Performance

Report

**1800 951 822**

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| Name: | Christophorus House Hostel |
| Commission ID: | 0200 |
| Address: | 396 Peats Ferry Road, HORNSBY, New South Wales, 2077 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 16 January 2024 |
| Performance report date: | 13 February 2024 |
| Service included in this assessment: | Provider: 431 Christophorus House Retirement Village  Service: 216 Christophorus House Hostel |

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 Christophorus House Hostel (**the service**) has been prepared by Therese Solomon, 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 12 February 2024.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not Applicable |
| **Standard 3** Personal care and clinical care | **Not Applicable** |
| **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 8(3)(d)

* Ensure effective risk management systems and practices are in place, specifically related to the management of high-impact/high-prevalence risks, abuse of consumers, managing and preventing incidents.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| 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. | Compliant |

Findings

Requirement 2(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated that risk assessment and planning took each consumer’s individual needs and preferences into consideration to inform the delivery of safe and effective care for each consumer. Management stated consumer care planning and risks were taken into consideration on a yearly basis and when needed. Staff were able to demonstrate their knowledge of specific consumer risks, and clinical documentation for each consumer was reflective of regular assessment when needed.

# Standard 3

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| Personal care and clinical care | |  |
| 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. | Compliant |

Findings

The service management team described actions they have undertaken to increase support and oversee clinical care provided. A new management structure has occurred as of November 2023 and plans are currently underway to improve education for all staff regarding behaviour management, wound management, documentation processes including incident reporting and risk mitigation.

Feedback from consumers and/or representatives is positive. Clinical staff described their process for identification of deterioration such as head-to-toe assessments, vital signs observations and neurovascular observations and referrals to the consumer’s doctor and were able to provide consumer-specific examples when asked. Care staff were able to describe their escalation processes when they recognise a change in consumer function, capacity, or condition.

The Assessment Team identified areas for improvement related to the monitoring and documentation of consumer conditions and prevention of incidents reoccurring.

The Approved Provider responded with additional documentation addressing the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(d) is found 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 organisation was unable to demonstrate effective risk management systems and practices in place for the service.

The Assessment Team acknowledges that since the employment of a clinical care manager significant improvements have been made to processes for managing high-impact risk to the care of consumers, however several actions have yet to be implemented and improvements made have yet to be evaluated for effectiveness. The organisation has not ensured that deficiencies in relation to risk at the service have been addressed or demonstrate effective corporate oversight of monitoring and management of risk at the service. This Assessment Team identified the correct process for mandatory reporting was not consistently followed.

The clinical care manager confirmed that the organisation does not have a risk register to identify high-impact, high- prevalence risk to consumers, and advised this is still in progress and is planned to be implemented in 2024.

The Approved Provider responded with additional documentation to address the identified non-compliance.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 8(3)(d) is found Non-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)