Boandik St Mary's

Performance Report

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**Commission ID:** 6234

**Provider name:** Boandik Lodge Inc

**Site Audit date:** 15 September 2020 to 17 September 2020

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

# Publication of report

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

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | 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) | Non-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) | 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** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | 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) | Non-compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | 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) | Non-compliant |
| Requirement 8(3)(e) | Compliant |

# Detailed assessment

This performance report details the Commission’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff and others
* the provider’s response to the Site Audit report received 23 October 2020
* the Assessment Contact Advice for the Assessment Contacts conducted 4 July 2019 and 1 October 2019.

# STANDARD 1 COMPLIANTConsumer 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 most sampled consumers interviewed considered that they are treated with dignity and respect and can maintain their identity. The following examples were provided by consumers during interviews with the Assessment Team:

* are able to inform staff what they want to do, which staff respect, and staff assist them in all their personal, emotional and activities needs.
* some staff have been here a very long time and know what they need and what assistance they need and allow them to do as much as possible for themselves.
* staff are respectful and ensure privacy is always maintained.

Staff interviewed spoke about consumers in a respectful and understanding manner and demonstrated familiarity with consumers’ backgrounds as well as their care needs. The service demonstrated how they deliver care and services that are culturally safe, and staff provided examples of how they value, and respect consumers’ needs and beliefs.

Consumers confirmed they are assisted to live their best life and are able to decide what care and services they want to receive. Risk assessments viewed by the Assessment Team outlined strategies to support consumer risks to ensure they are able to continue these activities safely. Staff were able to describe how they support consumers to take risks. However, the Assessment Team were not satisfied consumers are supported in making decisions about their own care.

Consumers interviewed confirmed they receive information in a way they can understand, including through handbooks, newsletters and meeting forums. Additionally, staff provided examples of how information is communicated to consumers with poor cognition and visual and hearing impairments. Consumers and representatives sampled confirmed consumers’ privacy is respected and staff provided examples of how they ensure consumers’ privacy is maintained.

The Assessment Team have recommended Requirement (3)(c) not met. 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)(c). I have provided reasons for my finding in the specific Requirement below.

## 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.*

The Assessment Team were not satisfied the service adequately demonstrated how consumers are supported in making decisions about their own care and independence. This was evidenced by the following:

* Consumers confirmed they are supported to make choices about their care, however, this does not always occur. Feedback from one consumer and two and representatives included:
	+ when the service is short staffed, they have to wait to go to the toilet and “it’s embarrassing when an accident happens”.
	+ staff are unable to get the consumer up in the morning, they are having breakfast late and are not up to be able to attend morning activities.
	+ due to the shortage of staff and staff being very busy, they are not always able to get up when they want or are having to wait to get to the toilet.
* A consumer who provided feedback to the Assessment Team was observed be in bed at 10.00am which was not in line with the family’s request.
* Staff confirmed they are not able to provide effective care to consumers when they are short staffed and this impacts the care, they are able to provide to the consumers in promoting their choice, including when they would like to be assisted with activities of daily living.

The provider’s response provided information directly addressing information in the Assessment Team’s report. The provider’s response indicates:

* Staff availability was impacted by State Government directives implemented in response to COVID-19. Since the lifting of the directives, staff impacted have returned to normal duties.
* Since the Site Audit, new staff have been employed and recruitment is ongoing.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service Compliant with this Requirement. The Assessment Team’s report indicates consumers and representatives are not satisfied with staffing and the timeliness of activities of daily living provided to consumers. However, I find this information more aligned to Standard 7 Requirement (3)(a) and, as such, have considered this information in my finding for Standard 7 Requirement 3(a). Information in the Assessment Team’s report indicates consumers and representatives are aware of and satisfied with persons appointed by consumers to assist with decision-making and were satisfied with decisions made. Additionally, consumer files viewed by the Assessment Team included contact details of representatives, guardians and/or other relevant support personnel to support and assist consumers with decision-making processes.

For the reasons detailed above, I find the provider, in relation to Boandik St Mary’s, Compliant with Requirement (3)(c) in Standard 1.

### 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

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

The Assessment Team found that overall consumers confirmed they were involved in assessment and planning processes when first entering the service. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* the service had not contacted representatives when changes are made to medications or when incidents occur.
* end of life goals and wishes were addressed when the consumer first entered the service.
* involved in initial assessment processes, however, have not been contacted in relation to reassessments or care plans.
* not seen care plan, however, have not wanted to as staff are good at asking what assistance consumers need.

Initial and ongoing assessment processes assist the service to identify each consumer’s care needs and preferences, including in relation to advance care planning and end of life planning. Care plans are developed and those viewed by the Assessment Team included consumers’ needs, goals and interventions and strategies to assist with the delivery of care and services.

The service demonstrated how consumers are supported to take part in assessment and planning processes. Allied health referrals are initiated when a consumer enters the service and assist with assessment processes. Representatives confirmed they were involved in the initial assessment and care planning process, however, are not consistently contacted when reassessments occur.

The service was unable to demonstrate care planning and assessments are reviewed in line with the service’s policies and procedures. Additionally, the Assessment Team were not satisfied the service demonstrated assessment and planning is completed when consumers enter the service and in the event of changes to consumers’ health status or when incidents occur.

The Assessment Team have recommended Requirements (3)(a) and (3)(e) not met. 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 in the specific Requirements below.

## 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 adequately demonstrated assessment and planning is completed when consumers enter the service and in the event of changes to consumers’ health status or when incidents occur. This was evidenced by the following:

* A skin assessment had not been completed for a consumer who entered the service in 2019.
* A Falls risk assessment report indicated only 20 of 64 consumers had an assessment completed. Four consumers who have sustained fractures as a result of falls had not had a falls risk assessment completed on entry or post falls.
* Senior clinical staff could not demonstrate knowledge of the assessment process or guidelines staff follow to ensure assessments are completed in line with the service’s policies and procedures.
* Clinical staff and management stated consumer assessments are not completed until a week after entry. This is not in line with the service’s procedure.
* A report indicated 83% of consumers did not have a completed skin assessment and 69% did not have a completed falls risk assessment.

The provider’s response provided information directly addressing information in the Assessment Team’s report and demonstrated the organisation has been proactive in addressing the issues identified. Information provided included:

* The Assessment Team did not have access to archived documents. There is a process to monitor completion of entry assessments. A sample of 14 New resident clinical assessment checklists were provided as part of the provider’s response demonstrating completion of assessments is monitored. However, a checklist for the consumer highlighted in the Assessment Team’s report was not provided.
* A risk and skin assessment have been competed for the consumer highlighted in the Assessment Team’s report.
* Reports provided to the Assessment Team are not used by the organisation to monitor completion of assessments. This is undertaken using the New resident clinical assessment checklists.
* All consumers have been reassessed for pressure injury and falls risk. Interventions have been implemented and support plans updated where required.
* Pain assessments have been completed for consumers who have had a change in analgesics.
* A Nurse advisor was appointed following the Site Audit to work with and support staff to ensure up to date support plans are in place for each consumer.
* Training provided to staff based on updated policies and procedures, including falls, pressure ulcer, wound and pain.

I acknowledge the provider’s response, the supporting documentation provided, and the proactive actions initiated in response to the Assessment Team’s findings. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, assessment and planning, including consideration of risks to consumers’ health and well-being, informs the delivery of safe and effective care and services. I have placed weight on the information in the Assessment Team’s report indicating assessments relating falls risk had not been completed for four consumers following incidents resulting in fractures. Whilst the provider’s response included checklists indicating completion of falls risk assessments on entry for two of these consumers, assessments following incidents were not included as part of the response. Additionally, the Assessment Team’s report indicated the service’s policies and procedures relating to assessment direct completion of risk assessments for consumers, including skin, falls, medication and nutrition within 24 hours of entry. A sample of checklists provided as part of the provider’s response demonstrated this is not consistently occurring.

For the reasons detailed above, I find the provider, in relation to Boandik St Mary’s, Non-compliant with Requirement (3)(a) in Standard 2.

### 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.*

### 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) 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 adequately demonstrated care planning and assessments are reviewed in accordance with the service’s policies and procedures. This was evidenced by the following:

* Skin and falls assessments were not completed for a consumer (Consumer A) following a fall resulting in a fracture. The last pain assessment was dated prior to the fall.
* A consumer’s (Consumer B) care plan review was completed six months after the last review. The review was not signed by the consumer’s representative or Medical practitioner.
	+ Consumer B had five unwitnessed falls with one resulting in a fracture. Skin and falls assessments had not been completed and the last pain assessment was dated prior to the fracture.
* Review of Physiotherapist mobility requirements records indicated 19 consumers have not had a four month review completed and of these, eight consumers had not been reviewed post falls.
* Clinical staff confirmed reassessments were behind due to staffing.

The provider’s response provided information directly addressing information in the Assessment Team’s report. The provider’s response demonstrated the organisation has been proactive in addressing the issues identified in the Assessment Team’s report and included information relating to actions implemented. Information provided included:

* The service has been impacted by a shortage of Registered nurses in the region. Additional Registered nursing staff have been engaged.
* A Nurse advisor was appointed following the Site Audit to work with staff to improve current practices.
* Procedures relating to falls management, pressure ulcers and pain management have been reviewed and updated. The support plan review process is being reviewed.
* Risk assessments are now completed with information gathered pre-entry to identify areas of risk.
* All consumers have been reassessed for pressure injury and falls risk. Interventions have been implemented and support plans updated where required.
* Pain assessments have been completed for consumers who have had a change in analgesics.

I acknowledge the provider’s response, the supporting documentation provided, and the proactive actions initiated in response to the Assessment Team’s findings. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, care and services were not being reviewed regularly for effectiveness, including when incidents impacted the needs of consumers. I have placed weight on the information in the Assessment Team’s report indicating assessments relating to pain, falls and skin were not completed for two consumers following incidents which resulted in fractures. Additionally, clinical staff interviewed by the Assessment Team confirmed reassessments were behind due to staffing.

For the reasons detailed above, I find the provider, in relation to Boandik St Mary’s, Non-compliant with Requirement (3)(e) in Standard 2.

# 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

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

The Assessment Team found some sampled consumers considered that they receive personal and clinical care that is safe and right for them. The following examples were provided by consumers during interviews with the Assessment Team:

* get the care and services they need and felt safe in the care they receive from staff.
* described having access to a doctor and other allied health practitioners.
* described being supported in accessing external specialists.

The service has initial and ongoing assessment and review processes. Individualised care plans are developed for each consumer to assist staff in delivery of care and services.

The service has processes to identify each consumer’s needs, goals and preferences in relation to end of life. Staff described processes implemented when a consumer is at end of life, including documentation completed. A care file viewed by the Assessment Team for a consumer recognised as palliative demonstrated ongoing monitoring of the consumer’s well-being, including pain and regular consultation with representatives.

Documentation viewed demonstrated deterioration or changes to consumers’ mental health, cognitive or physical function are identified and referrals to Medical officers or allied health specialists are initiated. Additionally, staff stated reassessments occur, and care plans are updated to reflect consumers’ current care needs.

The service demonstrated appropriate infection control measures are in place, including in relation to COVID-19 preparedness. Staff were observed using correct personal protective equipment and regularly washing their hands. Documentation viewed demonstrated records of consumer and staff influenza vaccinations are maintained and monitored. Additionally, there are processes to monitor compliance with influenza vaccinations for visitors to the service.

The Assessment Team were not satisfied the service adequately demonstrated consumers receive personal and clinical care that is best practice, tailored to their needs or optimises their health and well-being.

The service has been Non-compliant with Requirement (3)(b) since an Assessment Contact conducted 4 July 2019 identified the service was unable to demonstrate effective management of a consumer’s physically aggressive behaviours. The Requirement was again found Non-compliant following an Assessment Contact conducted 1 October 2019. At this Assessment Contact, the service was unable to demonstrate effective management of consumers with challenging behaviours and consumers who chose to smoke. At this Site Audit, the Assessment Team have recommended Requirement (3)(b) not met, specifically in relation to management of medications, falls, food intake and weight.

The Assessment Team have recommended Requirements (3)(a) and (3)(b) not met. 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)(b). I have provided reasons for my findings in the specific Requirement below.

### 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 adequately demonstrated consumers receive safe and effective services which are best practice, tailored to their needs or optimises their health and well-being. This was evidenced by the following:

* Consumers’ daily/weekly observations are not being completed in line with Medical officer directives.
* Wounds are not reviewed in line with wound management plans.
* The use of hip protectors was not documented in three consumer files. All three consumers are considered at high risk of falls and have had multiple falls.
	+ Staff did not demonstrate knowledge of which consumers required hip protectors.

Restraint

* Management said a low low bed has been provided for a consumer’s safety. Progress notes indicate mobility strategies include walking with staff, using a stand lifter and independently toileting. Management said a restraint form has not been completed.
	+ Eleven falls occurred whilst the consumer was attempting to get out of bed.
* Management confirmed low low beds are in use for safety for four consumers who are mobile. Management confirmed restraint forms have not been completed.

The provider’s response provided information directly addressing information in the Assessment Team’s report. The provider’s response demonstrated the organisation has been proactive in addressing the issues identified in the Assessment Team’s report and included information relating to actions implemented. Information provided included:

* Implemented a seven day handover sheet highlighting days when clinical observations are due for each consumer.
* A staff training session highlighted clinical staff responsibilities in relation to wound management.
* Implemented a weekly wound management audit for a period of six weeks
* Consumer support plans updated to include directives related to use of hip protectors.

In relation to restraint

* Conducted an audit of restraint devices to identify risk assessment completion and consultation with consumer and/or representative and Medical officer.
* Reassessments for all consumers with low low beds are being completed.
	+ A sample of risk assessments included in the provider’s response outlined risks associated with the use of restraint devices, goals and interventions to mitigate risks.

I acknowledge the provider’s response and the supporting documentation provided. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service had not ensured consumers received clinical and/or personal care in accordance with best practice, tailored to their needs, or which optimised their health and well-being. Consumers’ clinical care needs, specifically in relation clinical observations, wound management and falls risk have not been consistently implemented or monitored in line with consumers’ care and service needs or best practice guidelines. Additionally, management had not recognised use of low low beds for consumers as restraint stating these devices had been implemented for safety. As such, restraint authorisations had not been completed, consultation with consumers and/or representatives relating to risks had not been undertaken and strategies to mitigate risks had not been initiated.

For the reasons detailed above, I find the provider, in relation to Boandik St Mary’s, Non-compliant with Requirement (3)(a) in Standard 3.

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

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

The Assessment Team were not satisfied the service adequately demonstrated high impact or high prevalence risks associated with the care of each consumer are effectively managed. This was evidenced by the following:

* Clinical incident reports over a three month period indicate an increase in consumer falls. Eight consumers have recorded a combined total of 73 falls over this period.

Consumer A

* Medications were not consistently administered in line with Medical officer directives.
* A pain assessment had not been initiated following a change in pain medication.

Consumer B

* Another consumer’s medications were consumed by Consumer B, including a high dose of antidepressant, hypertensive and antipsychotic medications. Staff were unable to speak to the consumer’s Medical officer, and instead contacted the pharmacy who recommended the consumer be transferred to hospital. This was not actioned until approximately two and a half hours later as the service waited for the Medical officer to return the call.

Consumer C

* Wound charting indicates wounds are not being managed in line with the dressing schedule.
	+ In response to deterioration of wounds, the representative contacted an external wound service to attend to wound management.
* The consumer is on a 1.5 litre fluid restriction. Over a 13 day period, fluid intake forms were not completed on eight days and fluid intake documented for five days ranged from 950ml to 1550mls.

Consumer D

* The representative had been advised the consumer is not interested in eating and takes a long time to chew their food. The representative stated they find the consumer’s meals sitting on the tray when they visit.
* A Dietitian report dated May 2020 indicates ‘noted a number of occasions where (the consumer) is sleeping during mealtime and then only offered sweets and water when awake later in the evening’.
* A Dietitian report dated September 2020 notes the consumer had lost 22% of body weight, or 13.5kg over the past 12 months’. The representative stated they have not been informed of the significant weight loss.

Consumer E

* The consumer is prescribed short-term insulin. Consumer E was administered another consumer’s long acting insulin and was admitted to hospital for monitoring.
	+ Actions documented on the incident report included labelling of insulin containers and ‘possibly’ pens. Pens were observed by the Assessment Team not to be labelled.

The provider’s response provided information directly addressing information in the Assessment Team’s report. The provider’s response demonstrated the organisation has been proactive in addressing the issues identified in the Assessment Team’s report and included information relating to actions implemented. Information provided included:

* Updated the falls management procedure to include completion of a falls risk assessment following each fall.
	+ Updated the falls incident form.
	+ Appointed a Board member as Chair of the Clinical Governance Committee. This will include reviewing collated falls data to identify trends.

In relation to consumer A

* Updated pain procedure to include assessment where there is a change in analgesic dose.
* The consumer’s pain has been reassessed and support plan updated.
* An investigation confirmed the reason medication incidents occurred was due to the COVID-9 lockdown period when Medical officer reviews were being undertaken via telehealth.
	+ Implemented a new process to ensure medication charts are updated.

In relation to Consumer B

* Medication credentialing completed for required staff.
* Training provided in relation to medications, including administration.

In relation to Consumer C

* Implemented new handover sheets which include fluid monitoring.
* Staff training in relation to wound management, including the updated procedure.
* Information included in the provider’s response demonstrates regular consultation between the representative and the service occur.

In relation to Consumer D

* The consumer had been seen by allied health specialists and was on a high energy, high protein diet and supplements. The consumer’s weight had been gradually increasing.
* A weight monitoring chart included as part of the provider’s response included four weights recorded over a 21 day period following the Site Audit. Whilst the record indicates a gradual gain, weights recorded before this period were not provided.

In relation to Consumer E

* Insulin pens have been labelled.

I acknowledge the provider’s response, the supporting documentation provided, and the proactive actions initiated in response to the Assessment Team’s findings. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service did not consistently manage high impact or high prevalence risks associated with the care of each consumer. In coming to my finding, I have placed weight on information documented in the Assessment Team’s report relating to five consumers demonstrating high impact or high prevalence risks related to clinical care were not appropriately responded to or managed. Areas of clinical care highlighted in the Assessment Team’s report included medication, falls, weight loss, pain, fluid intake monitoring and wound management.

For the reasons detailed above, I find the provider, in relation to Boandik St Mary’s, Non-compliant with Requirement (3)(b) in Standard 3.

### 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) 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.*

# STANDARD 4 COMPLIANTServices and support for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

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

The Assessment Team found overall, consumers considered that they get the services and supports for daily living that are important for their health and well-being and enable them to do the things they want to do. The following examples were provided by consumers during interviews with the Assessment Team:

* supported to do things they like to do.
* supported to keep in touch with people who are important to them.
* like the food and are able to provide feedback and suggestions in relation to meals.

Assessment processes assist to identify each consumer’s goals, needs and preferences. Information gathered through assessment processes is used to develop individualised care plans which outline consumers’ life history, religious practices and other areas of importance to the consumer. For sampled consumers, staff described what was important to consumers, how they support consumers to remain independent and how they support consumers’ emotional, spiritual and psychological well-being.

The lifestyle program includes a range of activities programmed over seven days. There are processes to support consumers who do not wish to participate in scheduled activities, including one-on-one visits with volunteers. Care plans for sampled consumers included information relating to how consumers are supported to participate in the community and maintain friendships.

A sample of consumer files viewed by the Assessment Team demonstrated information about consumers’ conditions, needs and preferences is clearly documented and communicated within the service and with others where responsibility is shared.

The service offers a varied menu of suitable quality and quantity. The menu is reviewed by a Dietitian and there are a range of alternative meal options available. Most consumers said they like the food and can provide feedback in relation to meals directly to staff and at meeting forums. Dietary assessments and care plans sampled were noted to be reflective of consumers’ needs, goals and preferences.

The Assessment Team found the organisation has monitoring processes in place in relation to Standard 4 to ensure safe and effective services and supports for daily living are provided that optimise consumers’ independence, health, well-being and quality of life.

## 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.*

### 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 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 Compliant as all three specific Requirements have been assessed as Compliant.

The Assessment Team found most sampled consumers considered that they feel they belong in the service and feel safe and comfortable in the service environment. The following examples were provided by consumers during interviews with the Assessment Team:

* the service is clean, well maintained and feels like home.
* satisfied with the cleanliness of their rooms and the laundry services provided.
* rooms are personalised to their taste and liking, with furniture, soft furnishings and personal memorabilia from their home.

The Assessment Team observed the environment, furniture and equipment to be safe, clean and well maintained. The environment was noted to be welcoming and homely with adequate lighting and signage displayed at eye level. Consumer rooms and the living environment are spacious, and consumers were observed to be moving freely around the service, both indoors and outdoors.

Staff, including Maintenance staff described how they identify and report maintenance tasks and hazards. There are preventative and reactive maintenance processes, and documentation viewed confirmed maintenance issues are actioned. Cleaning processes are in place and staff interviewed were aware of their responsibilities in relation to cleaning tasks. However, some consumers and representatives interviewed stated they had recently noted a decline in cleaning quality. Management stated in response to a review, there had been a reduction in housekeeping shifts and evaluation of the change is pending.

The Assessment Team found the service has monitoring processes in relation to Standard 5 to ensure a safe and comfortable service environment is provided that promotes consumers’ independence, function and enjoyment.

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

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

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

# STANDARD 6 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

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

The Assessment Team found that overall, most sampled consumers and representatives considered they are encouraged and supported to give feedback and make complaints. However, feedback from interviews and documentation viewed by the Assessment Team demonstrated the service does not always ensure appropriate action is taken in response to complaints, open disclosure is not always used, and feedback and complaints are not consistently captured, reviewed or used to improve the quality of care and services. The following examples were provided by consumers and representatives during interviews with the Assessment Team:

* described how they would raise issues or provide feedback to the service and stated they felt comfortable to do so.
* the service does not act appropriately and promptly when responding to feedback and complaints and an open disclosure process is not always used.
* unable to provide examples of improvements as a result of the review of feedback and complaints provided to the service.

Consumers are provided with information about feedback and complaints mechanisms and advocacy services on entry. Feedback forms and external complaints and advocacy information were observed on display at the service.

Staff described how they assist consumers if they raise an issue or concern and, if they are unable to assist, they notify clinical staff or management. Management described how they seek consumer feedback, including through surveys and meeting forums.

The Assessment Team were not satisfied the service demonstrated appropriate action is taken in response to complaints or how feedback and complaints are reviewed and used to improve quality of care and services.

The Assessment Team have recommended Requirements (3)(c) and (3)(d) not met. 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 Requirements (3)(c) and (3)(d). I have provided reasons for my findings in the specific Requirement below.

## 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) 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 demonstrated appropriate action is taken in response to complaints. This was evidenced by the following:

* Two consumers and two representatives provided the following comments:
	+ Bring up issues all the time with the service but do not see these have been addressed in a timely manner.
	+ Following a meeting with management, the representative was told they would be kept informed about the actions agreed upon, however, have not received any further communication from management.
	+ Complained about the quality of food on several occasions but have seen no action taken as a result of the feedback.
	+ Have raised issues relating to quality of meals and fewer fresh vegetables but have not seen any improvements as a result of the feedback.
* Resident meeting minutes indicated there are some actions not resolved nor mentioned in the following meeting minutes.
* Feedback from consumers and representatives indicated the service is not complying with their feedback policy in relation to open disclosure to ensure the complainant is kept fully informed throughout the investigation.

The provider’s response provided information directly addressing information in the Assessment Team’s report, including further information and documentation clarifying issues raised. The provider’s response indicated:

* Complaints had been documented in progress notes as they occurred and not transferred to the complaints log. Complaints had been actioned as they arose.
* In relation to consumer and representative feedback:
	+ One representative raises issues regularly and these are discussed and agreed actions implemented. Further consultation with the representative has occurred.
	+ Progress notes included in the provider’s response demonstrate consultation with a representative in relation to a consumer has been ongoing.
	+ Meal preferences for one consumer have been updated.
* Clarifying information included in the provider’s response relating to action items discussed at Resident meetings demonstrate these are discussed and/or addressed.
* The provider’s response included further examples of where an open disclosure approach had been used.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service Compliant with this Requirement. Information and documentation included as part of the provider’s response demonstrated appropriate action is taken in response to feedback and complaints. Information included directly related to consumer and representative feedback highlighted in the Assessment Team’s report and action items addressed at Resident meetings in relation to feedback and complaints. Additionally, the Assessment Team’s report included two examples of where open disclosure processes had been applied in relation to consumer clinical issues and actions implemented as a result.

For the reasons detailed above, I find the provider, in relation to Boandik St Mary’s, Compliant with Requirement (3)(c) in Standard 6.

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

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

The Assessment Team were not satisfied the service demonstrated how feedback and complaints are reviewed and used to improve the quality of care and services. This was evidenced by the following:

* None of the consumers or representatives interviewed could describe improvements that had occurred following feedback.
* Three staff members said they had not been informed of outcomes or improvements as a result of their complaints or feedback.
* A Complaints Report had not captured complaints following 14 July 2020. Not all complaints are recorded in the complaints register to enable timely action and resolution to be monitored and review of processes to improve the quality of care.
* High-level reporting of complaints and survey results are provided at management team meetings and Board meeting. However, there is no evidence of analysis of complaints to inform continuous improvement.
* Information recorded on the Complaints Report and Plan does not provide information on how feedback has provided continuous improvements to the quality of care and services to consumers.

The provider’s response provided information directly addressing the information in the Assessment Team’s report, including further information and documentation clarifying issues identified. The provider’s response indicated:

* Documentation included in the provider’s response outlined an example of a staff complaint and actions and improvements initiated as a result.
* There has been a change in procedure for recording minor complaints in the last 12 months to enable trends to be identified.
* Information in the Assessment Team’s report relating to a consumer was not a complaint. The provider’s response included documentation demonstrating ongoing consultation with the representative.
* Complaints data is referred to the Executive committee monthly and reviewed for trends. The provider’s response included an example of an organisational continuous improvement initiative identified through complaints data. This example was also highlighted in the Assessment Team’s report for Requirement 3(c) in this Standard.
* Seven examples of continuous improvement plans were included in the provider’s response. The plans included complaints from representatives and staff identified through meeting forums and surveys and actions implemented.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service Compliant with this Requirement. Information included in the provider’s response demonstrates the organisation has processes to review feedback and complaints data and identify trends. Examples of improvements initiated in response to complaints and feedback were included in the provider’s response and noted in the Assessment Team’s report. Whilst consumers and representatives could not recall improvements implemented as a result of feedback, information included in the provider’s response demonstrates actions are initiated in response to feedback and complaints.

For the reasons detailed above, I find the provider, in relation to Boandik St Mary’s, Compliant with Requirement (3)(d) in Standard 6.

# 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

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

The Assessment Team found that most sampled consumers and representatives were not satisfied there were adequate staff to provide quality care and services when consumers need them. The following examples were provided by consumers during interviews with the Assessment Team:

* staff are kind, caring and do their best to assist consumers.
* not satisfied with staffing levels, staff are rushed, overworked, stressed and not always able to meet consumers’ care needs and preferences.
* described impacts on consumers’ health, well-being and dignity when personal and clinical needs are not met and safety issues and behaviours when staff assistance is not available when needed.

Staff were observed interacting with consumers in a kind, caring and respectful manner. Staff discussed what they would do if they observed a staff member being disrespectful or unkind to consumers, including reporting the behaviour to management.

Staff are recruited based on having the appropriate qualifications and/or experience for the role. Induction processes include an orientation and completion of mandatory training components based on job roles. A comprehensive training calendar incorporates mandatory training components and there are processes to monitor staff completion of these components. Training records viewed demonstrated all staff have completed required training.

The Assessment Team were not satisfied regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. Documentation viewed demonstrated most staff have not participated in an annual performance appraisal process.

The Assessment Team have recommended Requirements (3)(a) and (3)(e) not met. 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 in the specific Requirement below.

## Assessment of Standard 7 Requirements

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

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

The Assessment Team were not satisfied the service demonstrated 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. This was evidenced by the following:

* Feedback provided to the Assessment Team from four of six consumers included:
	+ Wait to be attended for continence needs as the service is so short staffed. When they do not make it to the toilet in time it makes them feel “bloody uncomfortable”.
	+ There are never enough staff and staff change around with so much to do. A treatment has been missed on some occasions which makes them uncomfortable and unable to sleep. They do not ring the bell as they know how busy the staff are.
	+ They are rushed and told to hurry up as staff are put under pressure. The support provided by staff could be more meaningful to consumers but will make allowances for staff ‘under the circumstances.’
	+ Try not to use the call bell as they know how long it takes for it to be responded to. On one occasion they had a fall in the bathroom and did not report it.
* Feedback provided to the Assessment Team from four of five representatives included:
	+ Delay with continence needs.
	+ Stressed about understaffing in the secure unit. Not sure how often family member receives showers and concerned about the time the family member spends in bed. Lack of communication between staff and representatives due to staff being too busy.
	+ Quality of staff is variable, dependent on the staff rostered. Concerned about lack of support to assist at mealtimes.
	+ Never enough staff and are scarcer on the weekends.
* Staff stated they are short staffed, with some shifts not being filled. This impacts on their ability to meet care and clinical needs of consumers.
* One staff member stated they provide showers to at least three consumers on the afternoon shift as there is no time on the morning shift for this to occur. This is not the consumers’ preference.
* On the second morning of the Site Audit, there was no coverage for three shifts (two of which were in the secure unit) and lifestyle staff were able to back fill half of one shift.

The provider’s response provided information directly addressing the information in the Assessment Team’s report. The provider’s response demonstrated the organisation has been proactive in addressing the issues identified in the Assessment Team’s report and included information relating to actions implemented. Information provided included:

* Staff availability was impacted by Government directives implemented in response to COVID-19. There were sufficient staff employed to cover the roster prior to implementation of the directives. Since the lifting of the directives, staff impacted have returned to normal duties.
* Recruitment had commenced prior to the directives. Since the Site Audit, new staff have been employed and recruitment is ongoing.
* With the above actions, there has been a significant decrease in unfilled shifts.
* Additional staffing resources have been added, including increased weekend clinical staff hours and the addition of an engagement shift seven days a week in the secure unit.
* Consulted with representatives of two of the three consumers who are showered in the afternoon.

I acknowledge the provider’s response and the supporting documentation provided. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service had not ensured the number and mix of members of the workforce enabled the delivery and management of safe and quality care and services to consumers. I acknowledge staffing numbers were impacted by the Government directives implemented in response to COVID-19. However, I have placed weight on feedback provided to the Assessment Team by consumers which indicated impact to their care, including delayed continence management, treatments not being attended, risk of falls and being rushed by staff with care needs. Two consumers also reported they do not use the call bell as they know how busy staff are and they know how long it takes for it to be responded to. Additionally, feedback provided to the Assessment Team by staff indicated they are short staffed which has an impact on their ability to meet care and clinical needs of consumers.

For the reasons detailed above, I find the provider, in relation to Boandik St Mary’s, Non-compliant with Requirement (3)(a) in Standard 7.

### 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) Compliant

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

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

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

### 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 were not satisfied the service demonstrated regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. This was evidenced by the following:

* Staff interviewed who were employed longer than one year stated they had not had the opportunity to participate in an appraisal for over a year.
* No current performance appraisals or performance management information was noted in staff personnel files viewed.
* A report indicated annual performance appraisals for 43 staff were overdue. One staff member’s performance appraisal had been overdue since 7 March 2019.

The provider’s response indicated they agreed with the Assessment Team’s recommendation. The provider’s response demonstrated the organisation has been proactive in addressing the issues identified in the Assessment Team’s report and included information relating to actions implemented, such as:

* Established a new performance review monitoring system, including generation of monthly reports.
* Reports are provided to the executive team to monitor compliance with key performance indicators.
* Documentation provided in the response indicates performance appraisals have been completed for 30 of 54 staff with the outstanding appraisals planned to be completed by end of October 2020.

I acknowledge the provider’s response and the supporting documentation provided. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, regular assessment, monitoring and review of performance of each member of the workforce was not being conducted or in line with the organisation’s processes. Staff interviewed stated they had not been involved in a performance appraisal for over 12 months, current performance appraisals were not noted in any of the staff files and documentation indicated performance appraisals were overdue for the majority of staff.

For the reasons detailed above, I find the provider, in relation to Boandik St Mary’s, Non-compliant with Requirement (3)(e) in Standard 7.

# 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

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

The Assessment Team found most sampled consumers and representatives considered that the organisation is well run, and they can partner in improving the delivery of care and services. Consumers provided examples of how they are involved in the development, delivery and evaluation of care and services through involvement in meeting forums and co-design groups.

The organisation demonstrated established governance systems to promote a culture of safe and quality care and services. Consumers have input into the service through several feedback mechanisms and forums, including meeting forums, surveys, food appreciation group, clinical co-design group and feedback and complaints processes.

The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. There are a range of reporting mechanisms to ensure the Board is aware of and accountable for the delivery of services.

The organisation has a governance structure to support all aspects of the organisation, including information management, financial governance, workforce and clinical governance and feedback and complaints. However, the Assessment Team were not satisfied the organisation demonstrated effective organisation wide governance systems relating to continuous improvement and regulatory compliance.

The organisation has a risk management system in place, however, the Assessment Team were not satisfied the organisation’s risk management system and practices adequately demonstrated management and monitoring of high-impact or high-prevalence risks associated with the care of consumers.

The service has been Non-compliant with Requirement (3)(d) since an Assessment Contact conducted 4 July 2019 identified representatives were not satisfied the organisation effectively managed a consumer’s physically aggressive behaviours and they were concerned for the safety of their relatives. The Requirement was again found Non-compliant following an Assessment Contact conducted 1 October 2019. At this Assessment Contact, the service was unable to demonstrate effective risk management systems and practices to manage high impact or high prevalence risks, specifically in relation to completing incident reports for verbal and physical aggression, not taking appropriate action in relation to an allegation of abuse and not recording incidents for allegations of a consumer smoking in their room.

At this Site Audit, the Assessment Team have recommended Requirement (3)(d) not met. Whilst the organisation has a risk management system in place, the Assessment Team were not satisfied the organisation’s risk management system and practices adequately demonstrated management and monitoring of high-impact or high-prevalence risks associated with the care of consumers.

The organisation has policies and procedures to guide staff practice in relation to antimicrobial stewardship, minimising use of restraint and open disclosure. Staff interviewed demonstrated an awareness of these policies and provided examples of their relevance to their work.

The Assessment Team have recommended Requirements (3)(c) and (3)(d) not met. 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)(c) and (3)(d). I have provided reasons for my findings in the specific Requirements below.

## 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 organisation demonstrated effective organisation wide governance systems relating to information management, financial governance, workforce governance and feedback and complaints. However, the Assessment Team were not satisfied the organisation effectively demonstrated governance systems in relation to continuous improvement and regulatory compliance. This was evidenced by the following:

Continuous improvement

* Of 107 continuous improvement activities, 62 did not identify action taken, outcome or evaluation.

Regulatory compliance

* Management were asked on four occasions how representatives had been advised on the commencement of the Site Audit, however, the Assessment Team was not provided this information.
* Representatives confirmed they were not advised the Site Audit was in progress.
* The service did not take reasonable steps to notify nominated representatives that the Site Audit had commenced.

The provider’s response provided information directly addressing information in the Assessment Team’s report. The provider’s response demonstrated the organisation has been proactive in addressing the issues identified in the Assessment Team’s report and included information relating to actions implemented. Information provided included:

In relation to Continuous improvement

* The Assessment Team was provided the continuous improvement plan which included current significant corporate and site specific improvements. Those actioned, evaluated and finalised were not included.
* As a result of impacts of COVID-19, management were behind in updating continuous improvement forms on the database. Many of the forms had been investigated and action implemented.
* All continuous improvement forms and the plan are up to date.

In relation to Regulatory compliance

* This was an oversight due to the process being very disjointed and staff interaction was restricted due to COVID-19 restrictions on entry to the service.
* The procedure guiding actions, including during Site Audits has been updated to ensure this does not occur again.

I acknowledge the provider’s response, the supporting documentation provided, and the proactive actions initiated in response to the Assessment Team’s findings. Based on the Assessment Team’s report and the provider’s response, in relation to Continuous improvement, I find whilst actions, outcome and evaluation of continuous improvement initiatives were not electronically documented, documentation provided as part of the provider’s response demonstrates ongoing identification of improvement initiatives at both a site and corporate level. The Continuous improvement plan provided included actions implemented to achieve the initiatives, including actions pre-dating the Site Audit visit.

However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service did not take reasonable steps to notify nominated representatives of the commencement of the Site Audit in line with legislative requirements. Whilst posters indicating the commencement of the Site Audit were displayed around the service, representatives interviewed by the Assessment Team confirmed they had not been advised the Site Audit was in progress. This is not in line with the *Aged Care quality and Safety Commission Rules 2018, Part 3, Division 3, Section 31 (1).*

For the reasons detailed above, I find the provider, in relation to Boandik St Mary’s, Non-compliant with Requirement (3)(c) in Standard 8.

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

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

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

The Assessment Team were not satisfied the organisation effectively demonstrated effective risk management systems and practices, specifically in relation to managing high impact or high prevalence risks associated with the care of consumers. This was evidenced by the following:

* The risk management policy and risk control plan identifies two areas of risk relating to consumers, including ability to take risks and modification of medication.
* The organisation does not outline effective risk management systems and practices relating to management of high impact or high prevalence risks, such as preventing and managing falls, pain management and administration of medications.

The provider’s response provided information directly addressing information in the Assessment Team’s report. The provider’s response demonstrated the organisation has been proactive in addressing the issues identified in the Assessment Team’s report and included information relating to actions implemented. Information provided included:

* Updated the corporate risk identification and assessment register and risk control plan to strengthen clinical risk areas.
* Reviewing and amending the Clinical governance framework to provide greater focus on high impact and high prevalence risks.
* Risk assessment process for individual consumers has been strengthened. Procedures relating to falls management, pressure ulcers and pain management have been updated.

I acknowledge the provider’s response, the supporting documentation provided, and the proactive actions initiated in response to the Assessment Team’s findings. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the organisation’s risk management systems and practices were not effective, specifically in relation to high impact or high prevalence risks associated with the care of consumers. The organisation’s risk framework did not identify areas of high impact or high prevalence risks, specifically in relation to medication, falls and pain. Information documented in the Assessment Team’s highlights issues in relation to these specific clinical risk areas.

For the reasons detailed above, I find the provider, in relation to Boandik St Mary’s, Non-compliant with Requirement (3)(d) in Standard 8.

### Requirement 8(3)(e) 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.*

# 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.

The provider’s response included actions initiated by the organisation to address the deficiencies identified by the Assessment Team in the Non-compliant Requirements and included improvements which directly address the issues identified by the Assessment Team. The service should seek to ensure:

**Standard 2 Requirements (3)(a) and (3)(e)**

* Staff have the skills and knowledge to:
* initiate assessments and update care plans where changes to consumers’ health are identified or when incidents occur.
* Consumer care plans are updated and reflective of consumers’ current and assessed needs and preferences to enable staff to provide quality care and services.
* Policies and procedures in relation to assessment and care planning are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to assessment and care planning.

**Standard 3 Requirements (3)(a) and (3)(b)**

* Staff have the skills and knowledge to:
* review and undertake treatments in line with wound management plan.
* monitor consumers’ clinical observations in line with Medical officer directives.
* ensure care plans are accurate and reflective of each consumer’s current care and service needs.
* Identity devices used as restraint, complete authorisations for use, initiate consultation with consumers and/or representatives in relation to risks and develop strategies to mitigate risks.
* Ensure policies, procedures and guidelines in relation to medication management, restraint and high impact or high prevalence risks are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to medication management, restraint and management of high impact or high prevalence clinical risks.

**Standard 7 Requirements (3)(a) and (3)(e)**

* Appropriate and adequate staffing levels and skill mix are maintained to deliver care and services in line with consumers’ needs and acuity.
* Regular staff performance review processes are conducted, and staff are effectively monitored.

**Standard 8 Requirements (3)(c) and (3)(d)**

* Review the organisation’s governance systems in relation to regulatory compliance.

Review the organisation’s risk management processes in relation to managing high impact or high prevalence risks associated with the care of consumers.