**Performance**

**Report**

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| Name: | Interchange Wingecarribee Inc |
| Commission ID: | 200027 |
| Address: | 3 Forest Lane, BOWRAL, New South Wales, 2576 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 14 February 2024 to 15 February 2024 |
| Performance report date: | 25 March 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

Home Care Packages (**HCP**) included:  
Provider: 1847 INTERCHANGE WINGECARRIBEE INC  
Service: 26508 Interchange Wingecarribee

Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 7957 Interchange Wingecarribee Inc  
Service: 24837 Interchange Wingecarribee Inc - Care Relationships and Carer Support  
Service: 25074 Interchange Wingecarribee Inc - Community and Home Support

**This performance report**

This performance report for Interchange Wingecarribee Inc (**the service**) has been prepared by S Byers, 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) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the performance report for the Quality Audit completed 10 to 13 July 2023
* the provider did not provide a response to the Assessment Team report.

# Assessment summary for Home Care Packages (HCP)

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| --- | --- |
| Standard 1 Consumer dignity and choice | Not Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| --- | --- |
| Standard 1 Consumer dignity and choice | Not Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **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 1(3)(b) - develop and implement an effective system to ensure culturally safe care and services are delivered to consumers, supported by consistent and accurate consumer documentation to guide staff practice and relevant workforce training.
* Requirement 2(3)(b) - develop and implement an effective system and process to ensure assessment and planning captures each consumer’s needs, goals and preferences, including discussions relating to advanced care planning and end of life planning, ensure consumer documentation is consistent and accurate and staff understand the assessment and planning documentation process.
* Requirement 7(3)(e) - develop and implement an effective system and process to ensure each member of the workforce is regularly assessed, monitored and reviewed.
* Requirement 8(3)(c) - establish effective organisation-wide governance systems relating to information management, financial governance, workforce governance and regulatory compliance, supported by relevant policies and procedures and relevant workforce training. Establish and implement effective information management systems to support the management of financial systems and deliver accurate financial information to consumers. Establish and implement systems to support the review of workforce performance, relevant workforce training and to monitor workforce compliance documentation.
* Requirement 8(3)(d) – establish a risk management framework that is supported by accurate and effective risk registers, consumer documentation and relevant workforce training.

# Standard 1

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| --- | --- | --- | --- |
| Consumer dignity and choice | | HCP | CHSP |
| Requirement 1(3)(b) | Care and services are culturally safe | Not Compliant | Not Compliant |
| 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

The service was found non-compliant in Standard 1 in relation to Requirement 1(3)(b) and 1(3)(e) following a Quality Audit undertaken 10 to 13 July 2023 where it did not demonstrate care and services are culturally safe, and information provided to the consumer is accurate, timely or easy to understand.

Requirement 1(3)(b)

At the February 2024 Assessment Contact, the Assessment Team found the service had not addressed the deficits identified at the July 2023 Quality Audit.

The Assessment Team provided the following evidence:

* while most consumers said support workers know their background and what is important to them, negative feedback was received in relation to communication and language barriers between consumers and support workers
* support workers reported accessing information about each consumer’s cultural needs and preferences from the scope of work, however this information is limited and does not include information about diversity
* support workers do not receive cultural safety training.
* cultural awareness or cultural safety training does not form part of the services mandatory training. Approximately 10% of staff have completed cultural safety training.
* the service does not have diversity or inclusion policies in place to guide staff practice
* despite delivering services to a culturally diverse consumer cohort, sampled care plans for both HCP and CHSP consumers provided limited detail about the consumer’s cultural needs and preferences.

I have considered the information in the Assessment Team report. The information in the report does not demonstrate the Provider has taken appropriate action to rectify the previous non-compliance, particularly that systems are in place to ensure each consumers cultural needs and preferences are understood, staff have access to current and accurate documentation that reflects each consumers cultural needs and preferences, and the workforce is trained to deliver cultural safe care and services. Based on the evidence available, summarised above, I agree with the Assessment Team’s recommendation and find requirement 1(3)(b) is Non-compliant.

Requirement 1(3)(e)

At the February 2024 Assessment Contact, the Assessment Team found the service had implemented improvement actions to address the deficits identified at the July 2023 Quality Audit.

The Assessment Team provided the following evidence:

* consumers described clear and consistent information is provided, they understand their monthly statements and they communicate with coordinators to seek clarification, where needed
* staff provided examples where they supported consumers to understand statements including phone calls and face to face meetings
* management confirmed that outbound written communication is limited to monthly statements. This was supported by a letter explaining a change to CHSP prices that clearly explained the changes for each service type.

I have considered the information in the Assessment Team report. I have placed weight on the positive consumer and staff feedback in relation to monthly statements being timely, clear and easily understood. On the balance of evidence available, summarised above, I agree with the Assessment Team’s recommendation and find requirement 1(3)(e) is Compliant.

# Standard 2

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| --- | --- | --- | --- |
| Ongoing assessment and planning with consumers | | HCP | CHSP |
| 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 Compliant | Not 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 was found non-compliant in Standard 2 in relation to Requirements 2(3)(b) and 2(3)(e) following a Quality Audit undertaken 10 to 13 July 2023 where it did not demonstrate advanced care planning or end of life planning is completed as part of assessment and planning processes, and care and services are not reviewed regularly for effectiveness, when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

Requirement 2(3)(b)

At the February 2024 Assessment Contact, the Assessment Team found the service had not addressed the deficits identified at the July 2023 Quality Audit.

The Assessment Team provided the following evidence:

* consumers and representatives described their needs and goals and confirmed receiving services to support these
* staff reported they did not receive current information about consumers’ needs and preferences at point of care. The scope of work they rely on to access consumer information is often incomplete, out of date and provides limited details
* scope of work documents for three HCP consumers demonstrated inconsistent levels of information detail
* most consumers reported the service did not discuss end of life planning or advance care directives with them. Two consumers recalled discussing end of life planning
* sampled care plans did not document advance care directives or end of life wishes
* management explained the service does not have advance care or end of life planning policies and procedures.

I have considered the information in the Assessment Team report. The information in the report does not demonstrate the Provider has taken appropriate action to rectify the previous non-compliance, particularly that systems are in place to ensure that staff have access to current information about consumer needs and preferences, and that advance care planning and end of life planning are completed as part of the assessment and planning process. Based on the evidence available, summarised above, I agree with the Assessment Team’s recommendation and find requirement 2(3)(b) is Non-compliant.

Requirement 2(3)(e)

At the February 2024 Assessment Contact, the Assessment Team found the service had implemented actions to address the deficits identified at the July 2023 Quality Audit.

The Assessment Team provided the following evidence:

coordinators demonstrated through feedback and supporting documentation that consumers receiving HCP and CHSP services are regularly reviewed for effectiveness and following a change in condition or health status. Clinical reviews occur 3-monthly for HCP consumers. CHSP consumers who are discharged from hospital receive timely reviews

* the service’s client management system reflects care plan review dates. CHSP and HCP consumers are scheduled for review annually. Review of documentation demonstrated all reviews were current but for 2 that were overdue by one week.
* consumers and representatives reported being unsure about how they could adjust their services. Support workers reported they were not involved in care plan reviews.

I have considered the information in the Assessment Team report. I acknowledge that consumers and support workers reported being unfamiliar with care plan reviews, however I have placed weight on the examples demonstrating regular review and reassessment of HCP and CHSP by coordinators, supported by client management systems and associated documentation. On the balance of evidence available, summarised above, I agree with the Assessment Team’s recommendation and find requirement 2(3)(e) is Compliant.

# Standard 3

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| --- | --- | --- | --- |
| Personal care and clinical care | | HCP | CHSP |
| 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. | Compliant | Compliant |

Findings

The service was found non-compliant in Standard 3 in relation to Requirement 3(3)(g) following a Quality Audit undertaken 10 to 13 July 2023 where it did not demonstrate minimisation of infection related risks occurs.

Requirement 3(3)(g)

At the February 2024 assessment contact, the Assessment Team found the service had implemented some actions to address the deficits identified at the July 2023 Quality Audit.

The Assessment Team provided the following evidence:

* positive feedback from consumers in relation to staff practice in hand hygiene and use of personal protective equipment (PPE)
* reporting processes are in place to report when a consumer or staff are unwell. Processes are in place to ensure staff have ready access to PPE
* the service has an infection control policy in place that reflects standard precautions
* the service has a COVID-19 safety plan and COVID-19 management plan. COVID-19 response plans are included in consumer care plans
* most staff have completed mandatory infection prevention and control training including hand hygiene
* PPE stock was observed readily available at the service’s office
* management said the organisation does not have an antimicrobial stewardship policy.

I have considered the information in the Assessment Team report. I have placed weight on the processes and policies in place to minimise infection related risks. Based on the available evidence, I do not have sufficient evidence to making a finding on Requirement 3(3)(g)(ii) in relation to effective systems to promote and support antibiotic prescribing and risks. I have considered the lack of organisational antimicrobial stewardship policy under Requirement 8(3)(e) where I consider it more relevant to governance. On the balance of evidence available, summarised above, I agree with the Assessment Team’s recommendation and find requirement 3(3)(g) is Compliant.

# Standard 7

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| --- | --- | --- | --- |
| Human resources | | HCP | CHSP |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Not Compliant | Not Compliant |

Findings

The service was found non-compliant in Standard 7 in relation to Requirements 7(3)(d) and 7(3)(e) following a Quality Audit undertaken 10 to 13 July 2023 where it did not demonstrate the workforce is recruited, trained, equipped and supported to deliver the outcomes required by the Quality Standards, and regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

Requirement 7(3)(d)

At the February 2024 Assessment Contact, the Assessment Team found the service had implemented some actions to address the deficits identified at the July 2023 Quality Audit.

The Assessment Team provided the following evidence:

* all support workers reported completing a comprehensive induction upon commencement. This included several buddy shifts and the completion of online training. Feedback indicated that new staff attend an organisation orientation day
* support workers reported feeling supported by their supervisors and were confident they could access training if they requested it
* The mandatory training matrix reflected improved rates for staff completion of training since the July 2023 Quality Audit. While the service is yet to implement dementia and falls prevention training, restrictive practices training has been introduced with most staff completing the online sessions
* medication competency training has been completed by most staff who require it for their role. For those staff who are yet to complete the training, they are not rostered medication shifts.

I have considered the information in the Assessment Team report. I have placed weight on the improved completion rates of mandatory training and positive staff feedback relating to induction and training. While I note that some training is yet to be implemented including dementia and falls prevention, I encourage the Provider to continue to implement, embed and evaluate the continuous improvement actions in relation to training to ensure the workforce is equipped and supported to deliver outcomes under the Quality Standards. On the balance of evidence available, summarised above, I agree with the Assessment Team’s recommendation and find requirement 7(3)(d) is Compliant.

Requirement 7(3)(e)

At the February 2024 Assessment Contact, the Assessment Team found the service had not addressed the deficits identified at the July 2023 Quality Audit.

The Assessment Team provided the following evidence:

* none of the staff interviewed could recall participating in a performance review or receiving formal feedback from their supervisor
* management described a workforce performance framework had recently been approved but was yet to be implemented. The Assessment Team observed performance review supporting documentation including self-evaluation and supervisor evaluation forms, discussion plan and agreements
* position descriptions are currently being updated and will inform performance reviews.

I have considered the information in the Assessment Team report. The information in the report does not demonstrate that the Provider has taken appropriate action to rectify the previous non-compliance, to implement systems to ensure regular assessment, monitoring and review of workforce performance. While I acknowledge the remedial actions taken by the Provider, they are yet to be implemented, embedded and evaluated. Based on the evidence available, summarised above, I agree with the Assessment Team’s recommendation and find requirement 7(3)(e) is Non-compliant.

# 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. | Not Compliant | 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 | Not 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. | Compliant | Compliant |

Findings

The service was found non-compliant in Standard 8 in relation to Requirements 8(3)(c), 8(3)(d) and 8(3)(e) following a Quality Audit undertaken 10 to 13 July 2023 where it did not demonstrate:

* effective organisation-wide systems in relation to information management, financial governance, workforce governance and regulatory compliance
* effective risk management systems and practices are in place to manage high-impact or high-prevalence risk, identify and respond to abuse and neglect and manage and prevent incidents
* effective clinical governance.

Requirement 8(3)(c)

At the February 2024 Assessment Contact, the Assessment Team found the service had not addressed the deficits identified at the July 2023 Quality Audit.

The Assessment Team provided the following evidence:

Information management

* the service is currently transitioning between electronic documentation systems. The new system is yet to be fully implemented with staff training and testing not yet completed. Currently data reports cannot be electronically accessed from the new system. Management described reporting is a manual and timely process which incurs human error
* management explained fees and charges have been incorrectly input into the new system resulting in inaccurate HCP balances for most statements. Finance is currently reconciling all accounts to ensure the new system reflects correct data
* information policies are out of date with a last review date of 2012
* information under Requirements 1(3)(b) and 2(3)(b) demonstrate that while the workforce can access information through a scope of work, the information provided is insufficient and inconsistent to support the delivery of safe and quality care and services.

Financial management

* as described under information management above, due to ineffective information systems incorrect financial information is being issued to HCP consumers, with most statements including inaccurate information
* board reports observed by the Assessment Team reflect HCP budget issues are reported to the Board.

Workforce Governance

* information under Requirement 7(3)(e) demonstrates that while the Provider has implemented some actions, workforce performance is not assessed, monitored or reviewed.
* position descriptions are not current or complete.

Regulatory compliance

* while the service has commenced the delivery of regulatory training in relation to the Serious Incident Response Scheme (SIRS), only a limited number of staff have completed the training
* effective monitoring systems and practices are not in place to ensure workforce compliance documents including driver licences, registration and insurance are current. Most staff licences and insurances were observed as expired. The service does not monitor car registrations.

Based on the information in the Assessment Team report, I agree with the Assessment Team that the Provider has demonstrated effective continuous improvement and feedback and complaints governance systems.

I have reviewed the information in the Assessment Team report. I have also considered information and the findings of non-compliance in Standards 1, 2 and 7 in relation to assessment and planning documentation and workforce performance. The information in the report does not demonstrate the Provider has taken appropriate action to rectify the previous non-compliance, and that effective information management, financial management, workforce governance and regulatory compliance systems are in place. Based on the evidence available, summarised above, I agree with the Assessment Team’s recommendation and find requirement 8(3)(c) is Non-compliant.

Requirement 8(3)(d)

At the February 2024 Assessment Contact, the Assessment Team found the service had not addressed the deficits identified at the July 2023 Quality Audit.

The Assessment Team provided the following evidence:

* support workers described the incident reporting process and provided examples relating to their work.
* the service has an incident management system in place that incorporates SIRS reporting. Incidents and risks are reported to the Board.
* consumer risks are identified through assessment, planning and review at the service level. While care plans observed by the Assessment Team reflected risk assessments and mitigation strategies, I have also considered information in Requirements 1(3)(b) and 2(3)(b) that reflect staff are provided with insufficient and inconsistent consumer information relating to cultural safety and needs, goals and preferences including advance care planning
* the service has a risk register in place; however, it is not current and is incomplete. Mitigating strategies to reduce risk and associated risk ratings are not documented. While management explained a more functional risk register is being developed, a timeline for completion was not provided
* a limited number of staff have completed training in SIRS.

I have also taken into consideration that the service has not introduced dementia or falls prevention training which are both high impact and high prevalence risks and associated with the prevention of incidents.

I have reviewed the information in the Assessment Team report. I have also considered information and the findings of non-compliance in Standards 1 and 2 in relation to assessment and planning documentation, and relevant workforce training. The information in the report does not demonstrate the Provider has taken appropriate actions to rectify the previous non-compliance, and that effective risk management systems and practices are in place. I have placed weight on the services lack of effective risk register to ensure risks are managed and accurately reported, workforce completion of SIRS training, dementia and falls prevention training to ensure risks and incidents associated with consumers are appropriately prevented, managed and monitored. Based on the evidence available, summarised above, I agree with the Assessment Team’s recommendation and find requirement 8(3)(c) is Non-compliant.

Requirement 8(3)(e)

At the February 2024 Assessment Contact, the Assessment Team found the service had implemented some actions to address the deficits identified at the July 2023 Quality Audit.

The Assessment Team provided the following evidence:

* a formal clinical governance framework is not in place; however, processes are in place to guide staff in the delivery of clinical care. Registered nurses’ complete clinical assessments and delivery clinical care. Clinical assessment for HCP occurs every three months which was supported by care plans
* management acknowledged a formalised clinical governance is required and this is documented in the services Plan for Continuous Improvement (PCI)
* registered nurses deliver competency training. Management provided evidence that supported the completion of relevant clinical workforce training and monitoring systems are in place
* the service has a restrictive practices policy and procedure in place that is not reflective of aged care requirements. However, staff demonstrated understanding of restrictive practices. Staff have completed relevant training in restrictive practices
* the service has an infection control policy in place. Most staff have completed relevant training in infection prevention and control practices
* management said the organisation does not have an antimicrobial stewardship policy and could not demonstrate understanding of antimicrobial stewardship.

I have considered the information in the Assessment Team report. I have placed weight on staff completion of relevant training, clinical review processes, staff understanding of restrictive practices and infection prevention and control. I encourage the Provider to continue to implement, embed and evaluate the continuous improvement actions particularly the development and updating of restrictive practices and antimicrobial stewardship policies to support a formalised clinical governance framework to align with best practice. On the balance of evidence available, summarised above, I agree with the Assessment Team’s recommendation and find requirement 8(3)(e) is Compliant.

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)