Performance

Report

**1800 951 822**

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| Name: | Boandik St Mary's |
| Commission ID: | 6234 |
| Address: | 71 Boandik Terrace, MOUNT GAMBIER, South Australia, 5290 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 18 June 2024 |
| Performance report date: | 2 July 2024 |
| Service included in this assessment: | Provider: 1551 Boandik Lodge Inc  Service: 5648 Boandik St Mary's |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Boandik St Mary's (**the service**) has been prepared by M Glenn, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the assessment contact (performance assessment) – site, which was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff and management;
* the provider’s response received 1 July 2024 acknowledging the assessment team’s report; and
* a performance report dated 25 August 2023 for a site audit undertaken from 4 July 2023 to 6 July 2023.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Fully Assessed |
| **Standard 5** Organisation’s service environment | **Not Fully Assessed** |
| **Standard 7** Human resources | **Not Fully Assessed** |
| **Standard 8** Organisational governance | **Not Fully Assessed** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |

Findings

Requirement (3)(a) was found non-compliant following a site audit undertaken in July 2023 as provision of personal and clinical care was not safe, effective, best practice or tailored, nor did it optimise consumers’ health and well-being. In response to the non-compliance, the provider implemented a range of actions, including, but not limited to, providing education to clinical staff relating to management of diabetes, falls, food and nutrition, pressure injuries and wounds; providing education to all staff on skin care, including monitoring, identifying and reporting abnormalities; and monitoring staff competency through observation and questionnaires.

At the assessment contact undertaken in June 2024, care and service provision was found to be best practice, tailored, and optimised consumers’ health and well-being. Care files show appropriate, tailored care provision, including in relation to management of behaviours, pain, diabetes, catheter care, skin integrity, and wounds. Care files also evidence involvement of general practitioners and allied health professionals in the management of consumers’ personal and clinical care needs. Consumers and representatives said consumers receive personalised personal and clinical care that improves their health and well-being.

Based on the assessment team’s report, I find requirement (3)(a) in Standard 3 Personal care and clinical care, compliant.

# Standard 5

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

Findings

Requirement (3)(b) was found non-compliant following a site audit undertaken in July 2023 as the service environment was not safe. In response to the non-compliance, the provider implemented a range of actions, including, but not limited to, no longer using expandable barriers; having locking mechanisms on hot water erns; locking electrical switchboards; and no longer using the internal courtyard of the memory support unit as a smoking area.

At the assessment contact undertaken in June 2024, consumers and representatives said the environment is always safe, clean and well maintained, and consumers confirm they can move freely both indoors and outdoors. Regular cleaning of consumer rooms and communal areas is undertaken in line with a schedule, and cleanliness of the service environment is regularly monitored. Outdoor gardens are well maintained, with clear pathways. Emergency evacuation and fire door signs are displayed throughout the service, and staff said they undertake annual mandatory fire evacuation training.

Based on the assessment team’s report, I find requirement (3)(b) in Standard 5 Organisation’s service environment, compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |

Findings

Requirement (3)(c) was found non-compliant following a site audit undertaken in July 2023 as the workforce was not competent nor effectively performing their roles in relation to monitoring consumers with diabetes and medication management. In response to the non-compliance, the provider implemented a range of actions, including, but not limited to, a comprehensive training plan, ongoing training and evaluation; introducing various training sessions to meet staff and consumers’ needs, such as diabetes and medication management; providing education to clinical staff undertaking blood glucose testing and insulin administration; and increasing oversight and monitoring by clinical staff to ensure staff work practices align with organisational values.

At the assessment contact undertaken in June 2024, the workforce was found to be competent and to have the qualifications and knowledge to effectively perform their roles. Staff files show staff have the relevant qualifications, with job descriptions and duty statements available to guide them in their roles. Competency checklists show all staff have completed competencies on dysphagia, hand hygiene, and personal protective equipment, and medication competencies have been completed by all clinical staff. Staff practices are monitored ongoing through observation, feedback and complaints and incident data. Where staff are identified as being not fully competent, additional training and support is provided to the staff member in the first instance, with performance management initiated if this is not effective. Staff described how they work within their skills, qualifications, and knowledge base, and said the service provides ongoing training and competency assessment. All consumers and representatives interviewed said staff are knowledgeable and they feel confident that staff delivering care have the right skills.

Based on the assessment team’s report, I find requirement (3)(c) in Standard 7 Human resources, compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |

Findings

Requirement (3)(d) was found non-compliant following a site audit undertaken in July 2023 as the risk management system was not effective in relation to management of risks to consumers’ care or identifying incidents where medication was not administered correctly. In response to the non-compliance, the provider implemented a range of actions, including, but not limited to, developing guidelines for daily clinical meetings to incorporate risk, deficits in care concerns and/or incident trends; and incorporating a summary report of the previous month’s incident management and trend analysis as part of the agenda for clinical/care staff meetings.

At the assessment contact undertaken in June 2024, effective risk management systems and practices for monitoring high impact or high prevalence risks; identifying and responding to abuse and neglect; supporting consumers to live the best life they can; and managing and preventing incidents were demonstrated. A high risk register is maintained and captures consumers who have significant risks associated with their care, with additional management strategies implemented depending on the risk identified. High impact or high prevalence risk data is captured and discussed at various service and organisational meetings, as well as board meetings. Elder abuse is included at staff induction and annual mandatory training. All staff interviewed confirm they have training in elder abuse and restrictive practices and described their role in reporting, documenting, actioning and escalating incidents. Clinical and care staff described individual mitigation strategies for consumers who choose to take risk, and care files evidence dignity of risk consultation with consumers. An incident register is maintained, and a breakdown of the data is discussed at various meeting forums. Meeting minutes evidence discussions relating to incident reporting and risk management, including falls, weight loss, behaviours, deterioration and serious incident response scheme reporting. Risk information is also tabled at board of directors meetings.

Based on the assessment team’s report, I find requirement (3)(d) in Standard 8 Organisational governance, compliant.

1. The preparation of the performance report is in accordance with section 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)