Performance

Report

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| Name: | Crowley Retirement Village |
| Commission ID: | 2718 |
| Address: | 154 Cherry Street, BALLINA, New South Wales, 2478 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 4 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: 1075 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.
* 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 the appropriate 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 Registered Nurse 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 post fall management, clinical deterioration, pain management, changed behaviours management, and identification of restrictive practice. While consumers generally provided positive feedback with the delivery of care, review of documentation and interviews showed that some risks are not identified or responded to in a timely manner. The Assessment Team Report noted some inconsistency in the documentation and identification of consumers who are subject to chemical restrictive practice, behaviour support plans which do not provide staff guidance to manage consumers with changed behaviour, and monitoring of pain and deterioration following a fall incident. Staff were unable to demonstrate an appropriate understanding of effective strategies and assessments implemented following a fall, changed behaviour, and other incidents.

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. The Approved Provider highlighted clear strategies that satisfy me that the service is undertaking relevant remediation action in relation to this Requirement. The service is undertaking ongoing review of education and training utilising the service’s 3-tiered approach of essential, enhanced, and expert education. The service is undertaking robust audit and review of their clinical care including assessment and care planning documentation and policies and procedures against identified deficits. The service demonstrated timely consultation with the consumers sampled by the Assessment Team, and the Approved Provider supplied evidence of involvement of allied health professionals contributing to effective care outcomes for these consumers.

I acknowledge the actions taken to ensure compliance against the Aged Care Quality Standards, and at this time I provide greater weight to the Approved Provider’s response in relation to effective management of high impact or high prevalence risks. As such, my decision differs from the Assessment Team’s recommendation, and I find the service compliant in Requirement 3(3)(b).

# 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 mixed feedback mainly related to the service’s staffing levels. Interview with consumers and representatives evidenced how insufficiency of staffing impacts their care including extended wait times or delays when requesting assistance specifically in the morning and on weekends, care not being delivered, provision of cold meals, and labour hire staff not knowing their care needs. Staff interviewed described the impact of the issues in the call bell system and insufficient staff including rushing, consumers left waiting for extended periods, and delays in tasks completion such as medication administration and wound care. Management acknowledged the issues identified from the call bell system which can result in delays in attending care and extended wait times and the lack of induction processes for labour hire care staff. 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 consistently able to fill staff shifts despite extensive efforts including accessing labour hire agencies.

In relation to workforce responsibilities including 24/7 RN responsibilities, the service has 24/7 Registered Nurse 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 Registered Nurse 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 Registered Nurses, 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 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 being implemented, the organisation’s efforts in relation to 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 were 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 adverse events outlined as mandatory 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.

In coming to my decision in relation to restrictive practices, I have considered information contained in the Assessment Team Report. 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 who may be subject to chemical restrictive practices, 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 reported by the Assessment Team during the site visit specifically on the policies and procedures, documentation gaps, and staff knowledge on serious incident response scheme (SIRS) reporting. There are clear strategies outlined in the Approved Provider’s response and their PCI submission including an overall review of the organisation’s clinical governance framework, enhanced clinical reporting, a review of the clinical policies and procedures related to consumer 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)