Performance

Report

**1800 951 822**

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| Name: | Mater Christi Aged Care Facility |
| Commission ID: | 0487 |
| Address: | 3 Marian Place, TOORMINA, New South Wales, 2452 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 9 April 2024 |
| Performance report date: | 13 May 2024 |
| Service included in this assessment: | Provider: 1283 The Trustees of the Roman Catholic Church for the Diocese of Lismore Sawtell Catholic Care of the Ag  Service: 503 Mater Christi Aged Care Facility |

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 Mater Christi Aged Care Facility (**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 26 April 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | 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 each consumer gets safe and effective personal care and/or clinical care that is best practice, tailored to their needs and optimises their health and well-being specifically related to medication management, behaviour support management and person-centred care.

# 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 |

Findings

The service did not demonstrate each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care that is best practice, tailored to consumer needs and optimises consumer health and well-being.

The service did not consistently demonstrate best practice related to medication management, and at times did not demonstrate safe medication management that is tailored to consumer need. Documentation indicated that consumers prescribed time sensitive medications are not consistently receiving their medication on time or at all. Staff did not demonstrate an understanding of the importance of consumers receiving time sensitive medication in a timely manner. Management was not aware of the deficits in medication management for time sensitive medication and did not demonstrate clinical oversight to ensure best practice.

The service did not demonstrate effective oversight or review of medication incidents. A consumer was administered a double dose of his medication, even though the charting error was discovered by the service and reported to the consumer representative prior to the administration error occurring. The service did not complete an incident form for the prescribing error, and the incident form completed for the dosing error did not indicate an analysis of why the incident occurred.

Inconsistencies were identified in behaviour support plans, particularly in relation to identifying consumer behaviours or individualised strategies to support consumers with changed behaviours. While most consumers and/or representatives indicated they were satisfied with the care and services consumers receive at the service, representatives of consumers residing in one of the memory support units indicated concern in relation to person centred dementia care.

* Over a one-month period, one consumer did not receive his time sensitive Parkinson’s medication in a timely manner on twenty-nine occasions.
* Over a one-month period, one consumer did not receive her time sensitive Parkinson’s medication in a timely manner on ten occasions.
* Over a one-month period, one consumer did not receive his time sensitive Parkinson’s medication in a timely manner on fourteen occasions.
* A consumer representative stated they had previously reported concerns with the timeliness of time sensitive medication to the management team. The consumer now wears a watch with an alert set to prompt the consumer to ring his call bell if he hasn’t received his medication when the alarm goes off, indicating actions implemented to address the concerns raised have not been effective consistently.
* The service’s quality systems did not identify the deficits in relation to consumer’s receiving their time sensitive medication in a timely manner.
* One consumer was administered a double dose of his prescribed medication.
* One consumer’s changing behaviour were identified by his medical officer, however this was not reflected in his behaviour support plan, nor were the suggested interventions to manage his changing behaviours.
* One consumer’s changing behaviour were not captured in her behaviour support plan, therefore did not contain any strategies to support the consumer while she is displaying changing behaviours.

Whilst the service demonstrated effective management of clinical care related to wound care, diabetes, falls, continence care, the service did not consistently demonstrate effective management of time sensitive medication, medication incidents and consistent person-centred dementia care including individualised behaviour support plans.

In coming to my decision for this requirement, I acknowledge the service has implemented some improvements including but not limited to completing a medication review, education and training provided to staff in relation to time sensitive medication, medication education, review of behaviour support plans; and have taken immediate action in response to areas of the Assessment Contact report including following up with consumers named in the report.

This requirement requires that each consumer receives safe and effective care and services, that is best practice, tailored to their needs and optimises their health and well-being. The service has not demonstrated that all consumers receive safe and effective care and services, that is best practice, tailored to their needs and optimises their health and well-being, and the response submission acknowledged these examples. Therefore, it is my decision requirement 3(3)(a) is 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)