Maltese Meals and Community Service - CHELTENHAM

Performance Report

Cheltenham Community Centre, 62 Stroud Street North
CHELTENHAM SA 5014
Phone number: 08 8241 0266

**Commission ID:** 600176

**Provider name:** Maltese Aged Care Association (SA) Incorporated

**Assessment Contact - Desk date:** 5 April 2022

**Date of Performance Report:** 6 June 2022

# Performance report prepared by

A.Grant, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

**Services included in this assessment**

**CHSP:**

* Domestic Assistance, 4-7XMWAFE, Cheltenham Community Centre, 62 Stroud Street North, CHELTENHAM SA 5014
* Flexible Respite, 4-7XN44WV, Cheltenham Community Centre, 62 Stroud Street North, CHELTENHAM SA 5014
* Meals, 4-7XN44ZO, Cheltenham Community Centre, 62 Stroud Street North, CHELTENHAM SA 5014
* Social Support - Group, 4-7XN452H, Cheltenham Community Centre, 62 Stroud Street North, CHELTENHAM SA 5014
* Social Support - Individual, 4-7XN455A, Cheltenham Community Centre, 62 Stroud Street North, CHELTENHAM SA 5014
* CHSP Transport, 4-7XN4583, Cheltenham Community Centre, 62 Stroud Street North, CHELTENHAM SA 5014

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 2 Ongoing assessment and planning with consumers** | **Not Compliant** |
| Requirement 2(3)(e) | Not Compliant |
| **Standard 8 Organisational governance** | **Not Compliant** |
| Requirement 8(3)(c) | Not Compliant |

# Detailed assessment

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 Standard and requirements are assessed as either compliant or not compliant at the Standard and requirement level where applicable.

The report also specifies areas in which improvements must be made to ensure the Quality Standards are complied with.

The following information has been taken into account in developing this performance report:

* The Assessment Team’s report for the Assessment Contact - Desk; the Assessment Contact - Desk report was informed by a review of documents and interviews with staff and others.
* The provider’s responses to the Assessment Contact - Desk report received 6 May 2022 and 13 May 2022.

# STANDARD 2 NOT COMPLIANTOngoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Quality Standard is assessed as Not Compliant as one of the five specific requirements in particular 2(3)(e) have been assessed as Not Compliant.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(e) Not Compliant

*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.*

The Assessment Team found at the point in time the assessment contact was conducted the Provider failed to demonstrate that consumers’ services are reviewed regularly for effectiveness, including when consumers’ circumstances have changed.

The Assessment Team viewed the providers annual reviews register which showed that at the time of the assessment contact, out of 257 consumers currently receiving services, 98 consumers were overdue for an annual review with 27 of these due to be completed in May to September 2020, 65 due to be completed in 2021 and 6 in 2022.

During interviews with management the Assessment Team was advised the Provider had not historically developed care plans for consumers. Services were informed by the My Aged Care Support Plan and conversations with the consumers, these are then documented in various systems such as the electronic database, case notes, meals preference sheets, meals delivery run sheets and transport list. Management advised staff, volunteers and contractors do not have access to the electronic database and case notes. However, the Provider has commenced developing care plans for consumers following their review.

The Assessment Team viewed care planning documents for 4 sampled consumers and identified that their services had either not been reviewed, including when their circumstances had changed, or reviews completed had identified individual needs, preferences and risks, however, this had not consistently and effectively informed an update to their care plan. A sample of examples and evidence of the Provider not meeting this requirement at the time of the Assessment Contact are included below.

Evidence obtained by the Assessment Team shows Consumer A is provided frozen meals and transport, and was due for an annual review on 23 November 2021, the review was still outstanding at the time of the assessment contact. Evidence shows the consumers’ circumstances had changed due to a stroke in December 2021 and another stroke early 2022. The Provider could not demonstrate that Consumer A’s service had effectively been reviewed and/or documented on a care plan following Consumer A’s health change.

The consumer was referred by the hospital for an Aged Care Assessment Team (ACAT) assessment which was completed on 28 March 2022, which identified Consumer A had trips and falls in the last 12 months and diabetes controlled by diet. The Assessment Team located evidence that showed although the transport list documents the use of a walker, it does not reflect the consumers’ risk of falls. Furthermore, her diabetes and dietary requirements were not documented in the consumers’ care planning documentation. The Provider did not provide a meals preference sheet for Consumer A.

Evidence obtained by the Assessment Team shows Consumer B is provided transport and was due for an annual review on 14 May 2021, the review was still outstanding at the time of the assessment contact.

Consumer B was assessed by My Aged Care in August 2021, which identified that Consumer B had two or three falls over the previous 12 months and declining mobility. Evidence showed the Provider could not demonstrate that Consumer B’s service needs had been reviewed and/or documented on a care plan following the assessment. Management advised that Consumer B had not yet had a review and there is no documented care plan. Consumer B’s transport needs are documented on the transport list, but the Assessment Team noted that the list states ‘must use a lift bus’, however, does not mention a history of falls or reduced mobility.

Evidence obtained by the Assessment Team shows Consumer C’s services were reviewed on 22 September 2022, the Service User Assessment Form completed during the review showed Consumer C had a history of stroke, diabetes, and dietary requirements including no custard, pasta or rice and not too much gravy. The care plan states that Consumer C has dietary requirements, however, the specific requirements are not documented. Management interviewed stated that staff in the kitchen do not have access to the care plan and are guided by Consumer C’s meals preference sheet. Evidence showed Consumer C’s individual menu did not indicate that the consumer has diabetes or has dietary requirements.

While I am satisfied that the approved provider, through its continuous improvement activities and response to the Assessment Teams report have already partially addressed the deficits identified by the team, and I am satisfied will continue to, at the time of the assessment contact the Provider was unable to demonstrate that all consumers’ services are being reviewed regularly for effectiveness. Consumers sampled, where reviews were completed, care plans and service delivery documents were not consistently updated to reflect the changing needs, preferences and risks for those consumers.

Based on all the available evidence the approved provider does not comply with this Requirement.

# STANDARD 8 NOT COMPLIANTOrganisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

The Quality Standard is assessed as Not Compliant as one of the five specific requirements in particular 8(3)(c) have been assessed as Not Compliant.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(c) Not Compliant

*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.*

The Assessment Team found at the point in time the assessment contact was conducted the Provider failed to demonstrate effective information management and regulatory compliance.

**Information Management**

The provider demonstrated limited understanding and application of this requirement, improvements have been made by the provider to address the identified deficiencies at previous visits conducted by the Aged Care Quality and Safety Commission,

Evidence obtained by the Assessment Team shows the provider’s information management systems are not effective or sufficient. The provider was not able to demonstrate that staff, volunteers and sub-contractors are provided with sufficient information to help them when delivering safe and effective services to consumers. A sample of examples and evidence of the provider not meeting this requirement at the time of the assessment contact are included below.

Evidence obtained by the Assessment Team showed two consumers sampled during the assessment contact with a history of falls did not have this reflected in the transport list. Evidence obtained by the Assessment Team showed two consumers sampled during the assessment contact did not have their dietary requirements or preferences documented in their care plan. The Assessment Team were not provided with preference sheets when requested. Refer to Standard 2 Requirement (3)(e) regarding how the provider did not demonstrate effective information management systems to ensure consumers’ needs, goals and preferences are reviewed regularly and as required.

Management advised they have received board approval to obtain new software to enable effective and efficient information management, however, have been unable to identify software that is suitable for the provider.

**Regulatory Compliance**

The provider demonstrated a regulatory compliance framework is in place, however, it is not always effective. Evidence obtained by the Assessment team shows the provider did not demonstrate understanding and application of requirements to review consumers’ service needs. A sample of examples and evidence of the Provider not meeting this requirement at the time of the Assessment Contact are included below.

As demonstrated under Standard 2 requirement (3)(e) consumers’ needs, goals and preferences are not reviewed annually as required by the CHSP funding requirements, and as required by the Aged Care Quality Standards, regularly for effectiveness and following changes or deterioration. Evidence obtained by the Assessment Team shows staff are not provided guidance on review requirements, such as policies, procedures and/or training.

The Assessment Team sighted a register for police checks, drivers' licences and vaccination status for staff and volunteers, however, the provider was unable to demonstrate they have an effective system to monitor these for sub-contracted providers. During the assessment contact management advised the Assessment Team they receive a Statutory Declaration confirming each sub-contracted provider has current insurance for vehicles and public liability, and each driver has a current drivers' licence and police check, however these Statutory Declarations and supporting documentation were unable to be produced as evidence during the Assessment Contact. Management advised during the Assessment Contact, they do not have the Statutory Declaration on file, and attempted to obtain the information from the contractors during the Assessment Contact but were unsuccessful. This documentation was later provided by the provider in a response to the Assessment Teams report. Despite providing this evidence in response to the assessment contact it doesn’t change the fact at the time of the assessment contact this documentation was not in the providers possession and could not be produced.

Evidence obtained by the Assessment Team shows the provider did not demonstrate effective management and distribution of information to staff, volunteers and sub-contractors to enable them to deliver safe and effective services. While the provider was able to demonstrate effective monitoring of some aspects of regulatory compliance, they were not able to demonstrate effective oversight of regulatory compliance for sub-contracted providers.

While I am satisfied that the approved provider, through its continuous improvement activities and response to the Assessment Teams report have already partially addressed the deficits identified by the team, and I am satisfied will continue to, at the time of the assessment contact the provider was unable to demonstrate effective oversight of regulatory compliance for sub-contracted providers.

Based on all the available evidence the approved provider does not comply with this Requirement.

# 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) Not Compliant

*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 8(3)(c) Not Compliant

*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.*