Royal Freemasons Flora Hill

Performance Report

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**Commission ID:** 3966

**Provider name:** Royal Freemasons Ltd

**Site Audit date:** 21 June 2022 to 24 June 2022

**Date of Performance Report:** 19 August 2022

# Performance report prepared by

S Byers, 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) | Compliant |
| Requirement 2(3)(b) | Non-compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | 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** | **Non-compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Non-compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | 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** | **Non-compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Non-compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Non-compliant |
| Requirement 7(3)(d) | Non-compliant |
| Requirement 7(3)(e) | Non-compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | 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
* the provider’s response to the Site Audit report received 22 July 2022
* the provider was issued a Non-Compliance Notice on 08 June 2021 following a finding of non-compliance in the Quality Standards in Standard 3 Requirement 3(3)(b), Standard 7 Requirement 7(3)(a) and Standard 8 Requirement 8(3)(d).

# 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

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. For example:

* Consumers and representatives said consumers are treated with dignity and respect, and described how staff value consumers’ identity and culture.
* Consumers and representatives said they are supported to exercise choice and independence about their care and services.
* Consumers confirmed that they are supported to take risks.
* Consumers and representatives were satisfied the consumer’s privacy is respected.

Staff demonstrated understanding of consumers individual choices, cultural needs and preferences and how a consumer’s culture influences staff delivery of care. Management and staff demonstrated understanding of the service’s risk assessment process, explaining where consumers choose to take risks, the risks are discussed with the consumer and risk assessments are completed. Staff described how consumers are provided with information to make informed choices. Staff described how they support consumers to make connections inside and outside the service. Staff explained the practices in place to support consumer privacy and maintain confidentiality of information.

Consumers’ care planning documents are personalised and include information about the consumers life history, culture, needs, preferences and the people who are important to them. Consumer care files demonstrated risk assessments are completed in consultation with the consumer and their representative.

Staff were observed interacting with consumers in a respectful and kind manner. Staff practice was observed to be considerate of consumer privacy.

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

## Assessment of Standard 1 Requirements

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

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

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

*Care and services are culturally safe.*

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

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

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

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

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

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

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

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

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

# STANDARD 2 NON-COMPLIANTOngoing assessment and planning with consumers

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

Overall, sampled consumers confirmed they feel like partners in the ongoing assessment and planning of their care and services. For example:

* Consumers and representatives said they are partnered in ongoing assessment and planning of their care and services, the consumer’s care plan is discussed in detail and they are offered a copy of the care plan.
* Representatives were satisfied they are informed of changes in the consumer’s health status and contacted following incidents.

The service did not demonstrate care planning documents reflect the current needs, goals and preferences for consumers on respite including strategies to inform care. Deficits were identified in end of life care documentation.

Staff demonstrated knowledge of consumers’ risks and described strategies to ensure their safe and effective care. Staff described the monitoring and review process following incidents or changes in a consumer’s condition.

Assessment and care planning documents reflected consideration of risks to individual consumers’ health, safety and well-being. Care planning documents demonstrated input from consumers, their representatives, specialists and external visiting care providers involved in the consumers care. Care documentation reflected regular review and evaluation when care needs, preferences and circumstances change.

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

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

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

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

*Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.*

The Assessment Team found that assessment and care planning did not reflect the consumer’s current needs, goals and preferences. For example:

* Care planning for respite consumers did not identify and address current needs. Care plans were not updated to reflect changes and associated care strategies or interventions to inform the delivery of safe and quality care. While the service’s procedure states interim care plans are to be updated for respite consumers, management confirmed this does not occur in practice.
* Care plans for two palliating consumers were not updated to reflect the commencement of end of life pathway. Advance care directives and end of life care plans were not completed or did not include current need, goals or preferences. Clinical management said end of life pathway should have been implemented for both consumers.
* The Assessment Team observed some deficits in documentation including charting for pain, hygiene and wounds.

The approved provider submitted a written response with clarifying information and documentation including an assessment and care planning procedure. Actions taken since the site audit include:

* updated assessment and care planning procedure to ensure respite consumers have appropriate assessments and care plans
* staff education on assessment and care planning.

I have considered the information provided by the Assessment Team and the approved provider’s response. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the approved provider did not demonstrate that assessment and planning identifies and addresses the consumer’s current needs, goals and preferences. I find the service is Non-compliant with this Requirement.

### 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.*

### 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.*

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

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

Overall, sampled consumers and their representatives were satisfied with the care provided. For example:

* Consumers and representatives were satisfied they are kept informed regarding changes to the consumers health status.
* Consumers and representatives were satisfied with the palliative care approach provided by the service.
* All consumers and representatives were satisfied they have access to a medical practitioner and other relevant health professionals when needed.

Most consumers considered that they receive clinical care that is safe and right for them, however, some consumers and representatives were not satisfied consumers receive personal care that is tailored to their needs. For example, regular showers and personal hygiene were found to not be delivered in line with consumer needs and preferences.

While the service demonstrated that consumers receive safe and effective clinical care in relation to pain management, skin integrity, chemical and mechanical restraint, the service did not demonstrate environmental restraint was recognised. Assessment, consultation and informed consent for consumers subject to environmental restraint had not been actioned.

The service did not demonstrate effective standard and transmission based precautions were in place to minimise infection related risks. The Assessment Team’s observations of staff identified poor adherence with infection prevention and control protocols.

While deficits were identified in end of life care planning documents, the service demonstrated end of life needs are met in line with consumer wishes and comfort is maximised.

Staff described how deterioration or changes are identified, actioned and communicated. Staff described the high impact and service specific high prevalence risks to consumers and the individualised strategies in place to minimise the risk.

Care planning documents demonstrated high impact or high prevalence risks associated with the care of each consumer are identified and managed, particularly in relation to fluid restriction, falls management and post falls monitoring, behaviour management, specialised nursing care and medication management. Care documents demonstrated staff identify and respond to changes in the health status of consumers in a timely manner.

Referral processes are in place and appropriate and timely referrals to a medical practitioner, allied health professionals and other external specialist services are documented. Information is effectively documented and communicated within the organisation and with external services involved in care as required.

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

### Assessment of Standard 3 Requirements

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

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

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

While the Assessment Team found that consumers receive safe and effective clinical care in relation to pain management, skin integrity, chemical and mechanical restraint, the Assessment Team identified deficits in environmental restraint and personal care including hygiene. For example:

* Negative feedback from consumers and representatives regarding consumer’s personal care, including the frequency of showers.
* Care documents demonstrated consumers are not showered in accordance with their needs and preferences. Documents demonstrated consumers were not receiving regular showers with one consumer with incontinence receiving 2 showers in June 2022.
* Staff provided feedback they often do not have time to meet consumers showing preferences, particularly when the consumer requires two staff to assist.
* Some consumers were observed in communal areas to have stained and unclean clothing, with some males unshaven.
* The Assessment Team observed consumers living in the service, including in the memory support unit who were environmentally restrained to an area by locked key coded doors. The consumers were observed pacing and attempting to leave the area. The service did not identify, assess and manage the consumers as being subject to environmental restraint. Management advised no consumers at the service had been assessed for environmental restraint. Consumer documents did not record environmental restraint or that consultation had occurred. Informed consent had not been obtained and no authorisations were in place.

The approved provider submitted that it relied on its own interpretation of the Commission guidelines in relation to environmental restraint, however immediately rectified the oversight during the site audit.

The approved provider provided a response that included clarifying information to the Assessment Team report as well as actions taken since the site audit. The approved provider did not submit supporting documentation for this requirement. For example:

* consumers subject to environmental restraint to be assessed, consulted and informed consent obtained
* review of care plans to ensure needs and preferences are accurate
* ongoing staff education.

I have reviewed all information provided. I have placed weight on consumer documents supported by the Assessment Team’s observations, and consumer, representative and staff feedback at the time of the site audit that demonstrated each consumer does not receive personal and clinical care that is effective, safe and optimises their health and well-being, particularly in relation to personal hygiene and environmental restraint. While I acknowledge the actions taken by the service since the audit, these actions have not been fully implemented and evaluated. I consider at the time of the site audit the approved provider did not demonstrate compliance with this requirement. On the balance of evidence available to me, I find the service is Non-compliant with Requirement.

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

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

The service was found non-compliant with this Requirement in April 2021 and November 2021. The Assessment Team found the service had implemented improvements to address the deficits identified at the last visit.

The Assessment Team found the service demonstrated effective management of high impact or high prevalence risks associated with the care of each consumer. The Assessment Team’s evidence included fluid restriction, falls management and post falls monitoring, behaviour management, specialised nursing care and medication management.

Consumers and representatives provided positive feedback in relation to the service’s management of falls, fluid restriction and medication management. Staff described specific high impact or high prevalence risks for consumers and demonstrated understanding of individual strategies to minimise and manage the risks. The Assessment Team observed consumers being provided care in accordance with their care documentation. Documentation review confirmed staff were adhering to the service’s falls procedure and neurological observations were completed for consumers post fall in line with the services policy.

In making my decision I have considered the Assessment Team’s findings. I am satisfied the approved provider has demonstrated effective management of high impact or high prevalence risks for each consumer. Based on the evidence provided I consider that the approved provider has demonstrated compliance with this requirement. I therefore find this Requirement Compliant.

### 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.*

### 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.*

### 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 observed several instances of poor infection minimisation practices during the site audit. For example:

* Staff practice in relation to face masks.
* Staff practice in relation to hand hygiene and sanitising between assisting consumers.
* Staff practice in relation to cleaning of high touch points. For example, desks, phones and computers.
* Lack of disinfectant wipes at the entry screening point and shared equipment.
* Staff and visitor practice at entry screening point. For example, the Assessment Team observed visitors entering the service prior to waiting for their Rapid Antigen Test (Rat) results and staff completing RAT’s in the nurse’s office.
* Insufficient personal protective equipment (PPE) supplies.
* No site-based Infection Prevention and Control (IPC) lead. The IPC lead had withdrawn from their role and the Facility Manager was overseeing IPC practices in the interim, however the Facility Manager does not have the relevant IPC qualifications and was not enrolled in an identified IPC course.
* The Assessment Team observed the service environment including shared lifting and standing equipment were unclean.

Staff said they had completed relevant infection control training, hand hygiene and PPE training. Hand Hygiene and PPE assessments conducted in January to March 2022 demonstrated approximately 50% of staff attained competency. I have also considered the Assessment Team’s evidence under Standard 7 Requirement 7(3)(d) that less than half of staff had completed the infection prevention and control mandatory module for 2022.

The service had an outbreak management plan and antimicrobial stewardship policy. Document review and staff feedback demonstrated the antimicrobial use is minimised.

The approved provider provided a response that included clarifying information to the Assessment Teams report as well as actions taken since the site audit including a plan for monitoring PPE practice by staff.

The Assessment Team report and the approved provider response had conflicting information regarding an IPC Lead being on site. I note the approved provider submits there were other IPC leads active at the service and the Facility Manager has been enrolled in the relevant IPC training course. The approved provider did not submit supporting documentation to verify these arrangements. As the information about the IPC arrangements in the approved providers response, was not presented to the Assessment Team at the time of the site audit, I do not consider I have sufficient evidence to demonstrate an IPC lead was on site at the time of the site audit. I have considered this further under Standard 7 Requirement 7(3)(c).

I have reviewed all of the information provided. I am not satisfied that at the time of the site audit the service demonstrated standard and transmission based precautions to prevent and control infection were in place to minimise infection related risks. I find the service is Non-compliant with this Requirement.

# STANDARD 4 NON-COMPLIANTServices 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

Overall sampled consumers considered that they get the services and supports for daily living that are important for their health and well-being and that enable them to do the things they want to do. For example:

* Consumers and representatives were satisfied the meals are of suitable quality, quantity and variety.

While consumers were satisfied with the services and supports provided by the service, including the level of emotional and spiritual care provided by staff, consumers and representatives were not satisfied with the program of lifestyle activities.

Staff demonstrated they know consumers well, describing how they provide care to support consumer independence, quality of life and well-being. Staff confirmed lifestyle activities were not offered in the memory support unit or at weekends. Staff explained dietary needs and preferences of consumers. Staff confirmed they have enough equipment to provide safe and appropriate care to consumers.

Lifestyle care plans reflected the interests and preferences of the consumers and their important social and personal relationships. Consumer documents demonstrated there is adequate information to support effective and safe sharing of the consumer’s care and timely and appropriate referrals are actioned where required. Consumer planning documents contained specific dietary needs and preferences.

While equipment was observed to be safe and suitable, not all equipment was observed clean, I have considered this further under Standard 5 Requirement 5(3)(b) in relation to the service environment.

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

## 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) Non-compliant

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

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

The Assessment Team found consumers were not provided with services and supports of daily living that assist them to participate in the community, have social relationships and do the things of interest to them. For example:

* Consumers and representatives were dissatisfied with the lifestyle activities offered stating they were bored, lonely and that staff were too busy to spend time with them.
* While care documentation recorded consumer’s activities of interest, these activities were not offered at the service. For example, one-on-one activities.
* All staff were dissatisfied with the lack of activities at the service and could explain the negative impact it has on consumers. Staff highlighted lack of lifestyle staffing as an issue.
* Staff confirmed one-on-one activities with consumers are not offered at the service.
* The activity program demonstrated activities are scheduled Monday to Friday and not weekends and activities in the memory support unit are not offered.

The approved provider acknowledged the issues with the services lifestyle program citing staffing issues and shortages. I acknowledge the recent appointment of a Lifestyle Coordinator. The approved provider submitted a response that included clarifying information to the Assessment Teams report as well as actions taken since the site audit. For example:

* the Lifestyle Coordinator will seek feedback from consumers to inform the lifestyle program through individual consultations and food focus and lifestyle meetings
* a plan for the lifestyle program to move to seven days with the recruitment of more lifestyle staff.

I have reviewed all of the information provided. While I note the actions taken by the approved provider these have not been implemented or evaluated. I consider at the time of the site audit the approved provider did not demonstrate compliance with the Requirement. I find the service is Non-compliant with Requirement.

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

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

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

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

### Requirement 4(3)(f) 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-COMPLIANTOrganisation’s service environment

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 5

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

* Consumers said they feel welcome and comfortable at the service.
* Consumers said that maintenance was responsive.

Mixed feedback was received from consumers and representatives about the cleanliness of the service environment. The Assessment Team observed the service environment was not clean. Not all consumers could move freely throughout the service, both indoors and outdoors.

The service is welcoming and offered a range of comfortably furnished communal spaces that optimise consumer engagement and interaction. Consumer rooms were observed to be home-like and personalised with photographs and furnishings.

Staff demonstrated an understanding of maintenance request processes and procedures. Maintenance records demonstrated maintenance is responded to in a timely manner.

Most furniture, fittings and equipment were observed as safe and suitable, however, some shared lifting and standing equipment was observed as not clean. Consumers were observed utilising a range of equipment including walkers and wheelchairs.

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

## Assessment of Standard 5 Requirements

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

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

### Requirement 5(3)(b) 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 found the indoor service environment was not safe, clean and well-maintained. The Assessment Team observed consumer rooms and bathrooms, shared lifting and standing equipment, staff rooms and amenities including sinks used for hand hygiene were not clean.

Several heaters throughout service including the memory support unit were hot to touch. In response to Assessment Team feedback, management decommissioned the heaters in the corridors during the site audit and stated they would monitor the heaters in the memory support unit. Management advised the temperature control dials are open and easily accessible to consumers and would engage maintenance to rectify the issue.

Mixed feedback was received from consumers and representatives regarding the cleanliness of the service environment including consumer bedrooms and bathrooms.

While cleaning staff said they follow a cleaning schedule, they described not being able to complete all cleaning tasks due to staff shortages. The Assessment Team observed only one cleaner on duty on the first day of the site audit and the second cleaner shift had not been replaced. Staff described maintenance reporting processes.

Review of cleaning audits for March and June 2022 demonstrated a decline in the cleanliness of communal areas and consumer bedrooms, this aligned with Assessment Team observations and consumer and representative feedback.

While maintenance documents demonstrated maintenance was attended in a timely manner, maintenance records were only available from June 2022 onwards.

While the service demonstrated that most consumers could move freely both indoors and outdoors, the Assessment Team observed consumers in the memory support unit did not have access to the main area of the service or the secure courtyard.

I acknowledge that management took action in response to Assessment Team feedback during the site audit to unlock the doors to the secure courtyard and display the keypad lock codes, so that consumers could open the doors independently. I have also considered this information under Standard 3 Requirement 3(3)(a) in relation to environmental restraint.

The approved provider provided a response that included clarifying information to the site audit report. The approved provider acknowledged the issues with the cleanliness of the service environment and associated staff shortages. An additional cleaning staff member has been employed.

I have reviewed the information provided. While I note the actions taken by the approved provider these have not been implemented or evaluated. I consider at the time of the site audit the approved provider did not demonstrate compliance with the Requirement. I find the service is Non-compliant with Requirement.

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

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

# STANDARD 6 NON-COMPLIANTFeedback and complaints

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 6

Most sampled consumers considered that they are encouraged and supported to give feedback and make complaints, and that appropriate action is taken.

For example:

* Consumers and representatives expressed satisfaction they are encouraged and supported to provide feedback and make complaints.
* Consumers and representatives described how they are aware of advocacy and language services.

While the service has an open disclosure policy, the service did not demonstrate the process is followed in practice. Staff did not demonstrate an understanding of the open disclosure process.

Staff described how they support consumers to provide feedback and make complaints and were aware of advocacy and language services. Management described the actions taken in response to complaints and provided examples of improvements to care and services informed by complaints and feedback.

Complaint documents recorded actions taken in response to feedback and complaints.

The Assessment Team observed information displayed within the service on internal and external complaints including advocacy services. Feedback boxes were observed throughout the service.

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

## Assessment of Standard 6 Requirements

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

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

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

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

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

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

The Assessment Team found the service did not demonstrate appropriate action is taken in response to complaints and open disclosure is used when things go wrong. For example:

* The service did not demonstrate open disclosure was followed in relation to an incident. Management confirmed the representative had not been informed of all relevant information relating to the incident, including that it was a result of lack of staff supervision.
* Staff were not aware of the term open disclosure and did not demonstrate understanding of the open disclosure process.
* Negative feedback from some consumers and representatives that appropriate action was not taken in response to their complaints.
* The service has an open disclosure policy.

The approved provider submitted a response that included clarifying information to the Assessment Team report as well as actions taken since the site audit. For example:

* toolbox training for staff on open disclosure.

While I note some consumers and representatives were not satisfied with the action taken in response to their complaints, based on the evidence available, it is my view that appropriate action has been taken. I have also considered Assessment Team information under Requirement 6(3)(d) that demonstrated that most consumers and representatives were satisfied their concerns had been addressed and had resulted in change at the service.

I have considered the information provided by the Assessment Team and the approved provider’s response. I consider at the time of the site audit the approved provider did not demonstrate that staff understand and follow open disclosure processes. I find the service is Non-compliant with this Requirement.

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

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

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

Overall, sampled consumers considered that they get quality care and services when they need them and from people who are knowledgeable, capable and caring. For example:

* While consumers and representatives confirmed staff are kind, caring and respectful, they provided feedback about insufficient levels of staff at the service impacting on consumers personal care.

Staff raised concerns about high unplanned leave at the service. Roster documentation demonstrated several shifts were unfilled. The Assessment Team observed consumers waiting for assistance.

Staff feedback and training records demonstrated not all staff have completed mandatory training, particularly in relation to Serious Incident Response Scheme (SIRS), infection control and open disclosure. Management explained staff engagement in training is low and training records confirmed less than half of staff having completed annual mandatory training modules.

The service did not demonstrate all members of the workforce have the qualifications and knowledge to effectively perform their roles, at the time of the site audit the service did not demonstrate it had a qualified and appointed IPC lead.

The service did not demonstrate regular assessment, monitoring and review of the performance of the workforce. The services continuous improvement plan reflected that most staff have not completed annual performance reviews. This was supported by staff and management feedback. The service is reintroducing the performance appraisal process.

The Assessment Team observed staff interactions with consumers to be kind, caring and respectful during the site audit.

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

## Assessment of Standard 7 Requirements

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

*The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.*

The service was found non-compliant with this Requirement in April 2021 and November 2021. The Assessment Team found that while the service had implemented some improvements they did not address the deficits identified at the last visit.

The Assessment Team received negative feedback from consumers and representatives about staffing levels impacting on consumer care, particularly personal hygiene. Consumers described waiting for assistance during the evenings which aligned with call bell reports. Staff described working short staffed, particularly in the memory support unit and hotel services. The Assessment Team observed some consumers to be unkempt and some consumers still in bed mid-morning waiting for staff assistance.

While call bell reports indicated most call bells are responded to in a timely manner, roster and allocation documents demonstrated several shifts were unfilled across all staff denominations due to unplanned leave.

Management described unplanned leave as the biggest challenge and the difficulties in filling vacant shifts. Strategies in place include staff working extra shifts, double shifts and the use of agency staff. The current clinical manager has resigned and at the time of the site audit there had been no response to advertisement for this role.

I have also taken into consideration the adverse impact workforce shortages have had on supports and services, specifically lifestyle activities and cleanliness of the service environment under Standard 4 Requirement 4(3)(c) and Standard 5 Requirement 5(3)(b).

The response from the approved provider refutes the Assessment Team findings. The approved provider submitted a response that included clarifying information to the Assessment Teams report as well as actions taken since the site audit including ongoing recruitment and engagement with local training organisations. The approved provider advised it has a roving Clinical Care Manager who remain on site at the service until a suitable replacement is recruited and trained.

While I acknowledge the workforce challenges in the sector resulting from the COVID-19 pandemic and the actions taken by the service to address the deficits in this requirement, I am persuaded by the Assessment Team’s evidence including observations, consumer and representative feedback. On the balance of the evidence available to me, I consider at the time of the visit the service did not demonstrate compliance with this Requirement. I find the service is Non-compliant with this Requirement.

### 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 report and the approved provider response had conflicting information regarding this Requirement.

The Assessment Team found that not all members of the workforce have the qualifications and knowledge to effectively perform their roles. For example:

* Management advised the service’s appointed IPC Lead had withdrawn from the role. Management advised a contingency was in place for a registered nurse and the Facility Manager to cover the IPC Lead role until a nurse showed interest in being enrolled in the IPC course. At the time of the site audit the Facility Manager had not completed the relevant IPC lead training and had not enrolled in the IPC training course and no nurses were enrolled in the relevant IPC lead course.
* Two care staff did not hold the relevant qualifications to provide care and services in accordance with their role description. While management said all new care staff are supported by experienced care staff when rostered, staff feedback indicated the unqualified care staff had been working without support or supervision. Staff also commented on whether current staffing levels allowed for supernumerary roles.

The approved provider provided a response that included clarifying information to the Assessment Teams report.

The approved provider refutes the Assessment Team’s findings that the service did not have an appointed and qualified Infection Prevention and Control (IPC Lead) rostered within the service and submits that there was an IPC Lead onsite at the time of the site audit and that the Facility Manager has since enrolled in the relevant training course. I consider it is reasonable to expect that if the service had a qualified IPC Lead on site, this would have been demonstrated to the Assessment Team during the site audit and other staff at the service would have been aware of this role during interview. Information about the IPC arrangements presented in the response were not provided to the Assessment Team at the time of the site audit. The approved provider did not submit supporting documentation to verify the IPC arrangements in its response. Based on the evidence available to me, I do not have sufficient evidence to demonstrate an appropriately qualified IPC Lead was on site at the time of the site audit.

In relation to the two care staff members who do not hold the relevant qualifications to provide care, the approved provider submits there is no legislative requirement for staff to hold a Certificate III or IIII in order to work in residential aged care and the staff are part of an apprenticeship training scheme. While there may be no legislative requirement for particular qualifications, it is my view that it is reasonable to expect that staff are suitably skilled and competent to effectively perform their roles.  I do not have sufficient evidence to demonstrate the staff are competent and have the relevant skills and knowledge to perform their roles.

I have reviewed all of the information provided. On the balance of the evidence available to me, I consider at the time of the visit the service did not demonstrate compliance with this Requirement. I find the service is Non-compliant with this Requirement.

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

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

While most consumers and representatives considered staff to be sufficiently trained, the Assessment Team received mixed feedback from staff regarding scheduled and completed training. While some staff did not demonstrate understanding of the term Serious Incident Response Scheme (SIRS), they demonstrated awareness of the responsibility to report a serious incident. Most staff did not demonstrate understanding of the term open disclosure, the open disclosure process and could not recall completing training on the topic.

Management described low engagement by staff in training. Training records demonstrated not all staff have completed mandatory training in 2022 and reflected a decrease in the completion of mandatory training from 2021. Less than half of staff had completed mandatory training including infection prevention and control, reporting abuse and SIRS modules. Training records demonstrated open disclosure training had not been offered to staff in the past 12 months. The services plan for continuous improvement identified staff training as an area of improvement.

The approved provider has been found non-compliant with Standards 3, 6 and 7 with deficits identified in staff competency to deliver safe and quality outcomes under the Quality Standards, particularly in relation to environmental restraint, infection control practices and open disclosure.

The approved provider provided a response that included clarifying information. The approved provider did not submit supporting documentation for this requirement. The approved provider submits that SIRS and open disclosure are both annual mandatory training requirements and currently being supplemented by toolbox training. The approved provider’s response identifies that less than 50% of staff have completed the open disclosure online training and toolbox training.

In making my decision I have considered the Assessment Team report and the approved provider’s response. On the balance of the evidence available to me, I consider at the time of the site audit the approved provider did not demonstrate the workforce is appropriately trained and equipped to deliver the outcomes required by the Quality Standards. I therefore, find the service is Non-compliant with this Requirement.

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

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

The Assessment Team found the service did not undertake regular assessment, monitoring and review of the performance of each member of the workforce. For example:

* While staff provided feedback that they were aware of the performance appraisal process, the majority of staff interviewed had not engaged in the process.
* Management advised several care staff had not had an appraisal completed in 18 months or more. Several changes in management at the service has not supported a robust performance review process for all staff.
* The services continuous improvement plan identified that most staff have not completed annual performance reviews.

I acknowledge at the time of the site audit the service had identified and recognised performance reviews as an area of improvement. The approved provider submitted a response that included clarifying information to the Assessment Team report as well as actions taken since the site audit. For example:

* reintroduction of the performance review process with education to be delivered to staff to support the process and guide staff practice.

I have reviewed all of the information provided. While I acknowledge the challenges the service has experienced during the COVID-19 pandemic, I have considered and placed weight on the Assessment Team’s evidence and the wording of the requirement, specifically ‘*of each member of the workforce…”*  It is on this basis that I find the service Non-compliant with this requirement.

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

Overall the sampled consumers considered that the organisation is well run and that they can partner in improving the delivery of care and services.

Management described how they engage consumers in the development, delivery and evaluation of care and services. Management described plans for a regular newsletter and scheduled consumer and representative meetings.

The service demonstrated the governing body promotes a culture of safe, inclusive and quality care with most consumers expressing satisfaction they feel safe and are living in an inclusive environment. Management described how audit outcomes including staff and consumer surveys are reported to the Board.

The organisation provided a clinical governance framework that includes antimicrobial stewardship, minimising the use of restraint and an open disclosure policy however, while a clinical governance framework and policy is in place, the approved provider did not demonstrate how environmental restraint is monitored and minimised by the service. Staff did not demonstrate they had been educated about all of the policies and were not able to demonstrate understanding or practical application of open disclosure processes.

While the organisation demonstrated it has effective governance systems in relation to information management, continuous improvement, financial governance, regulatory compliance and feedback and complaints, it did not demonstrate effective workforce governance systems are in place.

The organisation provided a documented risk management framework supported by policies and procedures documented to manage risk. The organisation has an incident management system in place. Risks are reported, escalated, and reviewed by management. The Assessment Team observed the service has reduced risks in relation to medication incidents.

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

## 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.*

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

*Effective organisation wide governance systems relating to the following:*

1. *information management;*
2. *continuous improvement;*
3. *financial governance;*
4. *workforce governance, including the assignment of clear responsibilities and accountabilities;*
5. *regulatory compliance;*
6. *feedback and complaints.*

The Assessment Team found that while the organisation has a suite of governance systems, management did not demonstrate these are effectively applied within the service, most specifically in relation to workforce governance systems. This is supported by evidence within the report, most specifically Standards 3, 6 and 7, that demonstrate the service is not effectively identifying and managing deficits in workforce levels, training and performance appraisals.

While the Assessment Team found some deficits in the services information management systems during the site audit, I do not consider these have been of a systemic nature.

The approved provider submitted a response that included clarifying information to the Assessment Teams report. The approved provider refutes the Assessment Team’s findings that the service did not have an appointed and qualified Infection Prevention and Control (IPC lead).

I have also considered information from Standard 3 Requirement 3(3)(g) and Standard 7 Requirement 7(3)(c) where I found the approved provider did not demonstrate that a qualified IPC lead was on site at the time of the site audit.

I have reviewed all of the information provided. On the balance of the evidence available to me, I consider at the time of the visit the service did not demonstrate compliance with this Requirement. I find the service is Non-compliant with this Requirement.

### Requirement 8(3)(d) 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 service was found Non-compliant with this Requirement in April 2021 and November 2021. The Assessment Team found the service had implemented improvements to address the deficits identified at the last visit.

Management described the process for managing high impact and high prevalence risks associated with the care of consumers. Staff demonstrated understanding of incident reporting processes.

The Assessment Team found incidents and events are reported, escalated and reviewed by management and incident data is reported to relevant organisational committees and the Board. Management is responsible for identifying and investigating SIRS incidents.

The service demonstrated it has taken action to improve medication management to reduce medication incidents and errors. This included management meeting with the pharmacist to review practices related to medication orders and dispensing systems.

Based on the available evidence, summarised above, I consider the approved provider complies with this Requirement. I therefore find this Requirement is Compliant.

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

*Where clinical care is provided—a clinical governance framework, including but not limited to the following:*

1. *antimicrobial stewardship;*
2. *minimising the use of restraint;*
3. *open disclosure.*

The Assessment Team found the clinical governance framework includes antimicrobial stewardship, minimising the use of restraint and an open disclosure policy. While a clinical governance framework and policy is in place, management and staff were not able to demonstrate understanding of open disclosure or how the use of environmental restraint is monitored and minimised by the service.

Most staff interviewed were not aware of open disclosure and had not received training on the process. Training records demonstrated that training on open disclosure had not been provided to staff in the last 12 months. I have also considered information from Standard 6 Requirement 6(3)(c) and Standard 7 Requirement 7(3)(d) in relation to an incident where open disclosure was not followed and where the Assessment Team identified deficits in training and support to ensure staff can implement and embed the open disclosure process in practice.

While the service demonstrated that chemical and mechanical restraint are used as a last resort, environmental restraint was not recognised by the service. The Assessment Team identified consumers in the memory support unit did not have access to coded keypads restricting the consumers free movement. Codes for keypads were displayed when the Assessment Team discussed the lack of access to codes with management. The application of environmental restraint was not documented for consumers and appropriate consent and authorisations for the use of the restrictive practice were not in place.

The approved provider submitted a response that included clarifying information to the Assessment Teams report and actions taken since the site audit. For example:

* environmental restraint is now in place for all relevant consumers
* open disclosure training has been supplemented by toolbox training.

In making my decision I have considered the Assessment Team’s report and the information in the response from the approved provider. I consider at the time of the Site Audit the approved provider did not demonstrate compliance with the Requirement. I find the service is Non-compliant with this Requirement.

# 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.

* Ensure care planning and assessment identifies and addresses respite consumers current needs, goals and preferences.
* Ensure all advance care directives and end of life plans are complete and reflect consumers current needs, goals and preferences.
* Ensure consumers receive safe and effective personal care tailored to their needs and in accordance with their preferences and implement processes to ensure consumer care documentation is accurate and complete.
* Ensure consumers subject to environmental restraint are identified, assessed, consulted and informed consent is obtained.
* Implement and monitor effective infection control and minimisation practices and educate and monitor staff to ensure adherence with infection control protocols.
* Appoint an IPC Lead who has enrolled and commenced in recognised IPC course.
* Ensure the lifestyle program reflects the current interests of consumers including one on one time.
* Implement effective processes to ensure the service environment and shared equipment is clean. Ensure that all consumers can move freely indoors and outdoors at the service.
* Ensure staff are aware of and able to apply open disclosure.
* Ensure staffing is planned to enable the management and delivery of safe and quality care and services to mitigate adverse impact to consumers.
* Implement processes to ensure staff complete all relevant and mandatory training and have the skills and competency to perform their roles in relation to the Standards.
* Ensure effective workforce governance systems are in place at the service.
* Ensure staff have the knowledge and skills to apply the organisation’s clinical governance framework.
* Ensure the governing body provides effective stewardship in returning the service to full compliance with the Standards.