Performance

Report

**1800 951 822**

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| Name of service: | Royal Freemasons Moe |
| Service address: | 1C Haigh Street MOE VIC 3825 |
| Commission ID: | 4581 |
| Approved provider: | Royal Freemasons Ltd |
| Activity type: | Assessment Contact - Site |
| Activity date: | 14 June 2023 |
| Performance report date: | 5 July 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 Royal Freemasons Moe (the service) has been prepared by V Stephens, 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 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 5** Organisation’s service environment | **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 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | 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. | Compliant |

Findings

Sampled care documentation demonstrates consumer risk is identified and considered in the assessment and care planning process upon entry to the service, through feedback from consumers and consumer representatives, following incidents and during regular care plan reviews. All sampled consumers are satisfied risks are appropriately assessed and that individualised strategies are planned to mitigate risks. These strategies are reflected in care planning documents reviewed by the Assessment Team which include risk assessment and care planning relating to falls, changed behaviours, choking or swallowing difficulties, use of restrictive practices and medication management. Management and staff described risk interventions for individual consumers.

# 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

The service was found non-compliant with Requirement 3(3)(a) following a site audit conducted from 3 January 2023 to 6 January 2023. The service at that time did not demonstrate effective management of chemical restrictive practices in line with legislative requirements, nor was pain always managed effectively. The service has implemented remedial action in response to the non‑compliance identified at the site audit in January 2023 including staff training and review and consultation in relation to the use of psychotropic medications.

During this assessment contact, The Assessment Team reviewed care documentation for eight sampled consumers which demonstrated pain and the use of restrictive practices are effectively assessed and managed. All sampled consumers expressed satisfaction with how their pain is managed. Management, staff and external health practitioners described how consumer pain and the use of restrictive practices are effectively monitored, managed and minimised. The Assessment Team observed completed behaviour support plans and signed consent for the use of restrictive practices. Accordingly, I find the service compliant with Requirement 3(3)(a).

The service was found non-compliant with Requirement 3(3)(b) following a site audit conducted from 3 January 2023 to 6 January 2023. The service at that time did not demonstrate effective management and prevention of high impact or high prevalence risks related to falls, medication management, changed behaviours and dysphagia. The service has implemented remedial action in response to the non-compliance identified at the site audit in January 2023 including staff training, introducing weekly audits for specific medication types and implementing weekly meetings to discuss risks.

During this assessment contact, the Assessment Team reviewed care documentation for eight sampled consumers which demonstrated effective identification, management and implementation of preventative strategies to mitigate high impact and high prevalence risks to consumers. Clinical staff described how newly-identified or existing risks are discussed with the multidisciplinary team during weekly meetings where preventative strategies are discussed and/or reviewed for effectiveness. Staff demonstrated knowledge of individualised strategies to prevent falls, medication documentation discrepancies, changed behaviours and choking. All sampled consumers indicated confidence their risks are effectively assessed and responded to. Accordingly, I find the service compliant with Requirement 3(3)(b).

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |

Findings

Staff stated they use the electronic maintenance system to manage preventative, scheduled and reactive maintenance, which is reviewed daily. Staff said they attend to consumers regularly and address any maintenance issues. Staff also outlined cleaning regimes and management of hazards. A review of online maintenance requests demonstrated there are no outstanding issues which pose a risk to consumers. The service was observed to be clean and well-maintained, the outdoor areas were tidy and security cameras are operational.

# Standard 8

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| Organisational governance | |  |
| 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 |
| Requirement 8(3)(e) | 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. | Compliant |

Findings

The service was found non-compliant with Requirement 8(3)(d) following a site audit conducted from 3 January 2023 to 6 January 2023. The service at that time did not demonstrate appropriate risk management in relation to dysphagia, falls prevention, medication administration, pain, and changed behaviours. The service has implemented remedial action in response to the non-compliance identified at the site audit in January 2023 including regular compliance auditing, enhanced incident reporting and staff training.

During this assessment contact the Assessment Team reviewed incident registers, training folders, care documentation, feedback and complaints registers and audit reports which demonstrated the service is identifying, managing and reporting high impact or high prevalence risks and ensuring actions to minimise risks are implemented. Management said the service informs the board of high incident risks through weekly facility manager meetings, monthly quality meetings with the executive team and monthly site operational and quality risk meetings. Accordingly, I find the service compliant with Requirement 8(3)(d).

The service was found non-compliant with Requirement 8(3)(e) following a site audit conducted from 3 January 2023 to 6 January 2023. The service at that time did not demonstrate effective management of chemical restrictive practices in line with legislative requirements. The service has implemented remedial action in response to the non-compliance identified at the site audit in January 2023 including targeted staff education regarding restrictive practices. obtaining consent to align with legislative requirements and regular auditing to monitor compliance.

During this assessment contact, the service demonstrated the clinical governance framework provides an overarching monitoring system to ensure effective clinical care for consumers. There are accessible policies and procedures in relation to minimising the use of restraint and the service demonstrated these policies were understood by management and staff. Management described how the use of restraint is reported, documented and monitored on the organisational electronic system. Accordingly, I find the service compliant with Requirement 8(3)(e).

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)