Performance

Report

**1800 951 822**

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| Name of service: | RFBI Moonbi Masonic Village - Moonby |
| Service address: | New England Highway, 52 Churchill Drive KOOTINGAL NSW 2352 |
| Commission ID: | 2741 |
| Approved provider: | Royal Freemasons' Benevolent Institution |
| Activity type: | Assessment Contact - Site |
| Activity date: | 3 May 2023 to 4 May 2023 |
| Performance report date: | 27 June 2023 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for RFBI Moonbi Masonic Village - Moonby (**the service**) has been prepared by T Solomon, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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 Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Not applicable as not all requirements have been assessed** |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

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

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | 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. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

Requirement 3(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The Assessment Team found that consumers get safe and effective personal care, and/or clinical care that is best practice, tailored to their needs and optimises their health and well-being.

Consumers and/or representatives provided positive feedback about the provision of clinical care and personal care. Staff members were able to identify the needs and preferences of consumers and were able to identify factors that may present any risk of harm. They were able to outline actions they take to minimise potential harm or progression of issues, such as reassessment techniques and manual handling techniques used for each consumer to ensure their personalised needs are met.

Requirement 3(3)(b) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The Assessment Team found the service demonstrated effective management of high impact and/or high prevalence risks associated with the care of each consumer.

The service demonstrated it has diabetic management plans, which include monitoring requirements and acceptable ranges for blood glucose levels, instructions to guide staff in the event that the blood glucose level falls outside of the consumer’s accepted range, and when to contact the medical officer for a review. Potential complications and risks associated with the consumer’s condition are also included in the plan, as well as additional services involved in consumer care, such as dietitians, podiatrists, and ophthalmologist reviews.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Requirement 6(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service was able to demonstrate that appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

Staff were able to explain the complaints process to the Assessment Team and understood their role as it relates to the open disclosure process. The current complaints register was reviewed by the Assessment Team with a sample of the consumers and representatives who had made a complaint, interviewed. Consumers and/or representatives stated they were satisfied with the services’ response and action to their complaint.

Requirement 6(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

All accident and incident forms are reviewed by the management team daily. Progress notes are also reviewed by the general manager and care manager to identify any incidents that may not have been reported. The regional general manager completes audits at the service to monitor if accident and incidents are recorded and completed within the organisational timeframes.

The general manager and the quality officer review the complaints register on a weekly basis to identify trends and ensure outstanding items are responded to and actioned. The service provides a more detailed and specific analysis of the complaints register to the clinical governance team on a monthly basis. This is to ensure greater oversight by the executive team and the board of directors.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

Requirement 7(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

Feedback provided by consumers and their representatives was positive in relation to staff being knowledgeable and progressive. Feedback showed that staff were professional, competent, and able to answer questions posed by consumers and/or representatives.

Documentation reviewed showed all staff have completed mandatory training including but not limited to manual handling, diabetes management training, Serious Incident Response Scheme training and training regarding the recognition and reporting of risks. Registered Nurses have further education provided as a twelve-month program, based on clinical leadership and clinical skills needed to ensure consumer needs are met in accordance with best practice guidelines.

The service has a recruitment program in place that is undertaken by the management team. Potential staff members have checks completed to ensure that qualifications are appropriate, valid and current, including police checks and employment reference checks. Successful candidates go through an induction process, orientation and buddy shifts and ongoing development programs to ensure their skills remain up to date.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(c) | 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. | Compliant |
| Requirement 8(3)(d) | 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. | Compliant |

Findings

Requirement 8(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service was able to demonstrate effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints.

Information provided to the Assessment Team evidenced systems and processes for managing care and services. Meeting minutes reviewed showed the governing body has information and current data to make informed decisions.

Staff were able to describe how they access policies, procedures, or flowcharts. Staff were able to describe where to find the toolbox talk information if they were unable to attend one of the sessions. Staff reported they have what is referred to as a scrum meeting, which the whole service can attend including the maintenance and gardening staff. The subjects discussed can be clinical care through to current maintenance works being carried out at the service.

The plan for continuous improvement recorded the identified issue, action, proposed completion date, outcome, and evaluation. The general manager stated the service identifies areas of improvement through resident meetings, feedback and complaints from consumers and representatives as well as staff.

Review of the Serious Incident Response Scheme register identified the register contained information relating to both the alleged perpetrator and victim. Review of the incidents identified all had been correctly prioritised and reviewed.

Requirement 8(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service was able to demonstrate they have effective risk management systems and practices in place. The service has risk management systems in place to manage high-impact and high-prevalence risks, identify abuse and neglect of consumers and support consumers to live the best quality of life they can. The service is in the process of reviewing its management and monitoring of incidents and high-impact high-prevalence risks and implementing changes.

A new organisation wide programme was introduced to better enable improved reporting, data analysis, and identification of trends and opportunities for improvements following incidents.

1. The preparation of the performance report is in accordance with section 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)