**Performance**

**Report**

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| Name: | Trilogy Care Pty Ltd |
| Commission ID: | 701080 |
| Address: | Level 3, 2 King Street, BOWEN HILLS, Queensland, 4006 |
| Activity type: | Assessment contact (performance assessment) – non-site |
| Activity date: | 28 October 2024 to 29 October 2024 |
| Performance report date: | 20 November 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.

# Services included in this assessment

Home Care Packages (**HCP**) included:  
Provider: 7069 Trilogy Care Pty Ltd  
Service: 27804 Trilogy Care

**This performance report**

This performance report has been prepared by Peter 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 services it operates, 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 providers response to the assessment team’s report received 19/11/2024.

# Assessment summary for Home Care Packages (HCP)

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| Standard 3 Personal care and clinical care | 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 3

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| Personal care and clinical care | | HCP |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |

Findings

Requirement 3(3)(a) was found non-compliant following an Assessment Contact undertaken 4 July 2023, as the service did not demonstrate each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care.

The Assessment Team’s report for the Assessment Contact undertaken on 28 October to 29 October 2024 included evidence of actions taken to address the non-compliance, including but not limited to, policies and procedures on care planning and assessment processes.

The Assessment Team found these improvements were effective and recommended Requirement 3(3)(a) met. The Assessment Team provided the following evidence relevant to my finding:

* Review of documentation evidenced record of discussions with consumers and representatives and instructions on delivery of care for staff, including identifying best practice, tailored care, and optimising their health and wellbeing.
* Reviewed policies and procedures on care planning and assessment processes, abuse and neglect and incident reporting for guidance when required, to inform and direct staff.
* Management and staff interviewed could speak to processes including triaging, discussing incidents with subcontracted services, and requesting hospital discharge documentation, validated assessments, photos and any other information to enable a management plan to be executed.
  + This plan will dictate the frequency of contact with both the consumer and the subcontracted service to ensure quality care that is best practice and tailored to the needs of the consumer.
  + Sampled consumer documentation for one consumer included the nursing team completing a management plan for wound management. Progress notes included a comprehensive assessment and notes on the frequent discussions held with the subcontracted RN (Registered Nurse) and consumer for condition updates.
    - subsequent notes documented that this consumers wounds are healing, and the management plan is ongoing. Frequency of calls were decreased based on feedback from the RN and consumer.
* Management advised that communication between the subcontracted services and Trilogy Care aligns with the goals and service expectations of the consumer. Meetings are undertaken with the service provider every 3-6 months, or as required, to discuss outcomes of consumer care and delivery and areas for improvement.
  + Viewed documented discussions with subcontractors verified this information with an external coordinator who confirmed frequent discussions with the provider in relation to best practice provision of quality care and services.

The providers response included comprehensive information in support of my finding of compliance including:

* *Initial assessment -* Trilogy undertakes a rigorous assessment process based on ACAT/ACAS assessments, medical records, care recipient questionnaire, and one-on-one discussions with the care recipient and/or care recipient’s authorised representative. This assessment is designed to understand the needs and goals of each care recipient and develop a care plan in line with this. If a RP (Restricted Practice) is in use at the time of initial assessment (i.e. transferred from another Provider) or there are considerations for a RP to be enacted, it is at this stage a RP is identified, and Trilogy will become aware. This would trigger further analysis consistent with the above, to ensure a RP is only used consistent with ACQSC and regulatory guidance and added to a register to monitor.
* *Regular care plan check-ins -* Scheduled care plan check-ins with the care recipient are conducted 4-monthly or 6-monthly (dependent on whether care recipient is self-managed or coordinator-managed) by the care partner, and 2-monthly by the care coordinator (or more frequently dependent upon client needs and preference) to ensure:
* Services are being delivered consistent with the care plan and the client’s needs, goals and preferences
* Any risks or issues are identified and raised to Trilogy to action
* Any changes to the care recipient’s health or wellbeing status are identified and appropriately managed
* Contact details are accurate and current
* Care plan evaluation - Formal care plan evaluations are conducted annually (or more frequently dependent upon client needs and preference) to ensure:
* Care plans are up-to-date and meet the care recipient’s current needs, goals and preferences
* Care plans meet the care recipient’s needs safely and effectively.

If throughout the check-in a care partner has identified a Trilogy subcontractor or brokered partner is using a RP or the consumer raises practices consistent with, or suggestive of a RP, it is at this stage of the process Trilogy is able to identify a potential RP use. This would trigger further analysis consistent with the above, to ensure a RP is only used consistent with ACQSC and regulatory guidance and added to a register to monitor.

*Feedback and complaints* - Trilogy has a 24-7 Feedback and Complaints mechanism. Our Feedback and Complaints Policy and Procedure, which all care recipients (and authorised representatives) and Trilogy partners are made aware of and acknowledge, is a further mechanism for a potential RP, if identified, to be raised to Trilogy for review.

*Code of Conduct* - Each Trilogy partner is required to acknowledge the Aged Care Code of Conduct inclusive of their expected behaviours and responsibilities. If a Trilogy subcontracted partner observes behaviour that is inconsistent with this code, inclusive of the use of RP, they are aware of the mechanisms to raise concerns to Trilogy for review.

Additional self-identified areas of improvement have been added to the providers Continuous Improvement Plan (CIP).

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with information provided in response. I acknowledge the provider has responded to the deficiencies previously identified, embarking on embedding solutions that have displayed results in care and delivery.

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

# Standard 8

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| Organisational governance | | HCP |
| 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)(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 |

Findings

Requirement 8(3)(b) was found non-compliant following an Assessment Contact undertaken 4 July 2023, as 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’s report for the Assessment Contact undertaken on 28 October to 29 October 2024 included evidence of actions taken to address the non-compliance, including but not limited to, the evolution of bimonthly Board meetings with the service’s care quality compliance committee and department meetings. Both management and the Board members interviewed said if any issues and concerns were identified the Board will make a recommendation of direction to the senior leadership team through the Chief Executive Officer (CEO).

The Assessment Team found these improvements were effective and recommended Requirement 8(3)(b) met. The Assessment Team provided the following evidence relevant to my finding:

* Board member interviews, and reviewed documentation confirmed the service’s care quality compliance committee is chaired by 2 Board members. Both Board members ensure information delivered to the Board meets all requirements of the Quality Standards, recommendations of directions are put in place and reviewed by Board members bimonthly.
* Evidenced meeting agenda items such as Serious Incident Response Scheme (SIRS), incidents, complaints and continuous plan for improvement are presented to the Board for oversight and recommendations of direction. For example.
  + Care quality compliance committee meeting minutes from 10 May 2024 and 7 August 2024 and The Board of Directors meeting minutes from 28 May 2024 advised the following.
    - On 28 May 2024, the Board provided a written response to the care quality compliance committee’s recommendations which included actions for each department head and managers as well as Board of directors’ actions addressed to the organisation’s CEO.
    - In July 2024, a report to the Board of directors addressing action items from each department head and managers on their progress and outcome was also provided to the Board.
* Regarding subcontractors’ oversight of safe, effective and quality care and service delivery and brokerage agreements, senior leadership team and a Board member advised the partnership and compliance manager prepares a report with key performance indicators, complaints of services and service providers, separated between self-managed and brokered providers. This report is presented to the Board and is also used to monitor subcontractor and brokered provider’s performance.
* Management and Board advised, and documentation viewed evidenced trends incident reports, measuring incidents per 100 consumers from each service model to help make sound decisions on the management and oversight of these subcontracted or brokered services.
* Viewed Dashboards for incident trending - Management advised if there were concerns about subcontracted and brokered providers on their performance delivery and incidents frequency, the service would conduct an audit and performance review.
  + Sighted provider audit conducted on 29 August 2024 regarding a brokered nursing agency included review of the agency’s incident and risk register, staff training, staff certification, police checks and vaccination status, and agency’s certificate of currency.
* Management advised, and documentation reviewed, evidenced the organisation performs consumer experience surveys monthly and has quarterly check ins with consumers to ensure they are satisfied with their care and service providers. This was confirmed through consumer and representative interviews.
* Progress notes and complaint registers evidenced open disclosure through feedback and complaints resolution.

The providers response included comprehensive information in support of my finding of compliance including:

Information pertaining to maintaining high training standards for subcontracted and brokered workforce through a layered verification and support system, including:

* Quarterly compliance reporting
* Annual audits
* Monthly training for coordinators
* Home care academy

Additional evidence included established and clear protocols to ensure that all subcontracted and brokered providers remain fully informed of their reporting responsibilities:

* Onboarding and ongoing training
* Clear reporting pathways
* Proactive compliance checks

Further, in the absence of receiving progress notes as standard practice, the provider ensures oversight of service provision through the following mechanisms, including.

* Regular care plan check-ins
* Care plan evolution
* Invoice and accounts monitoring
* Consumer experience Surveys
* Feedback and complaints mechanisms
* Informal care recipient communication

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with information provided in response. I acknowledge the provider has responded to the deficiencies previously identified, embarking on embedding solutions that have displayed results in care and delivery.

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

Requirement 8(3)(d) was found non-compliant following an Assessment Contact undertaken 4 July 2023, as the service did not demonstrate effective risk management systems and practices relating to managing high-impact or high-prevalence risks associated with the care of consumers, Identifying and responding to abuse and neglect of consumers, managing and preventing incidents, including the use of an incident management system, and supporting consumers to live the best life they can.

The Assessment Team’s report for the Assessment Contact undertaken on 28 October to 29 October 2024 included evidence of actions taken to address the non-compliance, including but not limited to the introduction of effective risk management systems, incident management systems and education.

The Assessment Team found these improvements were effective and recommended Requirement 8(3)(d) met. The Assessment Team provided the following evidence relevant to my finding:

*Managing high-impact or high-prevalence risks associated with the care of consumers*

* Management advised, and documentation review confirmed that during onboarding, the care partners review the consumer’s Aged Care Assessment Team (ACAT) reports and consumers are required to complete a 15-page questionnaire where risk are identified. Through identified risk, the clinical team will review and create a management plan and refer to other allied health as required for ‘Self-Managed Plus’ consumers. ‘Self-Managed’ would be given a recommendation to see their preferred allied health professionals for assessments.
* Subcontracted and brokered providers are aware to report any changes and deterioration of consumers into the organisation’s incident management system. This was confirmed through interviews with the subcontracted and brokered providers.
  + Sighted assessment documentation in consumer’s management plans confirmed clinical assessments provided by subcontracted and brokered providers are shared with the organisation and are documented in their care management plan.

*Identifying and responding to abuse and neglect of consumers*

* Documentation and systems viewed confirmed mechanisms for identification of abuse and neglect of consumers are reported through the provider’s incident management system and education is provided through policies and SIRS training.
  + Review of documentation evidenced training materials have been provided to internal staff, subcontracted and brokered providers on incident reporting, SIRS and code of conduct. Policies and procedures such as ‘Elder Abuse and Neglect Policy and Procedure’ are available to guide staff on handling reports of such nature.

*Supporting consumers to live the best life they can*

* Management advised when risks are identified during onboarding, they are reviewed by the service’s clinical team, which then provide recommendations to the care partners to have a conversation with the consumer and their representative.
* Care plans reviewed evidence detail with each consumer’s needs, goals and preferences identified. Level of assistance required for each service type is documented to allow consumers to be independent and live their best lives.

*Managing and preventing incidents, including the use of an incident management system.*

* Reviewed systems, guidance, documentation and training evidenced the organisation has a robust and responsive incident management system.
  + All incidents reported are triaged by a clinical nurse within two business hours. The incident management triaging system is similar to a hospital setting with 5 categorisations with Category 5 being the lowest and Category 1 being the highest. For example, SIRS are classified as Category 1 and Falls are classified as Category 2 in the provider’s incident management system.
  + Review of incident management system entries showed subcontracted and brokered providers are reporting incidents such as SIRS, falls, hospitalisation and changes in consumer’s health and conditions. Clinical staff and care partners are updating consumer’s care management plans in a timely manner once incident has been reported.
  + Reviewed documentation evidenced policies and procedures are in place to guide staff and subcontracted and brokered providers on incident reporting process. Training has also been provided for both internal staff, subcontracted and brokered providers.

The providers response include comprehensive evidence that overlaps Requirements 8(3)(b) and 8(3)(d).

Please see previous evidence submitted in my determination on compliance in Requirement 8(3)(b). In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with information provided in response.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 8(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)