Bonney Lodge

Performance Report

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**Commission ID:** 6149

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

**Site Audit date:** 14 June 2022 to 17 June 2022

**Date of Performance Report:** 25 July 2022

# 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 1 Consumer dignity and choice** | **Non-compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Non-compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Non-compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Compliant** |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | 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 Site Audit; the Site Audit report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff, management and others;
* the provider’s response to the Site Audit report received 11 July 2022; and
* the Performance Report dated 29 October 2021 for an Assessment Contact – Site undertaken from 14 September 2021 to 16 September 2021.

# STANDARD 1 NON-COMPLIANT Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

## The Quality Standard is assessed as Non-compliant as one of the six specific Requirements has been assessed as Non-compliant.

The Assessment Team recommended Requirement (3)(d) in this Standard as Not met. The Assessment Team were not satisfied the service demonstrated each consumer is supported by staff to take risks which enable them to live the best life they can.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirement (3)(d). I have provided reasons for my finding in the specific Requirement below.

## In relation to all other Requirements in this Standard, the Assessment Team found consumers sampled considered that they are treated with dignity and respect, can maintain their identity, make informed choices about the care and services they receive and live the life they choose.

Consumers and representatives confirmed consumers’ identity, culture and diversity were valued and celebrated. All staff demonstrated familiarity with consumers’ backgrounds and could identify specific strategies which maintain their identity, culture, and diversity. Staff were familiar with the term cultural safety and described how this influences the delivery of care. Consumers said the service has sought to understand their cultural requirements and what is important to them, including on entry and through regular conversations with staff and during meetings. Consumers confirmed staff value who they are, understand their needs and preferences and enable them to feel respected, valued and safe.

Consumers are supported to exercise choice, maintain relationships and independence and communicate their decisions. Formal processes, such as care plan reviews, provide consumers and their representatives an opportunity to discuss the care provided and alter care plans in line with consumers’ evolving needs and preferences. Consumers and representatives said consumers feel comfortable communicating their decisions and that those decisions were respected and supported. Consumers also felt supported to maintain relationships and have made friendships within the service.

Consumers confirmed information is provided and communicated to them to enable them to make choices about the care and services they receive. Consumers receive information through a number of avenues, including meeting forums, newsletters and noticeboards. Staff communicate daily with consumers, including those with cognitive impairments, to ensure daily activities and meal choices are communicated and reminders are provided prior to activity commencement. For consumers with severe cognitive impairment, staff engage representatives to provide information about consumer preferences and care and service needs. There are processes to ensure each consumer’s privacy is respected and personal information is kept confidential.

Based on the Assessment Team’s report, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, to be Compliant with Requirements (3)(a), (3)(b), (3)(c), (3)(e) and (3)(f) in Standard 1 Consumer dignity and choice.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Compliant

*Each consumer is supported to exercise choice and independence, including to:*

1. *make decisions about their own care and the way care and services are delivered; and*
2. *make decisions about when family, friends, carers or others should be involved in their care; and*
3. *communicate their decisions; and*
4. *make connections with others and maintain relationships of choice, including intimate relationships.*

### Requirement 1(3)(d) Non-compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

The Assessment Team were not satisfied the service demonstrated each consumer is supported by staff to take risks which enable them to live the best life they can. The Assessment Team’s report provided the following evidence relevant to my finding:

* Dignity of choice/Risk assessments, dated November 2020, for Consumers A and B identified risks and mitigating strategies relating to activities both consumers choose to partake which include an element of risk. Mitigating strategies included supervision, designated times to undertake the activity, use of protective equipment and management of related equipment.
* Four care and/or lifestyle staff said Consumers A and B are not supervised whilst undertaking the activity as they have been assessed to manage the associated risks independently. They said they believe Consumers A and B have access to protective equipment but don’t believe they use it and described contradictory processes in relation to management of related equipment.
* Related assessments for Consumer A dated June 2022 and Consumer B dated February 2022, indicated both consumers require supervision whilst undertaking the activity. Consumer A had been identified as having burnt clothing as a result of behaviours associated with the activity.
* Consumer A was observed undertaking the activity without staff supervision at a time not listed on the Dignity of choice/Risk assessment.

The provider’s response included actions, completed and ongoing, in response to the deficits identified in the Assessment Team’s report, as well as supporting documentation. The provider’s response included, but was not limited to, distributing a memorandum to staff reminding them of processes related to the activity; met with consumers to revisit the service’s policy relating to the activity and requirements; and implemented monitoring processes to ensure ongoing compliance.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service did not demonstrate each consumer was supported to take risks to enable them to live the best life they can.

While activities Consumers A and B chose to partake which includes an element of risk had been identified and mitigating strategies developed, I find both consumers were not supported to undertake this activity in line with their assessed needs and agreed upon strategies. Despite recent assessments identifying specific strategies to undertake this activity safely, staff sampled indicated both consumers were independent with this activity. Additionally, Consumer A was observed undertaking the activity without supervision and not in line with agreed strategies. As such, I have considered that by not ensuring agreed upon strategies are consistently implemented, this has placed the consumers at risk. This is particularly so for Consumer A who has been identified as having behaviours related to the activity which have the potential to place them at risk of harm.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, to be Non-compliant with Requirement (3)(d) in Standard 1 Consumer dignity and choice.

### Requirement 1(3)(e) Compliant

*Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.*

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

# STANDARD 2 NON-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 of the five specific Requirements has been assessed as Non-compliant.

The Assessment Team recommended Requirement (3)(e) in this Standard as Not met. The Assessment Team were not satisfied the service demonstrated 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.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirement (3)(e). I have provided reasons for my finding in the specific Requirement below.

In relation to all other Requirements in this Standard, the Assessment Team found overall, consumers sampled considered that they feel like partners in the ongoing assessment and planning of their care and services.

Care files sampled demonstrated a range of assessments are completed on entry and on an ongoing basis. Information gathered from consultation with consumers and/or representatives and assessment processes is used to develop individualised care plans which incorporate each consumer’s goals, needs and preferences. Additionally, a range of validated risk assessment tools are used to inform care planning, including in relation to falls and malnutrition, and strategies are developed to mitigate risks.

Consumer files identified and addressed consumers’ needs, goals and preferences relating to care and services, and there are processes to identify consumers’ preferences relating to advance care planning and end of life planning. Consumers said staff are familiar with their preferences, which is demonstrated in their daily routine and the care received. One consumer indicated they had been involved in planning their advance care directive.

Care files demonstrated staff work with the consumer and/or representative to ensure care and service provision is in line with consumers’ needs and preferences. Involvement of other providers of care, including Medical officers and Allied health professionals was also noted. Consumers said they have input into their care through talking with staff on a day-to-day basis about what they like and want.

There are processes to ensure the outcomes of assessment and planning are communicated to consumers and documented in a care plan which is readily available to staff to guide provision of care and services and to consumers on request. Consumers and representatives said they are consulted about care and changes are communicated with them. Additionally, representatives were aware of care plan documents and said they understood they could see a copy of the care plan if they wanted.

Based on the Assessment Team’s report, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, to be Compliant with Requirements (3)(a), (3)(b), (3)(c) and (3)(d) in Standard 2 Ongoing assessment and planning with consumers.

**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.*

**Requirement 2(3)(b) Compliant**

*Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.*

**Requirement 2(3)(c) Compliant**

*The organisation demonstrates that assessment and planning:*

1. *is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and*
2. *includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.*

**Requirement 2(3)(d) Compliant**

*The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.*

**Requirement 2(3)(e) Non-compliant**

*Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.*

The Assessment Team were not satisfied the service demonstrated care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. The Assessment Team’s report provided the following evidence relevant to my finding:

Consumer C

* Progress notes and behaviour charting include behaviours, increasing since May 2022, with as required antipsychotic medication administered on five occasions over a 26 day period between May and June 2022 and a regular antipsychotic medication commenced by the Medical officer in May 2022.
* The care plan did not include behaviours identified through behaviour charting and progress notes, or those discussed with the Medical officer prior to commencement of a daily antipsychotic in May 2022 and an increase in the dose of the medication twice in June 2022.
* Progress notes did not reflect consultation with the consumer’s representative prior to commencement of the antipsychotic medication.
* A behaviour cover page was created by the service as it was determined the electronic template did not meet legislative requirements for content required within a Behaviour support plan. However, the cover page dated February 2022, did not reference the use of antipsychotic medication, non-pharmacological strategies did not address management of changed behaviours and unsuccessful strategies trialled had not been captured.
* Staff indicated Consumer C had deteriorated within the last two months and are struggling to find non-pharmacological management strategies. One staff member advised strategies recommended by specialist services in November 2021 were no longer effective.

Consumer D

* The consumer uses intermittent oxygen therapy. Clinical staff advised the consumer uses oxygen when they want and manages this. An assessment for self-management of oxygen is not in place.
* The consumer returned from hospital in June 2022 with an indwelling catheter, however, this did not trigger an update of the care plan.

The provider’s response included actions, completed and ongoing, in response to the deficits identified in the Assessment Team’s report, as well as supporting documentation. The provider’s response included, but was not limited to:

* The draft cover page was on trial and was to provide a ‘snapshot handover’ for oncoming staff. It has been determined the cover sheet is not effective and its use has been discontinued.
* The Behaviour support plan process is well covered in the electronic system and includes documenting successful and unsuccessful behaviour strategies. A Behaviour support plan, dated the last day of the Site Audit, was provided for Consumer C.
* An Acute care support plan was created for Consumer D’s indwelling catheter on the last day of the Site Audit. Consumer D’s ability to self-administer oxygen has been reassessed and a Dignity of risk form completed.

I acknowledge the provider’s response. However, I find at the time of the Site Audit the service did not demonstrate care and services were regularly reviewed for effectiveness or in response to changes in consumers’ care and service needs. Care plans for Consumers C and D had not been reviewed for effectiveness in response to changes in their condition and did not accurately reflect the consumers’ current care and service needs.

In relation to C, I have considered that while behaviours had been increasing since May 2022, information available in progress notes and behaviour charting had not been used to review existing and/or develop new management strategies. The care plan did not include information relating to emerging behaviours to guide staff in the provision of care. Staff sampled indicated they were struggling to find non-pharmacological strategies to manage the consumer’s behaviour and strategies recommended by specialist services were no longer effective.

I have also considered that behaviour assessments and care plans have not been reviewed in line with legislative requirements which indicates to review and make necessary revisions after any change in the consumer’s circumstances. I find that this did not occur for Consumer C following an antipsychotic medication being prescribed on a regular basis and an increase in the dose on two occasions. Commencement of the antipsychotic medication and required documentation was not included on the cover page and a Behaviour support plan for Consumer C included in the provider’s response was noted to have been created on the last day of the Site Audit. As such, I find the information available at the time of the Site Audit was not sufficient to guide staff in the provision of the consumer’s care and services, particularly in relation to behaviour management strategies.

In relation to Consumer D, I find that care and services had not been reviewed and updated in response to a change in the consumer’s continence needs following return from hospital. I have also considered that despite clinical staff indicating the consumer managed their own oxygen therapy, an assessment of the consumer’s ability to undertake this safely and effectively had not been undertaken.

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

# 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 one of the seven specific Requirements has been assessed as Non-compliant.

Requirement (3)(a) was found Non-compliant following an Assessment Contact – Site undertaken from 14 September 2021 to 16 September 2021 where it was found the service did not demonstrate each consumer was receiving safe and effective clinical care that was best practice, tailored to their needs or optimised their health and well-being, specifically in relation to psychotropic medications and wound management.

The Assessment Team’s report provided evidence of actions taken to address deficiencies. However, at the Site Audit, the Assessment Team recommended Requirement (3)(a) not met. The Assessment Team were not satisfied the service demonstrated use of best practice in relation to medication management and wound reviews.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirement (3)(a). I have provided reasons for my finding in the specific Requirement below.

In relation to all other Requirements in this Standard, the Assessment Team found overall, consumers sampled considered that they receive personal and clinical care that is safe and right for them.

High impact or high prevalence risks associated with the care of consumers are identified through assessment processes and management strategies are developed to ensure care and services are delivered in line with consumers’ assessed needs and preferences. Care files demonstrated appropriate assessment and management of risks relating to weight loss, skin integrity, swallowing issues and pain. Care and clinical staff were able to identify risks for most consumers in alignment with those identified within their care plan and describe strategies for management. Consumers and representatives said they felt consumers’ care was managed well, and they felt safe.

The service has processes to identify each consumer’s needs, goals and preferences in relation to end of life. An End of life pathway is commenced for consumers identified as actively palliating and goals and preferences are reviewed to ensure alignment with consumer and family wishes. Clinical and care staff advised when they note deterioration in consumers’ health suggesting entering end of life phase, this would be referred to the Medical officer for confirmation and medication management and they have access to palliative care specialists, if required. A care file sampled for a consumer who had recently passed demonstrated a focus on pain management, comfort, and communication with the consumer’s family.

Where changes to consumers’ health are identified, care files sampled demonstrated, assessments and monitoring processes are implemented and timely referrals to Medical officers and/or Allied health staff initiated. Clinical staff described escalation pathways and processes for referral for specialist services where a deterioration to a consumer’s health or condition have been identified. Additionally, where changes to consumers’ care and service needs occur, there are processes to ensure these are communicated to staff.

An effective infection prevention and control program is in place and the service has a designated Infection prevention and control lead. There was evidence staff were aware of and utilised guidelines and resources provided to manage COVID-19. Staff were aware of consumers who required additional precautions and what their role was to minimise the risk of transmission. Whilst staff could access, describe, and explain processes related to infection control, staff were not always observed to be participating in best practice relating to hand hygiene and wearing masks correctly. Practices that promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics were demonstrated.

Based on the evidence documented above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, to be Compliant with Requirements (3)(b), (3)(c), (3)(d), (3)(e), (3)(f) and (3)(g) in Standard 3 Personal care and clinical care.

### Assessment of Standard 3 Requirements

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

*Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:*

1. *is best practice; and*
2. *is tailored to their needs; and*
3. *optimises their health and well-being.*

The Assessment Team were not satisfied the service demonstrated use of best practice in relation to medication management and wound reviews. The Assessment Team’s report provided the following evidence relevant to my finding:

* Wound records for two consumers included photographs, however, there was inconsistency with the angle of the photos, in some cases making wound comparisons difficult, and some photographs were blurry or did not capture the wound at all. Positioning of the tape measure against the wound also varied, making it an unreliable reference. The quality of the photographs was not found to have any impact on wound management or healing.

Consumer D

* The medication chart did not include indications for administration of a narcotic analgesic medication. A Medical officer notation in June 2022 stated it could be used for shortness of breath and was also used for pain.
* A progress note entry in June 2022 indicates the medication was administered to assist the consumer to sleep. Management advised staff had indicated to them the administration of the medication was for shortness of breath and anxiety, rather than for sleep.
* A current medication order for use of oxygen was not in place and the previous medication chart with oxygen had not been signed by nursing staff, despite staff advising the consumer used oxygen most days. As such, there was no record of whether the consumer’s need for supplementary oxygen was increasing or decreasing over time, particularly when unwell, and no evidence that it had been administered at the flow rate ordered.
* The consumer returned from hospital in June 2022 with an indwelling catheter. Staff interviewed were aware of the catheter, but did not speak of management requirements in the interim.
* On the second day of the Site Audit, the consumer was observed to be sitting with the catheter drainage bag on the floor. Staff advised the consumer would not permit them to move the bag.

Consumer C

* Consumer C commenced on an as required antipsychotic medication in May 2022, with progress notes stating it was to be trialled ‘after all non-pharmacological measures exhausted’. A regular dose of an antipsychotic was prescribed four days later in conjunction with the as required order. Twelve days later, the regular dose was increased. Progress notes did not demonstrate the consumer’s representative was contacted or provided informed consent for the use of chemical restraint or in relation to the changed behaviours and management.
* Behaviour charting and progress notes did not document non-pharmacological strategies used prior to the use of chemical restraint on two occasions in May 2022 and did not demonstrate the representative was consulted prior to the use of chemical restraint.
* An as required dose of the antipsychotic medication was administered on two occasions in June 2022. On one of these occasions, the only strategy documented was to attempt to assist the consumer to the toilet or back to bed.

The service was found Non-compliant with Requirement (3)(a) following an Assessment Contact – Site undertaken from 14 September 2021 to 16 September 2021, where it was found the service did not demonstrate each consumer was receiving safe and effective clinical care that was best practice, tailored to their needs or optimised their health and well-being, specifically in relation to psychotropic medications and wound management. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Provided education to staff in relation to wound care management and documentation and restrictive practice identification, monitoring and risk. Reminders have also been provided to staff on the importance of documenting non-pharmacological interventions used prior to medications.
* Implemented quality audits to monitor wound care charting.
* Reviewed admission assessments to include skin assessment and evaluation on first day of entry.
* Appointed a Wound care champion.
* Developed a restrictive practice register, clearly documenting assessment, monitoring, consent and completion of Behaviour support plans.
* Conducted quizzes to assess staff knowledge of wounds and restrictive practices.

The provider’s response included actions, completed and ongoing, in response to the deficits identified in the Assessment Team’s report, as well as supporting documentation. The provider’s response included, but was not limited to:

* All medication charts have been updated by the Medical officer to include indications of use.
* An order for oxygen has been obtained for Consumer D and an oxygen monitoring record is in place.
* Memoranda to staff in relation to restrictive practices, specifically use of chemical restraint.
* There is clear documentation relating to non-pharmacological strategies tried before medication administered to Consumer C on the dates highlighted by the Assessment Team.
* Email sent to Medical officers in relation to consent prior to prescribing antipsychotic medication.

I acknowledge the provider’s response. However, I find at the time of the Site Audit the service did not demonstrate safe and effective clinical care that is best practice, tailored to consumers’ needs and optimises their health and well-being, specifically in relation to management of medications and behaviours.

In relation to Consumer D, I have considered that while staff were aware the consumer was self-administering oxygen, a current order for the oxygen was not in place and the consumer’s use of the oxygen, including ensuring the correct flow rate, was not sufficiently monitored. I find this has not enabled changes to the consumer’s frequency of oxygen use, which could be indicative of a change in the consumer’s health and condition, to be sufficiently identified and timely actions initiated. I have also considered that indications for use of medications had not been consistently documented on medication charts. I find that this has the potential for medications to be administered for reasons which are not in line with the Medical officer’s intended use for the medication prescribed.

In relation to Consumer C, I find the service has not ensured the consumer’s health and well-being was optimised or that the care provided in relation to use of antipsychotic medications was in line with best practice care. In coming to my finding, I have considered that while Consumer C was prescribed antipsychotic medications on an as required basis, a Behaviour support plan detailing use of the medications had not been completed. I have also considered that there was no evidence to demonstrate the consumer and/or representative had been notified of the commencement of an antipsychotic medication or when the medication was prescribed on a regular basis and the dose subsequently increased 12 days later. I find this has not ensured the consumer and/or representative have been supported to understand the associated risks or enabled them to make an informed decision in relation to use of the medication.

I acknowledge progress notes included in the provider’s response demonstrating that for dates highlighted in the Assessment Team’s report, alternative strategies were tried prior to administration of antipsychotic medication. However, on review of the progress notes and the six entries relating to Behaviour assessment, alternative strategies documented are noted to be generic and not tailored to the individual consumer. Additionally, strategies are noted on four occasions as being ineffective and with a slight and minimal effect noted on the other two occasions. As such, I find this does not demonstrate that care has been tailored or based on assessment of the consumer’s needs, goals and preferences.

In relation to wound records, while deficits identified were not found to have any impact on wound management or healing, I would encourage the service to continue to implement their monitoring processes to ensure wound records are regularly reviewed to enable recording issues to be promptly identified and actions implemented.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, to be 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.*

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

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

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

*Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.*

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

*Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 3(3)(f) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 3(3)(g) Compliant

*Minimisation of infection related risks through implementing:*

1. *standard and transmission based precautions to prevent and control infection; and*
2. *practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.*

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

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

### Organisation statement:

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

## Assessment of Standard 4

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

The Assessment Team found overall, consumers sampled considered that they get the services and supports for daily living that are important for their health and well-being and enable them to do the things they want to do.

Care files sampled included information relating to consumers’ background, interests, significant relationships, and spiritual and emotional needs and preferences. Care plans included individual strategies to address and support consumers’ emotional needs, including the kind of activities which provided purpose and meaning. Care staff spoke of the additional emotional support provided to consumers during a recent lockdown due to COVID-19, including spending extra time with consumers following care, and assisting lifestyle staff with coordinating video chats and phone calls with families to enable consumers to stay connected. Consumers felt well supported by staff, with many describing them as ‘family’.

* Services and supports for daily living are provided which enable each consumer to participate both in the internal and external community, maintain and develop social and personal relationships and participate in activities that are important to them and which they enjoy. An activities calendar is in place and is reviewed each month, and feedback relating to the activities program is sought from consumers through consumer meeting forums. Lifestyle staff described how activities are tailored to suit the needs of many, and consumers who do not enjoy group activities receive one-on-one visits. Consumers described friends made within the service, and the support provided to keep in touch with friends and family in the community, particularly during the most recent lockdown.
* Consumer files sampled demonstrated information about consumers’ conditions, needs and preferences is documented and communicated within the service and with others where responsibility is shared and, where required, appropriate and timely are referrals are initiated. Lifestyle staff spoke of efforts made to connect consumers with community services. Consumers said staff were familiar with their likes and preferences, and they are consulted on activities and invited to participate in things they enjoyed.

Meals are prepared and cooked fresh in line with a four-week rotating menu which has been reviewed by a Dietitian and developed in consultation with consumers. Care files reflected consumers’ dietary needs and/or preferences, including specific cultural and spiritual requirements, likes and dislikes. There are processes to ensure this information is provided to staff, including catering staff. Consumers and representatives were happy with the food provided, indicating it meets consumers’ cultural and spiritual needs and preferences, and consumers reported overall satisfaction with the quality and quantity of meals provided.

There are processes to ensure equipment, required to support delivery of services, is clean, safe and suitable for consumer use. Internal monitoring processes ensure equipment provided is maintained. Consumers confirmed the equipment provided to them is safe, clean, and well maintained.

Based on the Assessment Team’s report, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, to be Compliant with all Requirements in Standard 4 Services and supports for daily living.

**Assessment of Standard 4 Requirements**

**Requirement 4(3)(a) Compliant**

*Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.*

**Requirement 4(3)(b) Compliant**

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

**Requirement 4(3)(c) Compliant**

*Services and supports for daily living assist each consumer to:*

1. *participate in their community within and outside the organisation’s service environment; and*
2. *have social and personal relationships; and*
3. *do the things of interest to them.*

**Requirement 4(3)(d) Compliant**

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

**Requirement 4(3)(e) Compliant**

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

**Requirement 4(3)(f) Compliant**

*Where meals are provided, they are varied and of suitable quality and quantity.*

**Requirement 4(3)(g) Compliant**

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

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

The Assessment Team found overall, consumers sampled considered that they feel they belong in the service and feel safe and comfortable in the service environment.

The Assessment Team observed the service environment to be welcoming, easy to understand and optimises each consumer’s sense of belonging, independence, interaction and function. The 50-bed service contains a dedicated 16 bed memory support unit, with innovative pathfinding design to optimise independence for those consumers with cognitive deficits. The service has large and small communal lounge, dining and sitting areas where consumers can interact with friends and family. Consumers were observed using the communal areas to meet with loved ones, participate in activity programs and engaging in conversation with other consumers. Overall, consumers said they felt at home at the service and were able to personalise their room with items of furniture and personal ornaments that had sentimental value.

The service was observed to be safe, clean, well maintained and comfortable and the service environment supports free movement of consumers both indoors and outdoors. Doors in a communal loungeroom to the internal courtyard were unlocked during day light hours allowing freedom of movement for consumers and are secured at night to ensure security. There are processes to ensure regular cleaning of consumer rooms and common areas, and cleaning of high touch points has been increased in response to COVID-19. Staff described actions to take in the event of an emergency, and explained how consumers with hearing, sight and mobility impairments are assisted. However, three pieces of fire equipment were noted to not have been serviced within required timeframes. Overall, consumers and representatives said consumers felt safe and were able to move freely within the service environment and within the internal garden courtyard of the memory support unit. Consumers said the communal areas and their personal bedrooms were clean and well maintained.

Furniture, fittings and equipment was observed to be safe, clean, well maintained and suitable for the consumer. Staff described how they ensure the service environment and equipment is safe, cleaned and maintained. Preventative and reactive maintenance processes are in place and staff described how they report and manage maintenance issues, as well as hazards. Consumers said furniture, fittings and equipment were maintained and suitable to their needs and they felt safe when staff used equipment.

Based on the Assessment Team’s report, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, to be Compliant with all Requirements in Standard 5 Organisation’s service environment.

## Assessment of Standard 5 Requirements

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

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

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

*The service environment:*

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

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

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

# STANDARD 6 COMPLIANT Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

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

The Assessment Team found overall, consumers sampled considered that they are encouraged and supported to give feedback and make complaints, and appropriate action is taken.

Consumers and others are encouraged and supported to provide feedback and make complaints through a range of avenues, including meeting forums, care and service review processes, feedback forms, surveys and management’s open door policy. Consumers and representatives said the feedback process is supportive, they are confident in the system, and are encouraged to provide feedback, with several reporting options in place to support the process.

Consumers are provided with information about internal and external feedback and complaints mechanisms, advocacy and language services on entry. Feedback forms and external complaints, language services and advocacy information was also observed on display and secure drop boxes were observed – all accessible to consumers. Consumers confirmed they know how to make a complaint, including one consumer who was aware of external mechanisms, including advocacy services and the Aged Care Quality and Safety Commission.

The service has a framework to guide appropriate action in response to complaints and an open disclosure process is used when things go wrong. Feedback is logged, analysed and used improve the quality of care and services. Policy and procedure documents, including in relation to open disclosure, are available to guide staff practice and actions taken to address feedback and resolve complaints are reported to the Board for further review. Staff were aware of the service’s feedback policies and procedures, including the concept of open disclosure, and management provided an example of where an open disclosure process had been applied. Representatives confirmed the service is prompt to make contact when an incident occurs.

The service demonstrated how feedback and complaints are reviewed and used to identify and drive continuous improvement. A variety of feedback gathering mechanisms enables ideas for improvement to be identified, including meeting forums, feedback forms, audits and surveys. Management provided examples of improvements made in response to feedback and surveys, however, these improvements had not been documented on the Plan for continuous improvement. Consumers and representatives confirmed being able to give feedback regarding care and services and this information used to improve care and services.

Based on the Assessment Team’s report, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, to be Compliant with all Requirements in Standard 6 Feedback and complaints.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

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

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

# STANDARD 7 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 Compliant as five of the five specific Requirements have been assessed as Compliant.

Consumers sampled considered that they get quality care and services when they need them and from people who are knowledgeable, capable and caring.

The service has processes to ensure the workforce is planned and the number and skills mix enables the delivery of quality care and services. Rosters are reviewed based on number of consumers accessing the service and consumer acuity. Call bell data, feedback and complaints and incidents are monitored to ensure adequacy of the roster and identify areas for improvement. Roster working groups are held with staff providing them an opportunity to confirm their pressure points and provide feedback on the roster. All staff sampled said there are enough staff rostered each day to allow them to undertake their duties in a timely manner. Most consumers and representatives said there are adequate staff numbers to provide safe and quality care and services and consumers do not have to wait long for staff to attend to their needs.

Staff interactions with consumers were observed to be kind, caring and respectful. All consumers and representatives were complimentary of staff and confirmed staff are kind, caring and respectful with consumers.

There are processes to ensure the workforce is competent and have the qualifications and knowledge to effectively perform their roles. Duty statements and policies and procedures are available to guide staff practice and outline their roles and responsibilities. Staff competency is monitored through incidents, feedback, audits, peer feedback and observation. Additional training is provided where deficiencies are identified. Staff described their roles and responsibilities, and care and clinical staff said they felt confident to conduct their duties and are provided sufficient training opportunities. Consumers said they do not have any concerns about staff competency, they are confident in staffs’ abilities, and feel safe when staff are performing care.

The service has an onboarding process which involves organisational induction, orientation, mandatory training and buddy shifts. Following recruitment, ongoing training is provided and there are systems to monitor staff performance ongoing to ensure staff competency and knowledge. Ongoing training opportunities are provided to staff in addition to mandatory training components. Staff stated they felt supported by management, have been provided training opportunities and considered the training sufficient to enable them to conduct their role confidently and competently. All consumers and representatives said they thought staff know what they are doing, are able to meet consumer care and service needs, and did not express any areas for additional training.

The service has a staff performance framework which ensures staff performance, including poor performance, is regularly assessed, monitored and reviewed. Staff performance reviews are conducted bi-annually and regular monitoring of staff performance is undertaken through review of incident data, complaints and feedback, audits and observations. Staff confirmed they participate in annual performance appraisals where they discuss performance, additional training and development needs and/or wishes. Staff also indicated management actively seek peer feedback from staff and supervisors about staff performance.

Based on the Assessment Team’s report, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, to be Compliant with all Requirements in Standard 7 Human resources.

## 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.*

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

### Requirement 7(3)(c) Compliant

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

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

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

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

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

# 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 of the five specific Requirements has been assessed as Non-compliant.

The Assessment Team recommended Requirement (3)(c) in this Standard not met. While effective governance systems were demonstrated in relation to information management, financial governance, workforce governance, regulatory compliance and feedback and complaints, the Assessment Team were not satisfied effective governance systems relating to continuous improvement were demonstrated.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and find the service Non-compliant with Requirement (3)(c). I have provided reasons for my findings in the specific Requirement below.

In relation to all other Requirements in this Standard, consumers sampled considered that the organisation is well run and they can partner in improving the delivery of care and services. Consumers are engaged in the development, delivery and evaluation of care and services through meeting forums, feedback processes, surveys and care and service review processes. The Board of directors aim to visit the service annually, engaging with consumers and staff. Consumer experience is discussed at Board meetings, with one consumer speaking at the meeting about their experience living at the service. Two consumers have been elected as representatives and attend Quality risk and safety meetings and provide feedback and suggestions, as well as advocating on behalf of other consumers.

The governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. The governing body comprises of a Board of directors who are supported by sub committees and the leadership team. The Board satisfies itself that the service is meeting the Quality Standards through regular reporting from the leadership team which includes various governance and clinical information, such as quality indicators and trends, mandatory reporting, critical incidents and consumer feedback and complaints.

The organisation demonstrated effective risk management systems and practices in relation to managing high impact or high prevalence risks; identifying and responding to abuse and neglect of consumers; supporting consumers to live the best life they can and managing and preventing incidents, including use of an incident management system.

The organisation has policies and procedures to guide staff practice in relation to antimicrobial stewardship, minimising use of restraint and open disclosure. Staff sampled were aware of processes relating to these aspects and described how they implement these within the scope of their roles. Staff awareness of organisational policies and procedures relating to clinical governance was further demonstrated through evidence presented in other Standards.

Based on the Assessment Team’s report, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, to be Compliant with Requirements (3)(a), (3)(b), (3)(d) and (3)(e) in Standard 8 Organisational Governance.

**Assessment of Standard 8 Requirements**

**Requirement 8(3)(a) Compliant**

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

**Requirement 8(3)(b) Compliant**

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

**Requirement 8(3)(c) Non-compliant**

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

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

The organisation demonstrated effective governance systems in relation to information management, financial governance, workforce governance, regulatory compliance and feedback and complaints. However, the Assessment Team were not satisfied effective governance systems relating to continuous improvement were demonstrated. The Assessment Team’s report provided the following evidence relevant to my finding:

* The organisation was unable to demonstrate a documented Plan for continuous improvement (PCI) is maintained by the service or organisation, documenting how the service and organisation will assess, monitor and improve care and services against the Aged Care Quality Standards as required by the *Aged Care Quality and Safety Commission Rules 2018*.
* The service was previously capturing and monitoring plans for improvement on a register, however, this has not been updated since October 2021.
* Management said following the Assessment Contact visit in September 2021, the service has been focussed on addressing areas of non-compliance and is managing a PCI outlining areas for improvement, specifically in relation to the identified areas of non-compliance.

The provider’s response included commentary relating to the issues raised, as well as actions, completed and ongoing, in response to the deficits identified in the Assessment Team’s report. The provider’s response included, but was not limited to:

* Indicated additional actions and continuous improvements related to the aged care quality activities are monitored through the Quality risk and safety meetings and completion of a Self-assessment.
* All actions related to the self-assessment and quality activities will now be documented in the PCI so all information is available in one document.
* The PCI will now include all identified issues and opportunities for improvement, including from meeting forums, feedback, surveys and quality activities.

I acknowledge the provider’s response. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Site Audit, the service did not demonstrate effective organisational governance systems, specifically in relation to continuous improvement.

I have considered that while a continuous improvement framework is in place, the framework has not been consistently applied in line with the organisation’s processes. A register, used by the organisation and service to capture and monitor improvements, has not been updated since October 2021. While improvements identified through feedback and surveys were noted in the Assessment Team’s report, these had not been documented on the register and there was no evidence to demonstrate how these improvements had been monitored or evaluated for effectiveness. The provider’s response asserts additional actions and continuous improvements related to aged care quality activities are monitored, including through Quality risk and safety meetings. However, minutes from these meetings to demonstrate this process were not included as part of the response.

I have also considered that while a PCI was in place, the PCI only reflected non-compliance identified following an Assessment Contact undertaken in September 2021. As such, I have considered that the register and the PCI do not demonstrate ongoing improvements across all eight Quality Standards are identified, monitored and evaluated or that improvements are identified through a range of sources.

For the reasons detailed above, I find Riverland Mallee Coorong Local Health Network Incorporated, in relation to Bonney Lodge, to be Non-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.*

**Requirement 8(3)(e) Compliant**

*Where clinical care is provided—a clinical governance framework, including but not limited to the following:*

1. *antimicrobial stewardship;*
2. *minimising the use of restraint;*
3. *open disclosure.*

# Areas for improvement

Areas have been identified in which improvements must be made to ensure compliance with the Quality Standards. This is based on non-compliance with the Quality Standards as described in this performance report.

**Standard 1 Requirement (3)(d)**

* Ensure staff have the skills and knowledge to support consumers to take risks in line with agreed upon management strategies.

**Standard 2 Requirement (3)(e)**

* Ensure staff have the skills and knowledge to initiate assessments and develop and/or update care plans, including in response to changes in consumers’ health and well-being.
* Ensure care plans are reflective of consumers’ current and assessed needs and preferences to enable staff to provide quality care and services.
* Ensure policies and procedures in relation to assessment, care planning and review are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to assessment, care planning and review.

**Standard 3 Requirements (3)(a)**

* Ensure staff have the skills and knowledge to:
* Initiate non-pharmacological behaviour management strategies prior to use of psychotropic medications and monitor and document response;
* Identify and develop non-pharmacological behaviour management strategies that are individualised to the consumer and monitor effectiveness of such strategies; and
* Develop and/or initiate appropriate, documented care plans for consumers’ specialised care needs, including use of oxygen and indwelling catheters to guide staff in delivery of care and services.
* Ensure policies, procedures and guidelines in relation to medication management and use of psychotropic medications are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to medication management and use of psychotropic medications.

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

* Review the organisation’s governance systems in relation to continuous improvement.