**Performance**

**Report**

**1800 951 822**

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| Name of service: | Co.As.It Community Care |
| Service address: | 189 Faraday Street CARLTON VIC 3053 |
| Commission ID: | 300102 |
| Home Service Provider: | CO.AS.IT. - Italian Assistance Association |
| Activity type: | Assessment Contact - Desk |
| Activity date: | 25 October 2022 |
| Performance report date: | 22 November 2022 |

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 Co.As.It Community Care (**the service**) has been prepared by A.Grant, 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:**

* Co.As.It Community Care Packages-Barwon South Western, 18744, 189 Faraday Street, CARLTON VIC 3053
* Co.As.It. Eastern Metro Community Care Packages, 18746, 189 Faraday Street, CARLTON VIC 3053
* CO.AS.IT. Italian Assistance Association - EACH - Northern Region, 18747, 189 Faraday Street, CARLTON VIC 3053
* CO.AS.IT. Italian Assistance Association - EACH - Western Metro, 18748, 189 Faraday Street, CARLTON VIC 3053
* Co.As.It. Northern Metro Region Care Packages Project, 18749, 189 Faraday Street, CARLTON VIC 3053
* Co.As.It. Southern Metro Region Care Packages Project, 18750, 189 Faraday Street, CARLTON VIC 3053
* Co.As.It. Western Metro Region Care Packages Project, 18751, 189 Faraday Street, CARLTON VIC 3053

**CHSP:**

* Social Support Individual, 4-B8U486R, 189 Faraday Street, CARLTON VIC 3053
* Centre-based Respite - Care Relationships and Carer Support, 4-B8JK9OK, 189 Faraday Street, CARLTON VIC 3053
* Flexible Respite - Care Relationships and Carer Support, 4-B8HE548, 189 Faraday Street, CARLTON VIC 3053
* Specialised Support Services, 4-B8U48DH, 189 Faraday Street, CARLTON VIC 3053
* Social Support Group, 4-B8U4837, 230 Rosanna Road, ROSANNA VIC 3084

# 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.
* The provider’s response to the assessment team’s report received 18 November 2022.

# 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 as not all requirements have been assessed** |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **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** |

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| Standard 1 Consumer dignity and choice | Not Applicable |
| **Standard 2** Ongoing assessment and planning with consumers | **Not applicable as not all requirements have been assessed** |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **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** |

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 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** | **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. | **Not applicable** | **Not applicable** |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | **Not applicable** | **Not applicable** |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | **Not applicable** | **Not applicable** |
| 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** | **Compliant** |

Findings

Interviews with management and documentation requested by the Assessment Team during the assessment contact showed the organisation has a client assessment tool that covers a broad range of health and wellbeing topics that are discussed with consumers of low-level home care packages. Evidence analysed by the Assessment Team showed consumers in receipt of a high-level home care package receive a clinical assessment conducted by a clinical care coordinator with the support of the care manager. Evidence analysed by the Assessment Team showed care managers and the clinical care coordinator conduct assessments in the consumers home utilising information from My Aged Care. Evidence analysed by the Assessment Team showed a detailed assessment and further ongoing assessments are completed as required including home safety assessments and referrals occur for nursing and allied health assessments. The Assessment Team noted consumer risks identified during the assessment process are now included in the consumers personalised help plan.

Management when interviewed by the Assessment Team stated all consumers are risk assessed and the service has developed a vulnerability and risk register with a traffic light system to identify the risk. During interviews with the Assessment Team management stated consumers identified as a red risk are moved from a care manager to the clinical team for monitoring, once/if the consumers drop from the red risk, they will return to their original care manager. A sample of evidence to substantiate the Assessment Team’s findings is documented below.

Consumer A (HCP L4) file review completed by the Assessment Team identified Consumer A had an initial assessment on 25 January 2022. A nursing referral was issued on 30 May 2022 and a clinical assessment was conducted on the 17 June 2022 which included a mini nutritional, falls risk for older people and a basic foot assessment.

Evidence analysed by the Assessment Team showed Consumer A’s initial assessment, clinical assessment and personalised help plan identified Consumer A had a diagnosis of Alzheimer’s disease and that Consumer A has been referred to a geriatrician. The Assessment Team noted there were several geriatrician reports on Consumer A’s file with the most recent dated 16 May 2022.

Evidence analysed by the Assessment Team showed an occupational therapist assessment conducted on 2 March 2022 identified Consumer A was at risk of falls. The Assessment Team noted recommendations included a safety alarm pendant, supply and install rails in the bathroom, front and rear access and kitchen. The Assessment Team analysed evidence and noted photographs of the installed rails were sighted on Consumer A’s file.

Evidence analysed by the Assessment Team showed risks identified for Consumer A are documented in Consumer A’s personalised help plan with strategies documented to mitigate any risk. The Assessment Team noted the information is shared with support workers via a mobile ‘app’.

During interviews with the Assessment Team a representative for Consumer A stated they have access to Consumer A’s help plan and have been provided with access to a mobile ‘app’ to review Consumer A’s help plan and service schedule.

Evidence analysed by the Assessment Team showed Consumer A’s risk is identified in the vulnerability and risk register as amber and an action plan is in place to address the risk.

Interviews with management and documentation requested by the Assessment Team during the assessment contact identified care and services are reviewed regularly for effectiveness, when circumstances change and/or when incidents impact on the needs, goals or preferences of the consumer.

Management when interviewed by the Assessment Team stated that they have implemented a new electronic consumer database in the second half of 2022. Management stated the new database allows care managers to update the personalised help plan as changes occur and the most current version is on the system and that consumers and/or representatives will be able to access help plans via a mobile ‘app’. Evidence analysed by the Assessment Team showed consumer review dates are now monitored via the new consumer electronic database and an alert appears when a care manager logs into the system notifying them and their manager when a consumer is due for review and the alert remains until the review is completed.

Evidence analysed by the Assessment Team showed consumer reviews for high care consumers are discussed and case conferenced at the clinical governance committee. Evidence analysed by the Assessment Team showed clinical governance committee meeting minutes substantiated this approach. A sample of evidence to substantiate the Assessment Teams finding is documented below.

Consumer B (HCP L4) file review conducted by the Assessment Team showed a clinical assessment was conducted on 18 February 2022 and Consumer B’s personalised help plan had been reviewed and updated several times since February 2022 with the most recent update occurring on 19 October 2022.

The representative for Consumer B (HCP L4) when interviewed by the Assessment Team stated the care manager reviews Consumer B when he/she comes to visit and follows up on any appointments. The representative further went on to state I have access to the mobile ‘app’ and I can check Consumer B’s services and schedule. Consumer B’s representative stated I have been involved in the assessment process with the care manager and nurse.

# Standard 3

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| Personal care and clinical care | | HCP | CHSP |
| 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. | **Compliant** | **Compliant** |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | **Compliant** | **Compliant** |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | **Not applicable** | **Not applicable** |
| 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** | **Compliant** |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | **Not applicable** | **Not applicable** |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | **Compliant** | **Compliant** |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | **Not applicable** | **Not applicable** |

Findings

Interviews with management and documentation requested by the Assessment Team during the assessment contact showed consumers receive personal and clinical care that is tailored to meet their needs. Evidence analysed by the Assessment Team showed clinical assessments are conducted for high care consumers. Evidence analysed by the Assessment Team showed detailed care directives are provided to support workers via a mobile ‘app’. A sample of evidence to substantiate the Assessment Team’s finding is documented below.

Consumer C’s (HCP L4) file review completed by the Assessment Team identified Consumer C has type 2 diabetes that is managed through Consumer C’s diet. Evidence analysed showed Consumer C has six weekly home visits from a podiatrist to maintain good foot health. Consumer C’s personalised help plan includes his/her clinical care goals that are tailored to meet Consumer C’ needs. The Assessment Team noted they include processes to minimise Consumer C’s risk of falls by reminding Consumer C to take his/her time when he/she stands up and ensure he/she is well balanced before walking.

Evidence analysed by the Assessment Team showed a clinical assessment of Consumer C’s care needs was conducted on 15 March 2022. Evidence analysed by the Assessment Team showed the assessment includes information about Consumer C’s risk of falls, reference to vertigo, vision, mobility and the risks and side effects associated with Consumer C’s psychotropic medications. The Assessment Team noted the interpreter section of the assessment states an interpreter is required if representatives are unavailable. Evidence analysed by the Assessment Team showed a list of medications as at 23 November 2021 in included in her clinical assessment and continence issues are documented in the clinical assessment and personalised help plan to guide staff.

Discussion with management and documentation requested by the Assessment Team during the assessment contact identified high impact or high prevalence risks associated with the care and services of home care packages consumers is documented in the consumers personalised help plan and the vulnerability and risk register. Evidence analysed by the Assessment Team showed the clinical governance committee case conferences consumer risks as identified in the minutes dated 13 September 2022. Evince analysed by the Assessment Team also showed consumer high impact or high prevalence risks are documented in the consumers personalised help plan and shared with support workers via a mobile ‘app’. A sample of evidence to substantiate the Assessment Team’s finding is documented below.

Evidence analysed by the Assessment Team showed Consumer D (HCP L4) falls risk assessment identifies Consumer D as a moderate falls risk. Evidence analysed by the Assessment Team showed the vulnerability and risk register identified Consumer D’s risk as amber and includes his/her vulnerabilities and an action plan to mitigate the risk of falls. The Assessment Team noted Consumer D’s personalised help plan documents strategies to mitigate Consumer D’s falls. Evidence analysed by the Assessment Team showed support workers are to:

* Encourage Consumer D to go for short walks during the day to keep her mobility up.
* Be careful when mobilising Consumer D as she is on antihypertensive medication which can lower Consumer D’s blood pressure and cause dizziness.
* Supervise Consumer D when mobilising at all times within the home and out in the community.
* Stay with the Consumer D at all times if out in the community and ensure Consumer D is wearing appropriate footwear and that Consumer D has his/her 4WW with him/her at all times.

Interviews with management and documentation requested by the Assessment Team during the assessment contact identified 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. Consumers and/or representatives interviewed by the Assessment Team described how changes in consumers’ health are identified and responded to. Documentation analysed by the Assessment Team indicates timely identification, monitoring and appropriate care when changes occur.

Interviews with management and documentation requested by the Assessment Team during the assessment contact identified referrals occur to health professionals and other services when needed in a timely manner. Evidence analysed by the Assessment Team showed consent from consumers to share information is sought for referrals to occur. Staff when interviewed by the Assessment Team discussed referrals and advised they are completed online and/or via email depending on the type of services required. Files analysed by the Assessment Team identified referrals to nursing services, allied health professionals that included physiotherapy, occupational therapy, massage, dietitian and podiatry.

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)