Performance

Report

**1800 951 822**

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| Name of service: | Mater Christi Aged Care Facility |
| Service address: | 3 Marian Place TOORMINA NSW 2452 |
| Commission ID: | 0487 |
| Approved provider: | The Trustees of the Roman Catholic Church for the Diocese of Lismore Sawtell Catholic Care of the Ag |
| Activity type: | Assessment Contact - Site |
| Activity date: | 30 August 2023 to 31 August 2023 |
| Performance report date: | 12 October 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.

**This performance report**

This performance report for Mater Christi Aged Care Facility (**the service**) has been prepared by T 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 - Site; the Assessment Contact - 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 29 September 2023.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **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 3(3)(a)

* Ensure each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care that is best practice, tailored to their individual needs and optimises their health and well-being.
* Ensure staff have a comprehensive understanding of best practice related to diabetes management, pain management, wound management and restrictive practices and ensure consumer documentation reflects this practice.

# 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 |
| 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. | Compliant |
| 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. | Compliant |

Findings

During the Assessment Contact, The Assessment Team identified inconsistencies in relation to assessment and planning. Care planning documentation did not always clearly demonstrate the consideration of risks which could potentially impact on consumer wellbeing and the delivery of safe and effective care and services.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions completed to address the inconsistencies.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 2(3)(a) is found Compliant.

During the Assessment Contact, The Assessment Team identified inconsistencies in relation to assessment and planning. Care planning documentation did not always reflect current consumer needs and preferences which could potentially impact on consumer wellbeing and the delivery of safe and effective care and services.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions completed to address the inconsistencies.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 2(3)(b) is found Compliant.

During the Assessment Contact, The Assessment Team identified areas for improvement in relation to the regular review of care and services for consumers. The service was overdue with their completion of case conferences for consumers.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions completed to address the inconsistencies.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 2(3)(e) is found Compliant.

# 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. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

During the Assessment Contact, The Assessment Team identified care and service delivery for each consumer is not always best practice, tailored to their needs and optimising consumer health and well-being, specifically related to diabetes management, pain management, wound management, falls management and restrictive practices.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions completed to address the inconsistencies.

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

During the Assessment Contact, The Assessment Team identified inconsistencies in the effective management of high impact or high prevalence risks, potentially impacting on consumer wellbeing and the delivery of safe and effective care and services.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions completed to address the inconsistencies.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 3(3)(b) is found Compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |

Findings

The Assessment Team received mixed feedback from consumers and/or representatives regarding lifestyle activities and services, and documentation reviewed by the Assessment Team did not consistently reflect effective services and supports for daily living.

The Approved Provider responded with additional documentation and a comprehensive plan for continuous improvement containing actions completed to address the inconsistencies.

Based on the information provided by the Assessment Team and the Approved Provider, Requirement 4(3)(a) 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. | Compliant |

Findings

Requirement 8(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The board identifies risks through reporting of clinical data, briefings from the management team and the clinical subcommittee. The board is informed monthly by the clinical governance committee who provide feedback and suggestions to the board in relation to clinical governance. The board monitors clinical progress through the continuous improvement plan and quality advisory body. The quality advisory body consists of clinical board members, the management team and consumers and representatives who provide reporting to the board. The board investigates incidents and concerns relating to high-impact or high-prevalence risks and has approved strategies in the continuous improvement plan.

The board and management team have implemented a review of clinical documentation, additional competency assessments and conversations with individual staff members to ensure documentation is being accurately and consistently recorded. Electronic daily care forms have been changed to include prompts and alerts for staff to document and report consumer information and guidance material for staff to document actions.

The board implemented an increase in staff education and training for the Serious Incident Response Scheme and weekly meetings to review incidents with the clinical risk team. A Serious Incident Response Scheme process and checklist was developed to guide staff, and staff are empowered to report incidents and suspected incidents. Staff were able to articulate the process and registered nurses demonstrated a good understanding of Serious Incident Response Scheme policies and processes. Documentation confirmed Serious Incident Response Scheme incidents are recorded with details of actions, prevention strategies and the status of outcomes.

The board has policies and processes in place to manage incidents. The clinical governance committee and clinical team analyse how and why incidents occur and review prevention strategies and provide recommendations to the board. Documentation confirmed staff have completed training and education in incident management and staff were able to articulate how they manage the prevention of incidents such as observing changes in consumer behaviour and following strategies in care plans.

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)