**Performance**

**Report**

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| Name: | Multilink Community Care |
| Commission ID: | 700098 |
| Address: | 38 Blackwood Road, LOGAN CENTRAL, Queensland, 4114 |
| Activity type: | Assessment contact (performance assessment) – non-site |
| Activity date: | 10 July 2024 to 11 July 2024 |
| Performance report date: | 9 August 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: 1927 Multilink Community Services Inc  
Service: 18256 Multilink Community Care  
  
Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 7751 Multilink Community Services Inc.  
Service: 24604 Multilink Community Services Inc. - Care Relationships and Carer Support  
Service: 24603 Multilink Community Services Inc. - Community and Home Support

**This performance report**

This performance report for Multilink Community Care (**the service**) has been prepared by J. Bayldon, 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 non-site assessment, review of documents and interviews with staff, consumers/representatives and others.

# Assessment summary for Home Care Packages (HCP)

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| Standard 7 Human resources | Not Applicable as not fully assessed |
| **Standard 8** Organisational governance | **Not Applicable as not fully assessed** |

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| Standard 7 Human resources | Not Applicable as not fully assessed |
| **Standard 8** Organisational governance | **Not Applicable as not fully 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 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)

Requirement 7(3)(d) was found non-compliant following a Quality Audit undertaken from 4 July 2023 to 6 July 2023 as the service was unable to demonstrate that staff providing care and services are sufficiently training to identify changes in consumer conditions and identify the need for additional reviews of consumers care and services.

At the time of the Assessment Contact – Non-Site, the Assessment Team found the following relevant information to my finding:

* Staff interviewed were able to demonstrate an understanding in working with people with dementia and identifying changes in a consumer’s condition.
* Consumers interviewed said they are comfortable and feel safe with staff who provide care and services to them.
* Staff said they receive regular training at monthly staff forums in addition to monthly online training modules. Staff said the most recent training was dementia specific and identifying and escalation of deterioration.
* A review of the Clinical Risk and Escalation policy of the service evidenced that staff are escalating consumer deterioration in line with the services policy and procedures.
* A review of the training register evidenced scheduled training that is ongoing and regular and included topics such as safety September, cultural awareness, dementia awareness, and analysing and responding to incidents.
* Management advised knowledge checks are completed by staff at the completion of each training module to ensure the knowledge is understood and retained.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, and evidence in the Assessment Team’s report. Based on the information summarised above, I am satisfied that the service has taken sufficient actions to ensure that staff are now being trained and are equipped and supported to identify changes in a consumer’s condition and identify the need for additional reviews in these instances. Therefore, I find the provider in relation to the service, compliant with Requirement 7(3)(d) at the time of the performance report decision.

# 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. | 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)(c) was found non-compliant following a Quality Audit undertaken from 4 July 2023 to 6 July 2023 as the service was unable to demonstrate an effective organisation wide governance system relating to information management.

At the time of the Assessment Contact – Non-Site, the Assessment Team found the following relevant information to my finding:

* Internal documentation is regularly reviewed by care coordinators and made available to staff who provide care and services to consumers.
* Management said after a consumer’s condition has been identified as deteriorating or change identified they have a referral process in place which involves the coordination of the care coordinator throughout the assessment and review process with allied health providers.
* Staff said consumers care documentation, assessments, risk assessments and updates relation to a consumer's care and services is also available in consumers’ homes within the selected blue folder.
* A review of sampled consumer’s care documentation evidenced communication between the service, allied health providers, assessments, and referrals to allied health providers.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, and evidence in the Assessment Team’s report. Based on the information summarised above, I am satisfied that the service now has an effective organisation wide governance system in relation to the management of information for consumers. Therefore, I find the provider in relation to the service, compliant with Requirement 8(3)(c) at the time of the performance report decision.

Requirement 8(3)(d)

Requirement 8(3)(d) was found non-compliant following a Quality Audit undertaken from 4 July 2023 to 6 July 2023 as the service was unable to demonstrate effective management of high-impact and high-prevalence risks associated with personal and clinical care.

At the time of the Assessment Contact – Non-Site, the Assessment Team found the following relevant information to my finding:

* Staff demonstrated an understanding of consumers with high impact or high prevalence risks and demonstrated how they implement the service’s policies in alignment with best practice.
* Management said the service ensures consumers clinical information is obtained at entry to the service with consent gained for information sharing with external allied health providers. Reviews and assessments are completed by clinical staff to ensure appropriate care, services and supports are provided to consumers.
* The service has policies and procedures in relation to incident reporting which capture types of incidents to report under SIRS and reporting timeframes.
* Staff interviewed were able to demonstrate an understanding in working with people with dementia and identifying changes in a consumer’s condition.
* Staff said consumers care documentation, assessments, risk assessments and updates relation to a consumer's care and services is also available in consumers’ homes within the selected blue folder.
* A review of the Clinical Risk and Escalation policy of the service evidenced that staff are escalating consumer deterioration in line with the services policy and procedures.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, and evidence in the Assessment Team’s report. Based on the information summarised above, I am satisfied that the service has sufficiently addressed the gaps identified in the previous performance report and now is able to demonstrate effective management of high-impact and high-prevalence risks. Therefore, I find the provider in relation to the service, compliant with Requirement 8(3)(d) at the time of the performance report decision.

Requirement 8(3)(e)

Requirement 8(3)(e) was found non-compliant following a Quality Audit undertaken from 4 July 2023 to 6 July 2023 as the service was unable to demonstrate that staff are equipped with knowledge of the clinical governance framework and its application in the providing of safe and effective care and services to consumers.

At the time of the Assessment Contact – Non-Site, the Assessment Team found the following relevant information to my finding:

* A review of mandatory training documentation demonstrated staff had completed training on the Quality Standards, infection control processes (including antimicrobial stewardship), minimising the use of restrictive practices, and open disclosure as part of their mandatory annual training.
* The Assessment Team reviewed care planning documentation of sampled consumers, including progress notes and incident forms which demonstrated the service’s compliance with policies and procedures.
* The services clinical governance framework and clinical policies and procedures have been reviewed with recommendations for improvement scheduled to be reviewed by the board.
* A review of the Clinical Risk and Escalation policy of the service evidenced that staff are escalating consumer deterioration in line with the services policy and procedures.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, and evidence in the Assessment Team’s report. Based on the information summarised above, I am satisfied that the service has sufficiently addressed the gaps identified in the previous performance report and staff are now trained in the services clinical governance framework and are demonstrating practices in line with the services clinical policies and procedures. Therefore, I find the provider in relation to the service, compliant with Requirement 8(3)(e) at the time of the performance report decision.

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)