Performance

Report

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| Name: | Crowley Retirement Village |
| Commission ID: | 0010 |
| Address: | 154 Cherry Street, BALLINA, New South Wales, 2478 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 5 June 2024 |
| Performance report date: | 8 July 2024 |
| Service included in this assessment: | Provider: 201 The Trustees of the Roman Catholic Church for the Diocese of Lismore  Service: 19 Crowley 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 Crowley Retirement Village (**the service**) has been prepared by J Cayabyab, 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, consumers/representatives and others, and
* the provider’s response to the assessment team’s report received 1 July 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 7 Human resources** | **Not compliant** |
| **Standard 8 Organisational governance** | **Not applicable as not all requirements have been assessed** |

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 7(3)(a) – The approved provider must demonstrate staffing levels and mix is planned to ensure the delivery of safe and effective care and services to consumers. The service should ensure the provision of mandatory care minutes including RN minutes to ensure the care needs of consumers is met at all times.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

The Assessment Team Report recommended this requirement as not met as the service was unable to demonstrate effective management of risks associated with the care of some consumers particularly related to those who have unplanned weight loss, choose to eat a diet assessed as unsuitable for them, require pain management or wound management, exhibit changed behaviours and consumers who experience falls. Care documentation did not consistently demonstrate accurate recording of actions taken to manage consumers with unplanned weight loss, wound, and swallowing difficulties. The Assessment Team Report noted some inconsistency in the identification and informed consent of consumers subject to chemical restrictive practice and monitoring of pain prior to and following the introduction of psychotropic medications to manage pain and post fall incidents. Staff did not demonstrate appropriate understanding of the effective strategies to be implemented when consumers’ experience falls, unplanned weight loss, changed behaviour, and other incidents. For one consumer sampled who experienced weight loss, documentation review and representative interview evidenced the consumer has gained weight with appropriate interventions by the service. I have considered the deficiencies identified by the Assessment Team with regards to reporting and responding to Serious Incident Response Scheme (SIRS) incidents related to changed behaviour in Requirement 8(3)(e).

The Approved Provider submitted a response and supplied their Plan for Continuous Improvement (PCI) with additional information and clarification around documentation and the service’s processes in place. The Approved Provider’s response and their PCI outlined completed actions, comprehensive explanations of the service’s processes, their response providing clarification for the care provided to consumers sampled, and the actions taken to address the deficits identified by the Assessment Team. There are clear strategies reflected in the PCI and a number of actions have been completed which support appropriate remediation action for this Requirement. There is ongoing review of education and training utilising the service’s 3-tiered approach of essential, enhanced, and expert education; audit and review of clinical care including assessment and care planning documentation and policies and procedures against identified deficits; timely consultation with consumers sampled; additional equipment to enhance wound documentation; and evidence of involvement of other allied health professionals contributing to effective care outcomes for consumers.

I have considered the information in the assessment team report and the Approved Providers response. While I acknowledge deficits identified by the assessment team under this requirement, I have placed weight on the Approved Providers response and implementation of improvement actions to address the issues. I encourage the Approved Provider to continue implementing, embedding, and evaluating its continuous improvement actions to ensure high impact or high prevalence risks associated with the care of each consumer are effectively managed. Based on the evidence available, summarised above, I have come to a different view to the Assessment Team and find requirement 3(3)(b) is Compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | 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. | Not Compliant |

Findings

The Assessment Team Report recommended Requirement 7(3)(a) as not met as the service was unable to demonstrate staffing levels that meet the needs of consumers to ensure delivery and management of safe and quality care. Consumers and representatives provided positive feedback in relation to the consumers’ care and service delivery. However, mixed feedback provided mainly related to the sufficiency of staffing at times. One consumer provided feedback in relation to staff rushing when providing care, extended wait times when requesting assistance, and labour hire staff not knowing their care needs which has impacted their breathing issues. The service acknowledged the issues identified on the call bell system in place which can result in delays in attending care and extended wait times and the lack of induction processes for labour hire care staff.

The Assessment Team Report included evidence of Assessment Team observations of staff insufficiency including medication not administered on schedule due to a number of consumers being unwell in the morning of the assessment contact and staff not available in the memory support unit to manage consumers exhibiting changed behaviours. Care documentation evidenced a significant incident occurred on 9 April 2024 in the memory support unit. Staff described the support they receive from the appointed team leader every shift; however, they indicated the importance of always having 2 staff members in the memory support unit as changed behaviours can easily escalate. The service has one roster to cover shifts across both co-located services and the care minutes provided is calculated across both. Management acknowledged they are not always able to fill staff shifts despite extensive efforts.

In relation to workforce responsibilities including 24/7 RN responsibilities, the service has 24/7 Registered Nurses on site and on duty. The service emphasised they utilise enrolled nurses and Certificate IV personal care workers as team leaders to provide additional support in the provision of consumers’ care and a wider clinical support team who are not rostered on the usual allocations to provide additional clinical oversight. The service has 2 nurse practitioners rostered across both services on weekdays and available on call 24/7 to provide clinical support to staff on site as required.

In relation to care minutes requirements, documentation review and management interview evidenced the service is currently not meeting its care minutes target including the RN minutes. However, the service has been working towards meeting its care minute targets and has improved performance from January 2024 to April 2024. The service provided a range of strategies they implemented towards meeting the mandatory care minutes to ensure ongoing safe and quality care and service is delivered to consumers. These include the use of 2 labour hire companies with long-term contract agreement for RNs, providing provisional accommodation, visa sponsorship arrangements, staff incentives such as wellbeing programs, above award wages, and upskilling of staff.

The Approved Provider’s response and their PCI demonstrated there is evidence of roster reviews, documentation, and ongoing plans to ensure workforce is planned and recruited to enable delivery of safe care, and the installation of a new call bell system commenced on 25 June 2024. In coming to my decision for this Requirement, I acknowledge the service’s comprehensive recruitment strategies in place, the ongoing workforce review implemented, the training programs and upskilling for staff, and the improvements implemented to increase consistency of the labour hire staff orientation and induction process. However, while some actions planned are implemented and evidenced, more time is required for the service to implement the changes, embed processes, and evaluate their continuous improvement actions. As a result, it is my decision, Requirement 7(3)(a) is Non-compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

The organisation administers a clinical governance framework that include policies and procedures to guide clinical care, antimicrobial stewardship, minimising the use of restraint and open disclosure. However, the Assessment Team Report contained information that the organisation’s clinical governance was not effective in relation to identifying consumers who are or may be subject to chemical restrictive practices. Documentation review evidenced deficiencies identified in the service’s transition and information management, policies and procedures for unplanned weight loss was not developed, the restrictive practices policies and post fall checklist do not provide appropriate guidance to staff to ensure implementation of effective strategies. Staff interviewed did not demonstrate understanding of the application of advanced care health directive when a consumer experiences deterioration, serious incident response scheme (SIRS) reporting, and minimising restrictive practices particularly the use of chemical restrictive practices as a last resort and the implementation and evaluation of individualised non-pharmacological measures. Incident records did not evidence effective implementation of SIRS processes including thorough investigation, actions, and reporting specifically for one sampled consumer who exhibited changed behaviour towards another consumer in April 2024.

In coming to my decision in relation to restrictive practices, I have considered information contained in the Assessment Team Report under this and Requirements 3(3)(b). I acknowledge the organisation’s improved systems and processes in relation to monitoring and management of restrictive practices. As evidenced in the Approved Provider’s response and their PCI submission, the service’s clinical manager/nurse practitioner has undertaken work with the Aged Care Quality and Safety Commission’s (ACQSC) expert panel in formulating the national clinical guidelines for aged care and has undertaken engagement with the ACQSC’s Behaviour Support and Restrictive Practices Unit to seek further guidance on the use of restrictive practices and information on behaviour support plans. The service implemented improvements in its system and processes, related to restrictive practices, including review of individual consumers subject to restrictive practices, the completion of consents, increased oversight of consumers by clinical management including consumers prescribed psychotropic medication and the review of care documentation to ensure staff are guided and restrictive practices are used as a last resort.

The Approved Provider acknowledged the deficiencies brought forward by the Assessment Team during the assessment contact specifically on the policies and procedures, documentation gaps and SIRS reporting due to the absence of the risk manager. There are clear strategies outlined in the Approved Provider’s response and their PCI submission including an overall review of the clinical governance framework, enhanced clinical reporting, a review of the clinical policies and procedures against consumers clinical risks, development and ongoing audit and oversight of the service’s clinical risk register, the provision of education to the workforce on other high impact high prevalence risks identified, and the appointment of a suitably authorised person in the absence of the risk manager to ensure mandatory reporting is monitored. I am satisfied that the deficiencies identified by the Assessment Team have been addressed and relevant strategies are planned and are currently being implemented. As a result, it is my decision, Requirement 8(3)(e) is Compliant.

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