Assessment Team provided information that consumers are not supported to engage in the development, delivery and evaluation of care and services. Re-establishment of a consumer engagement panel is planned. A recent gap analysis conducted at the service does not reflect consumer input into the analysis of care at the service.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including a lifestyle audit and meeting agenda and minutes.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). Resident and Relative meetings are reinstated. Care plan consultations have commenced in April 2021 and the service aims to be completed within three months. Weekly afternoon teas with the Facility Manager with selected consumers has opened up communication and feedback gathering. Surveys are internally being conducted by the service in relation to lifestyle and food. Discussion with consumers about having a consumer ran activity (such as reminisces) has been proposed in the lifestyle audit and survey.

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined. I note the timeframes for some improvements are still occurring.

I find at the time of the Site Audit the Approved Provider did not demonstrate consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

I find this Requirement is non-compliant.

### Requirement 8(3)(b) Non-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 provided information that the governing body does not effectively promote a culture of safe, inclusive and quality care. The monitoring of monthly reports was not effective with current trends and data not informing the Board. The strategic growth plan on the organisation's website is not current.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including the process for a quality sweep of the service.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). Quality Sweeps are conducted by support services and commenced in April 2021. Overview of quality data in the service including complaints, incidents and clinical data is planned to be collated and shared as a run down to the Board at the Quality Safety Committee Meetings and as a summary complied in the Board meeting.

Weekly emails are sent to the Chief Executive Officer from the Quality Support Services Team outlining major incident which is then emailed to the board in real time. The organisation has commenced working with a new provider in relation to how the service access real time quality data which will also be accessible to the Board members in real time on a dashboard platform.

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined.

I find at the time of the Site Audit the Approved Provider did not demonstrate the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

I find this Requirement is non-compliant.

### Requirement 8(3)(c) Non-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 provided information that a methodical approach to identification of required improvements, ongoing monitoring, review and service improvement is not evident. Representatives complained about the lack of follow up in relation to account enquiries. The monitoring of the mandatory reporting system is not fully effective. Representatives and consumers were not advised in advance of the pending performance assessment. Monitoring of schedule eight medications is not fully effective. In response to complaints, management had not always provided information when requested. Workforce governance is not effective. The monitoring and trending of feedback and complaints is not effective with reporting to the Board not reflecting the extent of complaints.

The Approved provider provided a response that did not include a response to this Requirement. However, I note the improvement activities outlined in the overall response indicates that the service is pursuing continuous improvement in response to the Site Audit.

I have considered the information provided by the Assessment Team, as well as overall improvement activity been undertaken by the Approved Provider.

I find at the time of the Site Audit the Approved Provider did not demonstrate effective organisation wide governance systems

I find this Requirement is non-compliant.

### Requirement 8(3)(d) Non-compliant

*Effective risk management systems and practices, including but not limited to the following:*

1. *managing high impact or high prevalence risks associated with the care of consumers;*
2. *identifying and responding to abuse and neglect of consumers;*
3. *supporting consumers to live the best life they can.*

The Assessment Team provided information that there is a risk framework identifying high impact and high prevalence risks and abuse or neglect of consumers. Reporting to the Board does not identify trends in an effective and timely manner to support risk management. Medication management falls prevention and unplanned weight loss governance are not effective. The monitoring of incident reporting and recording in the mandatory reporting register was not effective. Oversight of outbreak management planning was not effective. Support for consumers to live the best life they can is not effectively monitored.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including a dignity of risk policy, a clinical risk management framework/pathways, serious incident response scheme information, and an incident reporting procedure.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). Organisation wide risk policies and procedures were reviewed, including dignity of risk and clinical risk. In line with the new serious incident response scheme, the organisations data base allows daily reports to run to review all incidents that require escalation. All serious incident response scheme matters reported are forwarded to the Quality Team, summarised and shared in summary at the Quality Safety Meetings and summarised for the Board. The electronic care system upgrade is due in May 2021 and will include an email alert for all incidents logged at the service. Quality sweeps conducted are evaluated with the service being risk categorised based on the risk matrix in Royal Freemasons policies and procedures.

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined. I note the timeframes for some improvements are still occurring.

I find at the time of the Site Audit the Approved Provider did not demonstrate effective risk management systems and practices.

I find this Requirement is non-compliant.

### Requirement 8(3)(e) Non-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 provided information that there is a clinical governance framework in place with reporting and monitoring occurring. Staff did not demonstrate understanding of documentation and psychotropic medication review requirements to ensure usage is minimised and safe. Governance of psychotropic medication usage and chemical restraint is not effective. Staff did not identify locked courtyard doors as a restrictive practice. Management has not demonstrated open disclosure occurs in response to complaints or where incidents may/have caused harm to consumers.

The Approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions to be taken since the audit. A range of supporting documents were also provided including psychotropic medication policy, an open disclosure policy and information on antimicrobial stewardship.

Actions taken by the Approved Provider included actions added to the Plan of Continuous Improvement. The service will assess, monitor and improve its quality of care and services, measured against the Aged Care Quality Standards (Standards). The organisation is including restraint care plans and assessments to be part of the quality sweeps. Psychotropic medication and restraint training, education and resources have been provided to clinical staff at the service. The psychotropic medication policy has been reviewed and updated. Psychotropic medication register has been updated and psychotropic medication use percentage to be put as part of risk classification for the service.

I have considered the information provided by the Assessment Team and the Approved Providers response. I note the Approved Provider has not refuted the findings of the Assessment Team, and whilst I note the improvement activities that are being undertaken, the effectiveness and sustainability of improvements is yet to be determined.

I find at the time of the Site Audit the Approved Provider did not demonstrate an effective clinical governance framework.

I find this Requirement is non-compliant.

# Areas for improvement

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

* Requirement 2(3)(c): Ensure assessment and planning: 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 includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.
* Requirement 2(3)(d): Ensure the outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.
* Requirement 2(3)(e): Ensure 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.
* Requirement 3(3)(a): Ensure each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice and is tailored to their needs and optimises their health and well-being.
* Requirement 3(3)(b): Ensure effective management of high impact or high prevalence risks associated with the care of each consumer.
* Requirement 3(3)(c): Ensure the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved.
* Requirement 3(3)(d): Ensure deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.
* Requirement 3(3)(e) Ensure information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.
* Requirement 3(3)(f): Ensure timely and appropriate referrals to individuals, other organisations and providers of other care and services.
* Requirement 3(3)(g) Ensure minimisation of infection related risks through implementing standard and transmission-based precautions to prevent and control infection; and practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics
* Requirement 4(3)(a): Ensure each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.
* Requirement 4(3)(c) Ensure services and supports for daily living assist each consumer to participate in their community within and outside the organisation’s service environment; and have social and personal relationships; and do the things of interest to them.
* Requirement 4(3)(f): Ensure where meals are provided, they are varied and of suitable quality and quantity.
* Requirement 6(3)(c): Ensure appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.
* Requirement 6(3)(d): Ensure feedback and complaints are reviewed and used to improve the quality of care and services.
* Requirement 7(3)(a): Ensure the workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.
* Requirement 7(3)(c): Ensure the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.
* Requirement 7(3)(d): Ensure the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.
* Requirement 7(3)(e): Ensure regular assessment, monitoring and review of the performance of each member of the workforce
* Requirement 8(3)(a): Ensure consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.
* Requirement 8(3)(b): Ensure the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.
* Requirement 8(3)(c): Ensure effective organisation wide governance systems.
* Requirement 8(3)(d) Ensure effective risk management systems and practices.
* Requirement 8(3)(e) Ensure an effective clinical governance framework.