Performance

Report

**1800 951 822**

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| Name of service: | Bonney Lodge |
| Service address: | 24 Hawdon Street BARMERA SA 5345 |
| Commission ID: | 6149 |
| Approved provider: | Riverland Mallee Coorong Local Health Network Incorporated |
| Activity type: | Assessment Contact - Site |
| Activity date: | 29 May 2023 to 30 May 2023 |
| Performance report date: | 11 July 2023 |

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 Bonney Lodge (**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.

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 consumers, representatives, staff, and management;
* the provider’s response to the Assessment Team’s report received 20 June 2023; and
* a Performance report dated 25 July 2022 for a Site Audit undertaken from 14 June 2022 to 17 June 2022.

# Assessment summary

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

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.

**Standard 3 requirement (3)(a)**

* Ensure staff have the skills and knowledge to:
* provide personal and or clinical/care and services to consumers in line with their assessed needs and preferences and that is best practice, tailored to their needs and optimises their health and well-being, specifically in relation to management of wounds, pain, skin integrity and the use of restrictive practices; and
* use restrictive practices in line with legislative requirements;
* Ensure policies, procedures, and guidelines in relation to best practice care are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures, and guidelines in relation to best practice care.

# 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. | Compliant |

Findings

Requirement (3)(d) was found non-compliant following a Site Audit undertaken from 14 June 2022 to 17 June 2022 where it was found each consumer was not supported to take risks to enable them to live the best life they could. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Rostered staff to supervise consumers partaking in an activity and undertaking regular monitoring of the areas the activity is undertaken in to ensure compliance with protocols outlined in consumers’ care plans.
* Consulted with consumers in relation to activities they choose to partake in and implemented a monitoring form to ensure consumers’ compliance with the service’s related policy.

At the Assessment Contact undertaken from the 29 May 2023 to 30 May 2023, consumers were found to be supported to take risks to enable them to the live the best life they can. Care files sampled included Dignity of choice/Risk assessments which outlined activities consumers choose to partake in and strategies to minimise risk. Staff provided examples of consumers who undertake activities with potential risks and described strategies and ways in which they support consumers. All consumers sampled felt supported to do the things they wish to do even when risk was involved, and said related risks are discussed and managed with them.

For the reasons detailed above, I find requirement (3)(d) in Standard 1 Consumer dignity and choice compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(e) | 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. | Compliant |

Findings

Requirement (3)(e) was found non-compliant following a Site Audit undertaken from 14 June 2022 to 17 June 2022 where it was found care and services were not regularly reviewed for effectiveness or in response to changes in consumers’ care and service needs. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed Behaviour support plans and consulted with consumers and representatives to ensure non-pharmacological strategies were suitable for individual consumers.
* Provided training to staff in relation to restrictive practice and Behaviour support plans.
* Consulted with each consumer with supplemental or constant oxygen and initiated Medical officer reviews.

At the Assessment Contact undertaken from the 29 May 2023 to 30 May 2023, care and services were found to be regularly reviewed, including in response to a change in circumstances and when incidents impacted on the needs, goals, or preferences of consumers. Assessments and care plans are routinely reviewed on a six-monthly basis and as required. Care files sampled for five consumers had been reviewed in line with the schedule and consultation with consumers and/or representatives was evident. Care files also demonstrated review of consumers’ care and service needs in response to a change in condition, including following identified weight loss and return from hospital. Allied health specialists were also noted to be involved in the review process. Care and clinical staff described reassessment processes, including when reassessment is required and how information is captured in consumers’ care plans. Consumers and representatives stated they are informed when a review is undertaken and where there have been changes to consumers' needs or assessments.

For the reasons detailed above, I find requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers compliant.

# 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. | Non-compliant |

Findings

Requirement (3)(a) was found non-compliant following a Site Audit undertaken from 14 June 2022 to 17 June 2022 where consumers were found not to receive safe and effective clinical care that was best practice, tailored to their needs and optimised their health and well-being, specifically in relation to management of medications and behaviours. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reinforced the process of consultation with consumers and/or representatives prior to commencement of antipsychotic medication.
* Consulted with Medical officers in relation to administering psychotropic medications and completed an audit of all consumers to ensure consent had been obtained.
* Implemented monthly consultation with Medical officers and developed a communication book and antipsychotic information booklet to prompt Medical officers to undertake discussions with consumers and/or representatives in relation to consent.
* Updated Behaviour support plans to include reference to use of as required antipsychotics and provided training to staff.

At the Assessment Contact undertaken from the 29 May 2023 to 30 May 2023, the Assessment Team found for two consumers, safe and effective delivery of clinical care that is best practice, tailored to their needs and optimises their health and well-being, specifically in relation to management of wounds, pain and behaviours was not demonstrated.

Consumer A

* Consumer A has three active wounds. Wound documentation shows inconsistent recording of wound size and measurements for all three wounds and photographs had been taken at various angles without rulers. Management had identified gaps in the way photographs were taken and sizing of wounds and confirmed additional wound training has been scheduled.
* The Community health nurse reviewed Consumer A’s wounds in May 2023, recommending wound dressings every second day. This recommendation had not been consistently implemented with wound treatment charts showing varying times between wound dressing changes and all three wounds showing signs of not improving.
* Consumer A confirmed they have ongoing pain relating to one of the wounds and said they receive medications for the pain in the mornings and sometimes in the evenings. Progress notes indicate Consumer A’s representatives have to ask staff for pain relief to be administered. The pain assessment identifies Consumer A has pain at the location of wound and management strategies are outlined.
* Pain monitoring charts for a 20-day period in May 2023 show Consumer A’s pain was recorded as assessed on six occasions. Pain charts only included records for when the consumer had pain scores and was administered as required analgesia. There were no records demonstrating monitoring over a consistent period to assess and monitor the efficacy of pain-relieving strategies. Documentation did not demonstrate Consumer A’s pain was assessed prior to wound dressing changes.
* The Medication chart shows Consumer A can be administered as required narcotic analgesic up to four times a day. This medication has only been administered on 13 out of a possible 68 occasions over an 18-day period in May 2023.
* Consumer A’s skin assessment indicates two-hourly repositioning. Charting shows Consumer A has been repositioned on only 23 occasions over a 25-day period.
* Clinical staff confirmed if a consumer is on regular repositioning and this is captured within the care plan, they are not required to complete the repositioning chart and provided a memorandum dated October 2020 to support this. The memorandum states a daily progress note is to be completed to verify that pressure area care was completed. Review of progress notes demonstrated this was not occurring.
* Management stated Consumer A is an independent person and often will not allow staff to assist with repositioning. Refusal of care is not captured in behaviour monitoring charting completed for May 2023.
* Care staff were unable to confirm Consumer A was repositioned every two hours and stated that it is based on when personal care is attended to.

Consumer B

* In May 2023, an as required antipsychotic was administered due to Consumer B being ‘very teary’ and approaching staff for help. This was not consistent with the Behaviour support plan which did not show this as a known trigger or an indication for administration of this medication. The administration of the medication was also not consistent with the indications for use outlined in the Chemical restraint authorisation. There was no evidence alternative strategies had been trailed prior to the administration of as required medication.

The provider’s response included commentary relating to the Assessment Team’s report, as well as supporting documentation. The provider’s response included, but was not limited to:

* Education provided to staff in relation to wound and pain assessment, with further training on pressure injury and skin assessments planned.
* Surveyed all consumers with active wounds for evidence of a pain assessment and/or administration of pain relief prior to dressing changes.
* Updated Consumer A’s Behaviour support plan to reflect choice of repositioning.
* Progress notes demonstrating alternative strategies were implemented prior to Consumer B being administered antipsychotic medication and a Behaviours of concern record outlining behaviour description and management.

I acknowledge the provider’s response. However, I find for Consumers A and B, safe and effective personal and/or clinical care that was tailored and optimised health and well-being was not provided, specifically in relation to management of wounds, pain, skin integrity and use of restrictive practices.

In relation to Consumer A, I have considered staff practices have not ensured wounds are effectively monitored or assessed to enable wound progression to be tracked. For the period sampled, wound treatments were not consistently undertaken in line with the frequency recommended by the Community health nurse, the size of the wound was not consistently documented, and photographs were found not to be a reliable record of wound appearance. I have also placed weight on feedback from Consumer A who stated they have ongoing pain relating to one of the wounds. While the Pain assessment identified the location of the pain and management strategies, consideration had not been given to the consumer’s experience of pain during wound treatments nor had the efficacy of management strategies been effectively tested as pain charting had only been completed in response to administration of as required analgesia. Furthermore, I have considered pressure area care has not been consistently undertaken in line with Consumer A’s assessed needs. Staff sampled were unfamiliar with the frequency of Consumer A’s pressure area care needs and progress notes relating to provision of pressure area care had not been completed in line with the service’s processes.

In relation to Consumer B, I acknowledge documentation included in the provider’s response demonstrates non-pharmacological strategies were trailed prior to administration of an antipsychotic medication. However, I have considered that the Behaviours of concern record, included in the provider’s response, indicates restrictive practices are not required in relation to the behaviours described. As such, I find use of restrictive practices in this instance is not in line with best practice nor has it been used in line with legislative requirements.

For the reasons detailed above, I find requirement (3)(a) in Standard 3 Personal care and clinical care non-compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(c) | 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. | Compliant |

Findings

Requirement (3)(c) was found non-compliant following a Site Audit undertaken from 14 June 2022 to 17 June 2022 where effective organisational governance systems, specifically in relation to continuous improvement, were not demonstrated. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to, introduction of a master Plan for continuous improvement; introduction of informal feedback processes, including Director of nursing and corridor conversations with consumers, representatives, and staff; implementation of processes to monitor and review progress of issues recorded in the Plan for continuous improvement; and attendance by management at consumer and representative meetings to obtain direct input for continuous improvement initiatives.

At the Assessment Contact undertaken from the 29 May 2023 to 30 May 2023, effective organisation wide governance framework, including systems and processes relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints were demonstrated.

An information management framework governs how information is maintained, shared, and stored and staff confirmed they have access to information through a range of avenues to enable them to undertake their roles. A Plan for continuous improvement is overseen by Quality risk and management, and includes issues and improvements sourced from a range of avenues. Audits undertaken in November 2022 were noted to have resulted in additions to the plan and consumer meeting minutes demonstrated suggestions are added to the plan and actioned.

Financial governance systems and processes ensure effective financial management. A budget, approved by the Board, is set annually, and monitored, financial delegations are linked to roles, and management have flexibility to make ad-hoc purchases as required. Financial governance processes include financial governance sub-committees and monthly Board meetings where financial reports and risks are tabled and discussed. Workforce governance systems and processes are supported by policies and procedures and include mandatory training, position descriptions and ongoing monitoring. Subscriptions to industry and peak bodies ensure compliance with legislation and regulatory requirements which are tracked. There are processes to ensure feedback and complaints are monitored and analysed for trends.

For the reasons detailed above, I find requirement (3)(c) 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)