**Performance**

**Report**

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| Name of service: | Decia Pty Limited |
| Service address: | 350 Liverpool Rd ASHFIELD NSW 2131 |
| Commission ID: | 201116 |
| Home Service Provider: | Decia Pty Limited |
| Activity type: | Assessment Contact - Desk |
| Activity date: | 8 March 2023 |
| Performance report date: | 1 May 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 Decia Pty Limited (**the service**) has been prepared by G. McNamara, 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:**

* Eremea Home Care Services, 26668, 350 Liverpool Rd, ASHFIELD NSW 2131

**CHSP:**

* Care Relationships and Carer Support, 24941, 350 Liverpool Rd, ASHFIELD NSW 2131
* Community and Home Support, 24940, 350 Liverpool Rd, ASHFIELD NSW 2131

# 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 11 April 2023.

# Assessment summary for Home Care Packages (HCP)

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **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 as not all requirements have been assessed** |
| **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 as not all requirements have been assessed |
| **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 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

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 1

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| Consumer dignity and choice | | HCP | CHSP |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant | Compliant |

Findings

One (1) of the six specific requirements of this Standard was assessed and I have found it to be Compliant. As not all requirements of this Standard were assessed no rating had been given at the Standard level.

Information management process have been improved. Consumers and representatives said they received information about the services provided verbally through the assessment process. They also receive an information pack, service agreement, Charter of Rights and information about confirmed services documented in their care plan. These were sighted on all consumer files viewed. For Home Care Package (HCP) consumers they also receive a budget once services are determined and receive monthly statements, keeping them informed of any unspent funds. When services are changed, or packages upgraded a new budget is created and provided to consumers. A budget and care plan are provided when they commenced with the service. HCP consumers/representatives confirmed they receive monthly statements and can track unspent amounts in their package.

Consumers and representatives said they felt empowered to ask for the services they want. They said service coordinator/representative assist them with information at any time should they call. Management said they have invested heavily in a telephone system to improve communication. Data presented to the assessment team indicated call response has been improved. Evidence noted on progress notes indicated timely follow up of consumers concerns.

Coordination/representative staff described how they adapt their form of communication with consumers, especially when speaking to those with reduced capacity or people from a CALD background. Depending on the consumer’s circumstances and consent given, communication may be through an advocate or representative or an interpreter service.

# 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)(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

Four of the five specific requirements of this Standard was assessed and I have found them to be Compliant. As not all requirements of this Standard were assessed no rating had been given at the Standard level.

Requirement 2(3)(a)

The service demonstrated that it now ensures that assessment and planning includes the consideration of risk and informs the delivery of safe and effective care and services.

Management outlined the assessment process they follow. They said they use the initial assessment, home risk assessment and the check list to trigger conversation with the consumer in relation to medical history, physical health, mental health, and activities of daily living to assess the emotional well-being of the consumer. A service representative said support workers reported to her regarding a consumers non-response to a visit, and then she followed up the process.

During assessment risks are identified and discussed with the consumer and/or their representative. Mitigating strategies are agreed upon and documented in alerts, and the individual safety plan. Consumers discussed how the service identifies their care needs and any risks. Consumer documentation included the identification of risks such as mobility issues, falls history, cognitive impairment, hearing impairment, vision impairment, medical issues, allergies, and risk of isolation.

Requirement 2(3)(b)

The service now ensures that assessment and planning identifies consumer’s current needs and includes advanced care planning.

Consumers interviewed confirmed services meet their care needs.

Carer and support workers said they are provided information by the service coordinator/representative in relation to the care needs of consumers and are provided with access to the care plan that includes clear instructions. They access electronic progress notes on their phone, and are updated in relation to changes and discuss at regular staff meetings services provided to consumers. Care planning documentation sighted by the Assessment Team included specific tasks for support workers and in accordance with consumer goals.

Consumers are offered assistance with advance care planning, however staff said discussion in relation to end of life planning is not always appropriate.

Requirement 2(3)(d)

The service now ensures that the outcomes of assessment and planning are affectively communicated to the consumer and documented in a care plan available to the consumer and where care and services are provided.

Consumers/representatives interviewed confirmed they participate in assessments and ongoing reviews and were involved in development of their care plan. They felt they were well informed by the service coordinator/representative of the services they could access through their home care package. Most consumers were able to provide details of what services they receive, including days and times and these were noted to match with care plans sighted in their files. Most consumers said the services they receive are in accordance with their needs and preferences and agreed upon by them. Consumers/representatives confirmed they were provided with a copy of their current care plan. Consumers and representatives interviewed provided examples regarding their involvement including:

An initial assessment is conducted by the service coordinator/representative, and further referral to the clinical team and allied health to conduct an assessment for consumers where clinical needs are identified. Care plans are then developed in partnership with consumers and representatives based on the information gathered via the assessment. Once developed a copy is provided to the consumer/representative. Care plans were sighted in all sampled consumer files. Updated care plans were also sighted based on reviews and changes in consumers’ care needs.

Support workers interviewed said they have access to consumers’ care plans through the mobile apps. Those interviewed felt they get enough information on the needs of the consumers and how to deliver care.

Requirement 2(3)(e)

The service now ensures 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.

Policies and procedures guide staff in relation to review and reassessment. Management said they review the individual care plan with each consumer every year or as needed. In addition, the service has set up quality team who keeps track of assessment and documentation review.

Support workers said they tend to see the same consumers and are able to identify deterioration in their physical and mental wellbeing, and relay this to the service coordinator/representative and the branch manager who follows-up and keeps them informed of any changes.

Detailed service coordinator/representative notes were also sighted in the database that reflecting changes in needs based on reviews, upgrading to a higher-level package and discussions with support worker.

Consumers confirmed their services are reviewed. Sampled care plans sighted were current, with reviews, conducted at least yearly, and as circumstances changed. Progress notes sighted, included entries by support workers, and included notes outlining follow-up undertaken by the service coordinator/representative.

# Standard 3

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| Personal care and clinical care | | HCP | CHSP |
| 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)(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 | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant | Compliant |

Findings

Three of the seven specific requirements of this Standard was assessed and I have found them to be Compliant. As not all requirements of this Standard were assessed no rating had been given at the Standard level.

Requirement 3(3)(b)

The service is now managing risks relating to the personal and clinical care of each consumer, and following best practice guidance and applying measures to make sure the risk is mitigated

All consumers and representatives sampled informed they receive safe and effective care that is tailored to individual needs and optimises their health and wellbeing.

The organisation’s initial assessment identifies consumers that are at risk of isolation, diagnosed with chronic debilitating conditions, dementia or similar cognitive impairment, mental health and mobility issues that can affect the consumers ability to perform their activities for daily living.

A Clinical team completes a clinical assessment to add vulnerable consumers to the clinical risk register for ongoing monitoring, and case conferences are organised with the consumers HCP service co-ordinator (SCO) or CHSP service representative (SR) to discuss care options that meet the needs of each consumer. The SCO or SR will contact the consumers medical care team, specialist or social worker to discuss plan and strategies to be included into consumers care plan.

Vulnerable consumers are reviewed every 6 months or where a change to their health or wellbeing is identified or if there is an incident and an investigation is being conducted. Every consumer has 4-6 weekly check ins with their SCO or SR.·

Support workers sampled advised the organisation is good at responding to incidents as well as hazards reported. They could explain the process for reporting an incident and being able to see if an incident or concern has been acknowledged in the internal management system. The organisation supports support workers to identify and manage high impact or high prevalence risks through mandatory face to face and fortnightly practice training sessions. A mobile training app sends reminder notifications to all operational staff and subcontractors. The app has scenarios and a series of questions relating to dementia, infection control, end of life care and safe practice. The training app is monitored by management.

The Clinical Care Coordinator advised the nurse advice line is monitored by the registered nurse for workforce to identify and respond to emergencies or deterioration in a timely manner and to provide advice on best practice. The clinical team, SCO’s, and SR’s provided examples of the high impact and high prevalence risks identified for consumers majority being mobility and falls, during winter consumers are at risk of catching a cold, aspiration pneumonia, complex medical heart, kidney conditions and Urinary Tract Infections and confusion.

The organisation has an effective risk management systems in place to monitor, identify, communicate and manage risks relating to the care of consumers. The clinical nurse coordinator has oversight of clients in hospital and starts planning in consultation with family, updates the clinical risk register and does a risk assessments and updates the care plan if required. Instructions for managing the no response to door plan is flagged in a consumer's file.

Updates to assessments and care plans due to deterioration in health, hospital discharge or additional support services were sighted. Sampled consumers each had a 4-6-week review which was documented in schedule notes. Referrals to specialist and Dementia Australia were sighted in consumers notes. Assessments and Care plans sampled were current and contained information to manage risks.

Requirement 3(3)(e)

The organisation’s workforce has information about delivering safe and effective personal and clinical care and understanding the consumer's needs, goals and preferences

The clinical team, SCO or SR in consultation with the consumer work collaboratively and communicate through the organisations internal management system with service partners, support workers, rostering team, workforce capability team and clinical team to ensure that there are resources and skills to support the consumers ongoing care and to identify if support workers may need extra training to deliver the care the consumer needs. The clinical team, SCO or SR document through the organisations internal management system.

Consumers sampled expressed satisfaction with the personal and clinical care received, each consumer had a copy of their current care plan communicating their conditions, preferences, needs and goals.

The workforce advised of using the mobile app prior to providing a service to check care plans, service instructions, tasks notes, client information and where to document changes in the client’s conditions. Information considered important or urgent support worker will receive a phone call from SCO or SR. Support workers and sub-contractors can update task notes and check to see if the note has been acknowledged. Home modification subcontractors described how they receive and follow the occupational therapist report prior to assessing a job in consultation with the consumer and quoting a job. Domestic assistance contractors explained electronic system used to document communication with consumers and their representatives, phone calls and emails for any changes to schedule that is first discussed and agreed with the consumer. Scheduling team provided examples of consumers requesting certain support workers and being able to provide these workers or communicating challenges to meeting their request and offering different options to meet the consumers preferences.

The organisation has an effective communication system in place. Its Quality team reviews all care plans and assessments to make sure clients’ needs are reflected assessments and care plan are monitored by the workforce and capability lead. Documentation sampled was current and notes between consumers and workforce regarding updating of consumers conditions, service preferences and schedule preferences were responded to in a timely manner. The organisation has improved communication between consumers and workforce by investing in a telephone configuration system. Management monitors the call data and response time through a daily dashboard, and operational staff are expected to return phone calls within the hour.

Requirement 3(3)(f)

The organisation demonstrated and documented timely and appropriate referrals made to ensure consumers receive care and services needed.

Care plan and assessments showed services received and details of the provider. Consumers and their representatives understood there is a process in place to receive equipment, such as an assessment and recommendation conducted by an occupational therapist, quotes and documentation to be signed, suppliers to deliver equipment all consumers. Their representatives acknowledged waiting times are due to only being referred to listed provider.

Support workers are not responsible for making referrals to other providers however the training provided by the organisation enables support workers to identify changes and report these changes. Support workers advised they can make a phone call or create a task to report issues or concerns to operational staff. SCOs sampled explained the process for obtaining equipment and requesting home modifications, consumers and their representatives are informed of the 6-8 week processing time. An SCO advised the organisation has a supplier for urgent and immediate equipment where equipment can be supplied in 1-2 days. Consumers and their representatives are made aware of this service if they cannot wait 6-8 weeks. The SCO was able to provide an example of offering a consumer representative this service but consumer representative declined and purchased the mobility aid herself.

A Clinical care Co-ordinator is in contact with nurses at hospitals and can organise loan equipment for consumers prior to discharge. Home Modifications team categorize processes, low meaning consultation and important meaning internal process is complete.

The organisations care plans, assessments and file notes sampled have been amended in the appropriate time frames to reflect home modifications, providers external care and services and the equipment utilised. Documented communications with sampled consumers and/or representatives, sub-contractors, external providers regarding wait times reasons for delay, update to services and additional support to be provided were sighted in the organisations internal management system. The organisation has workforce teams that manage sub-contractors and home modifications to streamline their processes.

# Standard 4

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| Services and supports for daily living | | HCP | CHSP |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant | Compliant |

Findings

One (1) of the six applicable requirements of this Standard was assessed and I have found it to be Compliant. As not all requirements of this Standard were assessed no rating had been given at the Standard level.

Requirement 4(3)(d)

The service now provides its workforce with information about delivering safe and effective service and supports for daily living, and is helping its workforce to provide and coordinate services and supports that respect the consumers choices.

The organisation demonstrated effective communication systems and processes in place to ensure information about the consumers condition, needs and preferences is communicated within the organisation and with external providers. There is a specific team that looks after all subcontractor work, client service partner function deals with third party providers.

Consumers and representatives sampled said their services are consistent and continuity of service and supports.

Client service partners advised of the internal management system used to communicate with providers, view quotes, availability and make comments regarding consumers preferences and needs.

Sampled consumer file notes documented communication within the organisation as well as external parties. Documentation regarding the sub-contractors were sighted. Subcontractors can view client information in a mobile app, and communicate with the client service partner via email, and phone calls. Subcontractors must submit reports after every service is complete. Reports were sighted in sampled consumers files, detailing the service provided, length of service and any relevant information regarding the consumer. Monthly newsletters are sent to all consumers, sub-contractors with information on services, changes to regulation and updates on the organisation.

# Standard 8

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| Organisational governance | | HCP | CHSP |
| 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. | Compliant | Compliant |
| 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 |

Findings

Two of the five specific requirements of this Standard was assessed and I have found them to be Compliant. As not all requirements of this Standard were assessed no rating had been given at the Standard level.

Requirement 8(3)(c)

The organisation has demonstrated effective information management systems to demonstrate how an organisation maintains, stores, and shares relevant information.

The workforce sampled was able to explain organisation and relevant team’s information management system and the processes in place that ensure the workforce and external providers have access to current information that can be shared to support them in their roles.

Consumers and representatives advised they have a copy of their current care plan. Care plans and assessments are monitored by the quality audit team. New consumers, consumers flagged for reassessment or requiring a package upgrade document are reviewed by the quality audit team to ensure sufficient and current information is documented. Data is stored in a spreadsheet to identify continuous improvement points.

Support workers advised care plans are accessed through the mobile app and checked when logging into the app prior to conducting a service. Current care needs are reflected in the care plan as well as the consumers relevant services, service notes and co-ordinator notes.

Workforce training to utilise google translate to enable the provision of information to consumers/representatives on an ongoing basis was seen. Consumers advised communication has improved and office-based staff acknowledge and return their calls and send emails if that is the preferred communication.

Monthly statements are sent to consumers. Statements show the services received hours used, costs and balances of relevant funding and deposits. Package upgrades are booked into client management system checklists have been created to ensure consumes and their representatives receive updated agreements. Weekly rosters are sent to consumers and or representatives from the scheduling team, rosters show consumers the support worker booked into provide personal and clinical care, if changes occur consumers are consulted, and an updated roster is provided.

Requirement 8(3)(d)

The organisation has processes to identify high impact and high prevalence consumers in line with the organisations falls risk policy and complex care policy.

Clinical team SCO’s and SR’s demonstrated consistency in referral process in line with referrals and partners policy. Consumers files flag risks identified from initial and clinical assessment, risk assessment and strategies recommended can be found in care plans. Issues, actions and outcomes are recorded and monitored by the clinical team in the client risk register. The organisation has specific questions to ask consumers when SCO’s or SR’s are conducting 4-6 weekly face to face, telephone or email reviews with consumers, notes are added into the schedule.

High impact and high prevalence consumers care plans are reviewed every 6 months in line with the complex care policy. The organisations information management system can be accessed via the mobile app to provide support workers with current information regarding individual consumer risks and strategies to be used when providing personal and clinical care

The organisation created the home modification team to outsource the workload and streamline the process. Timeframes for product and service delivery are being communicated and documented to make sure consumers have that information in hand.

Consumer and representatives sampled acknowledged waiting times for home modifications and equipment are processed and received within communicated time frames given at initial consultation. The organisation has a process in place to obtain emergency equipment. The home modification sub-contractor is able to prioritise jobs based on risk and has identified risk factors when quoting a job, this is communicated to the OT or relevant SCO’s or SR’s.

The Quality audit team manages and monitors care plans and assessments to ensure all clients needs are assessed, especially high risk and or high prevalence consumers’ needs.

Support staff advised process for reporting deterioration of consumes back to the relevant SCO’s or SR’s and the clinical advice line. Risks and preventive measures are flagged in the consumers file. Support workers detailed the importance of checking care plans to familiarise themselves with the consumer prior to providing care, schedule notes will prompt support worker of any changes to care or concerns reported by the SCO’s or SR’s and or clinical team, consumers and representatives sampled all expressed satisfaction with service provided by support workers.

A SIRS data register of reported incidents detailing the incident is maintained, and SIRS response/recommendations, hazard and incident register documenting actions taken to address identified issues, clinical risk register of high impact and high prevalence consumers detailing issues, actions, reformations and outcomes were seen.

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)