Ridleyton Greek Home for the Aged

Performance Report

89 Hawker Street   
RIDLEYTON SA 5008  
Phone number: 08 8340 1155

**Commission ID:** 6115

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

**Assessment Contact - Site date:** 7 December 2021 to 9 December 2021

**Date of Performance Report:** 11 February 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 2 Ongoing assessment and planning with consumers** |  |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| **Standard 5 Organisation’s service environment** |  |
| Requirement 5(3)(b) | Compliant |
| **Standard 6 Feedback and complaints** |  |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** |  |
| Requirement 7(3)(a) | Compliant |
| **Standard 8 Organisational governance** |  |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(c) | 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 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 4 January 2022
* the Performance Report dated 11 August 2021 for the Site Audit conducted 16 June 2021 to 19 June 2021.

# STANDARD 2 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 Assessment Team assessed Requirements (3)(b) and (3)(e) in Standard 2 Ongoing assessment and planning with consumers as part of the Assessment Contact. All other Requirements in this Standard were not assessed, therefore, an overall rating of the Standard is not provided.

Requirements (3)(b) and (3)(e) in Standard 2 were found Non-compliant following a Site Audit conducted 16 June 2021 to 19 June 2021 where it was found the service did not demonstrate:

* assessment and planning consistently and accurately identified and addressed consumers’ current needs, goals and preferences; and
* care and services were reviewed regularly for effectiveness and updated when there was a change in consumers’ needs, goals, and preferences.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit. However, the Assessment Team were not satisfied the service demonstrated:

* assessment and planning identified and addressed consumers’ current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes; or
* care and services were reviewed regularly for effectiveness; when circumstances change, or when incidents impacted on the needs, goals, or preferences of consumers.

The Assessment Team have recommended Requirements (3)(b) and (3)(e) not met.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and based on this information, I find Greek Orthodox Community of SA Inc, in relation to Ridleyton Greek Home for the Aged, Compliant with Requirements (3)(b) and (3)(e) in Standard 2 Ongoing assessment and planning with consumers. I have provided reasons for my findings in the specific Requirements below.

**Assessment of Standard 2 Requirements**

**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.*

The Assessment Team were not satisfied the service demonstrated assessment and planning identified and addressed consumers’ current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. The Assessment Team’s report provided the following evidence relevant to my finding:

Consumer A

* Initial pain and bowel assessments had not been completed on entry in October 2021. The service was unable to locate the initial pain chart and there had been no evaluation of this in the progress notes.
* The Ongoing assessment and planning policy does not provide any information regarding assessments and timeframes in which they need to be completed.

Consumer B

* Care planning documentation did not capture the consumer’s current behaviours, and strategies documented were not in line with those being used by staff and observed by the Assessment Team.
* Behaviour charting for a 14 day period in November to December 2021 did not have triggers completed.

The service was found Non-compliant with Requirement (3)(b) following a Site Audit conducted 16 June 2021 to 19 June 2021 where it was found the service was unable to demonstrate that assessment and planning consistently and accurately identified and addressed consumers’ current needs, goals and preferences. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed assessments and completed a nursing care plan assessment checklist.
* Implemented Consumer of the day mini care plan reviews.
* Allocated time to Clinical nurses to complete care planning.
* All full care plan reviews will have charting related to pain, continence, sleep and behaviour completed.

The provider’s response addressed the deficits highlighted in the Assessment Team’s report and included further context to the evidence provided, as well as supporting documentation. The provider’s response included, but not limited to:

* Issues highlighted in the Assessment Team’s report relating to Interim care plans had been identified through an audit conducted by an external provider in November 2021. The service have been working on actioning opportunities for improvement.
* An admission checklist outlines assessments to be completed and timeframes for completion. The policy has been updated to include the checklist.
* Assessments completed did not map into the Interim care plan. Since the Assessment Contact, a My plan has been introduced and use of the Interim care plan ceased. Respite and permanent consumers now have the same process for clinical assessment and planning.

In relation to Consumer A:

* Pain charting commenced on entry and pain was monitored. The provider’s response included a pain chart, commenced on entry for a three day period and progress notes demonstrating pain was monitored and reviewed.
* Acknowledge an evaluation of the pain chart was missed and the staff member responsible has been counselled.
* A Bowel and bladder assessment was completed on entry and an Interim care plan, included as part of the provider’s response, included continence management strategies and scheduled toileting times. Documentation provided also demonstrated continence aids were allocated on the day of entry.

In relation to Consumer B:

* Specific terms describing behaviours and strategies has now been used and reassessment of the behaviour chart has been completed, identifying triggers.
* A memorandum has been sent to staff providing further guidance on completing behaviour charts.

I have also considered evidence highlighted in the Assessment Team’s report in Standard 3 Personal care and clinical care Requirement (3)(a) and the provider’s response. Specifically, evidence relating to triggers not being documented on behaviour charting for Consumer F.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service Compliant with this Requirement.

In relation to Consumer A, the provider’s response demonstrated initial assessments relating to pain and continence had been commenced on entry. While an evaluation of pain charting had not been completed, progress notes demonstrated monitoring and review of the consumer’s pain status occurred, including by a Nurse practitioner, Occupational therapist and clinical staff.

In relation to Consumer B, I have considered the wording used in the Cognition/behaviour/emotional needs care plan did not explicitly reflect the behaviours the consumer was displaying and management strategies were not consistently reflective of those being implemented. However, behaviours the consumer displayed had been identified and management strategies were in place. The care plan has since been updated to include specific terms to describe the behaviours and more detailed strategies have been implemented.

In relation to Consumers B and F, I have also information documented in Standard 3 Personal care and clinical care Requirement (3)(a) indicating Behaviour support plans for the consumers addressed triggers for behaviour. The provider’s response acknowledges that behaviour charting did not include triggers for behaviours. I acknowledge the actions taken by the provider both at the time of the Assessment Contact and since to address behaviour charting documentation. I also note, for Consumer B, behaviour charting undertaken in December 2021 and January 2022 demonstrates triggers are being documented.

In coming to my finding, I have also considered information in the Assessment Team’s report indicating care files for four consumers included end of life wishes and Special wishes/deterioration of health status forms had been completed for two consumers. Clinical staff sampled described how end of life discussions are approached with consumers and/or representatives and indicated preferences/wishes are updated as required. For another consumer, a Diabetic management plan was in place and included clear guidance to enable staff to manage their diabetic status.

For the reasons detailed above, I find Greek Orthodox Community of SA Inc, in relation to Ridleyton Greek Home for the Aged, Compliant with Requirement (3)(b) in Standard 2 Ongoing assessment and planning with consumers.

**Requirement 2(3)(e) 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 were reviewed regularly for effectiveness; when circumstances change, or when incidents impacted on the needs, goals, or preferences of consumers. The Assessment Team’s report provided the following evidence relevant to my finding:

Consumer C

* A Cognition, depression and emotional assessment updated in December 2021 did not reflect changes in mood following the death a significant other four days earlier.
* The care plan did not outline management strategies to support the consumer’s emotional well-being.

Consumer A

* Over a 10 day period in November/December 2021, the consumer was administered a narcotic analgesic medication on eight occasions for pain. Location of pain documented on the Pain assessment completed in November 2021 differs from the locations identified in the medication chart.
* An initial assessment completed in October 2021 indicates occasional incontinence and use continence aids for prevention. The care plan has not been updated since entry and does not identify the consumer is incontinent or include management strategies to guide staff.
* The consumer experienced 18 falls over a 60 period in October to December 2021. While strategies to prevent further falls have been implemented, these strategies have not been documented on the Falls risk assessment, updated in November 2021.

The service was found Non-compliant with Requirement (3)(e) following a Site Audit conducted 16 June 2021 to 19 June 2021 where it was found the service was unable to demonstrate care and services were reviewed regularly for effectiveness and updated when there was a change in consumers’ needs, goals, and preferences. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Specialist services will be involved to support behaviour management. Strategies suggested will be trialled and the care plan updated.
* A six-monthly care plan review schedule has been implemented and a Resident of the day review occurs monthly.
* For new or existing behaviour, seven-day behaviour charting will commence with new strategies.

The provider’s response addressed the deficits highlighted in the Assessment Team’s report and included further context to the evidence provided, as well as supporting documentation. The provider’s response included, but not limited to:

In relation to Consumer C:

* Progress notes included in the provider’s response demonstrated emotional support was provided to the consumer prior to and following the death a significant other.
* The staff member who updated the assessment has been counselled and provided further education.
* The Psychosocial assessment has been reviewed and updated to reflect the consumer’s current needs, goals and preferences.

In relation to Consumer A:

* A specific Pain care plan has been implemented.
* An Interim care plan completed on entry, submitted by the provider, includes information relating to continence management strategies. This was also outlined in progress notes provided.
* The consumer was identified as a high falls risk on entry and falls risk prevention strategies were included on the Interim care plan.
* Strategies from an Occupational therapy review were documented in progress notes and the assessment, therefore, this information did not map into the Interim care plan.

Based on the Assessment Team’s report and the provider’s response, I have come to a different view from the Assessment Team’s recommendation of not met and find the service Compliant with this Requirement.

In relation to Consumer C, while the assessment and care plan did not include strategies to support the consumer’s emotional well-being, progress notes included in the provider’s response demonstrates the consumer’s emotional well-being was considered and monitored both prior to and following the death of a significant other. Support was noted to have been provided to the consumer through monitoring and one-on-one discussions, including by staff, the Nurse practitioner and Consumer well-being coordinator. Additionally, a referral had been initiated to a specialist service provider to provide further support.

In relation to Consumer A, documentation included in the provider’s response demonstrated initial entry processes identified care needs related to pain, continence and mobility, including falls risk. Management strategies for these care aspects had been developed and were noted to be included on the Interim care plan. While I acknowledge falls risk strategies were not outlined on the Falls risk assessment, the Assessment Team’s report and the provider’s response demonstrates strategies to minimise the consumer’s risk of falls were implemented and outlined on the Interim care plan, used by staff to guide care. I have also considered that while locations of pain documented on the Pain assessment differed from those documented in the Medication chart, progress notes demonstrated monitoring and review of the consumer’s pain status occurred, including by a Nurse practitioner, Occupational therapist and clinical staff.

In coming to my finding, I have considered information in the Assessment Team’s report indicating consumers’ care and services had been reviewed in response to changes in circumstance. A care file for Consumer B demonstrated a referral to a behaviour specialist had occurred and recommended strategies had been trialled and added to the care plan to guide delivery of care and services. Behaviour charting had also been initiated for three consumers in response to new or existing behaviours.

For the reasons detailed above, I find Greek Orthodox Community of SA Inc, in relation to Ridleyton Greek Home for the Aged, 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 three specific Requirements assessed has been found Non-compliant. The Assessment Team assessed Requirements (3)(a), (3)(c) and (3)(d) in Standard 3 Personal care and clinical care as part of the Assessment Contact. All other Requirements in this Standard were not assessed.

Requirements (3)(a), (3)(c) and (3)(d) in Standard 3 were found Non-compliant following a Site Audit conducted 16 June 2021 to 19 June 2021 where it was found the service did not demonstrate:

* personal and clinical care was consistently best practice to optimise consumers’ health and well-being, specifically in relation to the safe use of continence aids to prevent wounds and wound management;
* effective pain management for one consumer to ensure their needs were met and comfort was maximised during the end of their life; and
* deterioration or change of a consumer’s condition was recognised and responded to in a timely manner.

The Assessment Team’s report provided evidence of actions taken to address deficiencies relating to Requirements (3)(a), (3)(c) and (3)(d). The Assessment Team have recommended Requirements (3)(c) and (3)(d) met.

However, in relation to Requirement (3)(a), the Assessment Team were not satisfied the service demonstrated each consumer gets safe and effective clinical care which is best practice, tailored to their needs and optimises their health and well-being, specifically in relation to behaviour management, skin and wound care. The Assessment Team have recommended Requirement (3)(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 and based on this information, I find Greek Orthodox Community of SA Inc, in relation to Ridleyton Greek Home for the Aged, Non-compliant with Requirement (3)(a) and Compliant with Requirements (3)(c) and (3)(d) in Standard 3 Personal care and clinical care. I have provided reasons for my findings in the specific Requirements 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 which is best practice, tailored to their needs and optimises their health and well-being, specifically in relation to behaviour management, skin and wound care. The Assessment Team’s report provided the following evidence relevant to my finding:

Consumer D

* Grazes/scratches were identified in October 2021. However, the Assessment Team noted the wounds were a stage 1 pressure injury.
* On identification, the frequency of wound treatments was not documented. The wound was next dressed seven days post identification and noted as inflamed.
* Documentation 22 days post identification describes the wound as a graze and indicated daily dressings. However, the wound was noted to present as a small, open shallow ulcer and had not been attended daily on three occasions in November 2021.
* Thirty-one days post identification, the wound was still classified as a graze, however, presented as a stage 2 pressure injury.
* Wound treatment charts for an eight day period in October/November 2021 were not consistently completed and four wound photographs in the same period were taken from varying angles and proximity.

Consumer E

* A long, deep laceration was identified in September 2021. Documentation indicated the wound had not been classified correctly since identification or consistently monitored and assessed.
* The wound was identified as a pressure injury, however, the classification was not identified on 11 of 14 occasions between September and December 2021.
* The wound had been identified as a stage 2 pressure injury in November 2021, however, photographs indicate the wound appearance had not changed since identification.
* While daily dressings were indicated, the wound was not dressed in line with the directive on 10 occasions between September and December 2021. Photos of the wound did not occur weekly, in line with the service’s process.

Consumers F and B

* For both consumers, triggers were not completed on Behaviour charting for a 15 day period in November to December 2021.
* Triggers for behaviour had been addressed in Behaviour support plans, however, were not in line with behaviours observed or described by staff for Consumer B.

Consumer A

* Consumer A’s care plan did not address oedema, including strategies to manage the condition.

The service was found Non-compliant with Requirement (3)(a) following a Site Audit conducted 16 June 2021 to 19 June 2021 where it was found the service was unable to demonstrate personal and clinical care was consistently best practice to optimise consumers’ health and well-being, specifically in relation to the safe use of continence aids to prevent wounds and wound management. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Complex wounds are being reviewed by wound specialists and the service now has links with external specialists to provide advice and guidance.
* Updated wound documentation to improve wound monitoring.
* Lower limb assessments have been completed for all consumers with strategies, based on information gathered, to be implemented to mitigate risk and deterioration.
* Completed a wound audit in November 2021.
* Training in relation to wound management, care planning and defensive documentation provided to staff. Training content included reportable incidents, as required orders and restrictive practices.

The provider’s response directly addressed the deficits highlighted in the Assessment Team’s report and included further context to the evidence provided, as well as supporting documentation. The provider’s response included, but not limited to:

* An internal Wound Audit completed in November 2021 identified deficits highlighted in the Assessment Team’s report. A Continuous improvement plan was raised following the internal Audit and areas have been completed.
* Wound are photographed between six to 10 days during the review schedule.
* Further education for clinical staff relating to wound assessment and management and pressure injuries has been booked for January 2022.
* The Wound management form has been reviewed in response to the audit to ensure best practice assessment and treatment is in place. All wounds have been reviewed and transferred to the new form.
* Education provided to staff in December 2021 relating to wound documentation and escalation and changes to the Wound management form.

In relation to Consumer E:

* The wound was identified as a laceration (ulcer) due to its appearance. An assessment at the hospital classified the wound as a pressure injury.
* A medication chart included in the response demonstrated the wound was treated daily, in line with Medical officer directives. The wound has since healed.

In relation to Consumer A:

* The interim care plan included in the response included management strategies relating to oedema.
* Monitoring and review of oedema has occurred, including by a Dietitian, Nurse practitioner and Physiotherapist.

The provider’s response did not directly reference deficits highlighted in the Assessment Team’s report relating to Consumer D.

I acknowledge the provider’s response and the supporting documentation provided. I also acknowledge that internal auditing processes, completed prior to the Assessment Contact, identified deficits as highlighted 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 provided safe and effective clinical care which was best practice or optimised their health and well-being, specifically in relation to wound management for Consumers D and E.

In relation to Consumer D, I find wound treatment records were not accurately completed, treatments were not conducted within the documented timeframe, the wound was not correctly classified and photographs had been taken from varying angles and proximity. I have also considered that initial wound records did not include frequency of treatments and when the wound was next dressed seven days later, the wound was noted to be inflamed. Additionally, progression of the wound to a stage 2 pressure injury was not identified by staff, with the wound still being classified as a graze.

In relation to Consumer E, I have considered that the wound had either not been correctly classified or classified at all and where the wound was identified as a stage 2 pressure injury, photographs indicated the wound appearance had not changed since identification. I do, however, acknowledge documentation included in the provider’s response demonstrates wound treatments were occurring in line with Medical officer directives and note since the Assessment Contact, the wound has healed.

I find it is reasonable, considering the nature of the wounds, that wound treatments are completed accurately to reflect the appearance and classification of the wound. Such practices would ensure wound progression is monitored and wound deterioration is identified in a timely manner.

In relation to Consumers F and B, I have considered that the evidence presented in this Requirement does not demonstrate deficiencies relating to delivery of care. Rather, the evidence presented specifically relates to deficiencies associated with assessment and planning. As such, I have considered the evidence with my finding for Standard 2 Ongoing assessment and planning Requirement (3)(b).

In relation to Consumer A, I find the consumer’s oedema was identified on entry and management strategies were implemented. I have also considered supporting documentation, included in the provider’s response, demonstrates the consumer’s condition has been appropriately monitored and managed, including through referrals to allied health professionals.

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.

**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.*

The service was found Non-compliant with Requirement (3)(c) following a Site Audit conducted 16 June 2021 to 19 June 2021 where it was found the service did not demonstrate effective pain management for one consumer to ensure their needs were met and comfort was maximised during the end of their life. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* A spare medication storage cupboard keyset is now available and are kept in different houses to ensure access to the cupboard at all times.
* New subcutaneous infusion pumps have been purchased.
* Training provided to staff relating to continuous infusion pumps and behaviour assessment. The training included end of life management, palliative care, documentation, end of life responsibilities, and pain.
* End of life has been added to the internal audit program.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* Feedback provided by representatives of one consumer indicated they were satisfied with the care provided at the end stage of life. The consumer’s pain was monitored and well controlled, repositioning occurred frequently, mouth care was attended and input from the Medical officer and Geriatrician occurred. The representative indicated staff were attentive and warm and the consumer’s death was serene and calm.
* The consumer’s care file demonstrated input into care by palliative care specialists, discussions relating to goals of care had occurred and end of life charting, including consideration of pain, mouth care, eye care, restlessness and agitation and continence, had been initiated.
* End of life wishes had been documented in all four consumer files viewed.
* Care staff sampled described care provided to consumers at the end stage of life to ensure their comfort is maximised and their dignity preserved.

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

**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.*

The service was found Non-compliant with Requirement (3)(d) following a Site Audit conducted 16 June 2021 to 19 June 2021 where it was found the service did not demonstrate deterioration or change of a consumer’s condition was recognised and responded to in a timely manner. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Implemented documentation relating to recognising and response to clinical deterioration to guide staff practice.
* Training provided to clinical staff relating to Deteriorating patients, understanding care plans and continence.
* Twenty-four hour progress note reviews occur daily.
* Progress note reviews sampled for a 36 day period from November to December 2021 included information relating to falls, medication changes and clinical incidents.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* The service demonstrated 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.
* One representative reported they were informed when their family member had a fall and when they had been reviewed by the Medical officer.
* Consumer files demonstrated when there’s a deterioration in consumer function/capacity/condition, additional monitoring is initiated and relevant assessments are completed with information used to deliver care and services.
* Care staff sampled were aware of their responsibilities to report deterioration or changes to consumers’ health and well-being to senior staff.
* Clinical staff described use of a flowchart for deteriorating consumers and described assessment processes implemented in response.

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

# STANDARD 5 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 Assessment Team assessed Requirement (3)(b) in Standard 5 Organisation’s service environment as part of the Assessment Contact. All other Requirements in this Standard were not assessed, therefore, an overall rating of the Standard is not provided.

Requirement (3)(b) in Standard 5 was found Non-compliant following a Site Audit conducted 16 June 2021 to 19 June 2021 where deficits relating to cleanliness and safety of the service environment were found and consumers were not able to move freely inside and outside of the service environment. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended Requirement (3)(b) met.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and based on this information, I find Greek Orthodox Community of SA Inc, in relation to Ridleyton Greek Home for the Aged, Compliant with Requirement (3)(b) in Standard 5 Organisation’s service environment. I have provided reasons for my finding in the specific Requirement below.

**Assessment of Standard 5 Requirements**

**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.*

The service was found Non-compliant with Requirement (3)(b) following a Site Audit conducted 16 June 2021 to 19 June 2021 where deficits relating to cleanliness and safety of the service environment were found and consumers were not able to move freely inside and outside of the service environment. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Relayed pathway pavers which were either lifting or uneven.
* Rectified ongoing build-up of bird droppings on outdoor furniture.
* Resolved broken or unsafe furniture, fittings or equipment.
* Installed an operational closed circuit television camera in an internal courtyard.
* Added an external lighting review to the monthly maintenance program.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* Overall, sampled consumers considered that they feel safe and comfortable in the service environment and are supported to go outside when they want to. They said the service is clean and well maintained and maintenance systems in place ensure buildings, gardens and furniture are kept in good condition. Consumers also indicated cleaning of their private rooms is carried out to their satisfaction and communal areas are kept clean.
* The Assessment Team observed the living areas of the home to be light with natural light available through large windows. Furniture was observed to be clean, comfortable, and suitable for the consumers. Consumers were observed moving freely between indoor areas and outdoor courtyards.
* Reactive and preventative maintenance programs are in place. Staff described maintenance request and hazard reporting processes and said requests for repairs are attended to quickly.
* Cleaning staff were observed attending to consumer rooms, common areas and service areas. Cleaning staff work to a schedule and a daily duty list.
* A Resident experience survey report dated December 2021 indicated consumers enjoy spending their time in general areas and are satisfied with the cleanliness of their room and the service environment.

For the reasons detailed above, I find Greek Orthodox Community of SA Inc, in relation to Ridleyton Greek Home for the Aged, Compliant with Requirement (3)(b) in Standard 5 Organisation’s service environment.

# STANDARD 6 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 Assessment Team assessed Requirements (3)(a) and (3)(d) in Standard 6 Feedback and complaints as part of the Assessment Contact. All other Requirements in this Standard were not assessed, therefore, an overall rating of the Standard is not provided.

Requirements (3)(a) and (3)(d) in Standard 6 were found Non-compliant following a Site Audit conducted 16 June 2021 to 19 June 2021 where it was found:

* consumers, representatives and staff did not feel encouraged and supported to provide feedback and make complaints; and
* the service did not demonstrate that feedback and complaints were reviewed and used to improve the quality of care and services.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended Requirements (3)(a) and (3)(d) met.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and based on this information, I find Greek Orthodox Community of SA Inc, in relation to Ridleyton Greek Home for the Aged, Compliant with Requirements (3)(a) and (3)(d) in Standard 6 Feedback and complaints. I have provided reasons for my findings in the specific Requirements below.

**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.*

The service was found Non-compliant with Requirement (3)(a) following a Site Audit conducted 16 June 2021 to 19 June 2021 where it was found consumers, representatives, and staff did not feel encouraged and supported to provide feedback and make complaints. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed the feedback and complaints process to ensure all feedback is channelled through the service’s formal process.
* Changed the colour of the feedback form to increase anonymity in July 2021.
* Lowered the placement of three feedback/suggestion boxes and feedback form holders to ensure consumers have easier access to deposit forms anonymously.
* Information was included in the Consumer and Representative newsletters for July, August, September 2021 in relation to the feedback process.
* Consumer meeting minutes now include Information in relation to feedback, comments, complaints and improvements is now included in Consumer meeting minutes.
* Engaged an external consultant to investigate and find solutions to issues raised by staff and relatives in relation to feedback and complaints.
* Arranged meetings with the Aged Rights Advocacy Service (ARAS) to provide the opportunity to discuss any issues with consumers and staff.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* Overall, sampled consumers and representatives were satisfied they are supported and encourage to provide feedback and are aware of feedback mechanisms. Consumers said they feel comfortable to tell staff or their family if they have a concern.
* Care staff described how they advocate for consumers and said if consumers raise any concerns, they will try to resolve them and report the concern to the Registered nurse.
* Consumers are encouraged and supported to provide feedback and raise concerns through meeting forums and surveys

For the reasons detailed above, I find Greek Orthodox Community of SA Inc, in relation to Ridleyton Greek Home for the Aged, Compliant with Requirement (3)(a) in Standard 6 Feedback and complaints.

**Requirement 6(3)(d) Compliant**

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

The service was found Non-compliant with Requirement (3)(d) following a Site Audit conducted 16 June 2021 to 19 June 2021 where it was found the service did not demonstrate that feedback and complaints were reviewed and used to improve the quality of care and services. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Undertaken a range of actions to address staffing levels and ensure gender preferences for consumers are respected.
* Increased visiting hours.
* Purchased equipment in response to feedback.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* Consumers and representatives said they are satisfied if they tell staff something, they will help fix it.
* Consumers said information about improvements is provided to them through meeting forums and newsletters.
* Feedback and complaints data is reviewed weekly, trended monthly and reviewed over a 3-month period to identify any ongoing trends.
* Feedback, complaints and improvements are discussed at various meetings, with consumer confidentiality maintained.

For the reasons detailed above, I find Greek Orthodox Community of SA Inc, in relation to Ridleyton Greek Home for the Aged, Compliant with Requirement (3)(d) in Standard 6 Feedback and complaints.

# STANDARD 7 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 Assessment Team assessed Requirement (3)(a) in Standard 7 Human resources as part of the Assessment Contact. All other Requirements in this Standard were not assessed, therefore, an overall rating of the Standard is not provided.

Requirement (3)(a) in Standard 7 was found Non-compliant following a Site Audit conducted 16 June 2021 to 19 June 2021 where it was found the service did not demonstrate that the number and mix of the workforce deployed enabled the delivery and management of safe and quality care and services. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended Requirement (3)(a) met.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and based on this information, I find Greek Orthodox Community of SA Inc, in relation to Ridleyton Greek Home for the Aged, Compliant with Requirement (3)(a) in Standard 7 Human resources. I have provided reasons for my finding in the specific Requirement below.

**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.*

The service was found Non-compliant with Requirement (3)(a) following a Site Audit conducted 16 June 2021 to 19 June 2021 where it was found the service did not demonstrate that the number and mix of the workforce deployed enabled the delivery and management of safe and quality care and services. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed consumer acuity and the standard roster against current benchmark data.
* Implemented a Primary care model which includes a new roster and allocation of duties.
* A key performance indicator for call bell responses has been set and a new call bell screen has been installed to assist with monitoring response times.
* Reviewed unfilled shift data, and implemented a range of improvements in response, including a new roster.
* Engaged a Greek speaking social worker to address consumers’ gender preferences. The Social worker has engaged in individual discussions with representatives and consumers. All care plans were reviewed and updated to reflect gender preferences.
* Updated Duty statements following staff review.
* Introduced a bi-monthly staff newsletter. Standing agenda items include rostering/sick leave and call bell data. The newsletter for December 2021 included duty statement updated and call bell policy and procedures.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* Overall, sampled consumers considered that they get quality care and services when they need them and from people who are knowledgeable, capable, and caring. Consumers said staff are kind, caring and respectful and their call bells are answered, however, staff can appear rushed.
* The service demonstrated the number and mix of members of the workforce is planned to delivery safe, quality care and services.
* The roster is reviewed in line with consumers’ changing needs. Clinical indicators, such as falls, skin tears and behaviours are monitored and further assist in ensuring the workforce is sufficient to meet consumers’ care and service requirements. There are processes to manage staffing shortfalls.
* Staff sampled generally felt they had enough time to complete their work.
* Call bells are monitored to ensure consumers’ care needs are addressed. Responses outside of the service’s key performance indicator are investigated.
* Consumer and staff satisfaction in relation to staffing is monitored through feedback processes, surveys and meeting forums.

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

# STANDARD 8 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 Assessment Team assessed Requirements (3)(a) and (3)(c) in Standard 8 Organisational governance as part of the Assessment Contact. All other Requirements in this Standard were not assessed, therefore, an overall rating of the Standard is not provided.

Requirements (3)(a) and (3)(c) in Standard 8 were found Non-compliant following a Site Audit conducted 16 June 2021 to 19 June 2021 where it was found the service did not demonstrate:

* that consumers were engaged in the development, delivery and evaluation of care and services and supported in that engagement; and
* organisation wide governance systems relating to information management, feedback and complaints, and continuous improvement were effectively implemented.

The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended Requirements (3)(a) and (3)(c) met.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and based on this information, I find Greek Orthodox Community of SA Inc, in relation to Ridleyton Greek Home for the Aged, Compliant with Requirements (3)(a) and (3)(c) in Standard 8 Organisational governance. I have provided reasons for my findings in the specific Requirements below.

**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.*

The service was found Non-compliant with Requirement (3)(a) following a Site Audit conducted 16 June 2021 to 19 June 2021 where it was found the service did not demonstrate that consumers were engaged in the development, delivery and evaluation of care and services and supported in that engagement. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewing systems to support solicitation of feedback and complaints, including ensuring a wide range of options/methods are readily available to provide feedback and that all feedback is registered and analysed for improvement opportunities.
* Reviewed the Consumer/representative meeting agenda to ensure specific areas of care and services are discussed and feedback encouraged.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* Most consumers sampled considered that the organisation is well run and that they can partner in improving the delivery of care and services. Consumers and representatives discussed ways they can provide feedback and have input into the design and delivery of care and services. Consumer input was noted in documentation relating to meeting forums, care documentation and feedback and complaints.
* Management described how the service provides forums and opportunities for consumer input into development and delivery of care and services.
* Consumer meeting minutes showed there are both feedback and opportunities for input into care and service delivery provided at meetings and quality improvements are discussed.
* Management provided an interim summary of responses to an ongoing consumer experience survey seeking current consumer sentiment across all Quality Standards.

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

**Requirement 8(3)(c) 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 service was found Non-compliant with Requirement (3)(c) following a Site Audit conducted 16 June 2021 to 19 June 2021 where it was found the service did not demonstrate organisation wide governance systems relating to information management, feedback and complaints, and continuous improvement were effectively implemented at the service. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed Quality and risk systems and processes, including in relation to continuous improvement.
* Reinstated a monthly Quality and risk committee meeting.
* Improving feedback and complaints governance by reviewing systems that encourage and support consumers and others to make complaints and provide input into care and service delivery.
* Developed Serious Incident Response Scheme policy and procedure documents.
* Developed a Board return to compliance sub-committee, communicating outcomes of regulatory visits and answering questions or feedback provided as a result.
* Engaged a consultant organisation to undertake a Standard 8 audit. The audit identified clinical actions which have been added to the service’s Continuous improvement plan.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* The service demonstrated effective organisation wide governance systems relating to information management, continuous improvement, financial and workforce governance, regulatory compliance and feedback and complaints.
* In relation to information management, staff demonstrated a solid depth of knowledge of consumers, including clinical needs which was generally reflected in service documentation. Guidance documents are available to direct proper handling of confidential or sensitive information and ensure consumer privacy. All policies have a timeframe for review and are updated as required. Staff indicated they have access to relevant policies and procedures to guide care and service provision.
* In relation to continuous improvement, improvements to care and service delivery are identified through an internal audit process. A Plan for continuous improvement is maintained, regularly reviewed and reported to the Board. Continuous improvement initiatives and improvements of safety and quality of care outcomes are monitored and discussed at regular meeting forums.
* In relation to financial governance, staff provided examples of where approval to make purchases had been sought, with management support.
* In relation to Workforce governance, governance arrangements are in place to ensure regulatory requirements relating to workforce are met. Organisational policy and procedure documents are available to support management and staff to meet workforce governance requirements, including in relation to induction, education, and performance management processes.
* In relation to regulatory compliance, the organisation is provided with updates/changes to legislation through subscription to various peak bodies. Departmental heads and senior management meet weekly to review changes and provide necessary updates to staff in relation to COVID-19 requirements/directives.
* In relation to feedback and complaints, senior management meet regularly to discuss feedback and complaints, with further monitoring occurring through regular Quality and risk committee meetings. Reports relating to complaints and feedback are tabled and discussed at Board meetings. Training in relation to feedback and complaints has been provided to care and nursing staff and staff sampled were aware of actions to take in response to complaints.

For the reasons detailed above, I find Greek Orthodox Community of SA Inc, in relation to Ridleyton Greek Home for the Aged, Compliant with Requirement (3)(c) 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:
* review and undertake wound treatments in line with wound treatment plans and the service’s policy and procedures, ensuring wounds are correctly classified and monitored.
* Ensure policies, procedures and guidelines in relation to wound management are effectively communicated and understood by staff.
* Monitor staff compliance with legislative requirements and the service’s policies, procedures and guidelines in relation to wound management.