**Performance**

**Report**

**1800 951 822**

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| Name of service: | Chizim Care Services Incorporated |
| Service address: | Unit 3/1 Sarasota Pass CLARKSON WA 6030 |
| Commission ID: | 500300 |
| Home Service Provider: | Chizim Care Services Incorporated |
| Activity type: | Assessment Contact - Desk |
| Activity date: | 27 June 2023 |
| Performance report date: | 1 August 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 Chizim Care Services Incorporated (**the service**) has been prepared by F.Nguyen, 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.

# Services included in this assessment

**Home Care:**

* Chizim Care Services Incorporated, 26234, Unit 3/1 Sarasota Pass, CLARKSON WA 6030

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Assessment Contact - Desk; the Assessment Contact - Desk report was informed by review of documents and interviews with staff, consumers/representatives and others.

# Assessment summary for Home Care Packages (HCP)

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| Standard 1 Consumer dignity and choice | Not Applicable |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Applicable** |
| **Standard 3** Personal care and clinical care | **Not Applicable** |
| **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** |
| **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

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Standard 8

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| --- | --- | --- |
| Organisational governance | | HCP |
| 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 |
| 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. | Compliant |
| 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 |
| 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 |
| 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. | Compliant |

Findings

Requirement 8(3)(b)

Evidence analysed by the Assessment Team showed the service demonstrated that the governing body promotes a culture of safe, inclusive and quality care and is accountable for its delivery. The Assessment Team identified improvements have been made to the Board’s processes since the last assessment.

Management advised of various actions undertaken to address the previously identified non-compliance at the Assessment Contact – Desk conducted 3 January 2023, including:

* the service is reviewing the composition of its Board with the view of expanding the expertise held by Board members. For example:
  + The Assessment Team sighted meeting minutes from the 2 recent Board meetings which showed decisions made and expectations for training staff on the issues discussed, for example, new policies implemented. The Assessment Team sighted training records showing staff were given education/training on the new policies implemented and staff confirmed they completed this training and were able to explain what the policies meant in practice.
  + The Assessment Team sighted reports and agenda documents presented to the regular Board meetings, addressing appropriate governance topics, including clinical data, regulatory requirements, registers, feedback and complaints, and financial documentation.
* The service has relevant processes and procedures in place to understand, identify and manage risks. The service has updated its electronic care system to the premium level, to have access to more functionality and reporting options. Management said the service will continue to improve how it collates and analyses data to identify trends. Management and staff confirmed falls is a high risk for their consumers and they have processes in place to identify and address risks.

In response to the non-compliance identified during the Assessment Contact – Desk conducted 3 January 2023, management stated, documentation reviewed and staff interviews confirmed:

* The Terms of Reference for the Board states meetings will be held quarterly. Documentation sighted by the Assessment Team confirmed the Board is now meeting this schedule, with meetings held in January 2023 and April 2023. The next Board meeting is scheduled for July 2023.
* Minutes for the Board meetings are being created. The detail in the minutes rely on readers also reviewing the documents presented to the Board as part of the agenda. Management agreed that more detail in the minutes may assist the service in the future and they will consider how to improve the minutes for future meetings.
* The service demonstrated it is continuing to develop the Board membership, with a Board Performance Evaluation Survey being undertaken for consideration at the next Board meeting.

Requirement 8(3)(e)

Evidence analysed by the Assessment Team showed the service demonstrated that it has a clinical governance framework in place, including antimicrobial stewardship, minimising restrictive practices and open disclosure.

* The Assessment Team sighted policies about antimicrobial stewardship and minimising restrictive practices, which also referred to other clinical governance framework documents.
* Staff could describe what restraint and restrictive practices look like in a community setting and confirmed they received training on a new policy in February 2023.
* Staff could describe the importance of antimicrobial stewardship and how it relates to infection control and the need to avoid overuse of antibiotics. The service has infection control processes in place and staff could explain what it means in a community setting.
* Open disclosure was evidenced in the feedback and complaints register.

In response to the non-compliance identified during the Assessment Contact – Desk conducted 3 January 2023, management stated and documentation reviewed and staff interviews confirmed:

* Management stated, documentation sighted, and staff confirmed that specific policies on antimicrobial stewardship and minimising restrictive practices were implemented in January 2023 and staff were trained on their role and expectations.
* Staff could describe the importance of antimicrobial stewardship and how it relates to infection control and the need to avoid overuse of antibiotics.
* The restrictive practices policy/procedure helps guide staff in the use of the assessment form.
* The service has improved the clinical information presented to the Board. As there are only 20 consumers, the service has not fully developed data analysis and statistics as a higher-level report for the Board. The Board Handover Report document contains details about each consumer and issues/risks to be discussed. The document also contains a summary about incidents or issues identified. The Director stated there has not been anything of note to summarise for the Board but, acknowledged as the service grows, further development of the summary data and trend data for Board consideration will occur.

1. The preparation of the performance report is in accordance with section 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)