**Performance**

**Report**

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| Name: | CatholicCare Canberra & Goulburn |
| Commission ID: | 200977 |
| Address: | Tenison Woods House, 57 MacArthur Avenue, O'CONNOR, Australian Capital Territoy, 2602 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 4 September 2023 to 5 September 2023 |
| Performance report date: | 14 December 2023 |

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.

# Service included in this assessment

Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 7621 Roman Catholic Church for the Archdiocese of Canberra and Goulburn as trustees for CatholicCare  
Service: 26680 Roman Catholic Church for the Archdiocese of Canberra and Goulburn as trustees for CatholicCare - Ca  
Service: 24802 Roman Catholic Church for the Archdiocese of Canberra and Goulburn as trustees for CatholicCare - Co

**This performance report**

This performance report for CatholicCare Canberra & Goulburn (**the service**) has been prepared by M Murray, 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 31 October 2023.
* information from the quality audit of January 2023.

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| Standard 1 Consumer dignity and choice | Not Applicable |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 4** Services and supports for daily living | **Not Applicable** |
| **Standard 5** Organisation’s service environment | **Not Applicable** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not Applicable** |
| **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.

**Standard 2,** (3)(a), (3)(b), (3)(e)

* Ensure assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.
* Ensure assessment and planning identifies and addresses the consumer’s current needs, goals and preferences.
* Ensure care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.
* Establish a system to prioritise the most at risk consumers in relation to the items above.
* Demonstrate adherence to the continuous improvement plan submitted to the Commission and the timeframes outlined in that plan.

# Standard 2

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| Ongoing assessment and planning with consumers | | HCP | CHSP |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Not applicable | Not compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Not applicable | Not compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Not applicable | Not applicable |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Not applicable | Not applicable |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Not applicable | Not compliant |

Findings

Requirement 2(3)(a)

The service was found non-compliant with this Requirement following a quality audit in January 2023.

At this assessment of performance, the Assessment Team reported that the service’s assessment and planning processes do not include consideration of risks to the consumer’s health and well-being.

The Assessment Team provided the following evidence in relation to the Requirement:

* The Assessment Team report the service has not made significant progress in addressing the non-compliant findings during the quality audit in January 2023 and could not demonstrate that consumer risks were current and informed the safe and effective delivery of care and services.
* There are approximately 700 active CHSP consumers and the service could not provide an estimate of the number of outdated risk profiles, or the number of risk profile reviews conducted since the January 2023 quality audit.
* The service provided four risk profiles that were completed for new consumers after the January 2023 quality audit. The Assessment Team noted that risks and mitigating strategies were identified and documented.
* Management acknowledged that risk profiles for most consumers are not current. A recruitment process is underway to have a part-time staff member assist with updating risk profiles.

The approved provider submitted a continuous improvement plan as part of their response. The continuous improvement plan outlines steps to address the deficits in this Requirement with a completion date of February 2024. It also notes they are prioritising their actions based on consumer risk.

The approved provider does not dispute the Assessment Team’s evidence.

Based on the information summarised above, I am satisfied the approved provider’s system, while effective for newly onboarded consumers, has not addressed risks for current consumers, and for this reason, the approved provider does not comply with this Requirement.

Requirement 2(3)(b)

The service was found non-compliant with this Requirement following a quality audit in January 2023.

At this assessment of performance, the Assessment Team reported that the service’s assessment and planning processes do not capture the consumer’s goals, needs and preferences.

The Assessment Team provided the following evidence in relation to the Requirement:

* The service has not made significant progress in addressing the non-compliant findings during the quality audit in January 2023 and could not demonstrate that consumers’ current needs, goals and preferences are consistently reflected in care plans.
* The service is forming a position on the extent that advance care planning will be discussed with CHSP consumers.
* The Assessment Team sampled six shift plans and found four of the six were out of date.

The approved provider has submitted a continuous improvement plan as part of their response. The continuous improvement plan outlines steps to address the deficits in this Requirement with a completion date of February 2024. The service also submitted a copy of its ‘Choices and Aged Care Services, Supporting National Palliative Care Standards and Advance Care Planning Guidelines and Interview Form’ which outlines the need to ask consumers if they need advice, advocacy or referral regarding a range of advance care issues.

The approved provider does not dispute the Assessment Team’s evidence.

Based on the information summarised above, I am satisfied that consumers will be provided information about advance care planning, however, the approved provider has not yet addressed the backlog of updating consumer care plans to reflect the tailored needs of consumers and for this reason, the approved provider does not comply with this Requirement.

Requirement 2(3)(e)

The service was found non-compliant with this Requirement following a quality audit in January 2023.

At this assessment of performance, the Assessment Team reported that the service does not have an effective process for ensuring that reassessment of each consumer’s needs goals and preferences occurs as scheduled.

The Assessment Team provided the following evidence in relation to the Requirement:

* Management described that they were utilising the client management system to monitor and track shift plan reviews moving forward. The service is currently putting review dates in the system. Once the review date occurs, an alert will be sent to the relevant team to undertake the review. This process is approximately 50% completed.

The approved provider submitted a continuous improvement plan as part of their response. The continuous improvement plan outlines steps to address the deficits in this Requirement with a completion date of February 2024. The service also submitted a copy of the review form it is using, which, once in use will support effective reassessments to occur.

The approved provider does not dispute the Assessment Team’s evidence.

Based on the information summarised above, I am satisfied that the approved provider’s system for scheduling reviews is not yet completed and for this reason, the approved provider does not comply with this Requirement.

# Standard 3

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| Personal care and clinical care | | HCP | CHSP |
| 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 applicable | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not applicable | 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. | Not applicable | Not applicable |
| 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 applicable | Not applicable |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Not applicable | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Not applicable | Not applicable |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Not applicable | Not applicable |

Findings

Requirement 3(3)(a)

The service was found non-compliant with this Requirement following a quality audit in January 2023.

At this assessment of performance, the Assessment Team reported the service is not delivering safe and effective personal care.

The Assessment Team provided the following evidence in relation to the Requirement:

* Clinical care is not being provided to CHSP consumers, personal care is being delivered.
* All consumers and representatives interviewed are satisfied with the quality of care provided and said staff are competent and know what they are doing.
* A consumer described their care needs to the Assessment Team. The consumer’s care plan and shift notes reflected the consumer’s description of their personal and mobility support needs.
* Communication between the sub-contracted organisation and the service was evident during documentation review. The service is regularly kept up to date on the consumer’s progress and any incidents and follow up actions are reported immediately to the service.
* The service is implementing client risk profiles as part of onboarding new consumers and during re-assessments. The client profiles identify risks such as mobility, behaviours, chronic medical conditions, vulnerabilities, manual handling and hazards. While the Assessment Team noted some profiles had been completed, most profiles reviewed were incomplete or out of date.
* As formal risk assessments are not currently being completed sufficiently and most care plans are not current, it is not evident that the service is using best practice to ensure consumers get safe and effective personal care.

I have considered the Assessment Team’s evidence on assessment of risk in my compliance finding in Requirement 2(3)(a) and do not intend to consider it again in this Requirement.

I have considered the Assessment Team’s evidence in Requirement 3(3)(b) which I find relevant here. Evidence includes staff descriptions of good practice care for consumers at risk of falls and consumers living with dementia.

I have also considered the Assessment Team’s evidence in Requirement 8(3)(c) which I find relevant here. Evidence includes staff clearly articulated and described each consumer’s needs and preferences.

The Assessment Team’s evidence does not demonstrate a systemic failure in the effectiveness or the safety of the personal care being provided by the service to consumers.

I am satisfied, based on the evidence summarised above, that the service complies with this Requirement as staff gave examples of good practice and tailored care and consumers are satisfied with the quality of the care provided.

Requirement 3(3)(b)

The service was found non-compliant with this Requirement following a quality audit in January 2023.

At this assessment of performance, the Assessment Team reported the service is not effectively managing high impact or high prevalence risks associated with the care of each consumer.

The Assessment Team provided the following evidence in relation to the Requirement:

* Management said falls have been identified as a high prevalent risk associated for CHSP consumers.
* Support workers interviewed described in various ways how they minimise the risk of falls to consumers when they carry out care and services. Some examples included, ensuring bathroom floors are dried following a shower, encouraging the consumer to use their mobility aid, removing trip hazards and not rushing a consumer when mobilising. Support workers also described strategies they use to support consumers living with dementia, such as using sort sentences and gentle encouragement when providing care.
* Incidents are reported to management through a form accessed via a ‘QR code’. Management demonstrated how incidents are actioned and trended.
* Staff could demonstrate strategies they use to mitigate risks; the service has an appropriate incident management system; and the Assessment Team did not identify any immediate risk to consumers.
* However, as the service is not currently demonstrating current and consistent risk assessments are being undertaken, the Assessment Team is not satisfied the service is effectively managing high impact or high prevalence risks associated with the care of each consumer.

I have considered the Assessment Team’s evidence on risk assessments in my compliance finding in Requirement 2(3)(a) and do not intend to consider it again in this Requirement.

I have considered the Assessment Team’s evidence in Requirement 3(3)(e) which I find relevant here. Evidence includes the service is in regular contact with sub-contracted providers and when an incident occurred, an incident report was documented and several subsequent emails regarding the consumer’s condition and follow up actions were sent / received. Further, support workers interviewed said they receive sufficient information through the shift plan to carry out care and services safely and effectively.

The Assessment Team’s evidence does not demonstrate a systemic failure in the effective management of high-impact or high-prevalence risks.

I am satisfied, based on the evidence summarised above, that the service complies with this Requirement as staff gave examples of risk management as it applies in the care setting and incidents, when they occur, are effectively managed.

Requirement 3(3)(e)

The service was found non-compliant with this Requirement following a quality audit in January 2023.

At this assessment of performance, the Assessment Team reported that the service is managing and communicating information appropriately.

The Assessment Team provided the following evidence in relation to the Requirement:

* All consumers and representatives interviewed said staff know their care needs and preferences and they did not need to repeat information.
* Management and staff interviewed were able to demonstrate that information about the consumer’s condition is documented and communicated within the organisation and with others where care is shared.
* Management said shift plans (care plans) were historically emailed to support workers, however since the January 2023 quality audit shift plans are now available at the point of care through a mobile application.
* Support workers interviewed said they receive sufficient information through the shift plan to carry out care and services safely and effectively. They said they write shift notes following every service.
* Shift notes were introduced in March 2023 and several training sessions have been conducted providing staff guidance on objective and comprehensive writing. The Assessment Team sighted the shift notes for multiple consumers which were detailed and easy to understand. The notes are available to other support workers, the consumer’s case coordinator and management for oversight.
* Communications between sub-contracted services and the provider were sighted by the Assessment Team. It is evident the service is in regular contact with the sub-contracted provider and updates on consumers are provided. Documentation regarding a recent incident of a consumer included an incident report at the time of the event and several subsequent emails regarding the consumers condition and follow up actions.

I am satisfied, based on the evidence summarised above, that the service complies with this Requirement as information is effectively shared.

# Standard 6

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| Feedback and complaints | | HCP | CHSP |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Not applicable | Not applicable |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Not applicable | Not applicable |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Not applicable | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not applicable | Not applicable |

Findings

Requirement 6(3)(c)

The service was found non-compliant with this Requirement following a quality audit in January 2023.

At this assessment of performance, the Assessment Team reported that the service’s is now taking appropriate action in response to complaints.

The Assessment Team provided the following evidence in relation to the Requirement:

* All consumers and representatives said when they have made a complaint to the service, they were happy with the actions taken and the outcome and gave examples of different type of complaints being managed by the service.
* All support workers demonstrated an awareness of open disclosure and advised they would always apologise to consumers if something went wrong and report the issue to management. Management said they ensure any issues are addressed promptly and they make sure consumers are kept informed of any actions being undertaken and the outcome.
* The service demonstrated how it uses a management response form to progress complaints. The forms sighted included actions undertaken by the responsible staff member - including an apology, the consumer’s response or level of satisfaction and the outcome of the issue.

I am satisfied, based on the evidence summarised above, that the service complies with this Requirement as actions are taken following complaints and the service applies an open disclosure approach.

# Standard 8

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| Organisational governance | | HCP | CHSP |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Not applicable | Not applicable |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Not applicable | Not applicable |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Not applicable | Compliant |
| 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 applicable | Compliant |
| 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. | Not applicable | Not applicable |

Findings

Requirement 8(3)(c)

The service was found non-compliant with this Requirement following a quality audit in January 2023. Failures were identified in sub-requirement (i) and (vi).

At this assessment of performance, the Assessment Team reported that the service has effective organisation wide governance systems.

The Assessment Team provided the following evidence in relation to the Requirement:

Information Management (i)

* The service has introduced a mobile application that ensure information in available to staff and accessible at the point of care.
* The service has a privacy and confidentiality policy.
* Staff contracts include a requirement to maintain the privacy and confidentiality of information.
* Consumer consent is obtained prior to sharing information.
* The service has addressed the issues which led to non-compliant findings during the quality audit in January 2023.

Feedback and Complaints (vi)

* The governing body receives a summary of serious complaints and identified risks. The service uses a traffic light system to rate the risks of complaints. Themes and trends are discussed annually at an agency-wide level.
* Meeting minutes demonstrated that high-level feedback, complaints and grievances are a standing agenda item for the governing body.
* The service has addressed the issues which led to non-compliant findings during the quality audit in January 2023.

The Assessment Team’s report evidences effective governance systems are also in place for continuous improvement; financial governance; workforce governance and regulatory compliance.

I am satisfied, based on the evidence summarised above, that the service complies with this Requirement.

Requirement 8(3)(d)

The service was found non-compliant with this Requirement following a quality audit in January 2023.

At this assessment of performance, the Assessment Team reported that the service’s now has effective risk management systems and practices.

The Assessment Team provided the following evidence in relation to the Requirement:

* Staff are alert to monitoring for consumer abuse and/or neglect and know how to report any incident that occurs.
* Consumers articulated that the services they received support them to live their best life, as staying in their own homes and living independently is important to them.
* An incident register is maintained.
* Management are immediately notified of incidents and incidents are actioned appropriately.
* The service has a risk management reference group and an audit and risk committee. The committee reports on incidents to the governing body and discussions about risks occur. The outcomes of discussions on risk are recorded in meeting minutes.
* The service has addressed the issues which led to non-compliant findings during the quality audit in January 2023.

I am satisfied, based on the evidence summarised above, that the service complies with this Requirement.

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)