Bonney Lodge

Performance Report

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**Commission ID:** 6149

**Provider name:** Riverland Mallee Coorong Local Health Network Incorporated

**Assessment Contact - Site date:** 14 September 2021 to 16 September 2021

**Date of Performance Report:** 29 October 2021

# Performance report prepared by

Michelle Glenn, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 2 Ongoing assessment and planning with consumers** |  |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| **Standard 7 Human resources** |  |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(c) | Compliant |
| **Standard 8 Organisational governance** |  |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | Compliant |

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site 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 Assessment Contact - Site report received 12 October 2021; and

the Performance Report dated 27 January 2021 for the Site Audit conducted 21 September 2021 to 25 September 2020.

# STANDARD 2 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 Assessment Team assessed Requirements (3)(a) and (3)(e) in Standard 2 Ongoing assessment and planning with consumers as part of the Assessment Contact. All other Requirements in this Standard were not assessed and, therefore, an overall rating of the Standard is not provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(a) and (3)(e) in Standard 2. These Requirements were found Non-compliant following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found:

* assessment and planning processes did not effectively consider risks associated with consumers’ health and well-being, specifically one consumer’s mental health, one consumer’s nutritional status and one consumer’s risk of falls; and
* the service did not effectively review one consumer’s care and strategies following several incidents of falls, including incidents where the consumer sustained injuries.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended Requirements (3)(a) and (3)(e) met.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and based on this information, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, Compliant with Requirements (3)(a) and (3)(e) in Standard 2 Ongoing assessment and planning with consumers. I have provided reasons for my finding in the specific Requirements below.

## Assessment of Standard 2 Requirements

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

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

The service was found Non-compliant with Requirement (3)(a) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found assessment and planning processes did not effectively consider risks associated with consumers’ health and well-being, specifically one consumer’s mental health, one consumer’s nutritional status and one consumer’s risk of falls. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed and updated care plans.
* Implemented a weekly operational report which includes a summary of incidents from the week, including behaviours, new infections and wounds.
* A clinical risk framework, comprised of the weekly operational report, Plan for continuous improvement and weekly Resident high risk meetings contributes to regular assessment and planning processes.
* Developed falls information packs which staff were observed referring to during the Assessment Contact.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* Consumers and representatives confirmed individual risks had been identified and used to inform care and services and prevention management strategies implemented. This includes in relation to swallowing difficulties, pain, falls and fluid restrictions.
* Entry assessment processes are conducted in line with the 28-day admission assessment process for both permanent and respite consumers. Information gathered is used to develop detailed care plans, incorporating each consumer’s goals, needs and preferences.
* Consumer files demonstrated a range of clinical, personal and lifestyle assessments are completed on entry and routinely reviewed, including in response to changes in consumers’ health and well-being.
* Accredited clinical risk assessment tools are used relative to each consumer’s needs and perceived risks, including in relation to skin, falls, pain, malnutrition and depression. Individualised management strategies to minimise impact of risks were documented in care plans.
* Staff described assessment and planning process and cited care plans as a primary source of knowledge to assist in the delivery of consumers’ care and services.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, Compliant with Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers.

### 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 21 September 2020 to 25 September 2020 where it was found the service did not effectively review one consumer’s care and strategies following several incidents of falls, including incidents where the consumer sustained injuries. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Implemented an Associate nurse unit manager duty statement to ensure prompt and timely response to identified changes in the provision of consumer care, needs and preferences. The duty statement plan is discussed weekly and all activities are informally monitored daily.
* Developed a Gantt chart detailing daily tasks and responsibilities of senior clinical staff. This is discussed daily at huddles with management.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* Care plans had been reviewed on a regular four-monthly basis. When circumstances had changed, or incidents occurred, such as choking incidents or weight loss, consumers had been reassessed, care plans updated, management strategies reviewed, charting commenced (where appropriate), next of kin contacted and Medical officer and allied health referrals initiated.
* All consumers confirmed staff had taken action in response to incidents, such as falls or increased pain, and care and services had altered as needed.
* Most representatives confirmed they had been notified of changes in care delivery and when incidents had occurred.
* Staff were familiar with the service’s policy for reviewing care plans on an ongoing basis, including at four-monthly care plan reviews and in response to changes in consumers’ health and following clinical incidents.
* Clinical and care staff described incident management processes and the need to inform Medical officers and representatives, as well as review the associated risk assessments and initiate allied health referrals.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, Compliant with Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers.

# 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 Non-compliant as one of the four Requirements assessed has been found Non-compliant. The Assessment Team assessed Requirements (3)(a), (3)(b), (3)(d) and (3)(e) in Standard 3 Personal care and clinical care as part of the Assessment Contact. All other Requirements in this Standard were not assessed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(a), (3)(b), (3)(d) and (3)(e) in Standard 3. These Requirements were found Non-compliant following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found the service did not:

* ensure each consumer received safe and effective clinical care;
* effectively manage one consumer’s risk of falls or adequately conduct clinical observations following incidents of falls to monitor for adverse outcomes;
* respond in a timely manner to changes in physical function or condition for two consumers who were presenting with clinical signs of change; and
* update relevant documentation to support effective assessment, planning and provision of care for two consumers following incidents which required hospital transfer.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended Requirements (3)(b), (3)(d) and (3)(e) met. However, the Assessment Team were not satisfied chemical restraint was consistently administered as a last resort in accordance with best practice or that pressure injuries were effectively assessed or documented. The Assessment Team have recommended Requirement (3)(a) 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 based on this information, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, Non-compliant with Requirement (3)(a) and Compliant with Requirements (3)(b), (3)(d) and (3)(e) in Standard 3 Personal care and clinical care. I have provided reasons for my finding in the specific Requirements 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 chemical restraint was consistently administered as a last resort in accordance with best practice or that pressure injuries were effectively assessed or documented. The Assessment Team’s report provided the following evidence relevant to my finding:

Consumer A

* Staff identified, and the care plan noted, Consumer A as having escalating physical and verbal aggression. The consumer is prescribed regular anti-depressants and anti-psychotic medication and as needed anti-anxiety medication for agitation and insomnia.
* A Dignity of choice/risk or restraint form for the chemical restraint, updated in December 2020, did not identify agitation or insomnia as a reason for the medication as documented in the medication chart.
* Over a six-week period between August and September 2021, as required medication was administered on 30 occasions.
	+ Behaviour charting indicates as required psychotropic medication was administered following unsuccessful attempts of non-pharmacological interventions. However, the medication was routinely administered alongside as required pain medication, rather than as a last resort following attempts to manage pain.
* Management acknowledged pain can be a trigger for the consumer’s behaviours and stated as required psychotropic medication was being used as a behaviour management strategy. Additionally, management indicated they had been advised previously to administer psychotropic medication alongside pain medication and had continued the practice.
* Two clinical staff advised they do not routinely assess or wait for the effectiveness of pain medication prior to administering as required psychotropic medication unless the consumer displays signs of pain.

Risk/restraint assessment forms for three sampled consumers subject to chemical restraint did not include:

* Details of how the restrictive practice is to be used, including duration and frequency.
* Alternative strategies for addressing behaviour of concern.
* How the restrictive practice is to be monitored and reviewed.
	+ For two of the consumers, behaviour management plans did not include any information pertaining to use of restrictive practices as required by the amendments to Quality of Care Principles 2014.

Consumer B

* Consumer B entered the service on respite in September 2021. A skin assessment identified the consumer’s existing pressure injury, high risk of further pressure injuries and management strategies. The assessment indicated the consumer had no skin problems despite photos evidencing skin excoriation and the use of an air mattress.
* A wound management plan initiated on entry demonstrates staff were not documenting or managing the wound in accordance with best practice or organisational procedure. For example:
	+ There is no documented size or stage of the wound.
	+ Two photos taken do not consistently include a ruler to ascertain the size.
	+ Staff do not routinely document wound progress.
	+ There is no wound chart.
* Staff confirmed the size and stage of wounds is not routinely documented and acknowledged this should be done.
* Staff advised they document changes to or deterioration of the wound in the free text box of the electronic management plan and will amend the plan as needed, thereby erasing previous comments. They do not use wound charting.
* Management advised they can obtain previous versions of the wound management template, however, this is difficult, and the current template makes effective monitoring of wound progress challenging.

The provider did not dispute the Assessment Team’s findings. A Plan for continuous improvement has been developed addressing the deficits identified in the Assessment Team’s report and was included as part of the provider’s response. Actions completed and/or planned include, but are not limited to:

* Update Behaviour support plans to reflect new legislation related to restrictive practices.
* Implement a restrictive practice register that supports compliance with legislation.
* Education to be provided to all staff relating to administration of as required medication as a last resort and documenting non-pharmalogical strategies.
* Site Wound care lead established and three Wound care champions to be assigned.
* Commence monthly pressure injury and chronic wound audits for a six month period.
* Ensure all wound assessments and management templates are consistently utilised and completed.

The service was found Non-compliant with Requirement (3)(a) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found the service did not ensure each consumer received safe and effective clinical care. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Implemented a performance monitoring framework incorporating a number of clinical topics, including pain.
* Developed a daily huddle schedule. A two-weekly cycle of topics commenced in December 2020 and was evident in training records.
* Training provided to staff relating to high-risk areas, such as elder abuse, clinical deterioration, pain management and behaviour management.
* Quality review schedule audit reports, including use of short observational frameworks for inspection (SOFIs) are conducted and disseminated to staff monthly. SOFIs for falls and medication management conducted in August 2021 demonstrated a score of 100% was achieved.
* Nutrition has been included in High risk meetings and consumers of concern with weight loss or choking risks are listed.

I acknowledge the provider’s response and actions implemented and/or planned to address the deficits identified in the Assessment Team’s report. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Assessment Contact, each consumer was not receiving safe and effective clinical care that was best practice, tailored to their needs or optimised their health and well-being.

For Consumer A, I have considered that psychotropic medication is not being used as a last resort with as required medication for pain being administered in conjunction with psychotropic medication. Management indicated pain can be a trigger for Consumer A’s behaviour. However, I find that the practice being undertaken does not ensure appropriate assessment and monitoring of the effect of the as required pain medication to be undertaken and the opportunity for the use of psychotropic medication to be minimised. I have also considered that documentation relating to use of chemical restraint for three consumers did not include key information to guide use of restrictive practices in line with best practice care and to ensure use of restraint was minimised. Additionally, I find the service has not complied with legislative requirements relating to restrictive practices with all required information not being included in behaviour support plans for two consumers.

In relation to Consumer B, evidence documented in the Assessment Team’s report demonstrates wound management plans were not consistently completed, including documenting progress of wounds. I find it is reasonable to expect wounds are monitored at each treatment, including consideration of wound appearance, and measurements of the wound undertaken in line with best practice care. Such practices would ensure wound progression is monitored and wound deterioration is identified in a timely manner. I have also considered that the service’s wound care/management documentation processes are not effective with staff indicating previous commentary relating to management and/or progress of the wounds being overridden by new comments when entered into the system. I find this process does not enable effective wound monitoring to occur or for changes in wound appearance to be effectively identified.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, Non-compliant with Requirement (3)(a) in Standard 3 Personal care and clinical care.

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

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

The service was found Non-compliant with Requirement (3)(b) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found the service did not effectively manage one consumer’s risk of falls effectively or adequately conduct clinical observations following incidents of falls to monitor for adverse outcomes. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Developed a Post falls checklist which includes neurological observations, open disclosure, pain assessments and review and update of falls risk assessments.
	+ Care documentation sampled demonstrated staff had adhered to the falls procedure and completed all neurological observations in line with the policy.
* A daily form is distributed to staff each shift to ensure tasks, such as neurological observations, are completed. This includes an exit checklist which is completed by clinical management each shift to ensure all actions have been followed up or handed over to the next shift.
* Routine and as-needed clinical audits, including use of SOFI, are conducted every four months. An audit of 10 consumers completed in August 2021 in relation to falls, medication and nutrition and hydration were found to be 100% compliant.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* Care files demonstrated where high impact or high prevalence risk are identified, management strategies are implemented, charting commenced, interventions evaluated and referrals to Medical officers and allied health professionals initiated. This included in relation to weight loss, choking risk and behaviours of concern.
* Risks associated with falls had been identified and strategies documented. In response to falls, consumers had been assessed, including pain, observations and neurological observations initiated, incident reports completed, and the consumer transferred to hospital where necessary, in line with service policy.
* All consumers confirmed they received the care they need and were satisfied with management of their individual risks, such as continence, wounds and pain.
* Two consumers confirmed that following a fall, they had been assessed for injury promptly, monitored frequently and falls management strategies had been implemented.
* Care and clinical staff were knowledgeable of sampled consumers’ high impact or high prevalence risks, and could detail how they identify, assess, and manage such risks.
* Care and clinical staff confirmed new, emerging, and existing high impact or high prevalence risk are highlighted through handover processes and felt informed of risk management strategies for each consumer.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, Compliant with Requirement (3)(b) in Standard 3 Personal care and clinical care.

### 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.*

The service was found Non-compliant with Requirement (3)(d) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found the service did not respond in timely manner to changes in physical function or condition for two consumers who were presenting with clinical signs of change. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Education provided to staff relating to clinical deterioration, falls and post fall management.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* Consumer files demonstrated identification and appropriate management of high impact or high prevalence risks, such as falls, weight loss and behaviours. A range of monitoring tools and assessments had been completed on entry and on an ongoing basis and were used to identify and evaluate changes to consumers’ health, condition and abilities.
* Where changes to consumers’ health were identified, further charting and monitoring processes had been implemented and referrals to Medical officers and/or allied health professionals initiated.
* Representatives and consumers confirmed appropriate and prompt action had been taken in response to deterioration in consumers’ health and recalled assessments, observations and medical reviews following falls and respiratory infections.
* Clinical and care staff described actions they had taken in response to changes in consumers’ health and well-being. For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, Compliant with Requirement (3)(d) in Standard 3 Personal care and clinical care.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, Compliant with Requirement (3)(d) in Standard 3 Personal care and clinical care.

### 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.*

The service was found Non-compliant with Requirement (3)(e) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found the service did not update relevant documentation to support effective assessment, planning and provision of care for two consumers following incidents which required hospital transfer. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* A detailed discharge summary is entered into notes on the electronic system following discharge from an acute setting.
* Discharge summary information has been included in the mandatory education session and discussed at weekly education sessions.
* Created a Return from hospital checklist to guide the process.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* Care plans included in depth and individualised information relating to each consumer’s condition, needs and preferences.
* Progress notes included ongoing commentary relating to changes in consumers’ condition, needs and preferences, including information relayed from Medical officers and allied health professionals and updates to care plans.
* Consumers were satisfied with personal and clinical care provided and felt their needs and preferences were known by staff.
* Clinical and care staff indicated changes in consumers’ care and service needs are communicated through handover processes ensuring they are provided with relevant, up-to-date information relating to each consumer.
* Staff described processes for sharing information with Medical officers and allied health staff.
* Care files demonstrated recommendations from the multidisciplinary team had been incorporated into consumer care plans.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, Compliant with Requirement (3)(e) in Standard 3 Personal care and clinical care.

# STANDARD 7 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 Assessment Team assessed Requirements (3)(a) and (3)(c) in Standard 7 Human resources as part of the Assessment Contact. All other Requirements in this Standard were not assessed and, therefore, an overall rating of the Standard is not provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(a) and (3)(c) in Standard 7. These Requirements were found Non-compliant following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found:

* feedback from consumers, representatives and staff indicated staff were not always available to assist consumers in a timely manner, including responding to call bells for consumers at known risk of incidents if not provided timely assistance; and
* while staff had been provided extra support and supervision by additional clinical managers, staff had not demonstrated they were able to effectively identify and manage risks associated with consumers’ care or respond appropriately or in a timely manner to changes in consumers’ clinical health status.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended Requirement (3)(a) met. However, the Assessment Team were not satisfied the service demonstrated staff have consistent knowledge in identifying and responding to pressure area care and wounds. 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 based on this information, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, Compliant with Requirements (3)(a) and (3)(c) in Standard 7 Human resources. I have provided reasons for my finding in the specific Requirements below.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) 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 21 September 2020 to 25 September 2020 where it was found feedback from consumers, representatives and staff indicated staff were not always available to assist consumers in a timely manner, including responding to call bells for consumers at known risk of incidents if not provided timely assistance. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Conducting daily audits of all call bells. Where a response is greater than the key performance indicator, this is addressed in real time with the staff involved.
* Implemented a process for capturing reasons for delayed call bell responses.
* Staffing numbers have been increased above the staffing ratio in line with consumer requirements.
* Established a casual staffing pool to fill any unplanned leave shifts.
* Conducted a review into the process for identifying consumers’ needs in relation to staff allocation and rostering.
* Reviewed role descriptions and individual staff classifications.
* Conducting six monthly performance reviews or staff discussions to discuss staff goals and professional development.
* Purchased DECT phones which are integrated with call bell system.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* The service has processes to ensure 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.
* Staffing allocations are checked daily to ensure the service is meeting the allocation. There are processes to manage staffing shortfalls.
* All consumers and representatives were generally happy with staffing levels and responsiveness of staff.
* All staff said while they are busy sometimes, they are able to complete their tasks. One staff member indicated staff morale is high and as staffing levels have increased they found staff were able to spend more time chatting to consumers.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, Compliant with Requirement (3)(a) in Standard 7 Human resources.

### 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.*

The Assessment Team were not satisfied the service demonstrated staff have the consistent knowledge in identifying and responding to pressure area care and wounds. The Assessment Team’s report provided the following evidence relevant to my finding:

* In relation to wound care, documentation for one consumer demonstrated staff were not consistently utilising and completing assessments and management templates to enable effective identification, management and monitoring of a pressure injury.
* Consumer files demonstrated staff did not follow the service’s guidelines or work instructions on wound care, and staff did not demonstrate consistent knowledge in identifying and responding to pressure area care and wounds.
* Documentation showed wounds were not always identified and assessed in a timely manner and wound dimensions, depth and staging for the one sampled consumer were not consistently recorded.
* Staff discussed processes used to identify and log skin issues, however, said they do not routinely document the size and stage of wounds but acknowledged this should be done.
* Staff advised they document changes to or deterioration of the wound in the management plan but have not considered using a separate wound charting tool.
* Staff said wound management has been discussed at staff meetings and they have talked about wound care as a huddle topic, however, have identified wound care training as a need.
* Clinical staff confirmed they need training in identification, staging and dressing types to be used on different wounds. Training has been organised on three occasions but has been cancelled due to COVID-19 requirements.

The provider’s response acknowledges the Assessment Team’s findings. A Plan for continuous improvement has been developed addressing the deficits identified in the Assessment Team’s report and was included as part of the provider’s response. Actions completed and/or planned include, but are not limited to:

* Wound training to be provided to all Leads and wound and skin education to be provided to care staff.
* Wound management quizzes to be developed and undertaken.
* Rolling weekly education on wound care to ensure consistent knowledge in identifying and responding to pressure area care and wounds.

The service was found Non-compliant with Requirement (3)(c) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found that while staff had been provided extra support and supervision by additional clinical managers, staff had not demonstrated they were able to effectively identify and manage risks associated with consumers’ care or respond appropriately or in a timely manner to changes in consumers’ clinical health status. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Training provided to staff relating to clinical deterioration, including use of regular case studies to inform and stimulate discussion.
* All staff have completed a training module covering high risk areas. Monthly compulsory training revising all the Quality Standards (one a month) and what they mean to service delivery have been undertaken by all staff.
* Implemented High risk resident management meetings.

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. In coming to my finding, I have considered that the evidence presented does not indicate systemic issues with workforce competency, qualifications or knowledge to effectively perform their roles. I acknowledge evidence presented by the Assessment Team demonstrates wound management plans were not consistently completed, including documenting progress of wounds, however, the issues highlighted related to one consumer. The evidence presented does not suggest systemic issues relating to wound documentation and management. As such, I have considered the evidence in my findings for other Requirements which reflect the core deficiency, specifically Standard 3 Personal and clinical care Requirement (3)(a).

In coming to my finding for this Requirement, I have considered information in the Assessment Team’s report indicating a comprehensive training calendar has been developed which includes a monthly focus for each month. Training is delivered in various formats and there are processes to monitor staff attendance. Individual training records sampled demonstrated training has been delivered and staff have attended. There are processes to monitor staff practice.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, Compliant with Requirement (3)(c) in Standard 7 Human resources.

# STANDARD 8 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 Assessment Team assessed Requirements (3)(c) and (3)(d) in Standard 8 Organisational governance as part of the Assessment Contact. All other Requirements in this Standard were not assessed and, therefore, an overall rating of the Standard is not provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(c) and (3)(d) in Standard 8. These Requirements were found Non-compliant following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found:

* the organisation’s governance systems were not effective in relation to information management, workforce governance and regulatory compliance; and
* the risk management framework was not effective in identifying ongoing falls and managing falls prevention.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit. However, the Assessment Team were not satisfied the service demonstrated effective information management systems in relation to wound care, regulatory compliance systems in relation to restrictive practices or effective high impact or high prevalence risks systems and practices in relation to wound management. 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 based on this information, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, Compliant with Requirements (3)(c) and (3)(d) in Standard 8 Organisational governance. I have provided reasons for my findings in the specific Requirements 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 Assessment Team were not satisfied the service demonstrated effective information management systems in relation to wound care or regulatory compliance systems in relation to restrictive practices. The Assessment Team’s report provided the following evidence relevant to my finding:

Information management

* Clinical staff reported finding the electronic clinical care system difficult to work with in relation to wound care and staff were noted to be unable to find information, such as wound measurements, reviews and treatment regimes.
* Clinical staff reported they document wound information in free text boxes, which erases previous comments.
* Wound care documentation showed wounds were not effectively documented, including size, stage and progress of wounds, photos did not consistently include a ruler to ascertain the size and were taken from different angles and distance and wound charts are not used in line with the service’s wound care guidelines.
* Management advised the current electronic wound management template makes effective documentation and monitoring of wound progress challenging.
* Management had recognised staff required further wound care education, including assessments, measurements, documentation and archiving which had been organised but was cancelled due to COVID-19 vaccination.

Regulatory compliance

* A Dignity of choice form for one consumer for chemical restraint indicated medication was required for the purpose of altering behaviour, however, it was not reflective of the reasons for the medication as documented on the medication chart.
* While as required psychotropic medications were administered following unsuccessful use of non-pharmalogical strategies, the medications were not always administered as a last resort, as they were at times administered with pain medications
* Resident activity at risk/restraint use forms for three consumers did not include:
	+ Details of when the restrictive practice is to be used.
	+ Alternative strategies for addressing behaviour of concern.
	+ How the restrictive practice is to be monitored and reviewed.
* Behaviour management plans for two consumers did not reflect the use of restrictive practices to manage the behaviour of concern.
* A Restrictive practices action plan has been developed:
	+ A draft restraint procedure did not include legislative requirements to implement Behaviour support plans from 1 September 2021, or provide guidance relating to information to be included in the support plans, such as assessment, monitoring, review, evaluation and provision of consent.
	+ Education and a memorandum in relation to behaviour support plan legislative requirements has been provided to staff, however, this was not effective as assessments and behaviour management plans viewed were not completed in line with restrictive practices legislative requirements as outlined in the Quality of Care Principles 2014.

The provider’s response acknowledges the Assessment Team’s findings. A Plan for continuous improvement has been developed addressing the deficits identified in the Assessment Team’s report and was included as part of the provider’s response. Actions completed and/or planned include, but are not limited to:

* Review the Wound management policy to ensure it aligns with best practice and supports the service’s electronic documentation requirements.
* Create a work instruction incorporating a checklist that supports the policy.
* Ensure all wound assessment and management templates are consistently utilised and completed in relation to pressure injuries, wound identification, management and monitoring.

The service was found Non-compliant with Requirement (3)(c) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found the organisation’s governance systems were not effective in relation to information management, workforce governance and regulatory compliance. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Implemented a four-monthly consumer personal, clinical care and activities of daily living review process.
* Developed a review schedule, which is allocated to relevant staff, and reports monthly on progress to the Board.
* Implemented a multi-disciplinary approach to the assessment and review process with the involvement of relevant health professionals, such as Medical officers and Physiotherapy services.
* Training provided to staff relating to high risk areas, including identification of reportable incidents and timely reporting and the Serious Incident Response Scheme legislated requirements.
* Reviewed the staffing roster with the involvement of staff and feedback related to allocation of resources.
* Developed a staffing methodology and implemented a static roster with the option to increase staffing ad hoc as required for consumers’ needs.

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. In coming to my finding, I have considered that the evidence presented does not indicate systemic issues with the organisation’s governance systems relating to information management and regulatory compliance.

I acknowledge evidence presented by the Assessment Team demonstrates wound management plans were not consistently completed, however, the issues highlighted related to one consumer. I also acknowledge wound care documentation is not consistently retained and is difficult to find on the electronic system. However, I have considered that the evidence presented does not suggest systemic issues relating to the organisation’s overall information management systems. As such, I have considered the evidence in my findings for other Requirements which reflect the core deficiency, specifically Standard 3 Personal care and clinical care Requirement (3)(a).

In coming to my finding for this Requirement, specifically information management, I have considered information in the Assessment Team’s report indicating wound care guidelines and processes, and an electronic clinical care system are in place for the management of information pertaining to pressure injuries. The service has a documented Clinical practice guideline on wound care and there are processes to monitor pressure injuries, including through care reviews, weekly high risk meetings, audits, and monthly trending and analysis of clinical incidents. I have also considered that for most of the Standards and Requirements assessed at the Assessment Contact, there are documented policy and procedure documents, consumer files, including care plans and communication processes available to management and staff to guide care and services.

In relation to regulatory compliance, I acknowledge psychotropic medication is not being used as a last resort with as required medication for pain being administered in conjunction with psychotropic medication for one consumer. I also acknowledge that for three consumers, documentation relating to use of chemical restraint does not include key information to guide use of restrictive practices in line with best practice care and behaviour support plans for two consumers do not include all information required as legislated. However, I have considered that the evidence presented does not suggest systemic issues relating to the organisation’s overall regulatory compliance systems. As such, I have considered the evidence in my findings for other Requirements which reflect the core deficiency, specifically Standard 3 Personal and clinical care Requirement (3)(a).

In coming to my finding for this Requirement, specifically regulatory compliance, I have considered that based on information in the Assessment Team’s report, there are processes to identify and implement changes in legislation and where changes to legislation have occurred, the organisation has taken measures to ensure staff are made aware of their responsibilities. All staff have received training in relation to the Serious Incident Response Scheme and behaviour management support plan requirements.

I have also considered that the Assessment Team’s report demonstrates the organisation has effective governance systems in relation to continuous improvement, financial governance, workforce governance and feedback and complaints.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, Compliant with Requirement (3)(c) in Standard 8 Organisational governance.

### Requirement 8(3)(d) Compliant

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

1. *managing high impact or high prevalence risks associated with the care of consumers;*
2. *identifying and responding to abuse and neglect of consumers;*
3. *supporting consumers to live the best life they can*
4. *managing and preventing incidents, including the use of an incident management system.*

The Assessment Team were not satisfied the service demonstrated effective high impact or high prevalence risk systems and practices in relation to wound management. The Assessment Team’s report provided the following evidence relevant to my finding:

* The service did not demonstrate effective high impact or high prevalence risks systems and practices, specifically in relation to wound management and clinical care assessment, planning and review.
* Monitoring processes did not identify staff were not consistently completing wound assessments or documenting wounds in line with best practice or organisational guidelines for one consumer.
	+ Management had recognised deficiencies in staff understanding and practice in relation to wound care, however, planned wound care training was cancelled.
	+ Audits completed did not identify deficiencies identified by the Assessment Team or inform a review of staff practices:
* Monitoring processes did not identify risk assessments for one consumer supported to take risks with smoking and a bed pole were not reflective of the consumer’s current practice or reflected in the consumer’s care plan.
* Monitoring processes did not identify four-monthly review of consumer care and services involves reviewing and updating individual assessments, however, does not involve a full review of consumers’ care plans.

The provider’s response acknowledges the Assessment Team’s findings. A Plan for continuous improvement has been developed addressing the deficits identified in the Assessment Team’s report and was included as part of the provider’s response. Actions completed and/or planned include, but are not limited to:

* Improve risk management processes for wound management and clinical care in relation to assessment, planning and review.

The service was found Non-compliant with Requirement (3)(c) following a Site Audit conducted 21 September 2020 to 25 September 2020 where it was found the risk management framework was not effective in identifying ongoing falls and managing falls prevention. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Monitoring of consumers’ risks through weekly high risk Resident management meetings, including review of consumers’ identified risks and actions taken to prevent and manage risks.
* Monthly audits and reporting to the Board, including consumer incidents and risks.

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. In coming to my finding, I have considered that the evidence presented does not indicate systemic issues with the organisation’s risk management systems and practices as they relate to managing high impact or high prevalence risks associated with the care of consumers.

I acknowledge evidence presented by the Assessment Team demonstrates wound management plans were not consistently completed, however, the issues highlighted related to one consumer. I have considered that the evidence presented does not suggest systemic issues relating to the organisation’s overall risk management system relating to high impact or high prevalence risks. As such, I have considered the evidence in my findings for other Requirements which reflect the core deficiency, specifically Standard 3 Personal and clinical care Requirement (3)(a).

In coming to my finding for this Requirement, I have considered information in the Assessment Team’s report indicating audit processes relating to wounds and pressure injuries are conducted. High impact or high prevalence risks related to consumers are monitored through weekly meeting forums and actions to prevent and/or manage risks are identified and implemented. Meeting minutes sampled demonstrated risks related to behaviours of concern, falls, pain, weight management, choking, pressure injuries, palliative care, infections and sensory deficits are identified, discussed and monitored through this forum.

In relation to risk assessments, I have considered that while assessments and the care plan were not reflective of current practices for one consumer, staff sampled were aware of the consumer’s current care needs.

In relation to a full care plan review not being undertaken, I have considered information in the Assessment Team’s report indicating care plans have been reviewed on a four monthly basis, including review and update of individual assessments, the care plan review schedule is followed and no impacts to consumers were observed. I have also considered evidence highlighted by the Assessment Team in relation to Standard 2 Ongoing assessment and planning with consumers Requirement (3)(e) indicating care and services are regularly reviewed for effectiveness and care plans are updated in response to changes in consumers’ circumstances and when incidents occur.

I have also considered that the Assessment Team’s report demonstrates the organisation has effective risk management systems and practices in relation to identifying and responding to abuse and neglect of consumers; supporting consumers to live the best life they can and managing and preventing incidents, including the use of an incident management system. There are processes to ensure these areas are monitored and reported on.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, Compliant with Requirement (3)(d) in Standard 8 Organisational governance.

# 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.

**Standard 3 Requirement (3)(a)**

* Ensure staff have the skills and knowledge to:
* monitor and review effectiveness of behaviour management strategies, including strategies implemented to address pain, to assist with minimising use of psychotropic medications;
* use psychotropic medications for management of behaviours as a last resort;
* understand legislative requirements in relation to behaviour support plans and develop and implement support plans in line with these requirements.; and
* review and undertake wound treatments, ensuring wound measurements and appearance are routinely documented.
* Review wound management processes to ensure documentation and review relating to wounds is easily accessible to enable effective monitoring of wound progression.
* Ensure policies, procedures and guidelines in relation to behaviour support plans, use of psychotropic medications and wound management, including assessment, monitoring and review are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to wound management, including assessment, monitoring and review.