Ridleyton Greek Home for the Aged

Performance Report

89 Hawker Street   
RIDLEYTON SA 5008  
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**Commission ID:** 6115

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

**Assessment Contact - Site date:** 3 June 2020 to 4 June 2020

**Date of Performance Report:** 7 August 2020

# 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)(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 staff, consumers/representatives and others.
* the provider’s response to the Assessment Contact - Site report received 30 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. This is in relation to Requirement (3)(a). All other Requirements in this Standard were not assessed.

The Assessment Team found the service does not meet Requirement (3)(a) in this Standard. Based on the Assessment Team’s report and the approved provider’s response, I find the service Non-compliant in relation to this Requirement. See this specific Requirement below for reasons for my decision.

### 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 found the service was unable to demonstrate that each consumer receives safe and effective clinical care. My decision is based on the care of one consumer for whom the service was unable to demonstrate they provided appropriate clinical monitoring following a significant incident, involving a fall. The Assessment Team provided the following findings and evidence relevant to my decision:

* A consumer’s representative indicated to the Assessment Team they had received three calls in a 30-minute period from staff of the service following an incident where their family member had fallen. The representative indicated they had not been told about the severity of the fall including how it occurred. The representative stated:
  + The phone calls indicated the consumer was very distressed and staff were seeking assistance to calm the consumer.
  + Staff asked the representative if they would like the consumer to be reviewed by a doctor to which they instructed staff to organise a medical review. Later that evening the representative was informed the consumer had been sent to hospital, however, staff did not inform them about the extent of injuries sustained due to the fall.
  + The representative stated they had received a call from a medical officer from the hospital the following morning who advised the consumer had suffered a fall, the details of the incident and the significant injuries sustained.
  + The representative indicated that the consumer died in hospital approximately six days following the fall, in severe pain.
* The Assessment Team viewed documentation related to the incident which indicated the incident occurred while the consumer was being transferred.
* Documentation following this incident does not support effective monitoring or review of the consumer’s condition, including disclosure to the representative of the seriousness of the incident and extent of injuries. The progress notes have limited information on the nature of the incident and the significant injuries to the consumer.
* A ‘statement of incident’ was not written by the registered nurse until five days after the incident.
* A progress note written five days after the incident, by a registered nurse stated they had assisted another registered nurse with the consumer’s hospital transfer. They noted the consumer was awake but not speaking, oxygen level was below normal at 84% and was given 10L oxygen via mask which increased levels to 98% and a visible bruise was noted to be on their chest.
* Management acknowledged the insufficient documentation to demonstrate monitoring of the consumer prior to hospital transfer and had requested nursing staff to retrospectively complete the required documentation in the days following the incident.

The approved provider submitted a response to the Assessment Team’s report and disagrees with the Assessment Team’s findings. The approved provider asserts the following in relation to the above consumer:

* The consumer’s representative was contacted three times in the evening of the incident but asserts it was not in a short-period, rather it was in a three-and-a-half-hour period and did not indicate the consumer was distressed but was rather upset.
* The consumer began to decline following the locum medical officer review and observations indicated the need for hospital transfer. The registered nurse also noted a haematoma on the consumer’s back, below their neck.
* The statement outlining the specific details of the incident is incorrect and there is no documentation to support the what the Assessment Team documented had occurred.
* The approved provider believes the consumer’s medical history and age may have contributed to their injuries.
* The approved provider acknowledges the details of the incident may not have been discussed with the representative on the evening of the incident, but staff discussed all injuries they were aware of and the locum medical officer assessment.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I find the service did not provide a consumer with appropriate or effective clinical monitoring or care following a significant incident impacting their health and well-being.

The approved provider asserts the incident did not occur as the Assessment Team documented and that nursing staff provided appropriate monitoring. While information about how the consumer was injured is inconsistent it is not my role to determine exactly what happened to cause the injuries. My role is to make a decision about compliance in relation to whether the consumer received safe and effective personal or clinical care while being transferred and following the incident involving a transfer. Consequently, I consider the transfer process was not conducted safely and resulted in an adverse outcome for the consumer, and the outcome of this incident should have prompted action to arrange urgent medical review, if not transfer to hospital, to be consistent with best practice and to optimise the consumer’s health and well-being. The first medical review was sought only at the request of the consumer’s representative.

I find that the service did not demonstrate appropriate monitoring of the consumer’s condition following the incident and that phone calls to the consumer’s representatives support my view that staff were not effectively managing the consumer’s distress. I have also considered the limited documentation made by nursing staff on the evening of the incident which does not support effective monitoring of the consumer’s clinical health status.

For the reasons detailed above, I find the approved provider, in relation to the service, is Non-compliant with Standard 3 Requirement (3)(a).

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

The Assessment Team found the service does not meet Requirement (3)(d) in this Standard. Based on the Assessment Team’s report and the approved provider’s response, I find the service Non-compliant in relation to this Requirement. See this specific Requirement below for reasons for my decision.

## 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 Assessment Team found the service was unable to demonstrate effective risk management systems and practices in relation to the use of high-risk equipment. The Assessment Team provided the following findings and evidence relevant to my decision:

* A faulty piece of equipment was used to transfer a consumer who subsequently suffered significant injuries.
  + The service was aware of a major fault with another piece of equipment of the same make and model.
  + The identified fault in this equipment in July 2019 was not escalated or considered in the service’s risk management system for consideration of how to reduce or remove the risk that was potentially posed to other equipment of the same brand and models being used in the service.
* During January 2020, the equipment involved in the incident with the consumer, was not provided its routine servicing in accordance with the service’s procedures.
  + Management said it was decided that since the equipment was only nine-months old and had been serviced in July 2019, therefore they did not feel it was necessary for it to be serviced as it was not a manufacturer’s requirement.
  + Following the incident with the consumer, the contractor for the equipment wrote a report that indicated ‘attempts to replicate the fault eventually led to the fault reoccurring 3 or 4 times in a row’.
  + A technical report in April 2020 also indicates the service should ensure equipment is serviced by qualified technicians at six-monthly intervals in accordance with regulations.
* The preventative maintenance report in July 2019 indicates the equipment used in the incident with the consumer had some deterioration and that two similar pieces of equipment had the same fault as the equipment involved in the incident. Eight other similar pieces of equipment were also identified as having deterioration or other faults.
* The service has only recently implemented a risk register and is currently working its way through risk assessments, including risk assessments for this equipment, other equipment in use at the service and tasks undertaken by staff associated with risk.
* The Assessment Team observed the service uses lengths of yellow plastic chains on door frames to deter consumers who wander from entering other consumers’ rooms. The chains are secured at one end by a single screw and is held in place by mental washers to prevent the chain slipping off the screw. Management stated no risk assessments have been undertaken for use of the plastic chains.

The approved provider submitted a response to the Assessment Team’s report and disagrees with the Assessment Team’s findings. The approved provider asserts the following:

* The equipment involved in the incident where the consumer fell was not the same make or model as the equipment identified in July 2019 as having a major fault and were subsequently removed from use.
  + The fault identified in the equipment involved in the incident with the consumer fall, was not the same fault identified in other similar equipment July 2019.
    - The equipment with the major fault identified in July 2019 has an electronic adjustment function, whereas the equipment used in the incident has a manual adjustment function.
* The service identified in April 2020 gaps in equipment management, including that there were no formal risk assessments being conducted for new equipment. A new formal risk assessment process has been developed and has been implemented.
  + The service has since conduced a risk assessment for the equipment involved in the incident and have also conducted make and model specific risk assessments.
* The equipment involved in this incident was deemed safe in July 2019.
  + The service was unaware that this equipment did not undergo its scheduled maintenance check in January 2020 because this omission was not written in the maintenance report. Since the incident the service has established a formal process to follow-up equipment maintenance reports and an escalation agreement.
  + Staff did not report any issues with the equipment to maintenance from the service in July 2019 up until the incident.
* The April 2020 technical report for the equipment involved in the incident, indicates a recommended routine practice with this equipment which the user manual does not recommend. Additionally, the fault at the time of the incident would not have been picked up at routine maintenance testing in January 2020 unless the fault occurred during that service.
* The service identified during an internal audit on 16 April 2020 the use of the plastic chains and have since been assessed and considered ‘low risk’. The occupational therapists are reviewing and risk assessing the need for door chains which will consider removal or replacement with crowd control sashes.

Based on the Assessment Team’s report and the approved provider’s response I find the service Non-compliant with this Requirement. I find the service’s risk management systems and processes were 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. While I acknowledge the approved provider’s assertion that the equipment used in the incident with the consumer is not the same model as the equipment identified with a significant fault in July 2019, I do highlight that these pieces of equipment are of the same brand. While the two pieces of equipment of the same brand have differing adjustment mechanisms and are not the same model, I find it reasonable that the service should have escalated this issue through its risk management system to reduce or remove risks associated with any equipment associated with this brand of equipment. Additionally, the service was unaware that routine maintenance checks for the equipment involved in the incident had not been undertaken and subsequently failed to act to ensure this maintenance was actioned. I find that the service’s risk management systems failed to identify this concern which related to a high-risk piece of equipment.

I acknowledge that since the incident where a consumer sustained significant injuries which involving the above-mentioned equipment, the service has acted upon this incident and have developed and are working to improve risk management systems and processes. However, in coming to my decision, I have considered that it took a serious incident which caused significant harm to a consumer for the service to make these improvements. Additionally, while these improvements commenced prior to the Assessment Contact, the improvements were either new or had only recently been implemented, and their effectiveness could not be completely tested. For example, the plastic chains on consumers’ door, while risked assessed and it has been considered they need to be removed or replaced, this has not yet been actioned and the risk, albeit identified as low by the service, have not removed the chains or reduced the risk.

For the reasons detailed above, I find the approved provider, in relation to the service, Non-complaint with Standard 8 Requirement (3)(d).

# 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 nursing staff document monitoring actions and consumers’ clinical conditions in a timely manner following significant incidents or changes in health status to ensure effective clinical care.
  + Ensure timely and appropriate medical review of consumers following significant incidents or changes in health status.
* **Standard 8 Requirement (3)(d):**
  + Ensure the service has effective risk management systems which includes the safe management of equipment.
  + Ensure staff/contractors escalate failure to complete routine checks on equipment, including high risk equipment.
  + Ensure the service acts on information indicating risk in a timely manner.