**Performance**

**Report**

**1800 951 822**

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| Name of service: | Comlink Australia: North Lakes |
| Service address: | 10/1-3 Business Drive Narangba QLD 4504 |
| Commission ID: | 700890 |
| Home Service Provider: | Be: Associated Limited |
| Activity type: | Assessment Contact - Desk |
| Activity date: | 15 December 2022 |
| Performance report date: | 16 January 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 Be: North Lakes (**the service**) has been prepared by M Abjorensen, 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:**

* Be: Brisbane North, 26326, 10/1-3 Business Drive, Narangba QLD 4504

**CHSP:**

* Care Relationships and Carer Support, 24420, 10/1-3 Business Drive, Narangba QLD 4504
* Community and Home Support, 24419, 10/1-3 Business Drive, Narangba QLD 4504
* CHSP – Domestic Assistance, 4-7YBCHRX, 10/1-3 Business Drive, Narangba QLD 4504

# 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 9 January 2023.

# 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 | **Compliant** |
| **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 as not all requirements have been assessed** |

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

Findings

The service demonstrated assessment and planning processes consider risks of consumer’s health and wellbeing to inform the delivery of safe and effective care and services. Through interviews, conducted by the Assessment Team, consumers and representatives reported care and services are delivered in accordance with their needs, regardless of staff consistency. Staff reported they have access to relevant consumer information to guide the delivery of care and services. The service has training modules, policies and procedures to guide staff practice in undertaking assessment and planning. The Assessment Team reviewed care documentation for sampled consumers and reported comprehensive assessments, using validated assessment tools to identify risks to consumer health and wellbeing. Assessed risks include falls, skin integrity, nutrition, cognition, mobility, changes in medical conditions, ability to manage medications, pain, environmental risk, behaviour management and non-response to scheduled visits. For example:

* A consumer sampled receives multiple services including transport, allied health, domestic assistance, gardening and maintenance. Care documentation identifies risks relating to the condition of this consumer, including, mobility equipment requirements, being rated as a high falls risk, living a sensory impairment and relevant medical history. This consumer reported being satisfied with the services they receive and described improvements in relation to service communication. Management described actions they have taken to improve communication protocols for this consumer, including providing the care manager’s direct phone number and email and efforts to send regular staff, wherever possible, as per this consumer’s preferences.
* Another sampled consumer receives shopping assistance through social support services. Care documentation identifies relevant medical history including mobility requirements. Care directives evidence tailored instructions to guide staff in delivering safe and effective services for this consumer.

The service demonstrated 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. Consumers and representatives interviewed, by the Assessment Team, reported the service discusses their care needs and goals they want to achieve with the delivery of services and have ongoing communication about their care needs. Staff were able to describe individual consumers and what was important to them in how their care and services are delivered. The Assessment Team conducted a review of care documentation for sampled consumers and reported consumers’ current goals, needs and preferences are contained within the care documentation. Care documentation evidenced discussions relating to advanced care directives and end-of-life wishes are discussed with the consumer at the initial assessment when care planning information is reviewed or when there has been a significant change in the consumers’ condition. For example:

* A sampled consumer receives multiple services including allied health, social support, garden maintenance and domestic assistance. The representative for this consumer told the Assessment Team this consumer is a high risk of falls, diagnosed neurological condition and described declines in this consumer’s health and conditions. During the interview, the representative confirmed having advanced care planning discussions with the service and the positive impact the services have for them and this consumer. Care documentation contained relevant details to guide staff on how to best support this consumer, based on their current needs, goals and preferences.

The service demonstrated that 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. Care planning information is completed, by the case manager and the consumer and or representative, where a copy is provided that is kept in the consumers in home file. Consumers and representatives reported, through interviews with the Assessment Team, that they are satisfied with the information they receive from the service and confirmed they have received a copy of the care plan. Consumers and representatives described the accessibility and responsiveness of the service when they have any queries. Staff interviewed stated they are informed of consumer’s care service delivery needs and preferences, and changes in a timely manner via the mobile application or phone. Care staff advised if they had any concerns with the service delivery or changes in the consumer’s condition or circumstances, they would contact the case manager. Consumer care documentation, reviewed by the Assessment Team, evidences the service communicates with consumers/representatives and documents assessment outcomes through dated notes, initial assessments, scheduled reviews or reviews in response to an identified change in the consumer’s health and well-being. For example:

* Three consumers and representatives told the Assessment Team they have a copy of consumer care plans, accessible within their home which is updated in accordance with any changes to their care and services.

The service demonstrated that 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. Through interviews conducted by the Assessment Team, consumers and representatives reported case managers and staff regularly phone them to obtain feedback on their satisfaction with care and service and ensure consumer needs are being met. Staff advised annual reviews are undertaken for HCP and CHSP consumers and in response changed circumstances. Management advised that timelines for reviews are monitored for HCP and CHSP consumers. The service allocated additional resources including a new position of CHSP Advisor to complete care and service reviews for CHSP consumers. The Assessment Team reviewed care documentation for sampled consumers and reported care planning information is reviewed for effectiveness, when circumstances change or when incidents impact on the needs, goals, and preferences of consumers. For example:

* The care documentation for a sampled consumer shows the service has responded to a change in needs through timely referrals for allied health assessments, home maintenance and regular discussions with the representative. While this consumer had not had an annual care plan review within the review timeframe, care documentation evidences how ongoing discussions and assessments to review services in response to this consumer’s circumstances and increased care needs.

# 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 | Not applicable |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant | Not applicable |
| 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. | Compliant | 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 | Not applicable |
| 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. | Compliant | Not applicable |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant | Not applicable |
| 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

The service demonstrated that each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, delivered according to best practice, tailored to their needs and optimises their wellbeing. Through interviews, with the Assessment Team, consumers and representatives described staff as knowing what they are doing and reported feeling safe and supported by staff. Care staff demonstrated they are aware of each consumers’ individual, personal, and medical conditions and described personalised strategies they use to deliver care. Staff are guided in the delivery of personal care through service documentation. The Assessment Team reviewed care documentation for sampled consumers which evidenced detailed care directives to guide staff practice. The Assessment Team reported sampled care documentations contained relevant information to inform the delivery of safe and effective personal care. For example:

* The Assessment Team reviewed consumes receiving personal care and allied health services. The care documentation, for a sampled consumer, identifies relevant medical information including diagnoses and allergies and the involvement of an occupational therapy to assess the environment for home modifications and the medical officer for pain management. Assessments have been undertaken for continence, skin integrity, cognition and fall risks. Care directives, reviewed by the Assessment Team, include relevant falls prevention strategies to guide staff in safe and effective care delivery.
* The Assessment Team also reviewed a consumer in relation to wound management, undertaken by brokered clinical staff, and found the service evidenced a best practice approach.

The service demonstrated effective management of high impact or high prevalence risks associated with the care of each consumer. Staff, including the clinical practice lead, described the high impact and high prevalence risks for consumers at the service. These include falls, medication management, pain management and infections. Through interviews with the Assessment Team, care staff explained, if they ever need further information relating to a consumer, they refer to the consumers care plan or contact the case manager for further guidance. Care staff described incident management processes including, how incidents are documented, reviewed, and how outcomes of any actions that require follow up are initiated. Management advised that incidents are discussed at meetings including the Governance Risk Committee. The Assessment Team reported sampled consumer care documentation identified key risks for sampled consumers including, falls, diabetes, weight loss, swallowing difficulties, skin integrity concerns and responsive behaviours. For example:

* The Assessment Team reviewed incident data and consumer care documentation which evidenced risk management strategies relevant to each consumer, including, skin integrity and falls management.

The service demonstrated that needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. Through interviews with the Assessment Team, staff demonstrated the service liaises, and coordinates services, with palliative care teams from which consumers are receiving services. The service has policies and procedures that guide staff in the management of end of life care, including pain management and comfort care. For example:

* A sampled consumer, reviewed by the Assessment Team, is receiving palliative care services through an external organisation, this consumer receives care several times a week. Care staff support this consumer to attend these appointments through social support services. The representative advised they are waiting to discuss additional services with the case manager. Management provided information to the Assessment Team evidencing ongoing discussions with this consumer, their representative, and the service.

The service demonstrated effective systems, staff communication and processes identify and respond to deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition. Consumers and representatives advised they report concerns or changes in consumer health to care staff or case manager and described actions taken by the service, including reassessment, referrals to medical practitioners or allied health clinicians. The Assessment Team reported all staff interviewed demonstrated an understanding of recognising, reporting, and responding to consumer deterioration or changes in their health and well-being. Care staff described the types of indicators they look for, including, changes in consumer’s usual behaviour or function. Staff told the Assessment Team they report changes to consumer’s health or conditions to the case manager and, where needed, record observed changes in the incident management system. The Assessment Team reviewed consumer care documentation which evidenced timely action following reports of changes to a consumer’s condition. The service has a suite of policies and procedures and related documents to support staff in recognising and responding in a timely manner to a decline or deterioration in a consumer’s health and/or well-being. For example:

* A sampled consumer living with diabetes, a cognitive impairment and a high risk of falls. The incident register evidenced staff reported a decline in this consumer’s mobility and an increase in care needs during social support and transport services. The Assessment Team reported care documentation showed actions taken by the service in response to the decline in function, including, discussions with this consumer, their representative and referrals to allied health clinicians for mobility assessments, equipment and physical therapy.

Through evidence collected by the Assessment Team, the service demonstrated 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. The Assessment Team reported, the service communicates consumer specific information with care staff through a mobile device application which includes alerts and any changes in the consumer’s condition. Consumer care documentation is accessible within consumers’ in home file and on the care management system, including ‘alerts’ outlining changes to consumers care and services. Consumers and representatives said, in various ways, to the Assessment Team, they are satisfied with the care and services they receive and consumer personal and clinical care needs are coordinated effectively by the service. Staff described communication protocols to the Assessment Team which enable effective information sharing in relation to consumer care needs, incidents and other relevant information. Information is recorded through dated notes, discussed at regular meetings and escalated to the case manager for further action, as necessary. For example:

* A sampled consumer told the Assessment Team they are engaged in ongoing discussions with the case manager about their care needs and service delivery. Care documentation contained details on the other organisation’s involved in the different aspects of the consumer’s care including pain management and oxygen supplements.

Through evidence collected by the Assessment Team, the service demonstrated that action is taken to ensure timely and appropriate referrals to individuals, other organisations and providers of other care and services. Consumers and representatives said, in various ways, that referrals coordinated by the service are timely and appropriate with medical practitioners and other health professionals accessible, as needed. Care documentation evidence communication, and relevant referrals, from allied health clinicians and other medical practitioners, to inform care and service delivery. The Assessment Team reported staff practice, in relation to referral processes, is guided through service policies and procedures guide. For example:

* A sampled consumer experiences vision impairment, dizzy spells and is identified as being a high falls risk. Care documentation evidenced referrals to physiotherapy, occupational therapy, podiatry and home modifications to manage mobility and falls risks and; a referral to a dietician following unplanned weight loss. The referrals received have supported the consumer to continue safely living independently at home.

# Standard 8

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| Organisational governance | | HCP | CHSP |
| 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 | 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. | Not applicable | Not applicable |
| 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 | 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. | Compliant | Compliant |
| 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. | Not applicable | Not applicable |

Findings

Through evidence collected by the Assessment Team, the service demonstrated that it has effective risk management systems and practices. The service has a risk management framework and an effective incident management system that is used by staff to report incidents and escalation process for the identification, evaluation and mitigation of risks. Incidents are categorised with a risk rating from low, medium to high. The Assessment Team provided the following examples:

Assessment and care planning incorporates risk identification and triggered assessment tools where risk is indicated. Strategies are developed to manage and minimise high impact and high prevalent risks for each consumer, including non-response to a schedule visit, falls risk, deterioration, elder abuse, complex and/or clinical care needs.

The service monitors consumer risks through regular review meetings and management and governance. Incidents reports are trended and analysed for management and governance meetings with serious incident escalated to senior management.

The service provided a list of consumers with identifying vulnerable consumers including those who are socially isolated, falls risk, living with dementia, behavioural concerns, cognitive impairments and requiring specific care and services. Changes in consumer wellbeing or observed deterioration is reported, with consultation with the consumers, representatives, and others involved in the consumer’s care.

The service has a clinical practice lead who reviews all clinical incidents and discusses strategies with case managers to manage consumer risks through reassessments and referrals to appropriate medical practitioner or allied health clinicians.

Service policies, procedures and training delivered by the service support staff on the identification and response to consumer risks.

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)