Ridleyton Greek Home for the Aged

Performance Report

89 Hawker Street   
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**Commission ID:** 6115

**Provider name:** Greek Orthodox Community of SA Inc

**Assessment Contact - Site date:** 22 April 2021

**Date of Performance Report:** 11 June 2021

# 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

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| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(c) | 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 17 May 2021
* the Performance Report dated 7 August 2020 for the Assessment Contact – Site conducted 3 June 2020 to 4 June 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 one of the seven specific Requirements has been assessed as Non-compliant.

### The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(a) in this Standard. This Requirement was found Non-compliant following an Assessment Contact conducted 3 June 2020 to 4 June 2020. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Assessment Contact. However, the Assessment Team were not satisfied consumers receive safe and effective personal care and clinical care, specifically in relation to behaviour management and restraint and have recommended this Requirement 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 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 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 each consumer gets safe and effective clinical care that is best practice, tailored to their needs or optimises their health and well-being. Issues identified related to behaviour management and restraint. The Assessment Team’s report provided the following evidence relevant to my finding:

Behaviour management

* Three representatives were not satisfied with a consumer’s (Consumer A) behaviour management and the impact on other consumers. Feedback included:
* Consumer A wandered into the consumer’s room and the representative asked for a belt to be placed across the door.
* The consumer is scared someone is going to wander into their room.
* The representative stated they don’t want the belt but is the only way to keep the consumer safe.
* Consumer A is fixated on the consumer and tries to get into their room. This has been going on for approximately 12 months.
* The consumer wasn’t sleeping, is distressed and can’t get on with their life. Consumer A would wake the consumer up and they would get scared.
* A safety gate has been installed; if the gate is left unattended or open Consumer A comes into the room.
* A representative stated they asked for a gate as Consumer A was wandering and disturbing the consumer’s sleep during the night and disturbing them during the day.
* Staff told the representative the consumer’s door could be locked during the day but it was unlocked when the representative visited at night.
* The consumer has a gate and needs it to feel safe.
* Seven consumers residing near Consumer A either have a ‘crowd control removable belt’ or a gate installed across their doorway to minimise impact of Consumer A’s behaviours.
* Incident records sampled did not include incidents relating to Consumer A’s wandering behaviours.
* Consumer A was observed to be wandering throughout the service during the Assessment Contact.
* Progress notes indicate Consumer A was reviewed by a specialist approximately two weeks prior to the Assessment Contact and medication changes initiated.

Restraint

* The service had not identified the use of low line beds as a form of restraint for two consumers who are able to mobilise.
* Management stated both consumers could stand from a sitting position from their beds with the assistance from staff when the bed was at a suitable height.
* Management stated the low line beds were in use for both consumers as they were a high falls risk.
* Care plans for mobility and transfers and sleep do not include use of a low line bed for Consumer B.
* Staff stated Consumer C is on a low line bed as they attempt to mobilise without waiting for staff assistance and when the bed is at the lowest it ensures Consumer C is unable to try to stand and will not fall.

The provider’s response included information and supporting documentation directly addressing information in the Assessment Team’s report. The provider’s response demonstrates actions to address the issues identified by the Assessment Team have been implemented. The provider’s response included, but was not limited to:

In relation to behaviour management:

* Written to consumers and representatives identified in the Assessment Team’s report, acknowledging their concerns, apologising for the distress caused and reassured them the organisation is investigating options to overcome the current situation.
* Senior clinical staff have met with consumers and/or representatives impacted by Consumer A’s behaviours to provide reassurance.
* Reviewed Consumer A’s behaviour management at the multidisciplinary meeting and updated the care plan to reflect interventions.
* Following Consumer A’s medication changes, a behaviour chart was initiated which demonstrated no wandering or intrusive behaviours. Additionally, sleep charting demonstrated the consumer slept on all nights.
* Additional charting undertaken following the Assessment Contact indicated no wandering or intrusive behaviours and Consumer A sleeping overnight.
* Conducted a behaviour case conference to review behaviours and possible further interventions. The care plan has been updated to reflect interventions.

In relation to restraint:

* Both Consumer B and C have been reassessed and restraint documentation updated.
* All consumers on low line beds have been reviewed by the Occupational therapist and documentation updated where required.
* Staff have been advised to read the ‘Decision making tool: supporting a restraint free environment in residential aged care’ to improve and/or refresh their knowledge.

This Requirement was found Non-compliant following an Assessment Contact conducted 3 June 2020 to 4 June 2020. The service was found not to have provided a consumer with appropriate or effective clinical monitoring or care following a significant incident which impacted their health and well-being. The Assessment Team’s report provided evidence of actions taken to address deficiencies, including:

* Education provided to clinical and allied health staff relating to deteriorating residents and rapid response, clinical monitoring and clinical documentation.
* Audited 20% of consumer files to verify if staff had implemented the training into practice.
* Provided staff refresher training on current processes, including rapid response, post falls monitoring and return from hospital.

I acknowledge the provider’s commitment to address the issues identified in the Assessment Team’s report. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Assessment Contact, each consumer was not receiving effective personal and clinical care that was best practice, tailored to their needs or optimised their health and well-being.

In relation to Consumer A, I acknowledge that following a specialist review and resulting medication changes, the service implemented appropriate monitoring processes which have demonstrated the incidence of wandering behaviours has settled and sleep patterns have improved. However, I have placed weight on feedback provided by three representatives which indicate Consumer A’s behaviours have impacted the health and well-being of other consumers. As a result of Consumer A’s behaviours, consumers report feeling scared and distressed and representatives feel their family members are not safe.

In relation to restraint, I have considered that the use of low line beds had not been considered as a restrictive practice for two consumers highlighted in the Assessment Team’s report. Additionally, staff sampled indicated for one consumer, use of the low line bed ensured the consumer was unable to try and stand up and fall. Whilst I acknowledge actions initiated by the service in response to the issues identified, these actions were only initiated subsequent to the Assessment Contact and the issues being highlighted by the Assessment Team.

For the reasons detailed above, I find Greek Orthodox Community of SA Inc, in relation to Ridleyton Greek Home for the Aged, Non-compliant with Requirement (3)(a) in Standard 3 Personal care and clinical care.

# 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 Standard 7 as part of the Assessment Contact and have recommended the Requirement not met. All other Requirements in this Standard were not assessed.

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 how they ensure the workforce is planned to enable, and the number and mix of members of the workforce enables, the delivery and management of safe and quality care and services. The Assessment Team’s report provided the following evidence relevant to my finding:

* Consumers and representatives sampled were not satisfied with staffing and call bell response times. Feedback provided to the Assessment Team included:
* Seven of nine consumers sampled stated they often wait 15 to 30 minutes for their call bells to be responded to.
* A consumer’s call bell was not responded to for over an hour the day prior to the Assessment Contact. The long wait time caused the consumer distress.
* One consumer stated staff were scheduled to come at 4.00pm to provide medication, however, came closer to 5.00pm.
* One consumer stated pressure area care was not attended to consistently each night resulting in poor sleep.
* Six consumers and representatives sampled stated there were inadequate staff numbers.
* Clinical staff stated shifts are generally not back-filled as the roster is based on a full consumer cohort.

The provider’s response included information and supporting documentation directly addressing information in the Assessment Team’s report. The provider’s response demonstrates actions to address the issues identified by the Assessment Team have been implemented. The provider’s response included, but was not limited to:

* All planned leave is covered unless the service’s staff or agency staff are unavailable. Short notice leave may not be replaced due to staff and agency availability.

I acknowledge the provider’s commitment to address the issues identified in the Assessment Team’s report. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Assessment Contact, staff response to call bells was not sufficient to provide consumers with quality care and services. In coming to my finding, I have placed weight on feedback from consumers and representatives indicating extended call bell response times. Feedback from consumers and representatives indicated negative impacts for consumers resulting from delayed call bell response times, including distress, late administration of medications, and inconsistent pressure area care resulting in poor sleep.

The Assessment Team’s report included evidence relating to the service’s call bell monitoring processes. I find this evidence aligns with Standard 8 Requirement (3)(c)(iv) Workforce governance and, as such, have considered this information, as well as the provider’s response to the Assessment Team’s report with my finding for Standard 8 Requirement (3)(c).

For the reasons detailed above, I find Greek Orthodox Community of SA Inc, in relation to Ridleyton Greek Home for the Aged, Non-compliant with Requirement (3)(a) in Standard 7 Human resources.

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

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(c) and (3)(d) in this Standard. The Assessment Team have recommended both Requirements not met. All other Requirements in this Standard were not assessed.

Requirement (3)(d) was found Non-compliant following an Assessment Contact conducted 3 June 2020 to 4 June 2020. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Assessment Contact. However, the Assessment Team were not satisfied the service’s incident management system was effective to identify and prevent incidents.

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 Requirements (3)(c) and (3)(d) and find the service Non-compliant with Requirements (3)(c) and (3)(d). I have provided reasons for my findings in the specific Requirements below.

## Assessment of Standard 8 Requirements

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

Regulatory compliance

* The Critical incident log, used to record all reportable allegations and/or suspicions of assault, contained no entries for the month of April 2021. Eight incidents which occurred in April 2021 were not recorded on the log.
* Management were unaware of the types of incidents to be recorded on the consolidated record. The Critical incident log contained incidents of unreasonable force alleged to have been perpetrated by consumers against staff.
* In March 2021, nine of 14 incidents recorded involved a consumer being physically aggressive towards staff.
* Two incidents were not reported in line with legislative requirements. Management stated the incidents were not reported as they believed they were not serious enough and no injuries requiring medical treatment were sustained.

Workforce governance

* There is no process to follow-up calls bell response times greater than the service’s key performance indicator.
* The service could not demonstrate how information relating to excessive call bell response times is used to inform staff planning.
* Evidence in the Assessment Team’s report highlighted in Standard 7 Requirement (3)(a) relating to the service’s call bell monitoring processes has also been considered with my finding for this Requirement, including:
* Call bell response times greater than the service’s key performance indicators are reported monthly. However, call bell data is not analysed to include the specific house or individual consumers.
* Call bell data is reviewed in response to incidents or complaints raised by consumers. Longer call bell waits are not routinely reviewed.
* Call bell times greater than 10 and 30 minutes were noted in Clinical reports sampled for February and March 2021. However, further context, such as the total number of calls, trends and strategies to reduce wait times is not documented.

The provider’s response included information and supporting documentation directly addressing information in the Assessment Team’s report. The provider’s response demonstrates actions to address the issues identified by the Assessment Team have been implemented. The provider’s response included, but was not limited to:

In relation to Regulatory compliance:

* A review of incidents identified six not eight incidents. All six incidents have been entered onto the Serious Incident Response Scheme (SIRS) log.
* In relation to the two incidents – agree one incident was reportable, however, would not have been compliant with reporting the time frame of 24 hours.
* Agree these incidents will be reported in the second SIRS phase in October 2021.
* Agree the Critical incident log did not include entries for April 2021 and staff have been informed to ensure it is a progressive entry.

In relation to Workforce governance

* Agree with the Assessment Team’s observations relating to poor data and response rate. In response:
* Emailed the Clinical lead relating to a complaint about call bells being turned off.
* An external contractor has undertaken preventative maintenance on the call bell system.
* Implemented a call bell escalation process which includes a reflective practice process for clinical staff and consultation with consumers involved.

I acknowledge the provider’s commitment to address the issues identified in the Assessment Team’s report. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Assessment Contact, governance systems relating to regulatory compliance and workforce governance were not effectively applied. In relation to regulatory compliance, the Assessment Team identified six incidents which had occurred in April 2021, however, these were not included on the service’s Critical incident log. Additionally, nine of the 14 incidents logged in March 2021 were incidents involving physical aggression of consumers towards staff and not reportable under legislation. Additionally, two incidents were not reported in line with legislative requirements and this has been acknowledged in the provider’s response.

In relation to workforce governance, the service’s call bell monitoring processes were not effective to monitor sufficiency of staff to meet consumers’ care and service needs. Analysis of call bell data does not include the total number of calls or identify trends and strategies to reduce extended wait times. Additionally, extended call bell responses were not routinely reviewed or individual consumers affected identified to allow impacts to consumers’ care and well-being to be identified and actions in response to be implemented. Ineffective call bell data analysis and follow-up was further supported through feedback provided to the Assessment Team by consumers and representatives, reflected in Standard 7 Requirement (3)(a).

For the reasons detailed above, I find Greek Orthodox Community of SA Inc, in relation to Ridleyton Greek Home for the Aged, Non-compliant with Requirement (3)(c) in Standard 8 Organisational governance.

### 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*
4. *managing and preventing incidents, including the use of an incident management system.*

The Assessment Team were satisfied the service demonstrated effective risk management systems in relation to supporting consumers to live their best life, managing high impact or high prevalence risks and identifying and responding to abuse and neglect. However, the Assessment Team were not satisfied the service demonstrated an effective incident management system to identify and prevent incidents. The Assessment Team’s report provided the following evidence relevant to my finding:

* The service was not able to demonstrate effective use of an incident management system through the use of the Critical incident log.
* The service was not logging all incidents which were required in line with legislative responsibilities or using this information to inform care planning.
* Eight incidents were not documented on the Critical incident log. Management were unaware of the incidents and stated they had no incidents for the month of April 2021 which were required to be logged.

The provider’s response included information and supporting documentation directly addressing information in the Assessment Team’s report. The provider’s response demonstrates actions to address the issues identified by the Assessment Team have been implemented. The provider’s response included:

* Review of the incident form to improve capturing Psychological support provided and better reflect prevention.
* A review of incidents identified six not eight incidents. All six incidents have been entered onto the SIRS log.

This Requirement was found Non-compliant following an Assessment Contact conducted 3 June 2020 to 4 June 2020. The service’s risk management systems and processes were found to be not effective in identifying, assessing and managing risks to the health, safety and well-being of consumers, specifically in relation to the use of high-risk equipment. The Assessment Team’s report provided evidence of actions taken to address deficiencies, including, but not limited to:

* Established a Risk Assessment Flow Chart. The process is used for all new equipment purchases, prior to hazardous work, changes in work environment and changes in work practice.
* Developed a new equipment purchasing procedure which includes trialling of equipment.
* Developed Standard operating procedures for equipment, including for sling lifters, hammock sling and general-purpose sling.
* Engaged a new contractor to maintain clinical equipment, such sling lifters.
* Two sling lifters which had the potential for further mechanical failures have been removed and three additional sling lifters purchased.
* Improved the escalation process for maintenance tasks and established weekly meetings with the maintenance manager and Director of care.
* Developed an organisational risk register which includes risks related to consumer care and services.

I acknowledge the provider’s response to the issues identified in the Assessment Team’s report. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Assessment Contact, the service’s processes relating to managing and preventing incidents was not effectively implemented. I have considered that six incidents occurring in April 2021 had not been logged on the Critical incident log used by the service to record all reportable allegations and/or suspicions of assault. In coming to my finding, I have placed weight on information in the Assessment Team’s report indicating management were unaware of the incidents, stating there were no incidents for the month of April 2021 which were required to be logged.

For the reasons detailed above, I find Greek Orthodox Community of SA Inc, in relation to Ridleyton Greek Home for the Aged, Non-compliant with Requirement (3)(d) in Standard 8 Organisational governance.

# 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:
* initiate assessments, develop appropriate management strategies and monitor effectiveness of strategies relating to behaviour management.
* implement appropriate behaviour management strategies to minimise the impact of these behaviours on other consumers’ health, well-being and safety.
* identify restrictive practices and initiate appropriate monitoring, consultation, authorisation and documentation processes to support use.
* Ensure policies, procedures and guidelines in relation to behaviour management and restraint are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to behaviour management and restraint.

**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.

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

* Review the organisation’s governance systems in relation to workforce governance and regulatory compliance. Specifically call bell monitoring processes and legislative requirements for reporting incidents.
* Review the organisation’s risk management processes in relation to identifying, managing and preventing incidents, and use this information to identify trends and drive improvements to the quality of care and services.