Performance

Report

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| Name of service: | Boandik Sutton |
| Service address: | 101 Lake Terrace East MOUNT GAMBIER SA 5290 |
| Commission ID: | 6025 |
| Approved provider: | Boandik Lodge Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 26 October 2022 |
| Performance report date: | 14 December 2022 |

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 Sutton (**the service**) has been prepared by R Beaman, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others; and

the provider’s response to the Assessment Team’s report received on 23 November 2022; and

the Performance Report dated 10 June 2021for the site audit undertaken from 23 March 2021 to 25 March 2021.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Non-compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Non-compliant** |

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

# 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.

Requirement 1(3)(d) – ensure each consumer is supported to take risks to live the best life they can;

* Requirement 2(3)(a) – ensure assessment and planning considers risks to the consumer’s health and well-being to inform the delivery of safe and quality care and services;
* Requirement 2(3)(b) – ensure assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes;

Requirement 3(3)(b) – ensure high impact or high prevalence risks associated with the care of each consumer are managed safely and effectively; and

* Requirement 8(3)(e) – ensure there is an effective clinical governance framework that includes systems and processes for minimising the use of restraint and antimicrobial stewardship.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Non-compliant |

Findings

The service was found Non-compliant with Requirement (3)(d) in this Standard following a site audit undertaken from 23 March 2021 to 25 March 2021 where the service did not demonstrate it supported consumers to take risks through mitigation strategies to prevent harm to continue them to undertake activities of risk.

The service has implemented a range of improvement actions to address the deficits identified, including development of a new suite of policies and procedures, including dignity of risk, and providing staff education in relation to dignity of risk. However, the Assessment Team have recommended this Requirement not met.

The Assessment Team found for three sampled consumers who undertake activities which include an element of risk, documentation did not include mitigation strategies to make those activities safe. For two of the three consumers, staff did not have an understanding of the mitigation strategies to support those consumers to undertake the activity of risk in a safe manner. For one of the three consumers, staff were not monitoring them when they undertook the activity to ensure they were supported to do so in a safe manner.

The provider’s response acknowledges the deficits identified in the Assessment Team’s report and in doing so they have outlined their plan of actions to rectify those, including implementing an updated Dignity of Risk policy to guide staff to deliver care that supports consumers to take risks, reviewing activities of risk undertaken by consumers and closer monitoring of consumers when undertaking activities of risk. The provider in their response acknowledges for one of the three sampled consumers, a risk assessment that was completed prior to the Assessment Contact visit was not provided to the Assessment Team at the time of the visit.

I acknowledge the provider has put in place an action plan to address the identified deficits in relation to consumers being supported to take risks to live the best life they can, and I encourage them to continue to implement those initiatives. However, at the time of the Assessment Contact visit, the provider was unable to demonstrate that each consumer is supported to take risks.

Accordingly, I find Requirement 1(3)(d) is Non-compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Non-compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Non-compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |

Findings

The service was found Non-compliant with Requirements (3)(a), (3)(b) and (3)(d) in this Standard following a site audit undertaken from 23 March 2021 to 25 March 2021 where the service did not demonstrate assessment and planning identified consumers’ current needs, goals and preferences, did not consider risks in relation to psychotropic medications or activities of risk to inform the delivery of safe and quality care, or the outcomes of assessment and planning were effectively communicated.

The service has implemented a range of improvement actions to address the deficits identified, including review of policies and procedures in relation to dignity of risk, reviewing risk assessment tools to ensure mitigation strategies are captured in care planning documentation, reviewing all psychotropic medication usage to ensure assessments are completed, reviewing consumers included in the previous report to ensure all assessments are up-to-date and care plans reflect current needs, goals and preferences, palliative and end of life procedures updated and review of progress notes regularly to capture any changes to consumer care and services.

While the service has implemented the above actions, the Assessment Team found Requirements 2(3)(a) and 2(3)(b) to be not met. Documentation confirmed two sampled consumers undertaking activities of risk do not have current risk assessments in place and the risks to their health and safety had not been considered to inform the delivery of their care. For another consumer, assessment and planning did not inform the delivery of care in relation to their behaviour support needs and interventions to effectively manage behaviours y were not recorded to guide staff practice.

Documentation sampled for two consumers confirmed care plans did not reflect their current preferences, including for specific gender staff to deliver care, sleep and rising times and preferences for drinks. For one of those consumers, the behaviour support plan did not reflect current strategies or interventions to manage their verbally aggressive behaviours.

The provider’s response acknowledges the deficits identified in the Assessment Team’s report and outlined the planned actions they intend to implement to address those deficits. In relation to Requirement 2(3)(a), the provider has referenced the planned actions to address Standard 1 Requirement (3)(d), including reviewing and updating the dignity of risk policy, updating consumer care documentation to include risk assessments for those consumers wishing to take activities of risk and the development of a behaviour assessment to identify effective interventions for the consumer mentioned in the Assessment Team’s report who did not have strategies to manage their behaviours.

In relation to Requirement 2(3)(b), the provider has completed a review of all consumers identified in the Assessment Team’s report and updated the care plans to reflect consumers’ preferences for care and service delivery, along with providing education to all clinical staff in relation to the updating of support plans when needs, goals or preferences for consumers change.

I have considered the information in the Assessment Team’s report and the provider’s response and find that whilst the provider has a plan of actions in place to address the deficits identified and is actively working through those to improve their performance, at the time of the Assessment Contact visit, they were unable to demonstrate assessment and planning effectively considered consumers’ needs, goals, preferences or risks to inform care and services.

Accordingly, I find Requirements 2(3)(a) and 2(3)(b) in Standard 2 ongoing assessment and planning with consumers Non-compliant.

In relation to Requirement 2(3)(d) the Assessment Team recommend this as met. The Assessment Team found the improvement actions implemented were effective. Consumer representatives confirmed they are involved in care planning discussions and outcomes of those and any assessments were communicated with them. Staff confirmed they had access to care plans to help them deliver care and services in line with consumers’ needs and preferences.

Accordingly, I find Requirement 2(3)(d) in Standard 2 Ongoing assessment and planning with consumers Compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |

Findings

The service was found Non-compliant with Requirement (3)(b) in this Standard following a site audit undertaken from 23 March 2021 to 25 March 2021 where the service did not demonstrate effective management of high impact or high prevalence risks associated with medication and falls management.

The service has implemented a range of improvement actions to address the deficits identified, including education to staff in relation to safe medication management, review of all medication charts to ensure psychotropic medications have a clear indication for use, and review of policies for medication and falls management.

While the Assessment Team found the improvement actions addressed the deficits previously identified they found this Requirement not met, specifically in relation to falls management for three consumers. Documentation confirmed the three consumers sampled had unwitnessed falls, and for two of those consumers no falls risk assessment was completed to identify strategies to reduce the risk of and prevent further falls and they had additional falls. The high risk register does not recognise the risk of falls for one of the three consumers who has a history of falls and staff described that consumer as being a high falls risk.

The provider’s response acknowledges the deficits identified in the Assessment Team’s report and the need for improvement in the way the service manages the risk of falls. In their response the provider has asserted post every fall an incident form is completed that includes strategies to prevent further falls from occurring. While the provider has made a commitment to undertake the improvement actions to address the deficits identified with falls management, their Return to Compliance action plan shows these are currently ongoing and not yet finalised.

I acknowledge the provider has stated the service uses incident forms to capture clinical incidents, including falls and update the strategies, however, a falls risk assessment was not being completed as per the service’s policy to identify and capture risks in relation to falls for consumers to prevent further recurrence. In coming to my finding, I acknowledge the provider’s work immediately following the Assessment Contact to identify and implement improvement actions and encourage them to continue to do so.

Accordingly, I find Requirement (3)(b) in Standard 3 Personal care and clinical care Non-compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | 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. | Compliant |

Findings

The service was found Non-compliant with Requirement 7(3)(a) in this Standard following a site audit undertaken from 23 March 2021 to 25 March 2021 where the service did not demonstrate it had the right number and mix of members of the workforce to deliver quality care.

The service has implemented a range of improvement actions to address the deficits identified, including increased hours for clinical staff, recruitment of additional staff, and implementing systems to ensure appropriate staff numbers are maintained to enable leave coverage.

Consumers sampled confirmed they didn’t have to wait extended periods for assistance. Consumers and representatives were satisfied there are enough staff on to deliver care and services in a way that meets consumers’ needs and preferences.

Staff confirmed the implemented improvements of additional hours and clinical staff and confirmed they had enough time to complete their tasks and deliver care in a way consumers wanted and needed.

Documentation confirmed the service is undertaking ongoing recruitment.

Accordingly, I find Requirement (3)(a) in Standard 7 Human resources Compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Non-compliant |

Findings

The service was found Non-compliant with Requirement (3)(e) in this Standard following a site audit undertaken from 23 March 2021 to 25 March 2021 where the service did not demonstrate an effective clinical governance framework, including effectively monitoring or managing psychotropic medications in line with legislated requirement or up-to-date policies and procedures for antimicrobial stewardship or falls management to guide staff practice.

The service has implemented a range of improvement actions to address the deficits identified, including reviewing the clinical governance framework in consultation with the Board, education provided to all staff around clinical governance, and the implementation of a suite of new clinical policies and procedures. However, the Assessment Team recommended this Requirement not met. Documentation confirmed behaviour support plans have not been completed for all consumers administered psychotropic medication for behaviour management and while antimicrobial usage is trended monthly, the service did not identify whether infections were new or ongoing or whether the antibiotic treatment was effective.

Documentation and management confirmed the service does not have a current antimicrobial stewardship policy to guide staff practice in relation to infections and identifying the effectiveness of treatment.

The service’s Specialised Clinical care policy does not include the requirement for behaviour support plans for consumers considered having a restrictive practice in place. Four care and clinical staff were unable to demonstrate understanding of restricted practices nor their role and responsibilities.

The provider’s response acknowledges the deficits identified in the Assessment Team’s report in relation to clinical governance. The provider asserts they have identified several actions to improve their performance in this Requirement, including education to all staff around antimicrobial stewardship and restrictive practices, updating the clinical monitoring form, including antimicrobial stewardship as a standing agenda item for the organisation’s medication advisory committee and having clinical staff track and monitor pathogen type and ensure this has been included on the clinical monitoring form. Further to this, the provider asserts in their response a commitment to improving their performance in relation to restrictive practices through a review of all consumers with a restrictive practice in place to ensure all legislative requirements are completed and in place and reviewing all consumers with a behaviour support plan to ensure they meet all requirements.

I acknowledge the provider’s commitment to improvements and the actions taken immediately following the Assessment Contact and those they continue to implement to improve their performance in this Requirement. In coming to my finding, I have placed weight on the evidence presented in the Assessment Team’s report that at the time of the visit the service did not have an effective clinical governance framework in place.

Accordingly, I find Requirement (3)(e) in Standard 8 Organisational governance Non-Compliant.

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