Mark Moran Warrawee

Performance Report

1496 Pacific Highway   
Warrawee NSW 2074  
Phone number: 02 9144 6958

**Commission ID:** 1117

**Provider name:** Mark Moran Group Pty Limited

**Site Audit date:** 1 June 2022 to 3 June 2022

**Date of Performance Report:** 26 July 2022

# Performance report prepared by

Marek Dubovinsky, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

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

# Detailed assessment

This performance report details the Commissioner’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; and
* the provider’s response to the Site Audit report received 29 June 2022.

# STANDARD 1 COMPLIANT Consumer dignity and choice

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 1

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

The Assessment Team found overall, 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. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* consumers are treated with dignity and respect;
* staff are kind and caring;
* consumers are supported to exercise choice and independence; and
* staff know consumers’ backgrounds and interests.

Consumers are treated with dignity and respect, with their identity, culture and diversity valued. Staff interviewed demonstrated an understanding of consumers’ needs and preferences. For consumers sampled, care planning documentation reflected their goals, interests and what is important to them.

Care and services are culturally safe. For the consumers sampled, staff described how they understand the culture of individual consumers. The organisation has documented policies, procedures and a Diversity policy.

Consumers are supported to exercise choice and independence about their own care, such as in relation to meals and the provision of personal care. Staff could describe how consumers are supported to make informed choices about their care and services. Processes support the identification of risks to enable consumers to live the best life they can. Staff provided examples of how they support consumers to take risks to live their best life. Documentation viewed showed the service has relevant risk assessment policies and processes.

Information provided to consumers is easy to understand, current, accurate and timely, and communication is provided to consumers which enables them to exercise choice. The consumer handbook is provided to all consumers and outlines the range of services offered. Staff could describe ways in which information is provided to consumers to support them to make decisions, such as for consumers with a cognitive impairment.

Staff were observed to be maintaining consumer privacy by securing sensitive information, identifying private information when individual consumers enter the service and disclosing to the consumer how they use this information. Care files are electronically stored and password protected.

Based on the evidence documented above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, to be Compliant with all Requirements in Standard 1 Consumer dignity and choice.

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

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

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

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

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

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

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

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

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

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

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

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

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

The Assessment Team has recommended the service does not meet Requirements (3)(a), (3)(c), (3)(d) and (3)(e) in Standard 2, as the service was unable to demonstrate:

* 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;
* assessment and planning occurred in partnership with consumers and others and included other organisations, individuals and providers of other care and services;
* outcomes of assessment and care planning are effectively communicated in the care and services plan or that it is readily available to the consumer; and
* 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 have considered the Assessment Team’s findings; the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirements (3)(a) and (3)(e). I have provided reasons for my findings under the specific Requirements below.

In relation to Requirement (3)(b) in this Standard, most consumers and/or representatives confirmed they have discussed aspects of consumers’ care with staff.

Processes support assessment and planning in relation to advance care planning and end of life planning if the consumer wishes. Management were able describe how they support consumers and identify needs goals and preferences in relation to advanced care planning. Progress notes viewed showed the service identifies and documents needs, goals and preferences in relation to advanced care planning when consumers first enter the service.

Based on this evidence, I find the service to be compliant with Requirements (3)(b), (3)(c) and (3)(d), in Standard 2 Ongoing assessment and planning with consumers.

## Assessment of Standard 2 Requirements

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

*Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.*

The Assessment Team were not satisfied the service was able to demonstrate 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, as all consumers had interim care plans and all relevant risks were not identified. This was evidenced by:

* Most consumers, or representatives on their behalf, confirmed they have discussed aspects of consumers’ care with staff. The physiotherapist assesses all consumers when they enter the service for such risks as falls, pressure injuries, and mobility and transfers. This assessment is populated into a care plan and includes interventions to deliver safe and effective care and services.
* Consumer A exhibited behaviours of concern and medication was prescribed in the form of chemical restraint. Progress notes show the consumer experienced agitation and aggression when staff attended personal care, however, there was no care plan for the consumer’s behaviours, continence or personal care needs.
* Consumer B has two specialised nursing needs, however, does not have specific management plans developed.
* Consumer C has a specialised nursing need, however, does not have specific management plan developed.
* One staff member said interim care plans lacked critical information regarding consumers’ clinical and personal care requirements. They said this impacted consumer care, as staff did not know their baseline clinical and lifestyle preferences.
* Most consumers or representatives confirmed discussions in relation to aspects of care with staff, however, they are not aware of any process of assessment and care planning.

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* Acknowledged Consumer A did not have a behaviour support plan.
* Acknowledged the care plans did not contain critical information.
* Asserted consumers have care plans and this was misunderstood by the Assessment Team.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I find the service was not able to demonstrate 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.

In coming to my finding, I have considered the evidence which shows consumers confirming their involvement in the assessment process. For Consumers A to C, relevant assessment and planning had not been completed and specifically in relation to behaviours of concern and specialised nursing needs. I acknowledge all three consumers were on respite, however, they had care and service needs which were unique and required appropriate assessment and planning to inform safe and effective care and service delivery. In addition, I have noted the feedback from the provider which acknowledged the care plans did not contain critical information.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Non-compliant with Requirement (3)(a) in Standard 2 Ongoing assessment and planning.

### 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) 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 were not satisfied the service was able to demonstrate assessment and planning occurred in partnership with consumers and others and included other organisations, individuals and providers of other care and services. This specifically related to recommendations documented in progress notes not triggering assessment and care planning. This was evidenced by:

* The service demonstrates care and services are based on ongoing partnership with the consumers and others that the consumer wishes to involve.
* For the consumers sampled, care planning documents reflect that the consumer and others are involved in their care and services.
* Consumer A was reviewed by an allied health therapist and had this information reflected in the interim care plan. However, a review by another specialist service with recommendations made were documented in progress notes and not in a relevant assessment. The representative of consumer A said they were closely involved in all decisions about the consumer’s care and services.
* The representative of a consumer said they were involved in an assessment to identify the consumer’s lifestyle preferences. The consumer has been provided activities as per the assessment. Issues in relation to the consumer’s communication have been identified but a specific care plan has not been developed.
* Consumers confirmed an allied health therapist is involved with their care.
* The director of nursing said they attend a case conference and they assess the consumer prior to their arrival to ascertain consumers’ care and service needs.
* Sampled consumers had interim care plans developed.

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* Acknowledged a lack of certain documentation but reaffirmed their view that no lack of service occurred nor adverse clinical outcomes.
* Interim care plans are completed which involves consumers and representatives which contain a range of information whilst full detailed assessments are being completed.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I have come to a different view to the Assessment Team and find the service was able to demonstrate assessment and planning is based on an 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.

In coming to my finding I have considered the feedback from consumers and representatives which indicates consumers and representatives are involved in the assessment and planning processes. In addition, I have relied on the documentation and feedback which indicates others, such as specialists, allied health providers and nursing staff are involved in the assessment and planning process. Finally, I have considered the Assessment Team’s information and the provider’s response which indicates all consumers had an interim care plan developed which occurred in partnership with the consumer and/or representative.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Compliant with Requirement (3)(c) in Standard 2 Ongoing assessment and planning.

### 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 were not satisfied the service was able to demonstrate outcomes of assessment and care planning are effectively communicated in the care and services plan or that it is readily available to the consumer. Consumers and representatives are not aware they have a care plan. This was evidence by;

* All consumers and representatives interviewed said they did not know about the consumer’s care plan.
* Progress notes indicate consultation about clinical and personal care with consumers at case conferences, there is no evidence a care plan is offered to them.
* Sampled consumers had interim care plans which included brief details about their clinical and personal care.
* A copy of consumers’ mobility plan is placed in their bathrooms.
* Care plans were observed to be available to staff on mobile electronic devices and at the registered nurses’ station and the management offices. The physiotherapist assessment for mobility, transfers, falls risk and pressure injury risk is populated into the comprehensive care plan.
* The organisation’s policy includes discussion about the care plan with the consumer and confirmation by the consumer that they have read it.

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* The consumers sampled were all respite and had an interim care plan which contained relevant information and included information on communication, pain, falls, diet and personal hygiene.
* The interim care plan was completed in partnership with the consumer and representative when they first entered the service.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I have come to a different view to the Assessment Team and find the service was able to 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.

In coming to my finding, I have considered and placed weight on the service being open for a short period of time and I have relied on the evidence which showed all consumers had an interim care plan completed. Furthermore, I have considered the evidence which showed the interim care plan contained information which was identified from an assessment when the consumer first entered the service and involved consumers and/or representatives. Finally, I have noted evidence from progress notes in relation to case conferences involving consumers and representatives which indicate discussions in relation to assessment and planning.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Compliant with Requirement (3)(d) in Standard 2 Ongoing assessment and planning.

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

*Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.*

The Assessment Team were not satisfied the service was able to 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. Incidents are not consistently reported, and care plans are not consistently reviewed when changes or incidents occur. This was evidenced by:

* There is a process for three monthly care plan reviews but this is not able to be demonstrated, as the service has not been open for that length of time.
* The Assessment Team identified the incident management system is not robust. Incidents are not consistently reported by staff to enable risks to consumers to be assessed and mitigated.
* Consumer A experienced an incident of bruising, however, an incident report was not completed and strategies were not developed to prevent further occurrence. In addition, the consumer experienced behaviours of concern and was involved in an incident which was reported to the Aged Care Quality and Safety Commission, as required under the Serious Incident Response Scheme (SIRS). However, there is no evidence of the consumer’s care and service needs being reviewed.
* Consumer B experienced bruising, however, incident reports have not been completed and strategies were not developed to prevent further occurrence.
* Consumer C reported, on the last day of the Site Audit to the Assessment Team, that they experienced three episodes involving their bowels overnight during the Site Audit and their care and services were not monitored or reviewed. Bowel charts showed the service was monitoring the consumer’s bowels with two entries recorded.
* Following a change in Consumer D’s pain medication, pain monitoring was incomplete. In addition, out of range blood pressure readings were reported to the medical officer.
* Consumer E was prescribed a medication on alternate days, however, the medication administration records showed the consumer was being administered the medication daily. An incident form and investigation was not completed. In addition, the consumer was prescribed a medication which was not commenced for three days. The consumer’s care plan was not reviewed following the incident.

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* Acknowledged the incident management process was not followed however no adverse outcome occurred.
* The service has been open for a short period of time and has effective processes.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I find the service was not able to 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.

In relation to Consumer A and B, I find their care and services were not reviewed following incidents of bruising. In addition, Consumer A experienced episodes of behaviours of concern, which did not result in the consumer’s behaviour management plan or support plan being developed and reviewed.

In relation to Consumer C, I have considered the service was monitoring the consumer’s bowel health and function. I have considered the report was provided to the Assessment Team by the consumer on the last day of the Site Audit and the service may have not had the opportunity to undertake an appropriate care and service plan review following the report. As such this, information did not influence my finding.

In relation to Consumer D, I find the consumer did not have their pain effectively monitored. I have relied on the evidence which shows the consumer had a change in pain medication and incomplete monitoring completed.

In relation to Consumer E, I find the consumer’s care and service needs were not reviewed following the medication incidents and appropriate investigation, analysis and review was not undertaken.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Non-compliant with Requirement (3)(e) in Standard 2 Ongoing assessment and planning.

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

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

The Assessment Team has recommended the service does not meet Requirements (3)(a), (3)(b), (3)(d), (3)(e) and (3)(g) in Standard 3, as the service was unable to demonstrate:

* personal and clinical care is always best practice; tailored to their needs; and optimises consumers’ health and well-being;
* all significant risks associated with the care of consumers have been identified and assessed;
* they consistently recognise and respond in a timely manner to deterioration or changes in consumers’ mental health, cognitive or physical function, capacity or condition;
* all information is documented and communicated within the organisation and with others where responsibility for care is shared; and
* an effective COVID-19 risk management plan and adequate screening practices.

I have considered the Assessment Team’s findings; the evidence documented in the Assessment Team’s report and the provider’s response and find the service non-compliant with Requirements (3)(a) and (3)(g). I have provided reasons for my findings under the specific Requirements below.

In relation to all other Requirements in this Standard, all consumers said they had access to the medical officer and allied health staff.

Processes support the identification of needs, goals and preferences of consumers nearing the end of life. The service has recently commenced operations and whilst no consumers have neared end of life, they were able to describe how they would involve other specialist providers of palliative care services. The organisation has policies and procedures to guide staff in advance and end of life care.

The service demonstrates consumers are referred to individuals, and other organisations and providers of other care and services in a timely and appropriate manner. Documentation sampled showed evidence of referrals being undertaken and consultation with consumers and staff for input.

Based on this evidence, I find the service to be compliant with Requirements (3)(b), (3)(c), (3)(d), (3)(e) and (3)(f) in Standard 3 Personal care and clinical care.

### Assessment of Standard 3 Requirements

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

*Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:*

1. *is best practice; and*
2. *is tailored to their needs; and*
3. *optimises their health and well-being.*

The Assessment Team were not satisfied the service was able to demonstrate personal and clinical care is always best practice; tailored to their needs; and optimises their health and well-being. Specifically, this related to management of restrictive practices, continence care, complex health care and behaviour management. This was evidenced by:

* Consumer A had a diagnosis associated with pain and displayed behaviours of concern. Records showed the consumers exhibited behaviours of agitation and verbal and physical aggression throughout their stay. Progress notes indicate the consumer was continually reactive to staff when they attended to their personal care, such as continence and showers. The consumer was commenced on a psychotropic medication to manage their behaviours. Progress notes documented reviews by the physiotherapist, dietitian, dementia services and the diversional therapist. There was no formal assessment and care plan evident to identify and manage the consumer’s behaviours to inform service delivery. In addition, behaviour and pain monitoring was not undertaken. The care plan was an interim care plan and did not include specific strategies. Strategies recommended by the dementia service were documented in the progress notes instead of the care plan. The representative said they were generally happy with the care provided and staff tried very hard to help and were able to de-escalate the consumer’s behaviours well. Staff said they had difficulties and needed family to be present, as the consumer was aggressive towards staff and wanted to go home.
* Consumer B was reviewed by the medical officer seven days prior to the Site Audit who recommended observations are to be completed daily. The observations were completed on two of the seven days. The consumer also had specialised nursing needs, which did not have management plans to effectively instruct staff on all aspects of the specialised nursing needs. The consumer was overall satisfied with the care being provided. Staff interviewed were aware of some aspects of the consumer’s specialised nursing needs. Consumer B was ordered a regular medication, however, on one day, the medication chart shows the medication was not administered. In addition, the charts showed another medication is to be administered every second, however, the medication chart showed the medication was administered daily for a three-day period. No incident forms were completed, and this was identified by the Assessment Team.
* Consumer C expressed they are frustrated as staff are not able to effectively communicate with them and do not understand their care and service needs. A relevant assessment and plan have not been completed to manage the consumer’s sensory care and service needs. In addition, the consumer had a specialised nursing need and brief directions were recorded in the progress notes. A specialised management plan was not developed. The consumer was satisfied with the management of their specialised nursing need. The consumer expressed they have pain and a relevant assessment and management plan was not developed. The interim care plan notes the consumer is unable to self-medicate their own medication, however, the consumer advised they do self-medicate a medication. Staff were aware the consumer self-medicates one medication but were not aware of the other medication being self-administered.
* Consumer D expressed dissatisfaction in relation to their continence management and provided examples of how it was impacting them. A specific assessment and care plan had not been developed to manage the consumer’s continence. Pain charting identifies the consumer has pain in various areas. However, management strategies have not been developed.
* Consumer E said their pain was manageable and is provided conservative treatment by allied health staff. The consumer’s pain medication was ceased, and another was commenced. However, the time difference was approximately two days and an incident form was not completed. Staff noted the consumers pain levels vary. Records showed the consumer has no pain assessment or care plan. In addition, the medical officer requested a daily observation to be completed and provided. On two occasions they were out of range which were not reported.
* Consumer F said they are satisfied with the care being provided and staff know his preferences. The consumer has an interim care plan.

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* Indicated the failure was predominantly in documentation.
* Will be reviewing their admission process and the assessments that are undertaken.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I find the service was not able to 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. This specifically related to the management of behaviours of concern, specialised nursing needs, pain management, continence management, medication management and monitoring and actioning reportable ranges.

In relation to Consumer A, I have placed weight on the feedback from staff and records from progress notes which indicate the consumer’s behaviours of concern were not being effectively managed. In addition, I acknowledge the involvement of other service providers in assessing the consumer, however, a holistic assessment and management plan to support service delivery was not undertaken in line with best practice to optimise the consumer’s health and wellbeing.

In relation to Consumer B, I have noted the consumer did not have specific specialised management plans for both of the consumer’s specialised nursing needs. I have noted staff were able to describe how they manage aspects of one of the specialised nursing needs. However, in the absence of relevant assessment and planning and noting the medication incidents, care and service delivery was not in line with best practice to optimise the consumer’s health and wellbeing. In addition to support my view, I have noted the recommendation made by the medical officer which was not followed.

In relation to Consumer C, I have noted the consumer was not provided care and services in line with best practice to support their wellbeing. To support my view, I have noted the consumer’s feedback in relation to their sensory impairment and the insufficient assessment and planning to support staff care and service delivery. In addition, I have noted the consumer had pain and relevant assessment and planning to manage the consumer’s pain was not undertaken to support service delivery. Finally, I have considered the consumer was assessed as unable to self-medicate and was subsequently self-medicating a medication which was not prescribed by the medical officer to support their overall health and well-being and in line with best practice.

In relation to Consumer D, I have noted they were dissatisfied with the management of their continence and relevant assessment and planning was not complete to support effective service delivery. In addition, the consumer was identified as having ongoing and unmanaged pain, however, relevant strategies have not been developed to support the consumer’s health and wellbeing.

In relation to Consumer E, I have noted the staff did not follow the medical officer’s direction in line with best practice to support the consumers well-being. This specifically related to medication management and associated pain and the ordered observations with reportable ranges. I have also noted that staff recognise the consumer’s pain varies and whilst the consumer had an allied health assessment outlining strategies, a holistic pain management plan was not completed to support the consumers health and well-being.

In relation to Consumer F, I have noted the consumer was satisfied with the care and services being provided and had an interim care plan. I find the consumer was being provided care and services which were tailored to the consumers needs and I have considered this information.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Non-compliant with Requirement (3)(a) in Standard 3 Personal care and clinical care.

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

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

The Assessment Team were satisfied the service was able to demonstrate systems are in place to manage high impact or high prevalence risks associated with the care of each consumer. However, these systems were not effective, as all significant risks associated with the care of consumers have not been identified and assessed. This was evidenced by:

* Sampled consumers’ care planning documentation does not include assessment of all risks.
* Consumer A does not have a behaviour support plan. An incident occurred approximately one week prior to the Site Audit, where the consumer threw an object, and this was reported as a SIRS incident.
* Consumer B has specialised nursing needs, and these have not been assessed and planned for.
* Consumer C has a specialised nursing care need and appropriate assessment and management strategies have not been developed. In addition, the consumer is self-medicating which was not assessed and planned for.
* Staff could generally describe high impact or high prevalence risks for sampled consumers.
* An allied health staff worker was aware of the falls risk for a consumer.
* Consumers’ high impact or high prevalence risks are documented on interim care plans.
* The organisation has systems to trend, analyse and respond to high impact high prevalence risks. However, the service does not yet have clinical data to be included for review. Data from incident reporting has not yet been included in the three-monthly data reports.

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* Discussed a range of processes which were implemented prior to the Site Audit to effectively communicate high impact and high prevalence risks.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I find the service was able to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer.

In coming to my finding. I have noted the core issues identified for Consumers A to C are more aligned with Requirement (3)(a) in this Standard and Standard 2 Requirements (2)(a) and (2)(e). I have therefore considered this information under these respective Requirements. I have also noted the service has been open for a short period and have considered this as part of my decision. I have relied on the feedback which indicated staff were able to overall describe high impact and high prevalence risks for individual consumers and these were documented in the care plan. I have also noted the service has processes to identify and record trends in incidents data to manage and monitor high impact and high perveance risks for individual consumers.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Compliant with Requirement (3)(b) in Standard 3 Personal care and clinical care.

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

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

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

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

The Assessment Team were not satisfied the service consistently recognises and responds in a timely manner to deterioration or changes in consumers’ mental health, cognitive or physical function, capacity or condition. This was evidenced by:

* Consumer A had an incident of bruising which was not documented in an incident form and strategies were not implemented.
* Consumer B did not have two medications administered as ordered.
* Consumer C had pain monitoring which was incomplete following changes in medication. In addition, orders made by the medical officer in relation to specific observations and reportable ranges have not been completed and actioned.
* Consumer D sustained bruising, however, incident forms were not completed and preventative measures were not implemented.
* Consumer E did not have a skin assessment completed despite the consumer being overheard by the Assessment Team complaining of pain during the Site Audit. The comprehensive care plan did contain strategies to manage the consumer’s skin which included preventative measures such as a pressure area matters and cushion.
* One consumer explained to the Assessment Team that they experienced three episodes involving their bowels overnight during the Site Audit. Bowel charts showed the service was monitoring the consumers bowels with two entries recorded.
* A clinical staff member provided an example of when a consumer’s deterioration or change in their condition was recognised and responded to.
* The organisation has policies and procedures for supporting staff to recognise and respond to deterioration or changes in a consumer’s condition.

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* Indicated the service has relevant policies and procedures and deficits are attributed to staff application.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I find the service was able to 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.

In relation to Consumers A to E, I have considered the evidence in my finding in Standard 2 Requirements (3)(a) and (3)(e) and Standard 3 Requirement (3)(a), as the core issues relate to deficits in assessment and planning processes and best practice care delivery. In coming to my finding I have noted and relied on the evidence where a clinical staff member had responded to a consumer’s deterioration. In addition, I have noted the service has relevant policies and procedures to support the identification of deterioration. Finally, I have relied on information under Requirement (3)(e) in this Standard, which indicates effective and timely clinical referral processes to health providers, such as medical and other specialist services and allied health.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Compliant with Requirement (3)(d) in Standard 3 Personal care and clinical care.

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

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

The Assessment Team were not satisfied the service was able to demonstrate all information is documented and communicated within the organisation and with others where responsibility for care is shared, as consumers have not been adequately assessed to inform a comprehensive care plan. This was evidenced by;

* All consumers are under respite care and therefore have not yet undergone a full suite of assessments.
* Interim care plans are available on the electronic care management system. However, interim care plans contain minimal details, no strategies and do not include consumers’ needs, goals and preferences.
* Three consumers provided examples in relation to ineffective communication. Consumer A indicated staff do not talk to each other. Consumer B indicated staff do not know how to communicate with consumers with a hearing impairment. Consumer C indicated staff were unable to find their medication.
* Management said the staff have a half hour handover time between each shift.
* The handover sheet is generated from the electronic system and contains only details allied health staff have entered into consumers’ assessments; mobility and falls prevention. Other significant information is not recorded.

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* A range of processes support effective communication which included shift reports, diary and email communication.
* Potential risk and issues identified have not crystallised and an adverse outcome has not occurred.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I have come to a different view and find the service was able to 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.

In coming to my finding, I have considered the core deficits relate to other Requirements, specifically in Standard 2 Assessment and planning with consumers and Standard 3 Personal care and clinical care and this has been reflected in the report. I have considered evidence which indicates consumers have interim care plans and processes exist, such as handovers and shift reports to support effective communication. In addition, I have noted evidence in Requirement (3)(f) in this Standard confirming effective communication to individuals and other organisations and providers of care and services.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Compliant with Requirement (3)(e) in Standard 3 Personal care and clinical care.

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

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

### 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 were not satisfied the service was able to demonstrate an effective COVID-19 risk management plan and adequate screening practices. The service has systems to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. This was evidenced by;

* Staff confirmed they have received training in hand hygiene and donning and doffing personal protective equipment (PPE). Staff said they have adequate supplies of PPE available.
* The organisation has written procedures relating to infection control and practices to reduce the risk of resistance to antibiotics.
* The Assessment Team identified a number of listed items were not in the COVID-19 outbreak kit.
* Pens were shared between visitors. There was no process to separate clean and dirty pens.
* Staff were observed not washing their hands between attending to consumers. No hand sanitiser dispensers were observed in the corridors. Management said they are planning to install hand sanitisers in each consumer’s room.
* The service has a COVID -19 outbreak management plan, however, deficits were noted.
* Rapid antigen tests were given to visitors to attend themselves in the café area. No instruction on how to use the rapid antigen tests was observed.
* Processes support the vaccination of consumers.
* Consumers are being visually observed daily for COVID-19 symptoms.
* Management said all staff undergo competencies for PPE donning and doffing and hand washing.
* Systems support antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* Asserts they were aware Commission staff were vaccinated following communication from the Commission. All other visitors are assessed on entry.
* All visitors are screened for COVID-19 on entry.
* Indicated COVID-19 has not been documented to be transmitted through a surface.
* Management report plentiful supplies of PPE and access to more if required through the organisation. PPE is available to staff and additional PPE is available.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I find the service was not able to demonstrate minimisation of infection related risks through implementing standard and transmission-based precautions to prevent and control infection, specifically in light of the current pandemic. The service was able to demonstrate practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.

In coming to my finding I have considered the totality of evidence in light of the current pandemic and risks posed to consumers. I have placed weight on the observations made by the Assessment Team, specifically in relation to ineffective infection control practices. In addition, I have considered and noted the outbreak kit did not contain relevant items as planned. Moreover, I noted observations of screening processes occurring in the café, which is a common area. Finally, I have noted deficits in the outbreak management plan to support my finding.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Non-compliant with Requirement (3)(g) in Standard 3 Personal care and clinical care.

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

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

The Assessment Team has recommended the service does not meet Requirement (3)(d) in Standard 4, as the service was unable to demonstrate information about consumers’ condition, needs and preferences are communicated within the organisation, specifically in relation to care planning.

I have considered the Assessment Team’s findings; the evidence documented in the Assessment Team’s report and the provider’s response and find the service Compliant with Requirement (3)(d). I have provided reasons for my findings under the specific Requirement below.

In relation to all other Requirements in this Standard, the following examples were provided by consumers and representatives during interviews with the Assessment Team:

* most consumers sampled indicated that they are receiving the supports and services for their daily living;
* consumers are satisfied they receive services which promote their emotional, spiritual and psychological well-being;
* overall majority enjoyed the activities on offer; and
* consumers said they are satisfied with the meals.

Initial and ongoing assessment processes assist to identify each consumer’s goals, needs and preferences relating to lifestyle and activities and emotional, spiritual and cultural support. Additionally, consumers’ life history, past interests and activities and current lifestyle choices are also identified in the ‘about me’ portion of the assessment. Lifestyle staff described how they monitor the activities program. The Assessment Team observed four consumers enjoying the music therapy in the dining area during the Site Audit.

Consumer files sampled demonstrated consumers’ emotional, spiritual and psychological well-being needs and preferences are identified and assessed. Lifestyle staff indicated they have connected to the local churches and the local Pastor. Posters were observed to support the wellbeing of consumers informing them of emotional support services available.

Services and supports assist consumers to participate in the community, have social relationships and do things of interest to them. Documentation identified relationships important to individual consumers. Consumers interviewed were aware of the activities. Staff interviewed were able to provide examples of how they supported consumers to do things that were not on the activities calendar and how they plan to engage consumers within the community.

Meals provided are varied and of suitable quality and quantity. Food focus groups are to be implemented in the near future to support consumer involvement in menu planning. Catering staff described how consumers are provided with the choice of selecting their meals on a daily or weekly basis. Observations showed catering staff understanding the food preferences of individual consumers.

Based on this evidence, I find the service to be compliant with all Requirements in Standard 4 Services and supports for daily living.

## Assessment of Standard 4 Requirements

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

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

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

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

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

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

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

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

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

The Assessment Team were not satisfied the service was able to demonstrate all information about consumers’ condition, needs and preferences are communicated within the organisation, specifically in relation to care planning. This was evidenced by:

* One consumer expressed concern that staff did not effectively communicate with each other in relation to their request of having an extra tissue box.
* Staff indicated that they are kept informed of consumers changing conditions and needs during handovers between shifts, and the director of nursing receives a shift report.
* Nursing staff indicated that staff may not know consumers’ lifestyle preferences, as the clinical care coordinator position was vacant.
* Lifestyle staff said they constantly talk to the consumer and their families on their interests.
* Care planning documentation showed inconsistencies amongst the consumers’ needs and preferences, where some care plans contained consumers’ lifestyle information and others did not.
* Care planning documentation showed that in some care plans information required for sharing consumers’ needs and conditions is not kept up to date and is incomplete. Consumers’ conditions and dietary requirements were not reflected in progress notes and care plans. Staff indicated that care plans may not contain important consumer information.

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* The service has an electronic documentation system and consumers have interim care plans.
* Communication at the service occurs both verbally and also through written communication.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I have come to a different view to the Assessment Team and find the service was able to demonstrate information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.

In coming to my finding, I have noted all consumers had an interim care plan and the service has an electronic documentation system. In addition, I have noted and considered the evidence which showed staff are kept informed of consumers changing conditions and needs during handovers between shifts, and the shift reports. Furthermore, I have noted the service has processes for lifestyle staff to communicate with consumers and representatives and to document this information in the electronic documentation system. I have also considered that communication processes have not attributed to deficits in services and supports for consumers’ daily living. Finally, I have considered that the service had newly opened and all the consumers were on respite and were in the assessment phase of their admission process.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Compliant with Requirement (3)(d) in Standard 4 Services and supports for daily living.

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

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

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

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

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

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

# STANDARD 5 NON-COMPLIANT Organisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

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

The Assessment Team has recommended the service does not meet Requirements (3)(a) and (3)(b) in Standard 5, as the service was unable to demonstrate:

* it promotes a service environment that is easy to understand, optimises each consumer’s sense of belonging, independence, interaction and function; and
* is safe, clean, enabled consumers to move freely, both indoors and outdoors.

I have considered the Assessment Team’s findings; the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirement (3)(b). I have provided reasons for my findings under the specific Requirements below.

In relation to the other Requirement in this Standard, consumers interviewed did not raise any concerns regarding the cleanliness, maintenance or suitability of their equipment and said they know who to contact if things are not working.

The service demonstrates that the furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. This includes cleaning, laundry and maintenance schedules. Consumers indicated they were satisfied with the cleanliness of their rooms and equipment. The furniture, fittings and equipment were observed by the Assessment Team to be clean, well maintained and appeared safe.

Based on this evidence, I find the service to be compliant with Requirements (3)(a) and (3)(c) in Standard 5 Organisation’s service environment.

## 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.*

The Assessment Team were not satisfied the service was able to demonstrate it promotes a service environment that is easy to understand, optimises consumer’s sense of belonging, independence, interaction and function. This was evidenced by:

* Consumer rooms are identifiable by room number only, do not have their names or photos and most rooms have not been personalised with consumers’ belongings.
* Wayfinding signage is located at lift entrances, in the form of a floor directory and there are signs guiding to consumer rooms. However, there is no signage to guide consumers and visitors to dining areas or facilities located in the lower ground of building B.
* The service has not demonstrated that it has incorporated dementia enabling design principles throughout the service environment.
* Two consumers interviewed indicated they were satisfied with the environment.
* Management indicated the building is designed as a neighbourhood model where like-minded people would be paired together to build small communities.
* The service currently does not have a memory support unit and has not demonstrated dementia enabling design principles. However, for one consumer, the service provided a dementia friendly toilet sign.
* All floors have a nurse’s station, dining and TV areas with ground floor providing direct access to the garden area.
* The Assessment Team observed there are no handrails in any of the service’s common corridors. However, corridors were observed to be wide and brightly light to allow for consumers to move freely.
* The entrance area consists of the reception, sitting area and café. There is minimal wayfinding signage for consumers, however floor directories are located at each of the lift entrances

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* Evidence which indicates they have considered best practice processes in designing the service environment to support consumers living with cognitive impairment and have considered the need and use of hand rails.
* Recognised all consumers living at the service were on respite and whilst they encourage consumers to personalise their rooms, all were new at the service. In addition the Resident Agreement and handbook encourages consumers to personalise their rooms.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I have come to a different view to the Assessment Team and find the service was able to demonstrate the service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.

I have also considered and placed weight on the evidence from the two consumers interviewed who expressed satisfaction with the environment. Furthermore, I have considered the evidence which showed the service had considered the use of handrails and also had implemented dementia specific aids to support consumers living with dementia. Finally, I have considered the use of floor directories to support consumers in their wayfinding.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Compliant with Requirement (3)(a) in Standard 5 Organisation’s service environment.

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

*The service environment:*

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

The Assessment Team were not satisfied the service environment is safe, clean, enabled consumers to move freely, both indoors and outdoors. However, noted the service is new and appeared well maintained and comfortable. This was evidenced by:

* The utility room opens directly into the dining area and was kept ajar with staff entering with dirty linen during a lunch service. Construction and landscaping work zones were not cordoned off appropriately.
* The door handle used to access the garden was incorrect and once exited, the door was locked from the outside. During the Site Audit management had conducted a review of all door handles after it was identified that an incorrect door handle was used for the garden access.
* The garden area does not have a seamless transition between pavement and artificial grass, the artificial grass is uneven to walk on, large pot plants are obstructing the pathway.
* The service environment was observed to clean and clutter free, with no malodours or pests sighted during the Site Audit.
* The ground floor nurses’ station door opened outwards directly into the corridor and did not have an observation window.
* The Assessment Team observed that the garbage room door was unlocked and contained bins for cytotoxic waste, clinical waste, recycling, general waste and construction waste bins.
* Landscaping was being conducted during the Site Audit and the work area was not cordoned off.
* Most consumers sampled indicated that the service environment was safe, clean and well maintained and they could access all areas of the service environment.
* Most staff interviewed were able to describe the process for maintenance requests by entering the request into the electronic maintenance system. They indicated that maintenance requests were actioned promptly.

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* The provider is addressing the issues in the report.
* Recognised the challenges in light of the current economic climate in relation to building works.
* Noted the significant rain events which had impacted on the artificial grass.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I find the service was not able to demonstrate the service environment is safe and enables consumers to move freely.

In coming to my finding, I have considered the evidence in relation to safety. This specifically related to the ground floor nurses’ station which opened outwards with no viewing window and posed a risk to consumers. In addition, I have considered the uneven floor surfaces in the outdoor environment and obscured footpaths as a further risk to consumers. Finally, I have noted the works being completed without appropriate cordoning off and noted the garbage room door was unlocked and contained bins for cytotoxic waste, clinical waste, recycling, general waste and construction waste bins posing a further to consumers’ safety.

In relation to the environment enabling consumers to move freely throughout the service. I have considered the evidence which showed the outdoor service environment had a one-way locking door which would prevent free movement and pose a risk to consumers. I have noted the service is in the process of reviewing and undertaking appropriate actions to address issues identified during the Site Audit.

I have considered the evidence in relation to the service having process to ensure appropriate maintenance is undertaken. In addition I have noted and considered the evidence which showed the environment was clean.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Non-compliant with Requirement (3)(b) in Standard 5 Organisation’s service environment.

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

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

# STANDARD 6 COMPLIANT Feedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

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

The Assessment Team has recommended the service does not meet Requirements (3)(b) and (3)(c) in Standard 6, as the service was unable to demonstrate:

* consumers are aware of and have access to advocates, language services and other methods for raising and resolving complaints; and
* appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

I have considered the Assessment Team’s findings; the evidence documented in the Assessment Team’s report and the provider’s response and find the service Compliant with Requirement (3)(b) and (3)(c). I have provided reasons for my findings under the specific Requirements below.

In relation to the other Requirements in this Standard, the following examples were provided by consumers and representatives during interviews with the Assessment Team:

* consumers and representatives consider they are encouraged and supported to provide feedback and make complaints; and
* consumers interviewed said management are responsive to their feedback and complaints and are satisfied with the improvements made in response to their complaints.

Consumers, their family, friends, and others are encouraged and supported to provide feedback and make complaints. Mechanisms to provide feedback include feedback forms and meetings. Staff interviewed commented they assist consumers who need help to fill out the feedback form and escalate any complaint from consumers and representatives to the registered nurse or manager. The admission pack and handbook outline the processes and mechanisms for providing feedback and making complaints including internal processes, external mechanisms and advocacy services.

Feedback and complaints are reviewed and used to improve the quality of care and services. Feedback and complaints identify opportunities for improvement. Staff interviewed were aware of the main areas of complaints, including catering services and laundry. Management explained they review all feedback and it is managed in line with the feedback and complaints policy and procedure to identify opportunities for improvement.

Based on this evidence, I find the service to be compliant with all Requirements in Standard 6 Feedback and complaints.

## 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.*

The Assessment Team were not satisfied the service was able to demonstrate consumers are aware of and have access to advocates, language services and other methods for raising and resolving complaints. This was evidenced by;

* All consumers interviewed were not aware of advocacy and external agencies to resolve complaints.
* The service demonstrates that information is provided to consumers about how to access advocates and other methods for feedback and complaints via admission pack and handbook.
* The service’s complaint system did not support consumers who have communication issues such as poor vision, hearing loss or cognition impairment.
* Most staff interviewed could not describe how to identify when consumers may need support from advocacy, language and hearing services and how to contact those complaint advocacy services. Management said that currently all consumers can communicate in English and none of them require translation and interpreting services. However, if required, the service will provide consumers with information and help them to access the interpreter service. Management explained the service communicates with the representatives of consumers who are living with a cognitive impairment and they are provided with opportunities to provide feedback and make complaints

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* Reaffirmed the respite agreement and handbook provides relevant information in relation to the Requirement.
* Feedback forms are available at the service and other documentation in relation to advocacy services and external complaint mechanisms near the entrance of the service and on various levels.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I have come to a different view to the Assessment Team and find the service was able to demonstrate consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.

In coming to my finding, I have considered the evidence which showed consumers and representatives are provided relevant information in relation to this Requirement. This includes on entry through the respite/resident agreement and also through a range of brochures and noticed boards which are available throughout the service. I have noted the feedback from consumers in relation to them not being aware of advocacy services and have considered this an area for improvement. Finally, I have noted the service has been open for a short period of time and as such has had limited opportunity and need to engage advocacy services and other methods for raising a complaint. To further support my view, other mechanisms to inform consumers and representatives such as newsletters and consumer meetings would be in their infancy.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Compliant with Requirement (3)(b) in Standard 6 Feedback and complaints.

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

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

The Assessment Team were not satisfied the service was able to demonstrate appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. Specifically staff were not aware of open disclosure practices and the service not being responsive to verbal feedback. This was evidenced by:

* The service demonstrated it takes appropriate action in response to complaints that have been recorded in the feedback register. The service feedback register showed that all complaints were closed.
* One consumer said they initially provided verbal feedback in relation to meal preferences, and following not having their issue addressed, provided written feedback. The consumer was satisfied with the outcome.
* One consumer provided feedback in relation to being dissatisfied with the verbal process as their concern in relation to the tissue box required multiple verbal requests but had been subsequently addressed.
* Management explained the process of open disclosure and provided examples of where this had been applied.
* Most staff interviewed were able to explain how they would respond to consumer complaints. They said they would offer consumers a feedback form to fill out and would notify the registered nurse or care manager. The staff interviewed were aware of the open disclosure policy but unable to describe how they implement it in their day-to-day practice.
* The service has a feedback and complaints management policy and an open disclosure policy on its online policy portal.
* Most staff interviewed said they have not attended training on open disclosure. Training on open disclosure is scheduled to occur in June 2022.

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* The service had been open for a short period and since then, 37 items of feedback had been recorded and actioned.
* The orientation process for staff includes an overview of the Standards which includes open disclosure as will future toolbox sessions
* Affirmed the view that those undertaking the investigation are primarily responsible for open disclosure practices.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I have come to a different view to the Assessment Team find the service was able to demonstrate appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

In coming to my finding, I have considered the evidence which showed the service is identifying, recording and actioning feedback. In addition, I have noted management are aware of open disclosure principles and were able to provide specific examples. Furthermore, staff were able to describe how they support consumers to provide feedback. I have also considered the consumer feedback which indicates feedback provided is addressed. To further support my view on staff being aware of open disclosure, I have considered the evidence provided in relation to the current training on feedback and future plans on further training which has been scheduled.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Compliant with Requirement (3)(c) in Standard 6 Feedback and complaints.

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

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

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

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

The Assessment Team has recommended the service does not meet Requirements (3)(a), (3)(c) and (3)(d) in Standard 7, as the service was unable to demonstrate:

* the workforce was planned to enable, and the number and mix of members of the workforce deployed enabled, the delivery and management of safe and quality care and services;
* staff are competent and have the knowledge to effectively perform their roles; and
* staff had the relevant skills and knowledge to deliver effective care and services.

I have considered the Assessment Team’s findings; the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirement (3)(c). I have provided reasons for my findings under the specific Requirements below.

In relation to the other Requirements in this Standard, most consumers sampled, said they find staff are kind, caring and gentle when providing care.

Workforce interactions with consumers were observed to be kind, caring and respectful. Assessment processes ensure staff are aware of consumers’ identity and culture to support respectful care and service delivery.

The service demonstrated regular assessment, monitoring and review of the performance of each member of the workforce. The service provided records showing staff performance is monitored in line with their staged 12-month new employee review system. Policies and procedures support the staff performance framework.

Based on this evidence, I find the service to be Compliant with Requirements (3)(a), (3)(b), (3)(d) and (3)(e) in Standard 7 Human resources.

## 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 were not satisfied the service was able to demonstrate the workforce was planned to enable, and the number and mix of members of the workforce deployed enabled, the delivery and management of safe and quality care and services. This specifically related to effective workforce contingency planning following the resignation of a staff member in the clinical leadership group. This was evidenced by:

* Overall consumers did not identify issues regarding the adequacy of staff numbers. Sampled consumers said when they ring the call bell it is usually answered quickly, and they usually do not need to wait long if they need help to move around the service or go to the toilet. Review of call bell and sensor mat response times showed that overall, call bell response times were under 10 minutes and most were less than 5 minutes.
* Management were able to describe how they address extended call bell wait times and actions implemented for individual consumers.
* The management team stated that the loss of their clinical care coordinator, who was responsible for developing interim care plans, soon after the service opened, negatively impacted their care planning capacity. The service recruited a replacement staff member who recently commenced in the role.

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* The service had recruited a replacement clinical staff member 19 days following the previous staff members resignation.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I have come to a different view to the Assessment Team and find the service was able to 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.

In coming to my finding I have considered the service has been open for a short period of time. I have noted the feedback from consumers indicating sufficiency of staffing. In addition, I have noted the call bell response data and actions taken to address increased call bell wait times for individual consumers. In relation to the effective workforce contingency planning, I have considered this in Standard 8 Requirement (3)(c) in relation to workforce governance.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Compliant with Requirement (3)(a) in Standard 7 Human resources.

### 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 were not satisfied all staff are competent and have the knowledge to effectively perform their roles. This was evidenced by:

* Two of four consumers interviewed raised issues around staff competence. One consumer provided an example of one staff member not being able to effectively communicate with them who has a sensory impairment and another consumer provided an example of staff not being aware of how to use a hoist lifter.
* Management described the competency matrix which is completed based on a set schedule.
* The quality and education manager said the service tracks training and competency assessment completions on its learning management system.
* The knowledge and skill gaps identified by the Assessment Team including comprehensive care planning and review including using the electronic care planning system, incident reporting, managing challenging behaviours and complex clinical care.

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* Described the recruitment of only suitably skilled and qualified staff and the relevant checks completed.
* Described the current challenges faced by the industry.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I find the service was not able to demonstrate the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

In coming to my finding, I have considered the deficits in Standard 2 and Standard 3 in my finding. These deficiencies included staff practices in identifying and managing; consumers behaviours of concern, specialised nursing needs, incidents, pain management and infection control practices. I recognise the service has an onboarding and competency process based on a set schedule and matrix. However this process was not effective in ensuring staff have the relevant skills and knowledge to effectively perform their roles.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Non-compliant with Requirement (3)(c) in Standard 7 Human resources.

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

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

The Assessment Team were not satisfied staff had the relevant skills and knowledge to deliver effective care and services following a review of care documentation. This was evidenced by:

* The service has a documented orientation and induction program with regular reviews and competency assessments, and mandatory training programs. It also has an annual performance review process that has not yet been evaluated because of the length of time the service has been open. Records for mandatory training and competency assessments completions were provided by the service.
* Some of the areas identified were already included in the service’s plan for continuous improvement.
* Two consumers interviewed raised issues in relation to staff training. One consumer provided an example of one staff member not being able to effectively communicate with a them who has a sensory impairment and another consumer provided an of staff not being aware of how to use a hoist lifter.
* Two care staff said they feel well supported in their roles and management were responsive and helpful.
* On staff member said they have not been trained on the electronic documentation system.
* Most staff interviewed said they had not attended training on open disclosure.
* The quality and education manager described how staff were trained in relation to the new SIRS/incident management system (IMS) requirements. She said staff completed the training on the learning management system, through onsite induction by the director of nursing who provides role specific training, and the corporate induction provides a high level over view of SIRS/IMS for all staff.
* The quality and education manager described the organisation’s processes for identifying staff training needs and feeding these into the training schedule. She said the service’s annual training calendar incorporates regulations and predictions based on industry trends and changes, performance appraisal data, learning needs identified by the director of nursing and/or indicated in proposed staff and consumer satisfaction surveys. Incident reporting data is fed into the ongoing monthly training calendar and data from moving on audits (MOA) will also be used in the future. The service had its first MOA in May 2022, and data from the report will be considered when the MOA report is released in June 2022. Significant trends from the report will be incorporated in one day workshops for registered nurses and care staff to be delivered in June 2022.
* Deficits in staff awareness of open disclosure practices.
* Training records showed all staff have completed their mandatory training modules which included SIRS and IMS.

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* The service only employs staff with the relevant skills and qualifications.
* Described the six-month probationary period.
* Acknowledged the feedback provided in relation to the electronic care management system and incident and risk reporting.
* After six weeks of operation the service had provided significant training to staff.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I have come to a different view and find the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these Standards.

In coming to my finding, I have placed weight on the evidence which shows the service has a documented orientation and induction program with regular reviews and competency assessments, and mandatory training programs. I have also noted some of the areas and issues identified by the Assessment Team were documented in the service’s plan for continuous improvement. I have considered the feedback from consumers and deficits in staff competency, skills and knowledge in my finding in Requirement (3)(c) in this Standard. To further support my view, I have also considered the prompt recruitment of staff to support care and service delivery during the current workforce challenges. Finally, I have considered the feedback from staff which showed they are supported in their roles and are provided orientation processes.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Compliant with Requirement (3)(d) in Standard 7 Human resources.

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

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

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

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

The Assessment Team has recommended the service does not meet Requirements (3)(b), (3)(c), (3)(d) and (3)(e) in Standard 8, as the service was unable to demonstrate:

* the governing body receives complete and accurate data on incidents and risk to be effectively accountable for the delivery of safe, quality care and services;
* effective organisation wide governance systems relating to information management; continuous improvement; workforce governance, including the assignment of clear responsibilities and accountabilities, regulatory compliance and feedback and complaints;
* effective risk management practices and process specifically in relation to incident management and effective protectives in relation to managing high impact or high prevalence risks; and
* clinical quality and risk committee provides effective oversight of the clinical governance system.

I have considered the Assessment Team’s findings; the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirements (3)(d) and (3)(e). I have provided reasons for my findings under the specific Requirements below.

In relation to the other Requirement in this Standard, on the whole consumers interviewed confirmed that the service is well run.

Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. The organisation was able to demonstrate a commitment to consumer engagement having held its first consumer and representative meeting within 6 weeks of opening. Sampled consumers expressed they felt comfortable providing feedback and raising concerns with staff to support the development, delivery and evaluation of care and services.

Based on this evidence, I find the service to be Compliant with Requirements (3)(a), (3)(b) and (3)(c) in Standard 8 Organisational governance.

## Assessment of Standard 8 Requirements

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

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

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

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

The Assessment Team were satisfied the service was able to demonstrate the governing body’s commitment towards promoting a culture of safe, inclusive and quality care and services. However, were not satisfied the governing body receives complete and accurate data on incidents and risk to be effectively accountable for the delivery of safe, quality care and services. This was evidenced by:

* The service did not demonstrate that the governing body receives completed and accurate data on incidents and risk to be effectively accountable for the delivery of safe, quality care and services.
* The board was able to describe how they implemented a volunteer program and recruited a coordinator following feedback.
* The chairman said that both executives review the shift reports from the service every day and are actively involved in supporting the service to resolve any issues as they arise. The chairman also noted clinical indicators are discussed in meetings at all levels of the organisation. In response to a recent increase in falls incidents the service created a specific falls committee to consider causative factors and recommend strategies to reduce the falls risk.
* The Board are provided a range of data including the national quality indicators, consumer and representative survey results - with performance benchmarked against other like organisations.

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* The service has been operating for a short period and has an audit schedule implemented.
* The executives and Board members attend the service regularly and are provided summaries of meetings.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I have come to a different view to the Assessment Team and find the service was able to demonstrate the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

In coming to my finding, I have considered the evidence which showed the organisation has processes to promotes a culture of safe, inclusive and quality care and services. I have noted a range of reports are provided to the Board and executives, who regularly attend the service. To further support my view I have noted the recent implementation of the volunteer program approved by the Board and executives. I acknowledge the Assessment Team’s evidence which indicates the governing body may have not received complete and accurate data, however, this has been considered within the scope of Requirements (3)(d) in this Standard, specifically relating to managing and preventing incidents, including the use of an incident management system.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Compliant with Requirement (3)(b) in Standard 8 Organisational governance.

### 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 found the service was able to demonstrate effective organisation wide governance systems relating to financial governance, however, they were not satisfied the service was able to demonstrate effective organisation wide governance systems relating to information management; continuous improvement; workforce governance, including the assignment of clear responsibilities and accountabilities, regulatory compliance and feedback and complaints. This was evidenced by:

* In relation to information management, overall staff did not raise any issues about communications regarding changes to policies and procedures. One staff said it is hard to locate the information on the electronic system in relation to policies and one incident of ineffective handover at night.
* In relation to continuous improvement the Assessment Team identified that the service’s incident management data is not complete, which means that some critical incident types/trends may not be included in the continuous improvement plan. Management stated that opportunities for continuous improvement are identified from consumer feedback, audit outcomes, research, needs analysis, networking incident reports and the risk register. This was reflected in the corporate governance framework.
* In relation to financial governance the chief executive officer said the service recently gave staff a significant pay increase of 10% to recognise their outstanding efforts during the COVID-19 outbreaks, and to attract and retain quality staff, to improve the quality and stability of care for consumers.
* In relation to workforce governance, the service demonstrated that staff are assigned clear responsibilities and accountabilities through its comprehensive job documentation and competency/capability framework. However, the service did not demonstrate effective contingency planning and management in relation to staffing to ensure the continuity of critical tasks such as care planning, when staff left the organisation, placing consumers’ health safety and wellbeing at risk.
* In relation to regulatory compliance, the quality and education manager ensures the changes are incorporated in the staff education program, through monthly toolbox sessions, updating existing training and orientation programs, such as the inclusion of recent restrictive practices legislation. However, the online policy for restrictive practices did not reflect changes to the definition of restraint contained in the legislative amendments made in 2021.
* In relation to feedback and complaints, the feedback register showed most feedback was actioned and finalised within one to two days, to the consumer’s satisfaction. However, the Assessment Team found some verbal complaints were not reflected in the feedback register and some were not addressed by management.

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* Asserts all policies are current and available electronically. Shift reports are generated electronically, and the organisation was not aware of concerns raised by the staff member.
* Acknowledged that the incident data may have been incomplete and noted the service has recently commenced operations.
* Asserted effective workforce governance as they have oversight and all shifts including personal care workers and registered nursing shifts were filled other than the recent clinical care coordinator role.
* Are subscribed to a peak body and the policy available in relation to restrictive practices complies with relevant legislation.
* Feedback is effectively addressed within one to two days, as recorded by the Assessment Team.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I have come to a different view and find the service was able to demonstrate effective organisation wide governance systems in relation to information management; continuous improvement; financial governance; workforce governance, including the assignment of clear responsibilities and accountabilities; regulatory compliance; feedback and complaints.

In coming to my finding, I have considered the totality of evidence in relation to governance systems including policies, procedures, workflows and the range of monitoring mechanisms including audits and meetings. In relation to information management, I have noted and accept the service has access to policies and procedures, and mechanisms to manage information including an electronic documentation system. In relation to continuous improvement, I accept the service had recently commenced operating and was able to provide examples of improvements and processes. In relation to financial governance, processes support the expenditure of finances which is monitored by executives and the Board. In relation to workforce governance staff have assigned roles and responsibilities. I have considered effective processes to include appropriate recruitment and retention which is indicated by all registered nurse and personal care worker shifts being filled other than the clinical care coordinator as a sign of effective workforce governance during current the employment challenges. In relation to regulatory compliance, I have noted the service has processes to identify and implement changes which includes through peak bodies. In relation to feedback and complaints, I have noted the service has processes to capture, action and report on feedback.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Compliant with Requirement (3)(c) in Standard 8 Organisational governance.

### 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*
4. *managing and preventing incidents, including the use of an incident management system.*

The Assessment Team were not satisfied the service was able to demonstrate effective risk management practices and process specifically in relation to incident management and effective practices in relation to managing high impact or high prevalence risks. The Assessment Team were satisfied the service has effective risk management systems and practices in relation to identifying and responding to abuse and neglect of consumers and supporting consumers to live the best life they can. This was evidenced by:

* In relation to managing high impact or high prevalence risks associated with the care of consumers, clinical risks identified in relation to care planning at the service since it opened, six weeks before the Site Audit, were not undertaken. The Assessment Team found interim care plans for sampled consumers contained brief information regarding their clinical and personal care needs and failed to identify all risks to consumers in relation to care and services in areas such as complex clinical care, continence care, behaviours and medication management.
* In relation to managing and preventing incidents, including the use of an incident management system. The service was not able demonstrate all incidents are identified and recorded. This specifically related to incidents of bruising and incidents associated with medications as described in Standard 2 Requirement (3)(e).
* In relation to identifying and responding to abuse and neglect of consumers, management and staff interviewed could describe the actions they need to take relevant to their role if they witness an incident involving the abuse and/or neglect of a consumer. This included describing the steps taken to respond to the immediate needs of those impacted, record, report and analyse incidents and implement remedial actions
* In relation to supporting consumers to live the best life they can. The service has a detailed policy on dignity of risk. However, when a nurse was asked what happens if a consumer wants to do something that might place them at risk, they were unable to provide a response that explained dignity of risk.

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* Acknowledged gaps in assessments and care planning processes.
* Acknowledge staff may have not been able to articulate the dignity of risk process, however, given the service has recently opened they have not had the opportunity to identify this potential deficit.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I find the service was not able to demonstrate effective risk management systems and practices specifically relating to managing and preventing incidents, including the use of an incident management system. I find the service was able to demonstrate effective risk management systems and practices in relation to managing high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers and supporting consumers to live the best life they can.

In relation to effective risk management systems and practices specifically relating to managing and preventing incidents. Processes failed to ensure relevant incident forms were completed to support effective incident management. In coming to my finding I have relied on the incidents recorded in Standard 2 Requirement (3)(e) to support my view which specifically related to incidents associated with medications and bruising.

In relation to supporting consumers to live the best life they can, I have relied on information documented in Standard 1 Requirement (3)(d) which provided examples of effective processes and practices. In relation to managing high impact or high prevalence risks associated with the care of consumers, I have considered deficits in clinical care in Requirement (3)(e) in this Standard as part of the clinical governance framework. In addition I have noted my finding of Compliance for Standard 3 Requirement (3)(b) in relation to effective management of high impact or high prevalence risks associated with the care of each consumer. In relation to identifying and responding to abuse and neglect of consumers, feedback and staff practices demonstrate the service is aware of their roles and responsibilities.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Non-compliant with Requirement (3)(d) in Standard 8 Organisational governance.

### 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 were satisfied the service has a documented clinical governance framework. The Assessment were not satisfied the service was able to demonstrate the clinical quality and risk committee provides effective oversight of the clinical governance system. This was evidenced by:

* The minutes of the committee’s monthly meeting contained minimal and unspecific information on recommended actions to address high impact high prevalence risks to consumers, in relation to clinical indicators identified there were no measurable outcomes and action completion dates recorded.
* Staff confirmed they had received training on antimicrobial stewardship.
* The organisation has a range of policies which are accessible electronically.
* In relation to open disclosure management, informed the Assessment Team that its policies and procedures are located on and external online policy portal.

The provider’s response indicates they disagree with the Assessment Team’s recommendation of not met. The following evidence was provided:

* The organisation’s policies were current and reflective of the legislative changes in relation to restrictive practices.
* Improvements identified in relation to the audits had not been completed as the service had recently commenced and sufficient time was not allocated.

I acknowledge the provider’s response and the additional information provided. Based on the Assessment Team’s report and the provider’s response, I find the service was not able to demonstrate an effective clinical governance framework.

In coming to my finding. I have noted the service has policies and procedures in relation to antimicrobial stewardship, restrictive practices and open disclosure. In addition, I have noted the service has a range of monitoring mechanisms including a range of audits. However, I have placed weight on the deficits identified by the Assessment Team in Standard 2 and Standard 3 and the integral overarching responsibility of effective clinical governance to ensure effective and safe quality care and services.

Based on the information summarised above, I find Mark Moran Group Pty Limited, in relation to Mark Moran Warrawee, Non-compliant with Requirement (3)(e) in Standard 8 Organisational governance.

# Areas for improvement

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

**Standard 2 Requirement (3)(a)**

* Review policies and procedures in relation to assessment and planning and specifically in relation to specialised nursing needs and behaviour assessment/management plans.
* Review training processes to ensure relevant staff are aware of their responsibilities to ensure behaviours of concern and specialised nursing needs are assessed and planned for.
* Implement monitoring processes to ensure staff are following policies and procedures in relation to assessment and planning.

**Standard 2 Requirement (3)(e)**

* Review policies and procedures to ensure care and services are reviewed following changes to consumers care and service needs and following incidents.
* Ensure relevant staff are aware of their roles and responsibilities in relation to review processes.
* Implement monitoring processes to ensure staff are following policies and procedures in relation to assessment and planning.

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

* Review policies and procedures to ensure each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, with a specific focus on management of specialised nursing needs, behaviours of concern, medication, pain and continence, and monitoring and actioning reportable ranges.
* Ensure relevant staff are aware of their roles and responsibilities in relation ensuring each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care ad specifically in relation to management of specialised nursing needs, behaviours of concern, medication, pain and continence, and monitoring and actioning reportable ranges.
* Implement monitoring processes to ensure staff are following policies and procedures and are providing safe and effective care that is best practice, tailored to consumers’ needs and optimises consumers’ health and well-being.

**Standard 3 Requirement (3)(g)**

* Review policies and procedures to ensureminimisation of infection related risks with a particular focus on minimising the risk of COVID-19 transmission.
* Review the outbreak management plan and sufficiency of PPE (Personal Protective Equipment) supplies and specifically in relation to the emergency outbreak kit.
* Implement monitoring processes to ensure staff understand and comply with the organisation’s infection prevention and control policies and procedures.

**Standard 5 Requirement (3)(b)**

* Review policies and procedures to ensure the service environment is safe, clean, well maintained and comfortable; and enables consumers to move freely, both indoors and outdoors.
* Ensure environmental safety issues identified in the Assessment Team’s report are reviewed and addressed.
* Review monitoring processes to ensure both the internal and external environment is safe, clean and well maintained.

**Standard 7 Requirement (3)(c)**

* Review policies and procedures to ensure the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.
* Ensure staff have the relevant knowledge in relation to management of specialised nursing needs, behaviours of concern, medication, pain and continence, and monitoring and actioning reportable ranges and incident reporting.
* Implement effective processes to ensure staff competency is monitored and appropriate action is taken when areas for improvement are identified.

**Standard 8 Requirement (3)(d)**

* Review processes to support effective risk management systems and practices, specifically in relation to managing and preventing incidents, including the use of an incident management system.
* Ensure staff are aware of processes to support identifying and responding to incidents

**Standard 8 Requirement (3)(e)**

* Review processes to ensure clinical risks associated with consumers’ care are monitored and reviewed to ensure safe, effective and quality care and services.
* Review processes to ensure effective oversight in relation to infection control practices including outbreak management,