**Performance**

**Report**

**1800 951 822**

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| Name: | 3Bridges Community Incorporated |
| Commission ID: | 200859 |
| Address: | 1/72 Carwar Avenue, CARSS PARK, New South Wales, 2221 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 25 September 2024 |
| Performance report date: | 1 November 2024 |

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.

# Services included in this assessment

Home Care Packages (**HCP**) included:  
Provider: 5158 3Bridges Community Limited  
Service: 19376 3Bridges Community Incorporated

Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 7576 3Bridges Community Limited  
Service: 23989 3Bridges Community Limited - Care Relationships and Carer Support  
Service: 23990 3Bridges Community Limited - Community and Home Support

**This performance report**

This performance report has been prepared by G Cherry, 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 services it operates, 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 service outlets, review of documents and interviews with staff, consumers/representatives, and others
* the provider’s response to the assessment team’s report received 16 October 2024
* Performance Report dated 1 December 2023

# Assessment summary for Home Care Packages (HCP)

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| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| Standard 2 Ongoing assessment and planning with consumers | 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 2(3)(b) – implement and effective system (including monitoring for compliance) to ensure assessment and planning identifies and addresses the consumer’s current needs/goal/preferences, including advance care planning and end of life planning if the consumer wishes.

# Other relevant matters:

3Bridges Community Incorporated is a not-for-profit organisation providing a range of programs in the Sydney metropolitan area. They provide aged care services through the Home Care Package (HCP) Program across levels 1- 4 for 804 consumers and the Commonwealth Home Support Programme (CHSP) for 756 consumers.

Services available via HCP funding include personal and clinical care (direct care staff and registered nurses are employed), allied health (occupational therapy, physiotherapy, and exercise physiology staff are employed), domestic assistance, social support, transport, home maintenance, and other services. CHSP programs include domestic assistance, home maintenance, home modifications, social support individual, social support group, flexible respite, and centre-based respite. Services are provided by either employees or brokered staff dependent on consumer needs and preferences.

# 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. | Compliant | Not applicable |
| 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 Compliant | Not Compliant |

Findings

Requirement 2(3)(a) – a decision of non-compliance made on 1 December 2023 followed an Quality Audit from 11 September 2023 to 14 September 2023, due to lack of undertaking Falls Risk Assessment Tools (FRAT) for consumers (receiving HCP services) identified at risk of falling. At an assessment contact on 25 September 2024 the assessment team bought forward evidence actions taken in response to previous non-compliant are not completely implemented or effective.

Management demonstrated incorporation of a risk matrix document into the Home Safety Risk Assessment Form completed for consumers receiving HCP and organisational policy guidance includes consideration of risk during initial and ongoing assessment. Case managers demonstrate knowledge of this process and monitoring for compliance. Staff attend risk screening and ensure referral to nursing or allied health professionals when clinical risk is identified. Risks are identified via observation and communication with consumers/representatives. Review of one consumer’s documents detail completed assessment of risk. Case managers advised referrals to allied health specialists occur when concerns are identified in relation to a consumer’s living environment. Documents detail referrals routinely occur and consumers express satisfaction.

Via review of 5 consumer’s documents the assessment team note referral to allied health professionals occur when a need is identified. They note occupational therapist (OT) assessment and recommendations for one consumer experiencing falls using the provider’s self-developed comprehensive assessment form which considers mobility, environment, and transfers. Another consumer’s file details a current support plain noting OT assessment/recommendations of equipment to maintain independence and directive staff regarding care delivery. Referral to an exercise physiologist and documented assessment relating to general risk/exercise tolerance and program implementation for another, and a comprehensive OT assessment including a section relating to falls for another. One consumer’s documents detail support required in relation to prompts for medications, however assessment/planning processes do not demonstrate assessment of risk associated with cognitive impairment regarding medication management. Management notes a weekly registered nurse visit however cognitive assessment/medication management plan not completed.

The provider’s response includes commitment to systematically transition all assessments to validated, evidence-based tools by January 2025 (including Falls Risk Assessment Tool (FRAT), developed by Peninsula Health Falls Prevention Service). While use of validated tools is optimal, in consideration of compliance, I am swayed by demonstration that consumers receive assessment when risks are identified. Lack of using validated assessment tools is not supported by negative consumer outcome, and I accept the provider’s documented commitment to implement validated tools. I find requirement 2(3)(a) is compliant.

Requirement 2(3)(b) – a decision of non-compliance made on 1 December 2023 followed a Quality Audit from 11 September 2023 to 14 September 2023, due to lack of system to ensure consumer care plans contain sufficient details of consumers’ current needs/preferences, nor a process to discuss advance care planning with consumers. At an assessment contact on 25 September 2024 the assessment team bought forward evidence actions taken in response to previous non-compliant are not completely implemented or effective.

The service’s assessment and planning process identifies most aspects relating to consumers’ needs, goals, and preferences. Some consumers/representatives’ express satisfaction relating to receipt of appropriate care/services aligned with current needs and documents detail care plan directives reflective of individualised goals/preferences to guide staff. Sampled consumers/representatives advised involvement in development of care preferences however, not discussions regarding advance care planning. Documents for one consumer receiving CHSP services contains conflicting information relating to dietary and mobility requirements.

Current assessment/care planning processes do not include gathering of data/information relating to advance care or end-of-life planning for consumers. While staff received specific training related to initiating discussions and development of advance care planning, Management advised progress to incorporate this element into admission/entry and reassessment processes does not occur. Case managers advised a process does not exist to alert staff when a consumer is palliating. Staff gave examples of some consumers providing information relating to advance care planning however consumers and/or family members initiated this, not as part of the service’s data gathering/assessment process.

In their response, the provider advised plans to incorporate advanced care planning discussions into initial assessment, ongoing reviews and/or when changes in consumer’s needs occur. They developed an Advance Care Planning Guide to support staff as per organisational expectations. In consideration of compliance, while acknowledging the service demonstrates some aspects/elements of this requirement, they do no demonstrate assessment/planning includes advance care and end of life planning if the consumer wishes. I find requirement 2(3)(b) 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)