**Performance**

**Report**

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| Name: | Meals on Wheels - Capalaba District Inc. |
| Commission ID: | 700551 |
| Address: | 56 Holland Crescent, CAPALABA, Queensland, 4157 |
| Activity type: | Assessment contact (performance assessment) – non-site |
| Activity date: | on 30 October 2023 |
| Performance report date: | 12 December 2023 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

# Service included in this assessment

Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 8313 Capalaba District Meals on Wheels Inc  
Service: 23680 Capalaba District Meals on Wheels Inc - Community and Home Support

**This performance report**

This performance report for Meals on Wheels - Capalaba District Inc. (**the service**) has been prepared by J Renna, 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; the Assessment contact – non-site report was informed by review of documents and interviews with staff, consumers/representatives and others
* the performance report dated 31 January 2023 in relation to the Assessment contact - desk conducted on 3 January 2023
* the performance report dated 21 July 2022 in relation to the Quality Audit undertaken from 25 to 27 May 2022.

The provider did not submit a response to the Assessment Team’s report for the Assessment contact (performance assessment) – non-site.

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **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.

Standard 8 Requirement (3)(d)

* Develop a shared understanding of what constitutes an incident and develop processes to ensure incident data is documented.
* Review the service’s incident management system to ensure all incidents are reported, recorded and addressed.
* Ensure incidents are reviewed, trended, analysed and discussed at management committee meetings and these discussions are documented.

# Standard 2

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| Ongoing assessment and planning with consumers | | 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 |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| 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 |

Findings

Requirements (3)(a), (3)(d) and (3)(e) were found non-compliant following a Quality Audit undertaken from 22 May 2022 to 27 May 2022 and an Assessment Contact undertaken on 3 January 2023. The service did not demonstrate:

* assessment and planning, including the consideration of risks to the consumer’s health and well-being, informed the delivery of safe and effective care and services, specifically not actively seeking out information on any risks which might influence how services are delivered and how these risks might be mitigated;
* the outcomes of assessment and planning were effectively communicated to the consumer and documented in a care and services plan that was readily available to the consumer, and where care and services are provided, specifically not providing consumers with a copy of a care plan/assessment that reflects the consumer’s needs, goals and preferences; and
* care and services were reviewed regularly for effectiveness, and when circumstances changed or when incidents impacted on the needs, goals or preferences of the consumer, specifically care plans/assessments were not reviewed at least annually.

The Assessment Team’s report for the Assessment contact undertaken on 30 October 2023 includes evidence of actions taken by the service in response to the non-compliance. These actions include, but are not limited to, using the My Aged Care summary and contacting new consumers to confirm health details to better understand individual consumer’s needs and risks, face-to-face interviews with consumers to complete a full service-level initial assessment, provision of service plans to consumers and/or representatives after the initial assessment to provide information about delivery days and types/quantities of meals, use of delivery run sheets with enough information to guide volunteers in the delivery of meals safely, and face-to-face reviews for all consumers who have been with the service for longer than 12 months to identify changes in circumstances, with plans in place to continue conducting reviews annually or as required. The Assessment Team was satisfied these improvements were effective and recommended Requirements (3)(a), (3)(d) and (3)(e) met.

Consumers stated volunteers know the consumer’s needs and help them while still allowing the consumer the level of independence they request. Staff, management and volunteers demonstrated an understanding of individual consumer needs and awareness of their associated risks. Whilst not all new consumers have had a face-to-face interview at the time of the Assessment contact, the service demonstrated effective assessment processes through initial phone calls to consumers to establish understanding of each consumer’s risks, needs and preferences. Documentation showed the service is using the My Aged Care summary and initial assessment to assess each new consumer.

Consumers and representatives said they understood what type of meals had been ordered for the consumers and when the meals would be delivered. Consumers and representatives confirmed they can change details such as the type of meals or the frequency of meal deliveries as needed. The service administrator and management committee members described the processes to ensure each consumer is offered a copy of their service plan. Volunteers reported the delivery run sheets provides all the information needed to deliver meals according to each consumer’s needs and preferences. Documentation demonstrated volunteers are provided with delivery run sheets which identify the consumer, their delivery address and any special instructions in relation to the meal delivery. Documentation demonstrated service plans are provided to consumers aft the initial assessment and the plans include days of delivery, quantity and type of meal to be delivered.

Consumers stated staff from the service have visited their homes to discuss their needs. Staff and volunteers reported having current information available to them to complete their roles safely and effectively. Management discussed the processes that are embedded to ensure each consumer is reviewed at least annually, unless required earlier. Documentation demonstrated the process and level of information obtained through the review process.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirements (3)(a), (3)(d) and (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. | Compliant |

Findings

Requirement (3)(d) was found non-compliant following a Quality Audit undertaken from 22 May 2022 to 27 May 2022 and an Assessment Contact undertaken on 3 January 2023. The service did not demonstrate feedback and complaints were reviewed and used to improve the quality of care and services. Namely, the service was not recording all complaints/feedback and did not demonstrate all complaints/feedback were actioned and outcomes provided to consumers. Therefore, the basis for any continuous improvement activity was not fully informed.

The Assessment Team’s report for the Assessment contact undertaken on 30 October 2023 includes evidence of actions taken by the service in response to the non-compliance. These actions include, but are not limited to, documenting feedback on the feedback register when received and forwarding to the appropriate person to action, discussing feedback and complaints at the management committee meetings and using feedback and complaints to improve services. The Assessment Team was satisfied these improvements were effective and recommended Requirement (3)(d) met.

Consumers reported confidence in their ability to provide feedback and that feedback was acknowledged and used to improve their individual service. The service demonstrated processes for capturing feedback both formally and informally. Meeting minutes demonstrated this information is discussed at management committee meetings and the service provided documented evidence of analysis and improvements based on consumer feedback.

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

# Standard 8

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| Organisational governance | | 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 |
| 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 |
| 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

Requirements (3)(b), (3)(c) and (3)(d) were found non-compliant following a Quality Audit undertaken from 22 May 2022 to 27 May 2022 and an Assessment Contact undertaken on 3 January 2023. The service did not demonstrate:

* the governing body promoted a culture of safe, inclusive and quality care and services and was accountable for their delivery, specifically not demonstrating what information was regularly provided to the governing body/committee and how the governing body/committee responded to any information provided to ensure the organisation was delivery quality services, policies and procedures were not updated, appropriate training was not in place and the service was not trending complaints or incident data;
* effective organisation wide governance systems in relation to continuous improvement, specifically by not having a documented continuous improvement plan and a deficit of workforce accountabilities resulting in assessments remaining incomplete for a percentage of consumers; and
* effective risk management systems and practices, specifically that risks associated with the service being delivered to the consumer were not consistently captured to inform safe services and incident reporting is not occurring.

Requirements (3)(b) and (3)(c)

The Assessment Team’s report for the Assessment contact undertaken on 30 October 2023 includes evidence of actions taken by the service in response to the non-compliance. These actions include, but are not limited to: committee members participate in the day-to-day running of the service; committee members meet with volunteers daily; committee members undertake the initial assessments and reviews with consumers; the management committee addresses quality of meals; training needs are monitored; the management committee discusses and analyses results from consumer surveys; policies and procedures have been updated; the management committee discusses continuous improvement with a continuous improvement plan implemented; appropriate assessment and planning processes implemented to identify risk; responding to consumer feedback appropriately and using feedback to make changes to service provision. The Assessment Team was satisfied these improvements were effective and recommended Requirements (3)(b) and (3)(c) met.

The Assessment Team provided the following evidence in relation to my finding:

* Governing body promotes a culture of safe, inclusive and quality care and is accountable for their delivery
  + Committee members remain informed of the service’s operations by participating in the day-to-day running of the service.
  + A committee member said they promote the service’s culture in an ongoing and informal manner by meeting with volunteers daily and demonstrating an ongoing interest in them undertaking a safe, inclusive and quality service.
  + Committee members undertake the initial assessments and reviews with consumers and/or representatives.
  + Documentation demonstrated committee meetings address quality of consumer meals, training needs of staff and volunteers, results from consumer surveys, policies and procedure updates and continuous improvement.
* Information management
  + Updated policies and procedures were sighted.
  + The service coordinator outlined how the service ensures consumer information is secure and volunteers confirmed they receive sufficient information to undertake their roles.
  + The service management outlined how a new electronic information management system will soon commence which will provide staff and volunteers better access to consumer information and will also provide consumers with information about meal choices.
* Continuous improvement
  + The service has implemented a continuous improvement plan which contains entries in relation to first aid training for staff and volunteers and consumer surveys.
  + Action plans from management committee meetings include the purchase of a new electronic information management system and equipment purchase for the kitchen after consumer feedback. However, these were not on the continuous improvement plan. The service administrator said they would review the process for inclusion of items on the continuous improvement plan.
* Financial governance
  + The service has appropriate systems and processes in place to manage the finances and resources of the service, with the management committee having oversight of the service’s income and expenditure.
* Workforce governance
  + Action plans and the continuous improvement plan outlined training for staff and volunteers.
  + Meeting minutes demonstrated training is discussed at the management committee level.
  + The minutes also demonstrated the service monitors staff performance agreements and when they are due.
* Regulatory compliance
  + The service has implemented a continuous improvement plan and has effective processes for identifying consumer risks through assessment and planning processes.
  + The service maintains up-to-date information on legislative, funding and relevant guidelines through information provided by Queensland Meals on Wheels.
* Feedback and complaints
  + The service has a feedback and complaints system.
  + The service is actioning and using feedback to make changes to service provision.

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

Requirement (3)(d)

The Assessment Team’s report for the Assessment contact undertaken on 30 October 2023 includes evidence of actions taken by the service in response to the non-compliance for managing high-impact or high prevalence risk, identifying and responding to abuse and neglect of consumers and supporting consumers to live the best life. These actions include, but are not limited to, processes to identify and mitigate high-impact and high-prevalence risks, capturing and documenting consumer risks in care plans, training provided to volunteers on being aware of risks for consumers, and training for staff and volunteers on elder abuse identification and reporting processes.

However, the Assessment Team was not satisfied the service had implemented improvements to address the non-compliance in relation to managing and preventing incidents. While the service demonstrated a system is in place for managing risks, the service did not demonstrate its effectiveness in preventing and managing incidents due to inconsistent reporting and lack of clarity on when an incident should be recorded. The Assessment Team recommended Requirement (3)(d) not met because incident management and prevention using an effective incident management system was not evident.

The service demonstrated consumer risks are captured and clearly documented on service documentation and there is a process in place when a consumer does not answer the door and, during the initial assessment, consent is obtained to call emergency services if required. Consumers said the service respects their wishes and supports their independence. Volunteers and staff described the process to follow when a consumer does not answer the door. Volunteers described how they were trained to be aware of risks when visiting consumers, including when they become aware the consumer may not be eating the meals provided, and how they report incidents to the service. Staff and volunteers confirmed they have received training on identifying and responding to elder abuse and described the reporting process. Management demonstrated how information about consumer meal preferences is initially gathered through the care planning process and updated when consumers advise the service of their preferences or through feedback and complaints processes. Consumer risks are documented, including risks around dysphasia, allergies, risks of falls or memory concerns.

While the service administrator said reports written for the management committee include incidents, none were included in those sampled for March to June 2023, despite the incident register showing incidents had occurred. They advised these minutes may not be accurate, as the service did not have a permanent person in the secretariat role for a period. The service administrator also advised committee members are actively involved in the day-to-day running of the service and are aware of incidents when they occur. The service administrator discussed a number of incidents which were not recorded on the incident register and said only incidents in which the service is directly involved are recorded as incidents. A management committee provided guidance about when incidents should be reported as a serious incident, however, this did not align with legislative requirements. Management said there is an incident management policy in place but, could not provide a copy to the Assessment Team at the time of the Assessment contact as it was currently with a committee member for review.

In coming to my finding, I have considered the information and evidence in the Assessment Team’s report which demonstrates ineffective risk management in identifying, managing and preventing incidents, including the use of an effective incident management system.

I have considered the intent of this Requirement, which expects organisations have systems and processes in place to help identify and assess risks to the health safety and well-being of consumers, including having a risk management system to identify and evaluate incidents and ‘near misses’ and use this information to improve its performance and how it delivers quality care and services. I find this did not occur because not all incidents were recorded on the incident register.

I find the service has systems in place to manage high-impact or high-prevalence risks, to identify and respond to abuse and neglect of consumers and the service supports consumers to live their best life. However, while the service demonstrated it has a system for managing incidents, the service did not demonstrate its effectiveness in preventing and managing incidents due to inconsistent reporting and lack of clarity on when an incident should be recorded. These deficits lead to lack of incident trending and analysis opportunities.

I note management acknowledged the deficits and stated the service would review its incident management system.

I acknowledge actions planned by management. However, at the time of my decision, there was no evidence indicating changes have been effectively implemented and embedded.

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

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)