

**Performance Report**

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| Name: | Calvary Corymbia |
| Commission ID: | 1096 |
| Address: | 51 Childs Circuit, BELROSE, New South Wales, 2085 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 15 October 2024 to 16 October 2024 |
| Performance report date: | 5 December 2024 |
| Service included in this assessment: | Provider: 2958 Calvary Aged Care Services Pty Ltd  Service: 27611 Calvary Corymbia |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for Calvary Corymbia (**the service**) has been prepared by L Glass, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Assessment contact (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, older people/representatives and others
* the provider’s response to the assessment team’s report received 8 November 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Compliant |
| **Standard 4** Services and supports for daily living | **Not Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

Areas have been identified in which **improvements must be made to ensure compliance with the Quality Standards**. This is based on non-compliance with the Quality Standards as described in this performance report.

* In relation to Requirement 3(3)(a) ensure clinical care is individualised and in particular that there is assessment, management and evaluation of unplanned weight loss, consumer deterioration, the use of restrictive practices, pain, the provision of end-of-life care, complex clinical needs and the support for consumers with changes in behaviour.
* In relation to Requirement 3(3)(b) investigate and manage incidents such as falls, changes in behaviour, and the significant deterioration of pressure injuries and, undertake the comprehensive assessment processes referred to in the organisation’s procedures for reviewing, assessing and planning regarding consumers who are administered psychotropic medications identified as being a chemical restraint.
* In relation to Requirement 4(3)(b) implement processes and strategies to ensure services and supports promote each consumer’s emotional and psychological well-being.
* In relation to Requirement 8(3)(d) identify, collate, trend and analyse risks to determine if systemic issues are present and use the information to strengthen systemic improvements practices and escalate identified high impact and high prevalence risks to the governing body for a response and to inform actions to be undertaken.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant |

Findings

In relation to Requirement 3(3)(a) the Assessment Team found consumers and representatives generally provided positive feedback about the personal and clinical care provided to the consumer and that they are kept informed, and consulted, about the care provided. However, the service has not ensured that each consumer’s care is best practice, tailored to their needs, and optimises their health and well-being. The team identified deficiencies in relation to preventing and responding to unplanned weight loss, identification and timely response to consumer deterioration, the use of restrictive practices, pain monitoring, the provision of end-of-life care, management of complex clinical needs and the support for consumers with changes in behaviour.

Management acknowledged they recently identified inconsistency in staff practices when monitoring and caring for consumers. They said education had been provided regarding these deficiencies. However, there were no activities related to these deficiencies in the plan for continuous improvement and the Assessment Team was not provided with any information to demonstrate that measures were implemented to ensure the education and support to staff was effective in addressing the identified deficiencies.

In relation to Requirement 3(3)(b) most consumers indicated they are satisfied with how the service manages high impact or high-prevalence risks. However, several representatives raised concerns. The concerns included failure to investigate and manage incidents such as falls, changes in behaviour, and the significant deterioration of pressure injuries. The service did not demonstrate evaluation of nonpharmacological interventions for consumers subjected to restrictive practices. It did not demonstrate it undertakes the comprehensive assessment processes referred to in the organisation’s procedures for reviewing, assessing and planning regarding consumers who are administered psychotropic medications identified as being a chemical restraint when the consumer enters the service.

The Approved Provider’s written response acknowledged the identified deficits. and stated it is in the process of implementing several improvement initiatives to address the identified gaps. The initiatives prioritise risk mitigation and the enhancement of care delivery processes, ensuring that individualised needs of residents are met effectively.

I have considered the Assessment Team report recommending the requirements are not met and the written response from the Approved Provider acknowledging the identified deficits. While the Approved Provider has stated it is implementing improvements, I consider there are gaps in clinical care presenting high impact risks to consumers. I find Requirements 3(3)(a) and 3(3)(b) Not Compliant and as a result Standard 3 is also Not Compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Not Compliant |

Findings

In relation to Requirement 4(3)(b) the Assessment Team found the service did not demonstrate it provided services and supports to promote each consumer’s emotional and psychological well-being. Consumers requiring psychological support including after experiencing trauma were not identified in a timely manner or provided with appropriate resources and support.

Care and lifestyle staff were knowledgeable about consumers emotional and spiritual needs however, lacked a clear understanding of the psychological support individuals needed.

A review of care documentation showed the service had identified consumers needing psychological support through assessment and planning, however, there were no referrals for support and internal additional pastoral care supports put in place were not sufficient to address psychological needs.

There was no immediate or ongoing support offered to promote consumers’ mental health and well-being. The service did not recognise the need to provide professional psychological trauma informed support for consumers directly and indirectly impacted by traumatic events.

The Approved Provider’s written response acknowledged the identified deficits. and stated it is in the process of implementing several improvement initiatives to address the identified gaps. The initiatives prioritise risk mitigation and the enhancement of care delivery processes, ensuring that individualised needs of residents are met effectively.

I have considered the Assessment Team report recommending the requirement is not met and the written response from the Approved Provider acknowledging the identified deficits. While the Approved Provider has stated it is implementing improvements, I consider effective services and supports for daily living for all consumers are not yet established. I find Requirement 4(3)(b) Not Compliant and as a result Standard 4 is also Not Compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(d) | 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. | Not Compliant |

**Findings**

In relation to Requirement 8(3)(d) the organisation did not demonstrate it ensures established risk management systems and processes had been fully implemented and were operating effectively. The documented risk management framework emphasises the need for both a proactive and reactive approach to risk management. The framework included risk controls and ratings. A multi-layered governance structure was in place, including national clinical, quality, governance and risk committees, and aged care boards, all reporting to the organisational boards at a national level. Systems were in place to ensure the governing body was informed of high-level risks occurring at the service level for clinical risks.

However, it was not clear from information provided to the Assessment Team that risks related to incidents or risk types including potential reputational risks at the service were being escalated to the governing body. The Assessment Team identified deficiencies in the service level management of wounds, incidents, pain, behaviour support, falls and restrictive practices and poor understanding of neglect and Serious Incident Response Scheme obligations. The governance reporting structure was also dependent on service level practices and procedures being followed for information being reported to be accurate and risks being managed effectively.

The risk management framework and associated policies have clearly defined responsibilities around management of risks, implementing and reviewing

effectiveness of the framework, and oversight and leadership of risk management. However, there was little evidence of the service or governing body implementing proactive monitoring or auditing of the effectiveness of internal systems and practices, adherence to policy and procedure, or potential for improvements. Audits undertaken at the service level were not collated, trended and analysed to determine if systemic issues were present and the information was not used to inform systemic improvements.

The Approved Provider’s written response acknowledged the identified deficits and stated it is in the process of implementing several improvement initiatives to address the identified gaps. The initiatives prioritise risk mitigation and the enhancement of care delivery processes, ensuring that individualised needs of residents are met effectively.

I have considered the Assessment Team report recommending the requirement is not met and the written response from the Approved Provider acknowledging the identified deficits. While the Approved Provider has stated it is implementing improvements, I consider the service did not demonstrate effective risk management systems and practices, are being implemented, impacting the identification, management and response to high impact and high prevalence risks to consumers. I find Requirement 8(3)(d) Not Compliant and as a result Standard 8 is also Not Compliant.

1. The preparation of the performance report is in accordance with section 68Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)