**Performance**

**Report**

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| Name: | Islamic Women's Association of Australia |
| Commission ID: | 700191 |
| Address: | 11 Watland Street, SPRINGWOOD, Queensland, 4127 |
| Activity type: | Assessment contact (performance assessment) – non-site |
| Activity date: | on 2 November 2023 |
| Performance report date: | 8 January 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: 1946 Islamic Women's Association of Australia (IWAA) Inc.

Service: 18222 Islamic Women's Assoc QLD - Brisbane South

Service: 18223 Islamic Women's Community Aged Care Service (EACH Dementia)

Commonwealth Home Support Programme (**CHSP**) included:

Provider: 7894 Islamic Women's Association of Queensland Inc

Service: 24171 Islamic Women's Association of Queensland Inc - Care Relationships and Carer Support

Service: 24170 Islamic Women's Association of Queensland Inc - Community and Home Support

**This performance report**

This performance report for Islamic Women's Association of Australia (**the service**) has been prepared by L. Malone, 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) – non-site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others

# 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 6** Feedback and complaints | **Not Applicable as not all Requirements have been assessed** |
| **Standard 7** Human resources | **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 6** Feedback and complaints | **Not Applicable as not all Requirements have been assessed** |
| **Standard 7** Human resources | **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

Requirement 1(3)(e) was found non-compliant following a Quality Audit undertaken from 13 March to 15 March 2023 as the service did not demonstrate effective communication of information to consumers and representatives in a way that is easy to understand and enables consumer choice, with some consumers not understanding recent changes to funding arrangements and services provided under their home care package.

The Assessment Contact Report dated 2 November 2023 includes evidence of actions taken by the service in response to the non-compliance. These actions included a process of consultation on written information for consumers with an internal Consumer Advisory Group (CAG) to ensure it is clear and easy for consumers to understand, translation of documents into consumer’s preferred languages including Farsi, Arabic, Bosnian and Hindi, provision of information on pricing and support for financial hardship in these languages, and consumer access to the service’s financial personnel to discuss concerns related to accounts and pricing.

Consumers provided positive feedback stating they are satisfied with the content or frequency of information provided, that requests for information are responded to promptly and described staff assisting them to seek information they need.

The Assessment Team was satisfied these improvements were effective and that consumers receive relevant information in a way they can understand. The Assessment Team recommended Requirement 1(3)(e) is met.

I am satisfied the evidence presented in the Assessment Contact Report and summarised above, demonstrates effective communication of relevant and timely information to enable consumers to be informed and make choices about their care and services. I find the provider, in relation to the service, compliant with Requirement 1(3)(e).

# 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 |

Findings

Requirement 2(3)(a) was found non-compliant following a Quality Audit undertaken from 13 March to 15 March 2023, as the service did not demonstrate effective systems and processes to identify and consider risks, and deficits were found in documentation of assessment outcomes and planned strategies to support consumer health and wellbeing.

The Assessment Contact Report dated 2 November 2023 includes evidence of actions taken by the service in response to the non-compliance including care documentation review. The Assessment Team found care planning documentation to be comprehensive and identified risks, and individualised care plans documented strategies informed by assessment and appropriate to the identified risks. For example, in relation to consumers with changed behaviours due to dementia and who are prescribed a restrictive practice, care files contained information as to the triggers for behaviours and alternative strategies to minimise the use of restrictive practices and support the consumer’s wellbeing. For consumers identified as at risk of falls, care documentation demonstrated recommendations of equipment in the home, and for another consumer living with cognitive difficulties and diabetes, relevant strategies to manage risks including appointment reminders, daily blood sugar monitoring and medication assistance were documented. Staff and management described the service’s assessment and planning process, and demonstrated knowledge of what safe and effective care and services means for individual consumers.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 2(3)(a) is met.

The Assessment Contact Report has a statement that for one consumer there is verbal consent to lock the doors overnight, but this is not documented. It is not clear from the statement whether this strategy is used as a restrictive practice. In considering the evidence, I have placed weight on other evidence of a comprehensive, documented behavioural support plan and documented consent for other forms mechanical and chemical restrictive practice which consider risks for the same consumer. I have also considered in my decision evidence presented under Requirement 3(3)(b) of the Assessment Contact Report that consumers with an identified high-impact, high-prevalence risk are assessed by a clinical staff member and a risk management plan is developed.

I am satisfied the evidence presented in the Assessment Contact Report and summarised above, demonstrates risks to consumer health and wellbeing are effectively considered and that processes of assessment and care planning supports minimisation of these risks, and supports safe and effective care, I find the provider, in relation to the service, compliant with Requirement 2(3)(a).

Requirement 2(3)(b) was found non-compliant following a Quality Audit undertaken from 2 November 2023 as the service did not demonstrate an approach to assessment and care planning which identifies and addresses consumers current needs, goals and preferences, and it was found no discussions or information had been provided to consumers in relation to advanced care planning (ACP).

The Assessment Contact Report dated 2 November 2023 includes evidence of actions taken by the service in response to the non-compliance. These actions included implementation of a new assessment form which allows consumers and/or their representatives to provide personal information such as religious backgrounds, personal preferences and goals, provision of training to staff to enable culturally sensitive discussions about ACP and end of life wishes, and information about end-of-life care being made available in English and Arabic.

Consumers and / or representatives interviewed by the Assessment Team provided feedback that previously services had been cut or were not sufficient to meet their needs, but they noted actions such as care plan reviews and providing them with appropriate information had improved their satisfaction. The Assessment Team found evidence of ACP discussions in consumer care documentation. The Assessment Team was satisfied these improvements were effective and recommended Requirement 2(3)(b) is met.

I am satisfied the evidence presented in the Assessment Contact Report and summarised above, demonstrates processes of assessment and care planning effectively address consumer’s needs, goals, and preferences, including end-of-life wishes. I find the provider, in relation to the service, compliant with Requirement 2(3)(b).

# 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 |

Findings

Requirement 3(3)(b) was found non-compliant following a Quality Audit undertaken from 13 March to 15 March 2023, as the service did not demonstrate effective management of high-impact, high-prevalence risks. Systems of reporting incidents were not consistent, care documentation did not provide adequate guidance to staff and risks to consumers were not effectively monitored. Specifically in relation to medication management, there were deficits in the management of risks related to medication administration and reporting of medication incidents, and deficits in staff knowledge and practice in the use of restrictive practices.

The Assessment Contact Report dated 2 November 2023 includes evidence of actions taken by the service in response to the non-compliance. These actions included changes to administration of medication processes with only one senior personnel responsible for ‘as required’ or PRN medication, implementation of daily ‘huddle’ meetings to discuss ongoing or new high-risk consumers or concerns, development of a policy to manage high-impact, high-prevalence risks, and delivery of information to consumers about the service’s responsibilities, consumer rights and reporting processes.

The Assessment Team found evidence gathered through care documentation reviews and interviews demonstrated high-impact, high-prevalence risks are identified and effectively managed. For example, in relation to risks related to changed behaviours in dementia and the use of restrictive practices, staff were informed of relevant risks to individual consumers and how changes to medication administration practices supported the minimisation of restrictive practices, and care documentation indicated the strategies in place are effective for the consumer. I have also considered evidence presented in Requirement 2(3)(a) describing the use of webster packed medication for consumers requiring medication assistance at cottage respite. The Assessment Team was satisfied these improvements were effective and recommended Requirement 3(3)(b) is met.

I am satisfied the evidence presented in the Assessment Contact Report and summarised above, demonstrates high-impact, high-prevalence risks to consumers are identified and addressed. I find the provider, in relation to the service, compliant with Requirement 3(3)(b).

# Standard 4

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| Services and supports for daily living | | HCP | CHSP |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant | Compliant |

Findings

Requirement 4(3)(a) was found non-compliant following a Quality Audit undertaken from 13 March to 15 March 2023 as the service did not demonstrate the delivery of supports which met consumers’ needs, goals and preferences. Consumers provided feedback that services had been ceased or current services were not effective in meeting their needs.

The Assessment Contact Report dated 2 November 2023 includes evidence of actions taken by the service in response to the non-compliance. These actions included input from the Commonwealth Home Support Program (CHSP) co-ordinator for consumers seeking services and support additional to current funding arrangements, a review of services and supports for identified consumers, and provision of accessible information in relation to services and pricing which I have considered in Requirement 1(3)(e).

Consumers provided positive feedback about how the services they receive support their independence and to live at home. Staff were informed of the type of supports and services for activities of daily living which are important to consumer’s independence. The Assessment Team was satisfied these improvements were effective and recommended Requirement (3)(a) is met.

I am satisfied the evidence presented in the Assessment Contact Report and summarised above, demonstrates improvements in the delivery of services and supports for activities of daily living. In coming to my decision, I place weight on the feedback from consumers that services and supports received meets their needs, goals and preferences. I find the provider, in relation to the service, compliant with Requirement 4(3)(a).

# Standard 6

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| Feedback and complaints | | HCP | CHSP |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant | Compliant |

Findings

Requirement 6(3)(d) was found non-compliant following a Quality Audit undertaken from 13 March to 15 March 2023, as the service did not demonstrate an effective system of capturing consumer feedback and complaints leading to resolution of some issues without documentation, thus feedback was not effectively captured for analysis of trends and improvement opportunities.

The Assessment Contact Report dated 2 November 2023 includes evidence of actions taken by the service in response to the non-compliance. These actions include but, are not limited to improvements to the systems of documenting feedback and complaints to allow analysis and the identification of trends. The Assessment Team found individual consumer complaints which resulting in system improvements such as more accessible language in Home Care Package (HCP) agreements and the engagement of a legal consultant and modification of the language in the documents. The Assessment Team was satisfied these improvements were effective and recommended Requirement 6(3)(d) is met.

Consumer and/or representatives provided examples of complaints they had raised which were responded to and led to improvements in their care and services such as changes to support staff or provision or required equipment, and spoke positively about how their concerns were handled.

I am satisfied the evidence presented in the Assessment Contact Report and summarised above, demonstrates feedback and complaints are used to improve care and services. I find the provider, in relation to the service, compliant with Requirement 6(3)(d).

# 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 |

Findings

Requirement 7(3)(d) was found non-compliant following a Quality Audit undertaken from 13 March to 15 March 2023 as the service did not demonstrate staff were sufficiently trained and equipped in relation to PRN medication prompting and administration and the use of restrictive practices. It was found training scheduled and delivered did not address these areas of care.

The Assessment Contact Report dated 2 November 2023 includes evidence of actions taken by the service in response to the non-compliance. These actions included a review of relevant policies and procedures, improvements to the schedule of training delivered, a training schedule which considers consumer feedback and approval of the training schedule through the quality committee. The organisation implemented an annual training day which had high participation of staff across multiple roles, and covered restrictive practices, medication management and other topics relevant to delivery of the outcomes required by the Quality Standards such as code of conduct, incident reporting and the Serious Incident Response Scheme (SIRS). The Assessment Contact Report presents evidence of effective processes to identify individual staff training needs and staff provided feedback they receive regular training and that training delivered improved their knowledge in how to best support consumers living with cognitive difficulties. The Assessment Team was satisfied these improvements were effective and recommended Requirement 7(3)(d) is met.

I am satisfied the evidence presented in the Assessment Contact Report and summarised above, demonstrates staff are trained, equipped and supported to deliver outcomes required by the Quality Standards. I find the provider, in relation to the service, compliant with Requirement 7(3)(d).

# Standard 8

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

Requirement 8(3)(b) was found non-compliant following a Quality Audit undertaken from 13 March to 15 March 2023 as incident, feedback and complaints systems were not centralised and information was not always captured at the governance level to support effective analysis and response, presenting risk to the safety and inclusivity of care and services.

The Assessment Contact Report dated 2 November 2023 includes evidence of actions taken by the service in response to the non-compliance. The Assessment Team found evidence of effective systems of communicating key information between the management at service and governing body. Regular quality committee meetings are held by the service where details of feedback and complaints, incidents including SIRS, clinical issues, staffing, and continuous improvement plans are addressed. A member of management attends the quality committee and communicates relevant information back to the management committee. The Assessment Contact Report presents evidence of recent examples of improvements made to support safe and inclusive care and service delivery which were identified through consumer feedback.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 8(3)(b) is met.

Requirement 8(3)(c) was found non-compliant following a Quality Audit undertaken from 13 March to 15 March 2023 as systems of workforce governance did not ensure staff were appropriately trained and practicing within scope in relation to medication management.

The Assessment Contact Report dated 2 November 2023 includes evidence of actions taken by the service in response to the non-compliance. These actions included the implementation of mandatory training and an annual training day considered under Requirement 7(3)(d), and management and quality committee oversight of expectations of staff knowledge and practice under brokerage arrangements.

The Assessment Team found evidence effective governance systems in information management with an electronic based care system and accessible information for staff the at point of care, continuous improvement with feedback and incidents informing improvement opportunities, and financial governance with systems of management oversight and internal and external financial audits. The Assessment Team found the organisation seeks information regulatory compliance through government and other resources and participation in sector forums and has effective systems to communicate changes to staff. The Assessment Team was satisfied these improvements were effective and recommended Requirement 8(3)(c) is met.

In coming to my decision related to workforce governance, I have considered evidence under Requirements 3(3)(b) in the Assessment Contact Report related to feedback from staff indicating they understand the scope of their role in relation to medication management, and under requirement 8(3)(d) noting improvements to systems and processes to capture and utilise incident data and feedback.

Requirement 8(3)(d) was found non-compliant following a Quality Audit undertaken from 13 March to 15 March 2023 as inconsistency in systems to document incidents across services leading to insufficient capture and lack of centralised incident management by then governing body, thus limiting analysis of incidents and effective risk management across the organisation.

The Assessment Contact Report dated 2 November 2023 includes evidence of actions taken by the service in response to the non-compliance. These actions included improvements to incident management and reporting practices to improve the analysis and trending data for service improvements.

The organisation has a range of current policies and procedures to support effective risk management including risk assessment, preventions and incident management, and scheduled work, health, and safety (WH&S) reviews of the service environment. The governing body regularly reviews incident data and trending analysis to identify high prevalence and/or high impact risks for consideration at management and quality committee meetings, to enable implementation of preventative strategies and quality improvements as a response to risk identified. The Assessment Team found receive adequate training in incident management, including SIRS, and preventing abuse and neglect.

Requirement 8(3)(e) was found non-compliant following a Quality Audit undertaken from 13 March to 15 March 2023 as the use of restrictive practices was not recognised despite being identified as part of some consumer’s care.

The Assessment Contact Report dated 2 November 2023 includes evidence of actions taken by the service in response to the non-compliance. The Assessment Team found relevant clinical policies such as minimisation of the use of restrictive practices, antimicrobial stewardship, and infection control to be accessible and current. The organisation has a management committee, clinical specialist and quality committee who receive monthly reports to conduct trending and address emerging clinical issues.

In coming to my decision, I have considered evidence under Requirements 2(3)(a), 2(3)(b) and 3(3)(b) of the Assessment Contact Report which reflects improved staff knowledge with restrictive practices in place identified for consumers, the implementation of behavioural support strategies and staff feedback related to improved knowledge of the care of consumers with changed cognition.

I am satisfied the evidence presented in the Assessment Contact Report and summarised above demonstrate improvements in organisational governance have been undertaken to address the non-compliance. I find the provider, in relation to the service, compliant with Requirement 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e).

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)