LHI Glynde

Performance Report

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**Commission ID:** 6200

**Provider name:** Lutheran Homes Inc

**Assessment Contact - Site date:** 12 November 2020

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# Publication of report

This Performance Report **may 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

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| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(g) | Non-compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(d) | Non-compliant |

# Detailed assessment

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

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

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

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff and others
* the provider’s response to the Assessment Contact - Site report received 9 December 2020.

# 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 two of the seven specific Requirements have been assessed as Non-compliant. The Assessment Team assessed Requirements (3)(b) and (3)(g) in relation to Standard 3. All other Requirements in this Standard were not assessed.

The Assessment Team have recommended Requirements (3)(b) and (3)(g) not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response to come to a view of compliance with Standard 3 Requirements (3)(b) and (3)(g) and find the service is Non-compliant with Requirements (3)(b) and (3)(g). I have provided reasons for my finding in the specific Requirements below.

### Assessment of Standard 3 Requirements

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

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

The Assessment Team were not satisfied the service effectively managed high impact or high prevalence risks, specifically behavioural management for one consumer. The Assessment Team’s report provided the following evidence in relation to the consumer:

* Progress notes viewed indicated over an 11 month period:
* Twelve occasions of physically aggressive behaviours towards other consumers.
* Four occasions of physically aggressive behaviours towards staff.
* Behaviours displayed included kicking, pushing, punching, hitting, grabbing and slapping.
* One consumer was pushed to the floor, striking their head. Following the incident, the consumer has lost the confidence to walk.
* Behaviour charting over a 21 day period included 42 entries relating to ongoing physically and verbally aggressive behaviour, wandering and agitation.
* Behaviours were noted to escalate over a two month period, however, referral to a behaviour management specialist did not occur until the end of the first month, with the review occurring 22 days after the referral was initiated.
* Recommendations from the behaviour management specialist have not been implemented by the service, 21 days after they were received. Information to guide and support staff to manage and minimise the consumer’s behaviour and impact on other consumers and staff is not documented in the care plan, falls safety risk assessment, care guide or handover sheet.
* Twenty-five entries of ongoing verbal and physical aggression, agitation and wandering behaviours have been charted since review by the behaviour management specialist and receipt of recommendations.
* A representative stated they were concerned regarding the aggressive nature of the consumer towards their parent. They stated they had been notified of an incident of physical aggression towards their parent by the consumer eight days prior to the Assessment Contact.
* Two staff stated they are frightened of the consumer’s ongoing physically aggressive behaviours.
* Antipsychotic and anti-anxiety medication has been administered to the consumer on 21 occasions over a 31-day period. Non-pharmalogical interventions implemented prior to administration of these medications has only been documented on two occasions.
* On one occasion, antipsychotic medication was administered to the consumer following a complaint of pain. Pain relieving medication was not initially offered to the consumer.

The provider’s response addressed information in the Assessment Team’s report and included further clarifying information and documentation. Additionally, the provider’s response included a Plan for continuous improvement outlining planned actions relating to aspects of the Assessment Team’s report. The response demonstrated the organisation has been proactive in addressing the issues identified. Actions included:

* Development of a process to ensure behaviour management specialist’s reports are acknowledged and communicated in a timely manner.
* Completed an information sheet providing staff with useful information about the consumer. Information includes strategies for communication, continence and wandering behaviours.
* Training provided to clinical staff in relation to responsive behaviours, documenting and reporting. This has been added to the annual credentialing program for clinical staff.
* Commenced pain assessments for all consumers, particularly for those residing in the memory support unit, to determine if pain is a trigger for responsive behaviours.

I acknowledge the provider’s response, the supporting documentation provided, and the actions initiated in response to the Assessment Team’s findings. However, in coming to my finding, I find at the time of the Assessment Contact, the service did not appropriately manage high impact or high prevalence risks, specifically behavioural management for one consumer. Information provided in the Assessment Team’s report demonstrates the consumer’s unmanaged behaviours have impacted other consumers and staff. One consumer, who was a target of the highlighted consumer’s behaviour, has lost the confidence to walk following an incident.

I have also considered that whilst a behaviour specialist review had been undertaken, recommendations have not been documented and/or implemented to guide and support staff to manage and minimise the consumer’s behaviour and the impact of those behaviours on other consumers and staff. Additionally, psychotropic medication has not been administered in line with legislated requirements with implementation of non-pharmalogical interventions not consistently undertaken and/or documented.

For the reasons detailed above, I find the provider, in relation to LHI Glynde, Non-compliant with Requirement (3)(b) in Standard 3.

### Requirement 3(3)(g) Non-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.*

The Assessment Team were not satisfied the service demonstrated it practices the minimisation of infection related risks through standard and transmission based precautions to prevent and control infections. The Assessment Team’s report provided the following evidence:

* A consumer had been placed in their room for isolation whilst awaiting a COVID-19 test result. The consumer was observed walking down the hallway towards an area where a number of consumers were sitting.
* Two staff members, who were not wearing personal protective equipment were observed to place their arms around the consumer and escort them back to their room.
* When asked if the consumer should be isolating, the staff member stated “yes, but when they have dementia, they wander so it can be hard to keep an eye on them”.
* Management agreed staff should have ensured the consumer remained in isolation in their room and applied personal protective equipment prior to approaching and touching the consumer.
* Management said the likelihood of the consumer being positive to COVID-19 is unlikely.
* COVID-19 testing records viewed for three consumers, who were displaying flu-like symptoms, indicated there had been a delay in COVID-19 testing of between two to five days.

The provider’s response addressed information in the Assessment Team’s report and included further clarifying information and documentation. Additionally, the provider’s response included a Plan for continuous improvement outlining planned actions relating to aspects of the Assessment Team’s report. Information provided included:

* Communication to staff in relation to isolating suspected COVID-19 consumers and required documentation and practice.
* An electronic message sent to staff relating to consumer isolation processes, arrangements for pathology testing and use of personal protective equipment.
* Updated the COVID-19 – management of a COVID-19 outbreak document to include reference to isolation of consumers who have a tendency to wander, including allocation of a single, one-to-one staff member.
* Employed an Infection control coordinator.
* Included a COVID-19 section on a weekly meeting agenda to capture consumers who have symptoms and are being tested.
* Staff have completed a range of training sessions related to COVID-19. Sessions relating to COVID-19 outbreak procedures, handwashing, personal protective equipment donning, and doffing have been and continue to be delivered to clinical, care and hospitality staff.

I acknowledge the provider’s response, the supporting documentation provided, and the actions initiated in response to the Assessment Team’s findings. However, in coming to my finding, I find at the time of the Assessment Contact, staff practices observed, and documentation viewed by the Assessment Team did not demonstrate effective standard and transmission-based precautions were in place to prevent and control infections. The Assessment Team’s observations of one consumer demonstrated the service was not fully complying with their obligations under the *Emergency Management (Residential Aged Care Facilities No 11) (COVID-19) Direction 2020*. The Direction dated 24 October 2020 states:

*“The operator of a RACF must ensure that a resident of the RACF who has undertaken a COVID-19 test remains isolated and segregated from other persons in accordance with the directions of an authorised officer until the result of the test is known.”*

This Direction was in place in South Australia and dated 24 October 2020, which is prior to the Assessment Contact visit. Therefore, despite the consumer having a tendency to wander, the consumer was required to remain isolated until the results of the COVID-19 test was known. Additionally, three consumers presenting with flu-like symptoms had a delay in COVID-19 testing of between three to five days.

For the reasons detailed above, I find the provider, in relation to LHI Glynde, Non-compliant with Requirement (3)(g) in Standard 3.

# STANDARD 7 NON-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 Non-compliant as one of the five specific Requirements has been assessed as Non-compliant. The Assessment Team assessed Requirement (3)(a) in relation to Standard 7. All other Requirements in this Standard were not assessed.

The Assessment Team have recommended Requirement 7(a) not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response to come to a view of compliance with Standard 7 Requirement (3)(a) and find the service Non-compliant with Requirement (3)(a). I have provided reasons for my finding in the specific Requirement below.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Non-compliant

*The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.*

The Assessment Team were not satisfied the service demonstrated the workforce is planned to ensure the delivery and management of safe and quality care and services. The Assessment Team’s report provided the following evidence:

* Three consumers described delays in call bell response times which resulted in issues with continence management.
* One consumer stated they constantly have to wait a long time to be taken to the toilet. Impacts described included discomfort, a sense of dread they are not going to make it, embarrassment and a loss of dignity when they soil themselves. The consumer said this had occurred more than three times in the last fortnight and it is worse at night.
* One consumer stated, “they take great care of me but sometimes I have to wait which is ok because I know they are short on people”.
* One staff stated, “we work short a lot of the time” resulting in consumers not receiving the care they need in a timely manner.
* Three staff said they do not have enough time to attend to all consumers who need toileting. Two said they sometimes do not conduct activities of daily living until late, with consumers being in the same continence pad for up to 10 hours.
* One care staff said they find it difficult to manage consumer requests to be toileted as most require two people to assist and there are only two of them on the floor in the afternoon.
* Two staff said they are not always able to monitor consumers’ behaviours in the memory support unit because of staff shortages.
* Two complaints registered in the three months preceding the Assessment Contact related to extended call bell response times. Impacts described included a representative assisting a consumer to the toilet, a consumer sobbing and a consumer soiling themselves and in distress. Wait times for call bell responses were recorded as 15 and 30 minutes.
* A document for one complaint indicates there was a delay in staff attending to respond to the call bell which has occurred on several occasions and staff had indicated they were short of staff at these times.
* Board meeting agenda and minutes over a three month period indicate there have been 10 complaints relating to staffing impacts. Issues included medications being administered late, consumers being soiled whilst waiting for staff to assistance, consumers being left unattended and unsupervised in the memory support unit and a consumer missing activities due to staff attending their shower late.
* Call bell audits are conducted monthly on a single day on a quarterly basis. No call bell audits were conducted on seven months as there was no Coordinator during this period.
* Reports for the six days preceding the Assessment Contact for two areas of the service indicated 450 call bells were over the service’s key performance indicator of 12 minutes.

The provider’s response addressed information in the Assessment Team’s report and included further clarifying information and documentation. Additionally, the provider’s response included a Plan for continuous improvement outlining planned actions relating to aspects of the Assessment Team’s report. Information provided included:

* The organisation benchmarks staffing levels using a benchmarking service. Data indicates the service was providing care hours per resident per day in excess of the average benchmark.
* The views expressed by some staff, consumers and representatives that the service doesn’t have enough staff is not evidence that the service has inadequate staffing levels to deliver safe and quality care. A review of rosters demonstrates staffing levels are well above industry benchmarks.
* There are processes to manage staffing shortfalls.
* It is acknowledged there have been instances where staff have not responded in a timely manner to call bells.
* Quarterly call bell response time audits and trending are routinely conducted. Where trends are identified, these are investigated, reminders provided to staff or formal performance management undertaken. Consumer impact statements are also considered.
* In response to the Assessment Team’s report, the service has enabled new reporting software to view calls from the last week over 12 minutes. Calls over 12 minutes are now escalated, and a message forwarded to the Registered nurse’s phone.
* Call bell audits were missed for some months due to a delay in employing a staff member.
* In response to the Assessment Team’s report, weekly audits (two areas per week) have been implemented and the findings evaluated.
* Call bell response times will be included as a standing agenda item at consumer meetings.

I acknowledge the provider’s response, the supporting documentation provided, and the actions initiated in response to the Assessment Team’s findings. I also acknowledge the provider’s view that benchmarking data indicates the service is providing care hours per resident per day in excess of the average benchmark. However, in coming to my finding, I have placed weight on feedback from consumers and staff which indicates staff are not always available to assist consumers in a timely manner, including to attend to activities of daily living and answer call bells in a timely manner. Additionally, complaints information documented in the Assessment Team’s report, along with feedback from consumers, describes negative impacts to consumers in response to staff not being available to assist them in a timely manner. I have also considered that call bell monitoring processes have not been effective.

For the reasons detailed above, I find the provider, in relation to LHI Glynde, Non-compliant with Requirement (3)(a) in Standard 7.

# 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 assessed Requirement (3)(d) in relation to Standard 8. All other Requirements in this Standard were not assessed.

The Assessment Team have recommended Requirement (3)(d) not met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response to come to a view of compliance with Standard 8 Requirement (3)(d) and find the service is Non-compliant with Requirement (3)(d). I have provided reasons for my finding in the specific Requirement below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(d) Non-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.*

The organisation demonstrated effective risk management systems and practices in relation to supporting consumers to live the best life they can. However, the Assessment Team were not satisfied the service demonstrated effective risk management systems and processes in relation to managing high impact or high prevalence risks and identifying and responding to abuse and neglect of consumers. The Assessment Team’s report provided the following evidence:

* The organisation’s Risk register is used to monitor and review risks at an organisational level. This tool identifies significant infection outbreaks, consumer abuse and neglect and serious non-compliance or breaches of the legislation and staffing issues. However, these fields have not been completed and no recommended actions or considerations have been applied.
* Incidents viewed for one consumer demonstrated behavioural management processes have not been effective. In the three months preceding the Assessment Contact, there have been 14 incidents involving the consumer causing harm to other consumers and/or staff and entering other consumers’ rooms in an agitated or aggressive state.
* The service did not demonstrate an understanding of their responsibilities in relation to discretionary reportable incidents in line with legislated requirements.
* The mandatory reporting database did not contain all incidents in relation to discretionary reporting. Two incidents which involved a consumer hitting other consumers, were not included on the database.
* Risks associated with staffing numbers have not been identified or managed. I have considered this information in Standard 7 Requirement (3)(a) which has been found Non-compliant.
* Infection control guidelines were not being following in relation to one consumer who was placed in isolation due to having flu-like symptoms and was waiting results of a COVID-19 test. I have considered this information in Standard 3 Requirement (3)(g) which has been found Non-compliant.

The provider’s response addressed information in the Assessment Team’s report and included further clarifying information and documentation. Additionally, the provider’s response included a Plan for continuous improvement outlining planned actions relating to aspects of the Assessment Team’s report. Information provided included:

* The Clinical governance framework will be reviewed and revised.
* The Compulsory reporting policy will be refined to inform staff of the type of incidents deemed reportable. This will be supported by a toolbox session for staff.
* Inclusion of a risk matrix tool as part of the assessment/evaluation of a responsive incident. This will assist in making decisions to report or to make a discretionary decision not to report.
* There is clear evidence that the service does understand its responsibilities in relation to discretionary reportable incidents based on the number of discretionary reports documented on the service’s database.
* The Assessment Team’s view was that any unwanted physical touch constituted a reportable assault. Staff elected not to document two incidents referred to in the Assessment Team’s report. The rationale was that the “flicking” action of the consumer, even though they made contact with another consumer, did not constitute a discretionary reportable assault.

I acknowledge the provider’s response, the supporting documentation provided, and the actions initiated in response to the Assessment Team’s findings. However, I find at the time of the Assessment Contact, the service’s risk management framework was not effective in identifying and responding to abuse and neglect of consumers or managing high impact or high prevalence risks associated with the care of consumers. In coming to my finding, I have considered that the service failed to effectively manage one consumer’s challenging behaviours which has impacted on the safety and well-being of other consumers and potentially exposed consumers and staff to preventable harm. Recommendations made by a specialist to minimise the impact of the consumer’s behaviours on staff and other consumers had not implemented at the time of the Assessment Contact, 21 days after they were received. A further 25 incidents have occurred in the period between the specialist’s review and receipt of the recommendations.

I acknowledge the provider’s response relating to understanding of their responsibilities of discretionary reportable incidents. In relation to two incidents, the provider describes contact made by a consumer to other consumers as a “flicking” action and, as such, does not constitute a discretionary reportable assault. The provider’s description of the incidents differs from the Assessment Team’s report which indicates the consumer hit the other consumers and would, therefore, be expected to be managed through the organisation’s discretionary reportable assault reporting processes.

For the reasons detailed above, I find the provider, in relation to LHI Glynde, Non-compliant with Requirement (3)(d) in Standard 8.

# 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 Requirements 3(b) and 3(g)**

* Ensure staff have the skills and knowledge to:
* initiate assessments develop appropriate management strategies and monitor effectiveness of strategies relating to behaviour management to minimise the impact of these behaviours on other consumers’ safety.
* initiate referrals in response to high impact or high prevalence risks to Medical officers and/or allied health professionals in a timely manner.
* implement Medical officer and/or Allied health recommendations in a timely manner and initiate processes to monitor effectiveness of recommendations.
* ensure care plans are accurate and reflective of each consumer’s current care and service needs.
* Ensure policies, procedures and guidelines in relation to management of high impact or high prevalence clinical risks, behavioural management, incident management and chemical restraint are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to management of high impact or high prevalence clinical risks, including behaviour management, incident reporting and chemical restraint.
* Ensure policies, procedures and guidelines in relation to infection control and management are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to infection control and management.

**Standard 7 Requirement (3)(a)**

* Ensure appropriate and adequate staffing levels and skill mix are maintained to deliver care and services in line with consumers’ needs and acuity.
* Review call bell response monitoring processes, ensuring consultation with consumers where call bell response exceeds key performance indicators.

**Standard 8 Requirement (3)(d)**

* Review the organisation’s risk management processes in relation to managing high impact or high prevalence risks associated with the care of consumers and identifying and responding to abuse and neglect of consumers.