**Performance**

**Report**

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| Name: | Indochinese Elderly Refugees Association - Victoria Inc |
| Commission ID: | 300614 |
| Address: | Suite B, 108 Elizabeth St, RICHMOND NORTH, Victoria, 3121 |
| Activity type: | Assessment contact (performance assessment) – non-site |
| Activity date: | on 12 March 2024 |
| Performance report date: | 12 April 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.

# Service included in this assessment

Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 8545 Indochinese Elderly Refugees Association-Victoria Inc  
Service: 25513 Indochinese Elderly Refugees Association-Victoria Inc - Community and Home Support

**This performance report**

This performance report for Indochinese Elderly Refugees Association - Victoria Inc (**the service**) has been prepared by P.Frangiosa, 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.

# 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) 12 March 2024) – non-site 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 28 March 2024 (IERA-SSG Assessment Report Action Plan 28.3.24).

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **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)(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.

**Requirement 6(3)(d)** - Feedback and complaints are reviewed and used to improve the quality of care and services.

**Requirement 7(3)(e)** - Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

**Requirement 8(3)(a)** - Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

**Requirement 8(3)(c)** - Effective organisation wide governance systems relating to information management, continuous improvement, regulatory compliance or feedback and complaints.

**Requirement 8(3)(d)** - Effective risk management systems and practices, including but not limited to managing high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers, and managing and preventing incidents, including the use of an incident management system.

# Standard 2

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| Ongoing assessment and planning with consumers | | CHSP |
| 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. | Not Compliant |

Findings

Requirement 2(3)(e) was found non-compliant following a Quality Audit undertaken from 10 March 2023 to 15 March 2023. The service did not demonstrate:

* services are reviewed regularly for effectiveness and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

The Assessment Team’s report for the Assessment contact undertaken on 12 March 2024 includes evidence of actions taken by the service in response to the non-compliance. These actions include development of a new care plan and client profile, increasing staffing to support reassessment of outstanding reviews and increased staff training and implementation of a new electronic records system. While the Assessment Team acknowledged improvements have been made, they were not satisfied care and services were reviewed regularly for effectiveness, or changes recorded, and outcomes of assessment and planning were communicated to consumers or available at the point of service delivery to staff or consumers. The Assessment Team recommended Requirement 2(3)(e) not met and provided the following evidence to support their assessment:

* All sampled consumers advised they could not recall their most recent review or assessment.
* Documentation showed scheduled reviews for consumers are not up to date, and consumers are not consistently reviewed after hospitalisations or changes in circumstances.
* Management advised the service is up to date with all scheduled reviews, however 3 of 4 care plans viewed by the Assessment Team were last reviewed in October 2022.
* Management advised the service is currently sourcing a suite of policies and procedures to guide staff in all areas of service, including assessment and review, however this process has not been completed.
* The Assessment Team requested a report of completed reviews, however, this was not provided to the Assessment Team during the Assessment Contact.

The provider provided information in response to the Assessment Team’s report, including:

* Scheduling reviews for Plans that were not reviewed in the last 6 months as a priority.
* Reviewing all (Social Support Group) SSG Care Plans in April and then quarterly according to a schedule.
* Scheduling the SSG Supervisor to allocate reviews to SSG staff in the schedule, activity staff to arrange appointments to conduct and finalise April reviews.
* Updating the Care Plan Register (the schedule) to record completed reviews and any significant changes during the April review such as when there is a change (e.g. after a hospital discharge).
* Scheduling the Supervisor to check reviews that are completed by Activity staff.
* Updating the Care Plan review format to include a section on consumer preferences.
* Finalising the development of the new care plan format, client profile and assessment guidelines.
* Reviewing and acquiring a software platform to enable care plans and compliance with the Standards to stored, amended and reviewed electronically to replace the paper based current processes.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows care plans are not being regularly reviewed, or consistently recording changes and available where care and services are provided.

I appreciate the provider’s explanation regarding the proposed timeframes to implement Care Plan reviews that were not reviewed in the last 6 months, and broader review of SSG participant Care Plan. However, at this stage the service is yet to conduct these reviews at the time of their contact assessment response (28 March 2024) or implement a software platform to enable recording of its care Plan reviews and updates.

The intent of this requirement expects organisations to regularly review the care and services they provide to consumers, ensuring they are up-to-date and meet the consumer’s current needs, goals and preferences, meet the consumer’s needs safely and effectively, and care and services are updated to apply better practice when available.

I have considered the provider’s response which demonstrates proportionate and practical actions for the type of services delivered, however, at the time of my finding, these actions have not been fully implemented or embedded.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 2(3)(e) in Standard 2 Ongoing assessment and planning with consumers.

# Standard 6

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| Feedback and complaints | | CHSP |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant |

Findings

Requirement 6(3)(d) was found non-compliant following a Quality Audit undertaken from 10 March 2023 to 15 March 2023. The service did not demonstrate:

* Feedback and complaints are reviewed and used to improve the quality of care and services.

The Assessment Team’s report for the Assessment contact undertaken on 12 March 2024 includes evidence of actions taken by the service in response to the non-compliance, including but not limited to developing a new feedback form to encourage consumers to provide feedback, providing training to staff and volunteers regarding feedback, and implementing new policies and procedures. While the Assessment Team acknowledged all sampled consumers were satisfied with the services they receive, they identified the service does not record feedback consistently for review and improvements to services. The Assessment Team recommended Requirement 6(3)(d) not met and provided the following evidence to support their assessment:

* Sampled staff and volunteers described feedback is generally received verbally and resolved immediately. They advised this feedback is not documented unless it is 'major'.
* Management described how some consumers are culturally reluctant to provide feedback, acknowledging the service could document verbal feedback better.
* The service's continuous improvement register contains one item originating from consumer suggestions.

The provider provided information in response to the Assessment Team’s report, including:

* Developing a feedback and complaints form that seeks a response from individual consumers to the benefit of activities and records verbal feedback.
* Establish a Continuous Improvement Register.
* Organise a meeting with SSG members in April, with the intention to organise more meetings with a target of 50 percent participation in April. Minutes to be kept, and agenda to be circulated. After the meeting, a brief summary to be circulated with suggested improvements. A formal analysis of the feedback to be conducted, complaints, compliments, suggestions, and responses.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows feedback and complaints are not reviewed and used to improve the quality of care and services.

Whilst I appreciate the provider’s explanation regarding the cultural sensitivities regarding engaging consumers to seek complaints and feedback, I also acknowledge that the service has an obligation to record and review complaints and feedback to improve the quality of care and services being provided, as per the expectations identified in Standard 6. The service’s proposal to develop a feedback and complaints form that seeks a response from individual consumers is a practical solution, in conjunction with establishing a Continuous Improvement Register. However, at the time of my finding, these actions have not been fully implemented or embedded.

The intent of this requirement expects an organisation to have a best practice system to manage feedback and complaints. Organisations should use this system to improve how they deliver care and services. As well as encouraging complaints and asking for feedback, the organisation should provide timely feedback to the organisation’s governing body, its workforce and consumers on complaints and the actions the organisation took. It’s expected that the organisation will use information from complaints to make improvements to safety and quality systems and regularly review and improve how they manage complaints.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 6(3)(d) in Standard 6 Feedback and complaints.

# Standard 7

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| Human resources | | CHSP |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Not Compliant |

Findings

Requirement 7(3)(e) was found non-compliant following a Quality Audit undertaken from 10 March 2023 to 15 March 2023. The service did not demonstrate:

* Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

The Assessment Team’s report for the Assessment contact undertaken on 12 March 2024 includes evidence of actions taken by the service in response to the non-compliance, including but not limited to commenced drafting a template to use for staff performance appraisals. The Assessment Team recommended Requirement 7(3)(e) not met and provided the following evidence to support their assessment:

* Management did not provide any examples of completed staff performance appraisals to address identified non-compliance at the Quality Audit in March 2023.
* Sampled volunteers advised they do not receive feedback on their performance, and they assume they are performing well as they have not received negative feedback.
* Management advised the service is currently developing a process for staff monitoring, assessment and appraisal, however, this process is not complete and has not been implemented. Management advised the service has not put interim solutions in place.

The provider provided information in response to the Assessment Team’s report, including:

* Developing and introducing a Staff appraisal form used to be modified, withstaff appraisals to be conducted in April and volunteers to be involved in service delivery process and provided feedback.
* Utilise Choice Aged Care and Learning Aged Care Quality resources to support volunteers, with training to commence in May 2024.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows regular assessment, monitoring and review of the performance of each member of the workforce is not being undertaken.

Whilst I acknowledge that the service has made an obligation to improve elements of its human resources responsibilities, I also acknowledge that assurances provided in the Quality Audit of March 2023 including the introduction of a staff performance template, or staff appraisals themselves have not been fully implemented or embedded.

The intent of this Requirement expects organisations to have an appropriate workforce regularly evaluate how they are performing their role, and identify, plan for, and support any training and development they need. I find this did not occur, as performance reviews had not been completed in line with the organisation’s policy.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 7(3)(e) in Standard 7 Human Resources.

# Standard 8

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| Organisational governance | | 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 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 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. | Not Compliant |

Findings

Requirement 8(3)(a)

Requirement 8(3)(a) was found non-compliant following a Quality Audit undertaken from 10 March 2023 to 15 March 2023. The service did not demonstrate:

* Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

The Assessment Team’s report for the Assessment contact undertaken on 12 March 2024 includes evidence of actions taken by the service in response to the non-compliance, including but not limited to management describing how the service holds a planning meeting with consumers every quarter to plan activities and outings and provides bi-monthly newsletters to keep consumers informed. Assessment Team recommended Requirement 8(3)(a) not met and provided the following evidence to support their assessment:

* The service was unable to provide documentation to demonstrate an effective process to engage with consumers regarding development and evaluation of services.
* Management did not provide a recent example of engaging with consumers through survey or other mechanisms to evaluate the quality and effectiveness of services delivered.

The provider provided information in response to the Assessment Team’s report, including:

* Coordinate meetings and invite SSG members to review the activity and outing plan each 3 months at a scheduled meeting with staff. Provide feedback on changes suggested. Evaluate the changes after implementation.
* The intention to establish a Continuous Improvement Register.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response, in which deficiencies remain in engaging consumers in the development, delivery and evaluation of care and services and are supported in that engagement.

Whilst I acknowledge that the service has made an obligation to improve its consumer engagement, I also acknowledge management advised of a range of actions being undertaken to address identified non-compliance at the Quality Audit in March 2023, including holding a quarterly planning meeting with consumers to develop the upcoming schedule of activities and outings for the social support group. At this stage this proposal has not been fully implemented or embedded.

The intent of this requirement expects organisations to have an organisation wide approach to involve consumers in developing, delivering and evaluating their care and services. This is an essential part of an organisation’s governance for a consumer-centred aged care service.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 8(3)(a) in Standard 8 Organisational governance.

Requirement 8(3)(c)

Requirement 8(3)(c) was found non-compliant following a Quality Audit undertaken from 10 March 2023 to 15 March 2023. The service did not demonstrate established, documented and effective organisation-wide governance systems in relation to information management, continuous improvement, regulatory compliance or feedback and complaints.

The Assessment Team’s report for the Assessment contact undertaken on 12 March 2024 includes evidence of actions taken by the service in response to the non-compliance, including but not limited to increased accuracy in record keeping and increased reporting. The Assessment Team recommended Requirement 8(3)(c) not met and provided the following evidence to support their assessment:

* The services planned improvements which have not been implemented including sourcing new policies and procedures and sourcing a new electronic record system.
* Management described how Executive Management are sourcing new policies and procedures to guide staff, as the existing guidance material is from 2016 and is not up to date.
* Management advised the provider recommended to not update policies and procedures at this point as new Standards are coming in July 2024, subsequently has not created any guidance material in the interim while policies and procedures are sourced and implemented.
* Staff advised the service does not keep progress notes for consumers unless an incident occurs within the group setting. Staff advised they do not document changes of condition or mood, and instead relay this information verbally.
* As demonstrated in Standard 2, requirement (3)(e), the service does not have an effective process for reviewing consumers regularly or when circumstances change.
* Management described how the continuous improvement register is new for the service and is still being improved, further advising the continuous improvement process will become more effective with the implementation of a new electronic system to better capture information and produce reports.
  + The services continuous improvement register contained 6 items.
  + Two items on the register do not have a timeframe for completion, and a further two items are beyond their estimated completion date with no details as to the outcome or the new estimated completion date.
  + The continuous improvement register does not contain items to address some areas of non-compliance from the Quality Audit in March 2023 including reviews and staff performance appraisals.
* The service does not have a mechanism to ensure consumers, staff and volunteers are made aware of aged care reforms. Staff advised, and documents confirmed, staff and volunteers have not been informed, trained, or provided guidance for the Serious Incident Response Scheme (SIRS) which has been in place in home services since December 2022.
* As demonstrated in Standard 7, requirement (3)(e), the service does not have a process to assess and monitor staff and volunteer performance. This issue has not been addressed since the Quality Audit in March 2023.
* Management advised the service's current training provider does not offer courses on risk, incidents or feedback and complaints, and will source this training for staff and volunteers as a matter of urgency.

The provider provided information in response to the Assessment Team’s report, including:

* Updating police check records.
* Conduct training in SIRS, document completion.
* Conduct education on consumer risk and establish administrative processes to support that process.
* Management advised they will create temporary guidance for staff while they source effective policies and procedures.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response, in which deficiencies remain in effective organisation wide governance systems.

I acknowledge management had previously provided assurances to implement a range of actions to address identified non-compliance at the Quality Audit in March 2023, however at this stage had not been fully implemented or embedded these actions.

The intent of this requirement expects organisations to illustrate how they apply and control authority below the level of the governing body. This requirement lists key areas that an organisation needs for effective organisation wide governance systems.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 8(3)(c) in Standard 8 Organisational governance.

Requirement 8(3)(d)

Requirement 8(3)(d) was found non-compliant following a Quality Audit undertaken from 10 March 2023 to 15 March 2023. The service did not demonstrate effective risk management system and practices, including, but not limited to, managing high impact or high prevalence risks associated with the care of consumers and managing and preventing incidents.

The Assessment Team’s report for the Assessment contact undertaken on 12 March 2024 includes evidence of actions taken by the service in response to the non-compliance, including but not limited to implementing effective risk management system and practices related to identifying and responding to abuse and neglect of consumers and supporting consumers to live the best life they can. The Assessment Team recommended Requirement 8(3)(d) not met and provided the following evidence to support their assessment:

* In relation to high impact or high prevalence risks associated with the care of consumers, management advised of a range of actions being undertaken to address identified non-compliance at the Quality Audit in March 2023, including incorporating risk monitoring into the service, however this has not been implemented yet.
* Staff advised they do not record progress notes for changes in consumers condition, mobility or mood, only if there is an incident.
* In relation to managing and preventing incidents, including the use of an incident management system, management advised of a range of actions being undertaken to address identified non-compliance at the Quality Audit March 2023, including adopting an incident register from the organisation's residential services.
* Management advised the service is sourcing both training and policies and procedures (including SIRS), however at the time of the Assessment Contact, these have not been obtained.

The provider provided information in response to the Assessment Team’s report, including:

* Introduce policies on continuous improvement (its purpose and review process, regulatory compliance, feedback processes related to compliments, complaints or suggestions).
* Introduce workforce policies on police checks, SIRS training, Elder abuse, staff performance appraisals, volunteer requirements and obligations, incidents and incident reporting. A policy on Dignity of Risk to implemented.
* Include risk level ratings within care Plans using a new format. Reviews to identify changes in risk indicators and response to reduce increased individual risk. Typical risk indicators such a s diabetes, impaired mobility.
* the introduction of basic first aid training for staff and volunteers.
* Engaging Choice Aged Care for training on SIRS and elder abuse.
* Introduction of a formal reporting process to inform the Executive Officer.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response, in which deficiencies remain in effective risk management system and practices, including, and managing high impact or high prevalence risks associated with the care of consumers and managing and preventing incidents.

Whilst I acknowledge that the service has made an obligation to improve elements of its organisational governance, management advised of a range of actions being undertaken to address identified non-compliance at the Quality Audit in March 2023, including incorporating risk monitoring into the service, and adopting an incident register from the organisation's residential services. I note within the providers *IERA-SSG Assessment Report Action Plan 28.3.24* many of the proposals for consideration are at draft stage, and yet to be fully implemented or embedded.

The intent of this requirement expects the organisation’s risk management system to identify and evaluate incidents and ‘near misses’ and respond accordingly. It’s also expected that the organisation uses this information to improve its performance and how it delivers quality care and services. Organisations are expected to escalate risks to the health, safety and well-being of their consumers within the organisation or to a relevant external service or organisation. It’s also expected that organisations continue to monitor risks to consumers and others and take action if a risk has increased.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 8(3)(d) in Standard 8 Organisational governance.

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)