Boandik St Mary's

Performance Report

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**Commission ID:** 6234

**Provider name:** Boandik Lodge Inc

**Assessment Contact - Site date:** 30 June 2021 to 1 July 2021

**Date of Performance Report:** 20 September 2021

# 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

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| --- | --- |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Non-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) | Non-compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | Non-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 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
* the provider’s response to the Assessment Contact - Site report
* the Performance Report dated 27 January 2021 for the Site Audit conducted 15 to 17 September 2020.

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

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 2

The Quality Standard is assessed as Non-compliant as one Requirement has been assessed as Non-compliant. The Assessment Team assessed Requirements (3)(a) and (3)(e) in this Standard at this Assessment Contact. All other Requirements in this Standard were not assessed.

The Assessment Team assessed Requirements (3)(a) and (3)(e) in this Standard at the Assessment Contact and recommended Requirements (3)(a) and (3)(e) as met. However, based on the information and evidence presented in Standard 3 Requirement (3)(a) and the response from the Approved Provider, I have come to a different view from the Assessment Team in relation to Requirement (3)(a) in this Standard. I have provided reasons for my finding in the specific Requirement below.

The service was found Non-compliant with Requirements (3)(a) and (3)(e) following a Site Audit conducted between 15 and 17 September 2020. Specifically, the service was unable to demonstrate that assessment and care planning occurs in a timely manner when consumers enter the service, and on an ongoing basis, including when a consumer’s condition changes or incidents occur. Further, the service was unable to demonstrate that care planning is regularly reviewed for effectiveness to ensure care provision is planned in accordance with the consumer’s needs, goals and preferences. In relation to Requirement (3)(a), the Assessment Team has recommended this Requirement as met as the service has updated policies and procedures to address the deficits identified during the Site Audit conducted between 15 and 17 September 2020, and implemented a new admission process to ensure assessment and planning was completed in a timely manner when consumers entered the service. In relation to Requirement (3)(e) the Assessment Team considered that while the service is behind in their regular support plan reviews, the service has strategies in place to mitigate the delay. The Approved Provider response did not address the Assessment Team’s report in relation to this Standard, however addressed the Assessment Teams’ evidence in relation to Standard 3 Requirements (3)(a).

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report to come to a view of compliance and find the service Non- compliant with Standard 2 Requirement (3)(a) and Compliant with Requirement (3)(e). The reasons for the findings are detailed in the specific Requirement 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 service was found Non-compliant with Requirement (3)(a) following a Site Audit conducted 15 and 17 September 2020. Specifically, the service was unable to demonstrate that assessment and planning was completed in a timely manner when consumers entered the service, or in the event of changes to consumers condition, including when incidents occur. In response to the deficiencies identified, the service implemented improvements, including (but not limited to):

* Nurse Advisor appointed to support staff in developing effective assessment and care planning processes.
* Pre-admission information is collected to inform risk assessments.
* Updated pain management and pressure injury prevention procedures to include requirements for initial and ongoing assessments, including when a consumer’s condition changes.
* Implemented falls risk re-assessments (FRAT) following consumer falls.
* Updated incident forms to capture information that relevant assessments following incidents have been completed.

The Assessment Team provided the following information and evidence relevant to my finding:

* Observed a new admission checklist form to ensure that new admissions have assessments completed in a timely manner. Registered Nurses provide oversight of the admission process and completion of the admission process. Clinical staff at the service confirmed that this process has been implemented.
* Interviewed consumers and representatives, who confirmed that they are consulted and informed regarding assessments.

I have also considered the following evidence included in the Assessment Team’s report in Standard 3 Personal Care and Clinical Care, Requirements (3)(a) in my finding for this Requirement:

* One consumer was assessed as requiring half hour visual observations to support safety and minimise risk of falling, however care planning documentation (including the visual observation chart) was not updated to inform the delivery of care. As such, the consumer did not have visual observations occur at the assessed frequency to support safety.
* The Assessment Team found that for two consumers, dignity blankets were in use and were tied to the bottom of the consumers’ chairs. Staff interviewed stated that the dignity blankets were in use due to the consumers being resistive to care. The Assessment Team found the service had not conducted risk assessments or care planning for the use of the tied dignity blankets.

The Approved Provider’s response did not address the Assessment Team’s report in relation to this Standard however addressed the Assessment Team’s findings in relation to Standard 3 Requirement 3(a). The provider’s response included (but was not limited to):

* All dignity blankets have been removed from the service and are no longer in use.

In coming to my finding, I have considered and recognise the actions taken by the service in response to the deficiencies identified at the Site Audit, including the evidence provided by the Assessment team that demonstrates the service has implemented a new admission check list to ensure timely assessment and care planning for consumers who enter the service. I also acknowledge that the service no longer uses dignity blankets. However, I find that at the time of the Assessment Contact, the service was unable to demonstrate assessment and planning, including consideration of risks to consumer’s health and well-being informs the delivery of safe and effective care. Specifically, risks regarding a potentially restrictive practice were not assessed in relation to two consumers where tied dignity blankets were in use due to responsive behaviours. In addition, the use of the dignity blankets occurred without care planning that directed the use of the dignity blankets according to an assessed need, consideration of risk mitigation strategies or monitoring. Further, the service was unable to demonstrate that care is planned according to consumers’ assessed needs in relation to monitoring of consumers to ensure their safety.

Based on 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)(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.*

### The service was found Non-compliant with Requirement (3)(e) following a Site Audit conducted 15 and 17 September 2020. Specifically, the service was unable to demonstrate that care and service plans are reviewed regularly for effectiveness, or when incidents and changes to a consumer’s condition occurs. Specifically, the service was behind in their four monthly reviews of consumer care and service plans, and re-assessments were not completed when incidents or changes in consumer circumstances occurred. In response to the deficiencies identified, the service implemented improvements, including (but not limited to):

* Nurse Advisor appointed to support staff in developing effective assessment and care planning processes.
* Scheduled review of consumer care and services plans has been changed from four monthly to six monthly.

* The scheduled care and services plan review process has been changed to include a multidisciplinary and consumer/representative forum to ensure care is planned according to consumer needs, goals and preferences.
* Implemented falls risk re-assessments (FRAT) following consumer falls.
* Updated incident forms to capture information that relevant assessments following incidents have been completed.
* Pain management procedure has been updated to include commencing pain assessments when analgesic doses are changed or ceased.
* Registered staff attended training in October 2020 related to the new procedures.

The Assessment Team provided the following information and evidence relevant to my finding:

* The service is two months behind in regards to the six-monthly review of consumer care and services plan. However, a Registered Nurse has been allocated to assist completing care plan reviews.

* Reviewed six consumer files and identified that the care and services plans are reflective of their needs and goals.
* Interviewed consumers and representatives who confirmed they are consulted in relation to assessments and care planning.

The Approved Provider’s response did not address the Assessment Team’s report in relation to this Standard. In coming to my finding, I have considered and recognised the actions taken by the service in response to the deficiencies identified at the Site Audit. While the service continues to remain behind on the regular review of consumer care and service plans, the service has implemented strategies to address the delay. In coming to my finding, I have relied upon the Assessment Team’s report which states that consumers are consulted regarding assessments and care planning, and the sample of consumer files demonstrated care and services plans are reflective of the consumer needs and goals.

Based on the reasons detailed above, I find the provider, in relation to Boandik St Mary’s Compliant with Requirement (3)(e) in Standard 2.

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 3

The Quality Standard is assessed as Non-compliant as two Requirements have been assessed as Non-compliant. The Assessment Team assessed Requirements (3)(a) and (3)(b) in relation to Standard 3. All other Requirements in this Standard were not assessed.

The service was found Non-compliant with Requirements (3)(a) and (3)(b) following a Site Audit conducted 15 and 17 September 2020. Specifically, consumer clinical care had not been consistently implemented or monitored in alignment with consumer care needs, medical officer instruction or best practice guidelines. Further, the service had not recognised the use of restrictive practices at the service or effectively managed high impact or high prevalence risks in relation to falls management, medication administration and clinical monitoring and pain assessment and management. The Assessment has recommended that Requirements (3)(a) and (3)(b) in this Standard as not met. The Assessment Team found that consumers were not receiving effective personal and clinical care that is tailored to their needs in alignment with care plans. Further, the Assessment Team found the service had not considered practices at the service may be a restrictive practice, or demonstrated the effective management of high impact or high prevalence risks associated with behaviour management, catheter management and pain management.

I have considered the Assessment Team’s findings, the provider’s response and the evidence documented in the Assessment Team’s report to come to a view of compliance with Standard 3 Requirements (3)(a) and (3)(b) and find the service Non-compliant with Requirements (3)(a) and (3)(b). The reasons for the finding are detailed 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 service was found Non-compliant with Requirement (3)(a) following a Site Audit conducted 15 and 17 September 2020. Consumer clinical needs, specifically in relation to clinical observations, wound management and falls risks had not been consistently implemented or monitored in alignment with consumer care needs, medical officer instruction or best practice guidelines. Further, the service had not recognised the use of restraint at the service. In response to the deficiencies, the service implemented improvements, including (but not limited to):

* Implemented a seven day handover sheet highlighting days when clinical observations are due for each consumer.
* Implemented weekly wound management audits for a period of six weeks.
* Consumer support plans were updated to include directives regarding the use of hip protectors.
* Conducted an audit of restraint devices to identify risk assessment completion and consultation with consumers, representatives and medical officers.

The Assessment Team found that consumers were not receiving safe and effective personal and clinical care that is tailored to their needs. Specifically, care and monitoring was not in alignment with consumer care plans or assessed care needs. Further, the Assessment Team found the service had not considered practices at the service may be a restrictive practice. The Assessment Team provided the following information and evidence relevant to my finding.

* One consumer, who was assessed as requiring hip protectors to minimise the risk of injury from falling, was not wearing hip protectors in alignment with their care plan when they fell on 17 June 2021.
* The majority of the consumers residing in Hakea area were not receiving showers in alignment with their care plan, and receiving washes instead. For example, on 28 June 2021, 13 of the 16 consumers received washes instead of showers.
* The Assessment Team interviewed a consumer who stated they would like to use the toilet rather than a bed ban as it is not dignified to use a bed pan. The Assessment Team found the consumer’s care and services plan did not include this preference, and the consumer had not been assessed by Allied Health in relation to a toileting assessment to facilitate the consumer’s preference.
* Two consumers who required visual observations to promote safety, did not have the monitoring completed. For example, monitoring did not occur on 14 occasions between 28 and 29 June 2021 for one consumer, to ensure they remained safe within the service.
* Restrictive practices were not recognised at the service. For example, the Assessment Team observed the use of tied dignity blankets for three consumers, and documentation of a seat belt for another consumer without the service considering these as potential restrictive practices and subsequent assessment and management in accordance with legislative requirements.

I have also considered the following evidence included in the Assessment Team’s report in Standard 3 Personal Care and Clinical Care, Requirements (3)(b) in my finding for this Requirement:

* Clinical observations and monitoring were not occurring in alignment with the medical officer, hospital discharge instructions or care plan for four consumers in relation to fluid, blood glucose and blood pressure monitoring. For example:
* One consumer’s care plan stated they required daily blood pressure monitoring, however the Assessment Team found that blood pressure monitoring occurred for 7 out of 85 days.

The provider submitted a response to the Assessment Team’s report which addressed the Assessment Team’s findings in relation to Standard 3 Requirement 3(a). The provider’s response included (but was not limited to):

* Review of consumer care plans will occur in relation to where consumers decline wearing hip protectors.
* Dignity blankets are no longer in use at the service.
* In relation to the consumer where a seat belt was documented in the care and services plan, this was an old domain that had been transferred from a previous and obsolete support plan. The support plan has been updated to remove this old statement.
* Identified that staff were continuing to utilise the old seven day handover sheet, where highlighting days when clinical observations are due for each consumer. The old sheets have now been removed.
* In relation to the consumer who expressed a preference to use the toilet, they have been assessed by Allied Health, and the current use of a bed pan is the safest option of the consumer and the consumer was satisfied with the outcome of the assessment. However, continence and further allied health assessments will occur to support the consumer’s toileting care planning.
* Visual monitoring charts will become electronic and incorporated into the task section of the service’s system to ensure staff compliance.
* Acknowledged that the service is not capturing information from medical officers and hospital discharge documents in a manner which provides clear direction for staff on the clinical monitoring required. A new form will be developed for recording these instructions to ensure clinical monitoring occurs in alignment with medical officer and hospital discharge instructions.

In coming to my finding, I have considered and recognise the actions taken by the service in response to the deficiencies identified at the Site Audit and the Assessment Contact. However, at the time of the Assessment Contact, the service was unable to demonstrate that each consumer gets clinical and personal care that is best practice; and is tailored to their needs; and optimises their health and well-being. Specifically, care, clinical observations and monitoring is not provided to consumers in alignment with their assessed needs, care and services plan or preferences. While I acknowledge that the service has removed all dignity blankets from the service, I consider that at the time of the Assessment Contact the service had not considered these as a potential restrictive practice and undertaken the appropriate assessments and management in accordance with legislative requirements.

Based on 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 service was found Non-compliant with Requirement (3)(b) following a Site Audit conducted 15 and 17 September 2020 .Specifically, the service was unable to demonstrate that high impact or high prevalence risks associated with the care of each consumer in relation to falls management, medication administration (resulting in medication incidents), clinical monitoring when fluid restrictions are in place, and pain assessment and management. In response to the deficiencies, the service implemented improvements, including (but not limited to):

* Implemented a new process to ensure medication charts are updated to reduce the risk of medication incidents occurring.
* Medication credentialing completed for required staff.
* Implemented a seven day handover sheet highlighting days when clinical observations are due for each consumer, including fluid monitoring.
* Pain management procedure has been updated to include commencing pain assessments when analgesic doses are changed or ceased.

At the Assessment Contact, the Assessment Team was not satisfied that the service demonstrated effective management of high impact or high prevalence risks associated with the care of each consumer. Specifically, in relation to behaviour management, catheter management and pain management. The Assessment Team provided the following information and evidence relevant to my finding.

In relation to behaviour management, the Assessment Team identified that behaviour management for one consumer (Consumer A) is not effective. Consumer A is resistive to care and experiences physical behavioural responses towards staff. The Assessment Team identified that the strategies are not effective. For example:

* Consumer A’s care plan stated that usually the consumer requires one staff member to assist with care, however if the consumer refuses care, two staff are required to complete the task. The Assessment team identified progress notes that described Consumer A’s responsive behaviours (kicking, yelling, grabbing, biting and scratching) towards staff on three occasions during assistance with continence and hygiene care.

In relation to catheter management, the Assessment Team identified that for one consumer, (Consumer B) with a suprapubic urinary catheter, management has not been effective. The Assessment Team identified that when the consumer’s catheter was blocked and bypassing on 23 June 2021, it was not changed for three days. The Assessment Team identified that the consumer can experience pain and discomfort when the catheter is blocked and bypassing. While the Assessment Team identified that the consumer had been referred to an urologist and continence nurse for review, the service had not followed up on the referrals due to the consumer’s pain/discomfort and recurrent catheter blockages and bypassing.

The Assessment Team found that one’s consumer pain was not effectively managed, as the consumer was not receiving analgesia in a timely manner and experiencing unrelieved pain. For example:

* The Assessment Team interviewed a consumer (Consumer C) who stated they do not always receive pain medication in a timely manner and experiences unrelieved pain.
* Progress notes and medical notes documented that Consumer C does not always receive pain medication, as the service does not have Registered Nurses on site overnight and the consumer has to wait until the on-call RN arrives to administer the analgesia resulting in Consumer C being distressed and in pain.
* The Assessment Team interviewed staff and management, who confirmed that Consumer C is not always able to get pain relief if there are no clinical staff available.

The provider submitted a response to the Assessment Team’s report which addressed the Assessment Team’s findings in relation to Standard 3 Requirement 3(b). The provider’s response included (but was not limited to):

* In relation to Consumer A, the service have been trying to access an in-depth behavioural and psychological assessment however have been unable to receive support through various referral pathways.
* Acknowledged that the three day delay in changing the supra-pubic catheter for Consumer B was unacceptable, and will ensure additional nursing staff are trained to change supra-pubic catheters.
* Explained that the current urology referral for Consumer B was determined non-urgent at the time of referral, and there is an expected 12 month wait time for review. The service will follow up with the consumer’s GP to have the priority of the referral escalated, and submit a second referral to a continence nurse, which currently has a three month wait time.
* Considered that the on-call system works effectively to provide clinical care for consumers, as all on-call nursing staff live within 10 minutes of the service.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the evidence provided by the service in response to the Assessment Team’s report. Based on the Assessment Team’s report and the provider’s response, I find at the time of the Assessment Contact, high impact or high prevalence risks were not effectively managed for each consumer in relation to behaviour management, catheter management and pain management. In coming to my finding, I have considered the Assessment Team’s report which described a behaviour management strategy for Consumer A, whereby when the consumer is resistive to care, an additional staff member is required to assist. I have considered that this approach does not demonstrate understanding of effective dementia care in identifying triggers to the behavioural response, and implementing strategies to reduce the behavioural response and impact of distress to the consumer and risk to staff. Further, I considered that for two consumers, their care in relation to pain and catheter management was not effective, impacting on their wellbeing.

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

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 7

The Quality Standard is assessed as Non-compliant as one Requirement has been assessed as Non-compliant. The Assessment Team assessed Requirements (3)(a) and (3)(e) in relation to Standard 7 and recommended Requirement (3)(a) not met and Requirement (3)(e) as met. All other Requirements in this Standard were not assessed.

The service was found Non-compliant with Requirements (3)(a) and (3)(e) following a Site Audit conducted between 15 and 17 September 2020. Specifically, the service was unable to demonstrate that the workforce is planned to enable, and the number and mix of the workforce enables the delivery of safe quality care and services. Consumers, representatives and staff reported the service was short-staffed which impacted care. Further, the Assessment Team observed no coverage of three shifts during the Site Audit. In addition, the service was unable to demonstrate that assessment monitoring and review of the performance of each member of the workforce was undertaken, as performance appraisals were overdue for 43 staff.

In relation to Requirement (3)(a), the Assessment Team has recommended this Requirement as not met. While consumer and representative views were mixed in relation to sufficient staffing and timely care, the majority of staff interviewed stated that the service has insufficient staffing which impacts consumers. I have also considered evidence presented in Standard 3 Requirement (3)(a) in the Assessment Team’s report in coming to my finding in relation to Standard 7 Requirement (3)(a).

In relation to Requirement (3)(e), the Assessment Team as recommended this Requirement as met, as the service demonstrated assessment, monitoring and review of the performance of each member of the workforce is undertaken.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the Provider’s response to come to a view of compliance and find the service Non-compliant with Standard 7 Requirement (3)(a) and Compliant with Requirement (3)(e). The reasons for the findings are detailed 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 service was found Non-compliant with Requirement (3)(a) following a Site Audit conducted 15 and 17 September 2020. Specifically, the service was unable to demonstrate that the workforce is planned to enable, and the number and mix of the workforce enables the delivery of safe quality care and services. Consumers, representatives and staff reported the service had insufficient staffing which impacted care. Further, the Assessment Team observed no coverage of three shifts during the Site Audit. In response to the deficiencies identified, the service implemented improvements, including (but not limited to):

* Employed new staff and recruitment is continuing and there has been a decrease in unfilled shifts due to lifting of government directives related to the COVID-19 pandemic
* Increased clinical staffing hours over the weekend, and implemented an engagement shift for the secure unit.
* Utilises a casual pool of staff to fill shifts.
* Utilises South Australian Government incentives for four personal care attendant trainees.
* Daily consumer call bell response audits will commence in July 2021.
* Increased shift times for both morning and afternoon shifts.

The Assessment Team provided the following information and evidence relevant to my finding. The Assessment Team reviewed recruitment and attrition numbers since the Site Audit, which indicated an overall increase of one RN and five personal care workers, however the Assessment Team found:

* Two consumers interviewed stated that the service had inadequate staffing to provide care and respond to call bells in a timely manner which resulted in delayed assistance with incontinence and monitoring.
* One consumer and one representative interviewed reported that they had no concerns with staffing and timeliness of response to call bells.
* Ten out of 14 clinical and care staff interviewed stated that the service does not replace staff absences which results in the service being short staffed and consumer preferences not being accommodated and missed care, such as missed pressure area care, showering and using bed pans for consumers instead of toileting. The interviewed staff reported consumers experienced skin integrity issues as a result of missed care.
* The Assessment Team provided evidence in Standard 3 Requirement (3)(a) where the Assessment Team reviewed handover sheets for Hakea area which documented that the majority of the consumers residing in Hakea area were not receiving showers in alignment with their care plan, and receiving washes instead. The Assessment Team interviewed staff who stated they do not have enough time or staff to ensure consumers receive showers in alignment with their care and services plan.
* The Assessment Team viewed staff rosters and allocation sheets which supported that shifts are not consistently filled. The Assessment team found that on average, 2.5 personal care shifts per week are not filled.
* The Assessment Team reviewed a performance appraisal form for a care worker, who reported in the appraisal that staff absences resulted in time constraints and expectations to cover other units which was a difficult aspect of their work.
* Reviewed the call bell response times for 29 and 30 June 2021, which indicated that 88 % and 82.6% of response times respectively were within 10 minutes.
* Reviewed the service’s call bell audit and summary for March to May 2021 undertaken by management, which documented reasons for call bell times outside of 10 minutes included staff being busy with other consumers, or covering other areas.

The provider submitted a response to the Assessment Team’s report which addressed the Assessment Team’s findings in relation to Standard 7 Requirement 3(a), stating that the service has sufficient numbers and hours to provide the support to consumers required, based on national benchmarking and internal benchmarking with another memory support unit in the Boandik group with the same number of consumers. The provider’s response included (but was not limited to):

* Acknowledged that for the consumer who reported a delay in assistance with incontinence, one call on 29 June (not the date of the incontinence) was not responded to in a timely manner. On the date that the consumer experienced the incontinence, one call bell activation occurred and was responded to in under 3 minutes.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the evidence provided by the service in response to the Assessment Team’s report. I find that the service has been unable to demonstrate that their workforce is sufficiently planned to enable the number and mix of members to provide safe and quality care and services. I acknowledge the provider’s response which indicates benchmarking demonstrates the service has adequate staffing numbers. However, in coming to my finding I have relied upon the Assessment Team’s consumer and staff interviews in relation to missed care, consumer’ needs not being met in a timely manner or care not provided in alignment with consumers’ care and services plan. Further, I considered that the service has not demonstrated consideration of consumer acuity in determining workforce requirements, or how the service utilises staff and consumer feedback to understand impact in relation to staffing numbers.

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

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

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

The service was found Non-compliant with Requirement (3)(e) following a Site Audit conducted 15 and 17 September 2020. Specifically, the service was unable to demonstrate that assessment, monitoring and review of the performance of each member of the workforce was undertaken, as annual performance appraisals were overdue for 43 staff. In response to the deficiencies identified, the service implemented improvements, including (but not limited to):

* Established a performance appraisal schedule for completion of performance reviews.
* Established a role responsible for monitoring staff performance appraisal completion, including providing monthly reports to each department head in relation to staff performance appraisal status, and reports to the Executive Team to measure compliance against the services key performance indicators.

The Assessment Team considered that the service demonstrated that regular assessment, monitoring and review of the performance of each member of the workforce is undertaken and provided the following information and evidence relevant to my finding.

* Viewed a report that indicated staff had completed their annual performance appraisals for 2021.
* Interviewed management, clinical and service department heads who demonstrated understanding and compliance with the annual performance appraisal process.
* All staff interviewed by the Assessment Team stated they have had an annual performance appraisal conducted within the last 12 months, and viewed two staff files with completed annual appraisals.

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

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 8

The Quality Standard is assessed as Non-compliant as one Requirement has been assessed as Non-compliant. The Assessment Team assessed Requirements (3)(c) and (3)(d) in relation to Standard 8 and recommended Requirement (3)(c) as met and Requirement (3)(d) as not met. All other Requirements in this Standard were not assessed.

The service was found Non-compliant with Requirements (3)(c) and (3)(d) following a Site Audit conducted between 15 and 17 September 2020. Specifically, the service did not demonstrate effective organisation wide governance in relation to continuous improvement and regulatory compliance. Further, the service did not demonstrate effective risk management systems and practices as the organisation’s risk framework did not identify areas of high impact or high prevalence risks associated with the care of consumers.

In relation to Requirement (3)(d), the Assessment Team have recommended this Requirement as not met, as the service was unable to demonstrate effective implementation of risk management systems in managing high impact of high prevalence risks associated with the care of consumers. The Assessment Team also provided evidence that demonstrated the service does not have an effective incident management system, as staff are not consistently reporting incidents. I have also considered evidence presented in Standard 3 Requirement (3)(a) and (3)(b) in the Assessment Team’s report in coming to my finding in relation to Standard 8 Requirement (3)(d).

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the Provider’s response to come to a view of compliance and find the service Compliant with Standard 8 Requirement (3)(c) and Non-compliant with Requirement (3)(d). The reasons for the findings are detailed in the specific Requirement below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(c) Compliant

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

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

### The service was found Non-compliant with Requirement (3)(c) following a Site Audit conducted on 15 to 17 September 2020. The Assessment Team found the service did not demonstrate effective organisation wide governance in relation to continuous improvement and regulatory compliance. Specifically, the service did not take reasonable steps to notify consumer representatives regarding the Site Audit conducted on 15 to 17 September 2020. In response to the deficiencies identified, the service implemented improvements, including (but not limited to):

* Updated the procedure guiding actions, including during Site Audits, to ensure representatives are appropriately notified of Site Audits occurring.
* Continuous improvement plans now shows date entered, details of the improvement initiative, assessment/action required, action taken, outcome, evaluation, review date and completed status.

The Assessment Team considered that the service demonstrated effective organisation wide governance systems and provided the following information and evidence relevant to my finding.

* In relation to information management, the Assessment Team found staff at the service could access the information they required, including, but not limited to, policies, procedures, electronic care information and communications to ensure they are kept up to date with organisational and legislative changes.
* The Assessment Team found the service was able to demonstrate how continuous improvement opportunities are identified, how critical incidents are used to drive continuous improvement and how dedicated quality staff oversee quality activities.
* In relation to financial governance, the Assessment Team found the service was able to demonstrate how changes to budget and expenditure is made to support the changing needs of consumers.
* In relation to workforce governance, the Assessment Team viewed duty statements and job descriptions for various clinical roles. Further, care staff, service staff and management staff sampled could describe and confirm competency training was completed in relation to mandatory training and competencies in relation to medication management, wound management and infection control.
* In relation to regulatory compliance, the Assessment Team observed that consumer influenza and COVID-19 vaccinations were up to date, and service staff sampled had a sufficient understanding of the mandatory serious incident reporting scheme (SIRS).
* In relation to feedback and complaints, the Assessment Team found the service completes a monthly trend analysis to inform continuous improvement.

For the reasons detailed above, I find the provider, in relation to Boandik St Mary’s 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*
4. *Managing and preventing incidents, including the use of an incident management system.*

The service was found Non-compliant with Requirement (3)(d) following a Site Audit conducted on 15 to 17 September 2020. The Assessment Team found the service did not demonstrate effective risk management systems and practices, specifically the organisations risk framework did not identify areas of high impact or high prevalence risks associated with the care of consumers, including (but not limited to), in relation to medication, falls and pain management. In response to the deficiencies identified, the service implemented improvements, including (but not limited to):

* Updated the corporate risk identification and assessment register and risk control plan to strengthen clinical risk areas.
* Reviewed the clinical governance framework to improve focus on high impact and high prevalence risks.
* Clinical governance committee added to the functions and delegations of the service’s Risk Management policy to strengthen clinical risk monitoring and oversight.
* The Clinical Governance Committee includes high impact and high prevalence risks, clinical trends and continuous improvement initiatives.
* A new incident reporting system was implemented in December 2020.

The Assessment Team found that that while the service has updated organisational systems, including policies and procedures to guide the risk management of high impact or high prevalence risks associated with the care of consumers, the service has not demonstrated these governance systems are effective. Specifically, the Assessment Team found staff at the service have not sufficiently implemented the policies, processes or procedures. As such, risks were not consistently identified, assessed, reported and managed, including risks associated with medication management, restrictive practices, catheter management and behaviour management. Further, the Assessment Team provided evidence that demonstrated the service did not have effective governance of the incident management system, as staff were not consistently reporting incidents. The Assessment Team provided the following information and evidence relevant to my finding.

* The Assessment Team found that staff are not always reporting incidents associated with consumer physical abuse towards staff members. The Assessment Team identified four occurrences of physical abuse towards staff members documented in progress notes for one consumer in a one month period that were not reported or recorded as incidents.

* Catheter management has not been effectively managed, resulting in negative impacts for one consumer.
* Pain and medication management has not been effective for one consumer, resulting in negative impacts.

I have also considered the following evidence included in the Assessment Team’s report in Standard 3 Personal Care and Clinical Care, Requirements (3)(a) and (3)(b) in my finding for this Requirement:

* The Assessment Team identified a medication incident that had not been identified by the service, related to incorrect documentation of schedule 8 medicine administration.
* The Assessment Team observed the use of tied dignity blankets for three consumers, and documentation of a seat belt for another consumer without the service considering these as potential restrictive practices and subsequent management in accordance with legislative requirements.
* Clinical observations and monitoring were not occurring in alignment with the medical officer or hospital discharge instructions for three consumers in relation to blood glucose and blood pressure monitoring.
* Two consumers who required visual observations to promote safety, did not have the monitoring completed.

The provider submitted a response to the Assessment Team’s report which addressed the Assessment Team’s findings in relation to Standard 8 Requirement 3(d) and Standard 3 Requirement (3)(b). The provider’s response included (but was not limited to):

* Boandik is currently reviewing the risk profiling and assessment policy and procedure to ensure that it is meeting the needs of consumers, with the aim to have a strong focus on high impact and high prevalence risks while supporting consumers to live as they choose.
* All dignity blankets have been removed from the service.
* In relation to the consumer where a seat belt was documented in the care and services plan, this was an old domain that had been transferred from a previous and obsolete support plan. The support plan has been updated to remove this old statement.
* In relation to the medication error, this has now been recorded as a medication incident.
* An update on incident reporting will be undertaken by staff and nursing staff will be reminded to review progress notes on a daily basis and complete incident reporting.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the information provided by the service in response to the Assessment Team’s report. However, at the time of the Assessment Contact, I consider the service has not demonstrated effective risk management systems and practices to support management of consumers high impact of high prevalence risks associated with their care. I consider the service did not sufficiently report incidents of consumer abuse towards staff such that the service could effectively use the information to identify and review management strategies or manage the risks to staff. Further, I consider that at the time of the Assessment Contact, the service was unable to demonstrate that staff supported effective risk management processes. Specifically, staff practice is not consistent in implementing the policies and procedures related to the identification and management of risks, including (but not limited to) restrictive practices.

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.

# 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 clinical monitoring and visual observations occur according to consumers assessed needs and care plans.
* Ensure consumer assessments inform care planning, to ensure care plans are reflective of the assessed needs and care requirements.
* Ensure staff have an understanding of what constitutes restraint and the service understands their legislative responsibilities in regards to restrictive practices.
* Ensure the service has a clinical governance framework related to restrictive practices that is effective.
* Ensure consumers with responsive behaviours have sufficient and comprehensive psychosocial and behavioural assessments to identify potential triggers to the responsive behaviours. Further, ensure consumers have a behavioural support (management) care plan that addresses the triggers and promotes consumer wellbeing and reduction of responsive behaviours.
* Ensure staff at the service have sufficient time to assist consumers with activities of daily living.
* Ensure all consumers have their care and services plan reviewed for effectiveness in accordance with the service policy.
* Ensure medical officer and hospital discharge instructions are clearly communicated to staff such that clinical monitoring and care occurs in alignment with the instructions.
* Ensure there are a sufficient number of staff competent with supra-pubic catheter changes such that when consumers require a catheter change, it can occur in a timely manner.
* Ensure the service has an effective system in place to ensure consumers receive timely administration of medicines, when the administration requires staff with specific qualifications.
* Appropriate and adequate staffing levels and skill mix are maintained to deliver care and services in alignment with consumers care needs and acuity.
* Ensure risk management systems are effectively implemented, such that risks are identified, assessed, reported and managed.
* Ensure incidents that occur are identified and reported.