**Performance**

**Report**

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| Name: | MiCare Home Care (Thuiszorg) |
| Commission ID: | 300120 |
| Address: | 736 Mt Dandenong Road, KILSYTH, Victoria, 3137 |
| Activity type: | Assessment contact (performance assessment) – non-site |
| Activity date: | on 8 July 2024 |
| Performance report date: | 31 July 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: 818 MiCare Ltd  
Service: 18787 MiCare Home Care Services Eastern Region  
Service: 22824 MiCare Home Care Services Gippsland  
Service: 18780 MiCare Home Care services Gippsland 2  
Service: 23536 MiCare Home Care services NMR  
Service: 22822 MiCare Home Care services SMR  
Service: 18779 MiCare Home Care services South East  
Service: 18778 MiCare Home Care services Southern Metro  
Service: 23537 MiCare Home Care services WMR  
  
Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 8549 MiCare Ltd  
Service: 27398 MiCare Ltd - Care Relationships and Carer Support  
Service: 25451 MiCare Ltd - Community and Home Support

**This performance report**

This performance report for MiCare Home Care (Thuiszorg) (**the service**) has been prepared by P.Frangiosa, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Assessment contact (performance assessment) – non-site report was informed by review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 25 July 2024

# Assessment summary for Home Care Packages (HCP)

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable |
| **Standard 3** Personal care and clinical care | **Not applicable** |
| **Standard 8** Organisational governance | **Not Compliant** |

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

Areas have been identified in which improvements must be made to ensure compliance with the Quality Standards. This is based on non-compliance with the Quality Standards as described in this performance report.

* Requirement 2(3)(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.
* Requirement 2(3)(e) - Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.
* Requirement 3(3)(e) - Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.
* 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.
* Requirement 8(3)(d) - Effective risk management systems and practices relating to high-impact or high-prevalent risk, which directly impacted managing and preventing incidents, including the use of an incident management system.

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

Findings

Requirements 2(3)(a) was found non-compliant following a Quality Audit in November 2022 and subsequent assessment contact in October 2023. The service did not demonstrate:

* 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.

While the Assessment Team acknowledged improvements have been made, they were not satisfied 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. The Assessment Team recommended Requirement 2(3)(a) not met and provided the following evidence to support their assessment:

* Sighted consumer assessments which did not reflect consumers current state, including the use of validated tools to inform risk and well-being.
* Consumer task lists evidenced for staff to guide service delivery and awareness did not provide details on the minimisation of falls risks, such as individual strategies to maintain balance or other environmental controls.
* Care planning documentation for specific consumers exampled was evidenced with numerous empty fields such as individual needs, goals, and preferences.
* Embedded practices relating to the completion of documentation to inform the delivery of safe and effective care and services.

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

* Acknowledgment of continuing deficiencies with steps to strengthen assessment and planning practice through the recruitment of clinical qualified staff including registered nurses/enrolled nurses.
* A newly employed Team Leader (Enrolled Nurse) in Home Care team commencing on the 05th of August 2024.
* Recruiting a Clinical Care Manager who will have responsibility for the clinical oversight of Home Care clients, including quality and risk assessments as well as education for non-clinical staff.
* Recruitment of Clinical/Allied Health staff expected to be assigned to regional clusters/hubs.
* The recruitment of some of the positions has commenced and some appointments have been made. While the recruitment process is underway, the service has recruited 2 Registered Nurses and 1 social work staff member within a locum capacity over 8 weeks. These positions commence on the 29 July 2024.
* CHSP clients with outstanding Domestic Assistance will be prioritised for screening and face to face assessment if vulnerabilities are identified.
* The reorganisation of the Care Management team within regional Hubs to oversee and manage intake assessment and planning. The Regional Hubs will provide greater direction and support staff as well as closer monitoring of assessment and planning processes. Communication about the Regional Hubs has been communicated to staff directly impacted at meeting held on the 22 July 2024 and to the broader team at meeting held on the 25 July 2024. Ongoing auditing and monitoring process will be embedded as part of the Regional Hubs to ensure that safe and quality services are being delivered.
* Assessment for vulnerability- The vulnerability thresholds have been expanded on the services initial and ongoing assessment tool. Expanded vulnerability thresholds includes personal – health, medical, comorbidities & complex needs (living alone dependent on others) sensory and cognitive impairments, social, environmental and geographical (i.e. heatwave bushfire significant disruption to services thunderstorm asthma). Further work will be undertaken July- August period to align vulnerability thresholds to intake processes.
* Risk assessments and strategies to be completed by qualified clinicians to commence as of the 29 July 2024, when staff are onboarded.
* Updates to 2 consumers assessments to ensure identified risks and support strategies are implemented.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows the service has responded to deficiencies previously identified and provided timeframes associated with implementing wholesale changes to address these deficiencies.

However, at this stage these strategies are yet to be fully embedded, with results evidenced to support an effective strategy. With the evolution of time, the resulting improvements should present themselves.

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

Requirements 2(3)(e) was found non-compliant following a Quality Audit in November 2022 and subsequent assessment contact in October 2023. The service did not demonstrate:

* 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 recommended Requirement 2(3)(e) not met and provided the following evidence to support their assessment:

* Management discussed the uplift in Commonwealth Home Support Program consumer reviews to 70% completion from 30% in October 2023, however Policy informing the timeliness of reviews state reviews are to be conducted every twelve-months or when circumstances change.
* Staff interviewed said they receive a new care plan if there have been changes in consumer needs but were uncertain of reviews schedules or methodology.

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

* An explanation that the service is currently transitioning to ACCPA’s policies procedures and documents. Policies and Procedures for standards 2 were distributed at the staff meeting held on the 25/07/24 with Care Managers, Services Coordinators and Care Coordinators. Policies and procedures to guide and direct practice.
* Advised that ongoing education on the standards was provided during staff meeting on the 25 July 2024.
* Goal directed care plans to be updated to gather more detailed information about the care support and strategies required to fulfil ADLS including mobility. To be implemented by 05 August 2024.
* The task list is to be updated to capture more comprehensive information about client needs, goals, preferences, including medical and clinical history mobility transport requirements and emergency /advance care planning.
* Validated assessment tools to manage high impact high prevalence risk to be rolled out from the week beginning the 29/07 with the onboarding qualified clinical personnel.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows the service has responded to deficiencies previously identified and implemented strategies to address these deficiencies. However, I acknowledge that the service is yet to embed many of these changes at the time of my finding.

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

# Standard 3

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| Personal care and clinical care | | HCP | CHSP |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Not applicable | Not Compliant |

Findings

Requirements 3(3)(e) was found non-compliant following a Quality Audit in November 2022 and subsequent assessment contact in October 2023. The service did not demonstrate:

* Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. The Assessment Team was not able to evidence regular, consistent and ongoing sharing of information of consumers’ goals, needs and preferences with all with whom responsibility for care is shared.

The Assessment Team recommended Requirement 3(3)(e) not met and provided the following evidence to support their assessment:

* Staff said they receive emails with care plans, but were uncertain when a review has taken place, as they only receive updated plans and no other information.
* Staff discussed how previously they were able to access a lot more information via a mobile application and were across the needs of the people they are supporting.
* A third-party provider interviewed said they did not receive a care plan or any other information from the provider, stating they only received a referral or service request form outlining the requested tasks or assessments.
  + When asked if they received additional information, such as end of life directives, the provider confirmed they did not receive any additional information.

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

* An explanation that the service is currently transitioning to ACCPA’s policies procedures and documents. Policies and Procedures for standards 2 were distributed at the staff meeting held on the 25/07/24 with Care Managers, Services Coordinators and Care Coordinators. Policies and procedures to guide and direct practice.
* Advised that ongoing education on the standards was provided during staff meeting on the 25 July 2024.
* Requirements discussed at staff meeting on the 22 and 25 July 2024. Privacy concerns raised by some staff – and questions raised about how much information to share. In response to the questions:
  + Further training and guidance will be provided.
  + Care Plan and task list templates to be updated to record client consent to share
* Advised that the sharing of information with external providers who have responsibility for direct care services has commenced.
* Advisement that due to transition to new CRM, the mobile portal to share information with internal staff isn’t currently available. Interim arrangement of sharing information via email implemented to share information about client care and services. Additionally, the AWACC tool was distributed to internal direct care staff on the 06th of July to harness information about client care needs and to prompt staff to report changes.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows the service has responded to deficiencies previously identified and implemented strategies to address these deficiencies. However, I acknowledge that the service is yet to embed many of these changes with documented results available at the time of my finding.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement (3)(e) in Standard 3 personal care and clinical care.

# 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. | 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 |

Findings

Requirements 8(3)(b) was found non-compliant following a Quality Audit in November 2022 and subsequent assessment contact in October 2023. The service did not demonstrate:

* The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

The Assessment Team recommended Requirement 8(3)(b) not met and provided the following evidence to support their assessment:

* Considered findings from the assessment contact in October 2023 in reference to ineffective oversight of subcontracted services and a reactive performance monitoring system.
* Documents reviewed regarding one consumer did not evidence any communication from a remedial therapist describing this consumers progress.
  + Purchase order sighted demonstrated that this consumer had been receiving remedial massage since 2 June 2023.
* Management described the provider’s actions taken since the October 2023 assessment contact.
  + Management stated that, at the time of the assessment, there was no effective system that accurately captured subcontractor performance.
  + At the time of the assessment, complaints relating to care and services were recorded in a CMS. However, the complaints data did not identify whether complaints were related to subcontracted services or internal staff, which impacted the provider’s ability to determine the cause of the complaint, inform corresponding actions, and have adequate oversight over the subcontracted service’s performance.
* Management spoke about continuous improvement items relating to subcontractor management, including.
  + Implementing a contract management platform that aims to capture contractor complaints and feedback. The provider underwent a procurement process for this system.
  + Budgeted for a position that would manage the contract management system, including recording, trending and analysing data.
  + While transitioning to a contract management system, quality staff would undertake root cause analysis for each care and services complaint and determine whether it relates to subcontractors. This information would then be included in quality reports submitted to the board.
* The Assessment Team was not satisfied that the provider had suitably addressed the non-compliant findings during the November 2022 Quality Audit and the subsequent October 2023 assessment contact relating to effective oversight over subcontracted services.
* There were no evident improvements embedded in the organisation’s practices that demonstrate effective oversight of these services. Furthermore, there were no evident proactive monitoring systems in place to monitor subcontracted service’s performance as the provider did not seek feedback that targeted consumers receiving subcontracted services to determine the quality of care and satisfaction.
* The Assessment Team acknowledges the provider’s planned improvements. However, these would take time to embed and would need to be evaluated for effectiveness, sustainability, and consistency in practice. Therefore, the Assessment Team recommends that the service has not met this Requirement.

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

* Explanation that Communication regarding the reporting of subcontractor performance issues to be reported on risk management system reinforced at meetings held on 22 and 25 July 2024.
* Further advice explaining the quality staff has commenced root analysis for each care and service complaint and incident to determine subcontractor performance issues.
  + For the month of June, there were 3 instances, and these were reported in the Aged and Migrant Service quality activity report escalated to the Board for the month of June.
  + These instances were reported under complaints/feedback as well as a separate category in the quality activity report: External contractors.

The intent of this requirement states the governing body of the organisation is responsible for promoting a culture of safe, inclusive and quality, care and services in the organisation. The governing body of the organisation is also responsible for overseeing the organisation’s strategic direction and policies for delivering care to meet the Quality Standards.

From an organisational perspective it is evidenced by how the governing body decides, explains, assigns and puts their quality, safety and cultural goals into action within the organisation.

This is further evidenced by how the governing body asks for and receives the information and advice it needs to meet its responsibilities under this requirement. This is available in strategic, business and diversity action plans that describe the priorities and strategic directions for inclusive care endorsed by the governing body. Evidence of how the organisation implements, monitors and improves these, and evidence that the governing body understands and sets priorities to improve the performance of the organisation is paramount.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows the service continues to improve its reporting and oversight by governance regarding promoting a culture of safe, inclusive and quality care and services, and is accountable for their delivery. However, I acknowledge that the service is yet to embed many of these changes with documented results available at the time of my finding.

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

Requirements 8(3)(d) was found non-compliant following a Quality Audit in November 2022 and subsequent assessment contact in October 2023. The service did not demonstrate:

* Effective risk management systems and practices relating to high-impact or high-prevalent risk, which directly impacted managing and preventing incidents, including the use of an incident management system.

The Assessment Team recommended Requirement 8(3)(d) not met and provided the following evidence to support their assessment:

* One consumer document review identified the following, after the consumer advised the Assessment Team of a fall in May 2024, resulting in a hip fracture, requiring surgery and subsequent rehabilitation.
* The last progress note entry was in February 2024. The consumers care plan was signed 9 May 2023.
* An Incident report showed an entry for the fall on 5 May 2024.
* Uploaded documentation for the consumer demonstrated purchase orders were made for physiotherapist on an ongoing basis since his May 2024 hospitalisation.
  + There were no uploaded reports or evidence of communication from the subcontracted physiotherapist.
* Management acknowledged the lack of care plan review following significant change in consumer condition that resulted in service provision amendments. Management also noted that the purchase order for ongoing physiotherapy did not align with expected practices. Management stated staff were instructed to indicate a timeframe for allied health engagement in purchase orders, as this prompted the staff to request a progress update/review/report.
* The Assessment Team was not satisfied that the provider had suitably addressed the non-compliant findings during the November 2022 Quality Audit and the subsequent October 2023 assessment contact relating to effective risk and incident management. The Assessment Team did not observe effective systems and processes to identify and assess risks to consumer safety and well-being. This was evident in Standard 2. Additionally, where incidents impacted consumer health and service provision, the timeliness of assessments and review was not followed, potentially impacting the prevention of its recurrence. The Assessment Team acknowledges the provider’s planned improvements. However, these would take time to embed and would need to be evaluated for effectiveness, sustainability, and consistency in practice. Therefore, the Assessment Team recommends that the service has not met this Requirement.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows the service continues to improve its implementation of effective risk management systems and practices. I also acknowledge the services positive results in identifying and responding to abuse and neglect of consumer and supporting consumers to live the best life they can. The service has acknowledged further updates are required within its CMS and incident reporting systems. However, I acknowledge that the service is yet to embed many of these changes with documented results available at the time of my finding.

Based on the information summarised 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 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)