Performance

Report

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| Name: | Charles Brownlow Retirement Village |
| Commission ID: | 4005 |
| Address: | 157 South Valley Road, HIGHTON, Victoria, 3216 |
| Activity type: | Assessment Contact (performance assessment) – site |
| Activity date: | on 28 August 2024 |
| Performance report date: | 30 September 2024 |
| Service included in this assessment: | Provider: 6868 Ryman Aged Care (Australia) Pty Ltd  Service: 27664 Charles Brownlow Retirement Village |

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 Charles Brownlow Retirement Village (**the service**) has been prepared by G. Harbrow, 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, which was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives, and others.
* information from the provider received 9 September 2024; and
* the provider’s response to the Assessment Team’s report received 24 September 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | 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.

Requirement 3(3)(a)

* Ensure continuity of consumer care, with consideration given to consumer preference and needs for provision of care that is tailored to the individual consumer and optimises their health and wellbeing. These include but are not limited to effective monitoring and management of wounds, providing timely assistance and care tailored to consumers’ needs, effective and comprehensive communication related to clinical and personal care that leads to positive consumer experiences and effective pain monitoring and reviewing processes.

Requirement 3(3)(b)

* Ensure effective management of high impact or high prevalence risks associated with the care of each consumer through clear demonstration and evaluation of associated risk management strategies. These include but are not limited to effective management of aspiration risks.

Requirement 3(3)(d)

* Ensure timely and appropriate response to recognised deterioration or change in a consumer’s condition with consideration given to consumer assessment outcomes and history. These include but are not limited to the identification and management of consumer deterioration relating to falls and urinary tract infections.

Requirement 8(3)(d)

* Ensure effective risk management systems and practices, through demonstration of clear processes for the management of incidents, and how these inform continuous improvement and prevent similar incidents from re-occurring.
* Ensure an effective process for identifying and responding to neglect of consumers, with demonstration of appropriate recognition and response to Serious Incident Response Scheme incidents.

# 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 |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | 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. | Not Compliant |

Findings

I am satisfied based on the relevant evidence presented in the Assessment Team’s report and the provider’s response that the service is not compliant with Requirements 3(3)(a), 3(3)(b), and 3(3)(d), and as a result is not compliant with Standard 3. I am satisfied the service is compliant with Requirement 3(3)(c).

Requirement 3(3)(a).

Not all consumers and representatives were satisfied with the provision of personal and clinical consumer care. The Assessment Team found monitoring and management of consumer pain and wounds was not aligned with best practice. The provision of personal care was not aligned with best practice and the Assessment Team found the service did not ensure access to medical care in a timely manner.

The Assessment Team identified staff did not demonstrate best practice wound care, or care tailored to individual needs by omitting to complete a wound assessment and implement wound specialist directives. Specialist directives for wound care were not documented in the consumers progress notes or care file, resulting in the recommended wound care not being provided.

The provider submitted a written response (the response) providing further evidence and acknowledging the omission of the development of a wound chart and subsequent wound reviews and care. The response advised of and provided evidence of staff remediation and provision of wound management education to staff. The response advised of, and included an updated draft policy, to provide staff guidance and ensure best practice in relation to specific wound management.

I acknowledge the provider’s response; however, I find this omission of documentation, indicates a breakdown in the service’s processes for the sharing and recording of consumer information to ensure care tailored to their needs, and to optimise consumer health. The omission of wound care resulted in contamination and maceration of the skin surrounding the wound and in making my decision I have given weight to the potential of wound infection and associated consumer risks.

The Assessment Team further identified a consumer who had experienced urinary incontinence following an extended period of waiting for staff assistance. This experience does not demonstrate tailored care and negatively impacted on the consumer’s well-being.

Management provided a commitment to review staff practice regarding call bell response at the time of the Assessment Contact.

The provider’s response provided further evidence including call bell data indicating staff response times for this consumer to be acceptable. I acknowledge this data, however, am mindful that while this indicates call bells are being answered and turned off, this data alone does not evidence timely delivery of required and tailored consumer care.

The response evidenced an internal investigation had been undertaken by service management; communication had been provided to staff reminding of the importance of answering call bells promptly; and an apology was provided to the identified consumer with the consumer satisfied the issue had been addressed.

Whilst I acknowledge the issue had been addressed by service management following the Assessment Contact, I have considered the consumer’s adverse experience and find this does not reflect best practice care that is tailored to the consumer’s needs or demonstrate the optimising of consumer health and well-being.

The Assessment Team identified a further consumer who through a breakdown in communication potentially experienced a delayed or missed medical appointment. The consumer also experienced an occasion of incontinence that was not effectively managed. The provider’s response contributed consumer background information, that possibly related to the incontinence episode. The response also evidenced improvement in care planning to enhance continence management strategies. Communication from the service to the consumer’s representative, including an apology to the representative, was also evidenced.

Although the response provided information including evidence of purposeful rounding, this was the second consumer identified to have experienced clinical care related communication breakdown and continence issues. I find the service’s clinical oversight, specifically the mechanism for monitoring consumer needs, did not identify and rectify the deficits, prior to them being identified by the Assessment Team. This does not demonstrate best practice personal and or clinical care that is tailored to consumers’ needs.

The Assessment Team identified the process for a consumer’s entry to the service was not aligned with the service’s consumer entry policy in relation to timely medical assessment. The policy indicates consumers to have a medical assessment completed on the first day of entry to the service. The Assessment Team found a consumer yet to be medically assessed 21 days post entry to the service.

The provider’s response advised of and provided evidence to support the consumer to have had a medical assessment completed within 4 days of entering the service. The response explained the consumer’s GP communication with the service being through email rather than documenting directly into the service’s electronic information management system. The response identified a delay of one day in the transference of this information, due to the requirement for manual input. The response advised of communication with staff and the consumer’s GP reminding of the importance of GP communication and documentation into the service’s electronic information management system, to ensure continuity of care.

Based on the evidence presented by the provider, and there was no information included in the Assessment Team’s report, or the provider’s response indicating possible or actual adverse impact resulted from a delayed medical assessment, I am satisfied the consumer was medically assessed within a reasonable time from entry to the service.

The Assessment Team identified the service does not have an effective process for charting and reviewing pain. Pain assessment is documented in consumer progress notes with limited pain descriptors to enable an effective review process.

The provider’s response acknowledged opportunity for improvement in the service’s current pain management process and advised of the introduction of an updated and improved pain monitoring chart and procedure in the service’s electronic consumer information management system. The response advised this was introduced on the final day of the Assessment Contact. The response further identified education for the introduced pain monitoring and management procedure was provided the same day, with an instructional video distributed in September. The response advised that pain assessments had commenced for all consumers, utilising the improved procedure, however confirmed this yet to be completed.

I acknowledge the provider is actively taking improvement actions to address pain monitoring and review deficits. However, I place weight on improvement actions not having been fully completed, requiring time to be embedded within the service’s normal processes, and testing to ensure their effectiveness and sustainability.

In summary, I find Requirement 3(3)(a) Not-Compliant based on multiple consumers experience relating to ineffective monitoring and management of a wound, not receiving timely assistance which resulted in adverse impact on consumer’s health and well-being, clinical and personal care related communication breakdown that led to negative consumer experiences, and an ineffective pain monitoring and reviewing process.

Requirement 3(3)(b).

The Assessment Team advised the service identified consumer falls, pressure injuries and changed behaviours as high impact and or high prevalence consumer risks with consumers and representatives dissatisfied with the service’s management of these risks. I have considered the relevant information available to me when preparing this performance report and I am unable to form a view related to the effective management of those risks due to a lack of evidence about the service’s management of risks associated with consumer falls, pressure injuries and or changed behaviours.

The Assessment Team report identified a high impact risk of aspiration when a consumer insists on assisting another consumer with eating and drinking. The assisting consumer is not following allied health professional’s recommended safe swallowing strategies and there was no record of dignity of risk discussion or documentation. The Assessment Team report also identified consumer risk associated with the assisting consumer’s behaviour, however, does not include information on the behaviour support strategies, or a lack of behaviour support strategies being in place.

The provider’s response acknowledged the aspiration risk identified and advised the service has provided education about safe assistance with eating to the consumer who insists on assisting the other consumer with meals. The response advised of numerous discussions with the assisting consumer regarding the associated risks of aspiration and identified both consumers to be involved in complex family dynamics including identified decision makers declining to authorise a dignity of risk agreement.

I have reviewed the consumer’s care planning documentation and while it does identify the risk of aspiration and staff being required to assist with meals, there is no documentation regarding the option for the assisting consumer’s presence at mealtimes. Nor is it clear that staff assistance is a priority to minimise the consumer’s risk of aspiration.

With the evidence available to me, I find that while the service has identified consumer risk relating to aspiration, I consider the effective management of this risk has not been clearly demonstrated.

The Assessment Team found the service did not demonstrate effective support for a consumer living with a sensory risk, as the service was not cleaning and charging the consumer’s sensory aids appropriately.

The provider’s response indicates a process is now in place for the appropriate care and cleaning of the consumer’s sensory aids. The provider submitted further evidence including evidence of staff education on the care and cleaning of the sensory aids.

I have considered an established link between assistance to hear and improved quality of life for the consumer. The omission of support for a consumer living with a sensory impairment with resultant frustration and challenges in communicating increases the risk of other high impact risks developing. While the service has not demonstrated effective management of a high impact and or high prevalence risk for the consumer, I am satisfied arrangements are now in place for the sensory aids to be cleaned appropriately and I encourage the provider to monitor the effectiveness of the newly implemented arrangements.

Based on the evidence and reasons detailed above regarding the ineffective management of a consumer’s aspiration risk, and the service not identifying the potential for further high impact risks for a consumer experiencing sensory deficits. I find Requirement 3(3)(b) Not Compliant.

Requirement 3(3)(c).

The Assessment Team report identified information regarding consumer end of life wishes is documented and filed in the service’s local computer system and not linked to the service’s electronic information management system. The Assessment Team determined, having consumer care files stored in 2 places impedes staff access and subsequent awareness of individual consumer’s end of life needs, goals, and preferences. The Assessment Team report further indicates identified deficits in clinical staff knowledge related to the provision of palliative care.

The Assessment Team recommended the Requirement is Not Met. I have come to a different view for the reasons outlined.

The Assessment Team provided an example to support the finding, of a consumer with multiple co-morbidities, admitted to the service, who advised of being ready to die and their wishes to remain at the service to do so. This was supported by the consumer’s representative. The consumer subsequently experienced a fall and further acute health deterioration and was hospitalised and later deceased in hospital. The Assessment Team report did not identify if the consumer and or the representative consented to the hospital transfer and or admission.

The Assessment Team found a staff member unable to locate information relating to consumer advanced care directives and end of life care in the service’s local computer system. At the time of the Assessment Contact, service management advised the service’s electronic information management system did not include an end-of-life assessment.

The provider’s response identified a process for regular review of consumer advance care directives and consumer enduring power of attorney. The response advised all consumers complete numerous documents informing care planning and care delivery when at the end of life. These documents are paper based, and on completion are uploaded for storage in a designated file located in the information management system. The response demonstrated the advance care directive for the identified consumer was in place and accessible by staff prior to the consumer’s hospitalisation.

I have reviewed the consumer’s progress notes and found evidence that prior to the consumer’s transfer to hospital, service staff did note the consumer’s advance care directive and associated preference not to be hospitalised for most conditions. The progress notes further indicate repeated unsuccessful attempts to contact the consumer’s GP made by service staff and emergency responders. The progress notes identify the emergency response team had consulted with the consumer’s next of kin for consent, prior to transfer to hospital.

I have considered the evidence available and find I am unable to establish adverse consumer impact resulting from information regarding consumer end of life wishes being filed in the service’s local system. I am also unable to identify evidence to indicate deficits in clinical staff knowledge related to the provision of palliative care. While I recognise the consumer did not experience end of life at the service as wished, I am unable to determine what care measures were provided in hospital. In the absence of identified systemic consumer risk and in consideration of proportionality and I have come to a different view. I find Requirement 3(3)(c) Compliant.

Requirement 3(3)(d).

While staff identified appropriate processes in place to monitor consumers if deterioration is noted, the Assessment Team found consumer deterioration and changes in condition were not effectively assessed and there was no consideration or review of consumer history for consumers with known clinical risks or health conditions.

The Assessment Team report identified a consumer who has a history of falling with a fracture prior to entering to the service. The consumer experienced 4 falls over an 18-day period after entering the service, prior to a fracture being identified by X-ray on day 20. The fracture was identified as occurring 2 weeks prior to detection. Despite the consumer’s representative identifying the consumer complaining of pain on movement a week following the initial 2 falls, and bruising identified by staff in the proximity of the fracture site, further GP review with X-ray did not occur until the consumer experienced another 2 falls. The Assessment Team report further indicates an omission of any advanced clinical assessment or referral for medical interventions undertaken or documented.

The provider’s response identified post falls management for the consumer was according to service policy inclusive of assessment of pain, physiotherapist, and GP reviews. I acknowledge, and documentation shows, post fall assessments provided to the consumer following each fall were mostly appropriate.

The response advised the service has provided education to staff regarding the recognition of consumer deterioration, however, did not include evidence of staff attendance or completion.

I have considered the evidence available to me and have identified information in the Assessment Team report contradictory to the Assessment Teams finding of omission of any advanced clinical assessment or referral for medical interventions undertaken or documented following the consumer experiencing falls. The Assessment Team report identified, and the provider’s response confirms, a GP and physiotherapist review between one to 3 days following each fall had occurred with no significant pain or abnormalities detected. The Assessment Team report further indicates a registered nurse (RN) assessment and musculoskeletal check following each fall with no abnormalities identified.

While I acknowledge this demonstrates mostly appropriate responses provided in the assessment of the consumer following their experience of falling, I consider the omission of escalation for investigation following the detection of bruising over the site of identified pain, demonstrates the changes in the consumer’s condition was not recognised nor responded to in a timely manner.

Another consumer with a history of chronic urinary tract infections (UTIs) experienced a fall which required transfer to hospital for treatment. The consumer returned to the service on the same day with a diagnosis of a UTI requiring treatment by antibiotics.

The consumer’s representative advised of being aware of changes in the consumer days prior to the fall describing increased drowsiness, frequency of urination and loss of appetite. The consumer’s representative said they had spoken to the nursing staff, however, while the Assessment Team found documentation in the progress notes providing the direction to monitor the consumer for drowsiness, there was no evidence the consumer’s change in condition was considered in relation to their background of chronic UTIs. The Assessment Team report identified, on return from hospital, the consumer’s care was updated to include daily monitoring of vital signs. However, other considerations such as food and fluid intake, pain and continence assessment were not included.

The provider’s response identified that staff acknowledged the consumer representative’s concerns regarding changes in the consumer’s condition. The response included consumer progress notes evidencing a review of the consumer’s vital signs and a request for a GP review. The response advised of continued consumer daily observations. The response further indicates the consumer’s post fall assessment identified the cause of the consumer’s fall to be a slip from their chair, possibly due to the consumer experiencing an episode of incontinence.

The response included the service’s policy relating to UTI identification and management, and advised this document provides staff guidance in the recognition of symptoms to identify UTIs and includes the symptom of increased frequency of urination. The response advised the consumer’s documented vital signs and progress notes did not indicate symptoms of a UTI and therefore, further investigation for a UTI was not required.

From the information available to me, I have found appropriate consumer assessment was not conducted to establish the presence or absence of the required symptomatic criteria for the identification of a UTI as outlined in the service policy.

I have considered the established link between the absence of early assessment for identification and timely response to consumer change with the potential for further health deterioration. I find the omission of consumer history used to inform consumer assessment, to potentially impede early intervention, with the potential for further health complications. I consider this does not demonstrate timely recognition and response to consumer deterioration.

Based on the evidence and reasons detailed above, I find Requirement 3(3)(d) 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

The Assessment Team found most consumers and representatives are not satisfied the service is supporting consumers to live their best lives. The service does not effectively investigate and evaluate consumer risk to recognise contributing factors to reduce the incidence of high impact high prevalence risks.

The Assessment Team found the service did not demonstrate effective clinical oversight of consumers with known high impact and or high prevalence risks. This includes the risk of aspiration for one consumer, risks associated with sensory impairment impacting on communication for another consumer, and inadequate monitoring of contributing factors, such as consumer history, to reduce or prevent incidents, such as falls resulting in injury for a further 2 consumers.

While I find these examples (provided under Requirement 3(3)(b) and 3(3)(d)), do not demonstrate the service is supporting consumers to live their best lives, with the evidence available to me and considering proportionality, I am unable to determine if these outcomes are a consequence of system and or process failure.

The Assessment Team report provides data from incident summary reports indicating confusion about the use of terminology when reporting incidents relating to consumer experiencing changes in behaviour.

The provider’s response advised of an updated policy relating to management of changed behaviour, and explained service staff often use these terms interchangeably. The response advised and documentation supports planned and delivered staff education on the revised policy and process for management of changed behaviour to ensure that terminology is clear and current.

I recognise this confusion to have potential impacts on service incident data analysis and trending to inform service response and subsequently the effective management of risk associated with changed behaviour. However, I acknowledge the service’s revision of policy and provision of staff education to address this concern. Based on the provider’s submission, I am unable to determine if these strategies have been evaluated for effectiveness.

The Assessment Team found the service has a process of incident review to identify and escalate incidents reportable under the Commission’s Serious Incident Response Scheme (SIRS), according to the Commission’s SIRS decision making tool. However, under Requirement 3(3)(a), the Assessment Team identified consumer neglect when wound care was not provided according to specialist direction. While the service acknowledged identified wound care deficits, the service did not appropriately identify this as neglect and a reportable SIRS incident.

The provider submitted further evidence to advise of and evidence a retrospective SIRS report identifying consumer neglect due to the omission of appropriate wound management. The response advised of staff education on SIRS reporting provided and planned, however, does not provide evidence of staff attendance for sessions held or the effectiveness of the staff education.

The response advised of and included the draft of an updated policy, to provide staff guidance and ensure best practice in relation to specific wound management.

I acknowledge the provider’s response; however, I consider the service did not meet the Commission’s mandatory SIRS notification and reporting requirements in relation to a notifiable incident and therefore did not demonstrate an effective process for identifying and responding to abuse and neglect of consumers. I also place weight on improvement actions not having been fully completed, requiring time to be embedded within the service’s normal processes, and testing to ensure their effectiveness and sustainability.

The Assessment Team identified the service has a bespoke electronic information management system in place, providing initial incident reporting functions and prompts further reporting requirements. However, the Assessment Team report indicated the service did not demonstrate an effective process of incident investigation, with identified outcomes to inform planned improvement to manage risks associated with consumer care. A review of consumer incident reports did not indicate a process of investigation. Management advised at the time of the Assessment Contact, incident investigation and identified actions are not documented on the initial report.

The provider’s response confirmed the service has a process of escalation available to all staff completing progress notes, to alert management to incident occurrence and ensure investigation. The response advised the service’s incident management system has capacity of incident analysis to identify trends, contributing factors and risks, and is used to inform regular reporting. The response further advised the service has a planned process of incident review, inclusive of investigations and outcomes, at multiple governance levels inclusive of the Board. The response did not identify how incidents drive the service’s continuous improvement and prevent similar incidents from occurring.

The Assessment Team report noted examples of consumers not being supported to live the best life they can. These relate to consumers and representatives advising of long wait times in response to call bells and experiencing distress about staff availability to meet consumer continence and toileting needs and preferences. The Assessment Team report indicated anxiety experienced by 3 consumers when calling for staff assistance. At the time of the Assessment Contact, management acknowledged the staff had been prompted to attend consumers bedsides and turn off the call bell, after providing consumers with an intended time of return to provide care. However, management was not aware of consumers becoming distressed due to staff not providing timely toileting assistance and provision of care.

The provider’s response and additional information submitted evidenced the service is currently meeting the industry required care minutes. Evidence supported the service mostly meeting rostering requirements with a planned process to fill unplanned leave. The response indicates numerous meetings, staff communications and available policy, to outline the service’s expectations of staff regarding response to call bells. Documentation further shows the service’s response to consumer complaints at having to wait to have care needs met in a timely manner.

While I acknowledge the service is working on staff response to call bells and responding to consumers’ call bell related complaints, I find the consumer and representative voice compelling and the risk management systems and practices in place not supporting consumers to live the best life they can.

I have considered the information available to me. While the response includes information indicating a governance framework for incident reporting and management. I am not persuaded that a clear process for the management and prevention of incidents is in place. The policy submitted in the response, relates to cyber incident management, and does not provide guidance or processes for the management of consumer and, or staff related incidents. While the response identifies a process of incident review, it does not identify how incidents inform the service’s continuous improvement to improve the quality of consumer care and services and prevent similar incidents from occurring.

Based on the evidence and reasons detailed above, I find Requirement 8(3)(d) 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)