**Performance**

**Report**

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| Name: | A1 Property Services - Thebarton |
| Commission ID: | 600132 |
| Address: | 4b Symonds Street, ROYAL PARK, South Australia, 5014 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 6 February 2024 to 7 February 2024 |
| Performance report date: | 5 March 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

Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 7994 A1 Property Services SA Pty Ltd  
Service: 24008 A1 Property Services SA Pty Ltd - Community and Home Support

**This performance report**

This performance report for A1 Property Services - Thebarton (**the service**) has been prepared by M Murray, 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) – site report was informed by [a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **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 8(3)(b)

Demonstrate the governing body is actively engaged in seeking out data about and considering how the service is performing against the Quality Standards and that strategic decisions are made on reliable evidence.

Standard 8, Requirement 8(3)(c)

Ensure the governance of information system supports all staff including the governing body to have the relevant information to undertake their roles.

Ensure continuous improvement systems are monitored and adjusted where continuous improvement activities are not progressing in line with expectations or not meeting the goal of the activity.

Standard 8, Requirement 8(3)(d)

Ensure the incident management system supports the trending of incidents and links into training and continuous improvement activities.

# Standard 1

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| Consumer dignity and choice | | CHSP |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Requirement 1(3)(f)

The approved provider was previously found non-compliant with this Requirement in assessments of performance in 2022 and 2023. At this assessment of performance the Assessment Team reported the personal information of consumers is held securely including when accepting payments from consumers.

The Assessment Team provided evidence, summarised below, relevant to my finding.

Consumers stated they felt their privacy and confidentiality is respected by staff.

Timesheets have been redesigned so that the consumer is de-identified to the greatest extent possible.

The Assessment Team viewed training documentation for staff that included topics on privacy and confidentiality.

Staff were confident they could raise any concerns about privacy with management.

I am satisfied, having considered the information of the Assessment Team, that the approved provider has demonstrated a return to compliance in this Requirement.

I find the provider, in relation to the service, compliant with this Requirement.

# 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)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | 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 |

Findings

Requirement 2(3)(a)

The approved provider was previously found non-compliant with this Requirement in assessments of performance in 2022 and 2023.

At this assessment of performance the Assessment Team reported the service did not demonstrate that current 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 provided evidence, summarised below, relevant to my finding.

The Assessment Team reviewed care planning documentation for consumers and identified that while the service has improved the documentation of consumers’ health risks, ‘Service Sheets’ did not contain sufficient information to inform and guide staff when delivering services.

The Assessment Team’s report outlines that consumers receiving domestic assistance do not have all their needs noted on ‘Service Sheets’, such as consumers’ mobility aids, communication preferences and/or functional deficits.

Consumers and/or representatives interviewed did not indicate ongoing issues with the delivery of their domestic assistance services, and stated they have long term support workers who undertake their service and know them well.

In coming to my finding, I have considered the Assessment Team’s assessment, which does not demonstrate a systemic failure in assessment and planning.

I have placed weight on the consumers’ feedback which is that the service being delivered is up to standard. While the Assessment Team reported that assessment and planning were not sufficient to inform the delivery of safe and effective care and services, there is no evidence of the domestic service being unsafe or ineffective.

I am satisfied, based on the information throughout the Assessment Team’s report that the approved provider has made continuous improvements in relation to assessment and planning and while gaps exist they are not systemic in nature.

I encourage the approved provider to include information which regular staff know about the consumer into ‘Service Sheets’ as they are being updated.

In my view the information collected is proportionate to the scope of the service being delivered.

I am satisfied, having considered the information of the Assessment Team, that the approved provider has demonstrated a return to compliance in this Requirement.

I find the provider, in relation to the service, compliant with this Requirement.

Requirement 2(3)(b)

The approved provider was previously found non-compliant with this Requirement in assessments of performance in 2022 and 2023.

At this assessment of performance, the Assessment Team reported consumers’ goals needs and preferences including advance care planning are captured during care planning.

The Assessment Team provided the evidence, summarised below, relevant to my finding.

Consumers and representatives interviewed confirmed in various ways, assessment and planning processes identify their needs, goals and preferences. Staff described how onboarding and ongoing discussions with consumers and representatives identifies preferences regarding how services are delivered and includes information regarding advance care directives. Care planning documents for sampled consumers demonstrated that consumers’ needs, goals, and preferences are discussed and documented, including advanced care directives.

Consumers and representatives advised they were happy with the services provided, and their regular support workers are aware of what is important to them in terms of how they like their services delivered.

I am satisfied, having considered the information of the Assessment Team, that the approved provider has demonstrated a return to compliance in this Requirement.

I find the provider, in relation to the service, compliant with this Requirement.

Requirement 2(3)(c)

The approved provider was previously found non-compliant with this Requirement in assessments of performance in 2022 and 2023.

At this assessment of performance, the Assessment Team reported the service demonstrated assessment and planning is based on ongoing partnership with the consumer and/or their representative, and others who are involved in the care and services of consumers.

The Assessment Team provided the evidence, summarised below, relevant to my finding.

Consumers and/or representatives interviewed confirmed they are involved in planning and making decisions about consumers’ care and services. Staff and management described how consumers, their representatives, family, and carers are involved in assessment and planning of their services.

Care planning documentation evidenced ongoing communication with others, such as family members and social workers.

I am satisfied, having considered the information of the Assessment Team, that the approved provider has demonstrated a return to compliance in this Requirement.

I find the provider, in relation to the service, compliant with this Requirement.

Requirement 2(3)(d)

The approved provider was previously found non-compliant with this Requirement in assessments of performance in 2022 and 2023.

At this assessment of performance, the Assessment Team reported consumers are aware of the outcomes of assessment and planning in relation to the services they are provided.

Consumers and/or representatives interviewed advised they receive information from the service, which contains their Service Sheet and other relevant information. Consumers confirmed support workers delivered their Service Sheet when it was last updated.

Service Sheets viewed for sampled consumers detailed information regarding scheduled supports, goals, home environment, and information regarding work health and safety and emergency requirements.

Support workers also receive a copy of Service Sheets for the consumers on their roster.

I am satisfied, having considered the information of the Assessment Team, that the approved provider has demonstrated a return to compliance in this Requirement.

I find the provider, in relation to the service, compliant with this Requirement.

# Standard 7

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| Human resources | | CHSP |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirement 7(3)(c)

The approved provider was previously found non-compliant with this Requirement in assessments of performance in 2022 and 2023.

At this assessment of performance, the Assessment Team reported the service demonstrated the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

The Assessment Team provided evidence, summarised below, relevant to my finding.

Staff and management demonstrated to the satisfaction of the Assessment Team, the process for ensuring staff have the required competencies to perform their role.

Consumers and/or representatives said they have confidence that their current support workers are competent and skilled and gave examples of how staff demonstrate their competency in the role when delivering services.

I am satisfied, having considered the information of the Assessment Team, that the approved provider has demonstrated a return to compliance in this Requirement.

I find the provider, in relation to the service, compliant with this Requirement.

Requirement 7(3)(d)

The approved provider was previously found non-compliant with this Requirement in assessments of performance in 2022 and 2023.

At this assessment of performance, the Assessment Team reported the service did not demonstrate the workforce is recruited, trained, equipped and supported to deliver services, specifically in relation to workforce education, training and policy support to deliver outcomes for consumers in line with the Aged Care Quality Standards.

The Assessment Team provided evidence, summarised below, relevant to my finding.

Evidence in Requirement 7(3)(c) includes the services’ recruitment drive for support workers using online recruitment platforms and recruitment agencies, with new service requirements that included first aid certification, and aged care industry knowledge.

Position descriptions provided to the Assessment Team used in job advertisements confirmed new staff requirements.

Evidence in the Assessment Team’s report under this Requirement 7(3)(d) includes:

Support workers said they had attended regular annual training.

A new supervisor role has been created to provide support and guidance to new employees, a role description is being developed and a tailored training program being established.

Tool box sessions on topics of interest are scheduled for March 2024.

While the training presentation delivered in November 2023 detailed the reporting of consumers’ changes in mobility, function, and cognition; changes to the number of adults living in the home, and hazards in the home, it did not discuss the reporting of near misses, unwitnessed and witnessed incidents.

The Assessment Team’s report outlines while the service could demonstrate that some improvements have been actioned and implemented to ensure all staff are trained and supported on an ongoing basis to perform their roles when delivering services to consumers, there was insufficient evidence available to be provided to the Assessment Team to demonstrate the effectiveness of the improvements at the time of the Assessment Contact.

Management acknowledged some additional training is required for office staff undertaking assessment and planning.

I am satisfied, having considered the information of the Assessment Team, that the approved provider has demonstrated a return to compliance in this Requirement.

I am satisfied that recruitment systems are effective.

I do not accept the Assessment Team’s assertion that the evidence is insufficient and find that the approved provider is free to prioritise training based on its on assessment of what is a priority for the service.

I am satisfied that the approved provider is actively supporting support workers to meet these Standards and while noting additional support is required in one Requirement of Standard 2, I do not consider the evidence provided by the Assessment Team demonstrates a systemic failure in this Requirement of Standard 7.

I find the provider, in relation to the service, compliant with this Requirement.

Requirement 7(3)(e)

The approved provider was previously found non-compliant with this Requirement in assessments of performance in 2022 and 2023.

At this assessment of performance the Assessment Team reported regular assessment, monitoring and reviews of the performance of each member of the workforce is undertaken.

Sampled staff members advised they have had a performance appraisal within the last 12 months, advising that management were supportive and encouraged feedback relating to on-the-job experiences and training needs.

Staff confirmed that they were supported in their performance appraisal process. Management described their processes for regular assessment, monitoring of staff performance, and their process to manage underperforming staff.

Management described and documentation showed the performance appraisal process using an updated template which included discussion points regarding work quality, attitude, punctuality/attendance, personal presentation, carrying ID card, aged care standard adherence, work, health and safety, compliance, and consumer feedback.

I am satisfied, having considered the information of the Assessment Team, that the approved provider has demonstrated a return to compliance in this Requirement.

I find the provider, in relation to the service, compliant with this Requirement.

# 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. | Not 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. | 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 |

Findings

Requirement 8(3)(b)

The approved provider was previously found non-compliant with this Requirement in assessments of performance in 2022 and 2023.

At this assessment of performance, the Assessment Team reported the service did not demonstrate the organisation promotes a culture of safe, inclusive and quality care and services, and is accountable for their delivery.

The Assessment Team provided evidence, summarised below, relevant to my finding.

As part of the previous non-compliance finding, the service submitted a continuous improvement plan which included a commitment that the managing director and program manager would meet regularly to ensure oversight of quality and safety matters. Ordinarily this would include the review of key performance indicators or similar to provide the governing body with relevant data.

The managing director said there have been no executive meetings since September 2023. The managing director said they have supported the service through ongoing recruitment and growing the business, however no evidence from a governance perspective was provided as to how these decisions came about.

I am satisfied, having considered the Assessment Team’s report, that the approved provider has not demonstrated a return to compliance in this Requirement. The governing body, in this case the managing director, has not demonstrated that they receive relevant data from the operational team to have effective oversight of the quality of service delivery.

The services Plan for Continuous Improvement detailed actions to improve previously identified deficiencies, including the managing director and program manager meeting regularly to discuss emerging operational issues. However, there is no evidence from the program manager that relevant data is being provided to the managing director to support them to inform the service’s priorities and strategic direction.

The intent of this requirement is that the governing body has information to hand to respond to deficits in the quality of services, and to direct any review of policies, uplift of skills or undertake other corrective actions as required. Consumers need confidence that the service is well run and the governing body needs to demonstrate how it has oversight to assure itself that the service is well run.

I find the provider, in relation to the service, non-compliant with this Requirement.

Requirement 8(3)(c)

The approved provider was previously found non-compliant with this Requirement in assessments of performance in 2022 and 2023 as the service did not demonstrate effective organisation-wide governance systems in relation to information management, continuous improvement, workforce governance, regulatory compliance, and feedback and complaints.

At this assessment of performance, the Assessment Team reported the service demonstrated evidence of effective systems in relation workforce governance, financial governance and feedback and complaints.

The Assessment Team reported the service did not demonstrate evidence of effective systems in relation to sub requirement (i) information management, and reported that:

* Management advised and documentation confirmed policies and procedures had been updated for clearer readability and clarity, however acknowledged additional procedural documentation supporting new staffing roles was outstanding.
* ‘Service Sheets’ do not contain sufficient information to inform and guide staff when delivering services.
* Care planning documentation viewed by the Assessment Team did demonstrate improved consideration of consumers' health and wellbeing risk.
* ‘Service Sheets’ have been updated with consumer details being de-identified to the greatest extent possible.

The Assessment Team reported the service did not demonstrate evidence of effective systems in relation to continuous improvement and reported that:

* The service developed a Continuous Improvement Plan (CIP) in October 2022, and has continued to add identified actions onto the CIP. While management advised they have been actively monitoring the service's CIP and updates to the plan support this, there was no documentation to demonstrate actions were regularly reviewed for effectiveness to ensure the desired outcomes are met.
* Aspects of review and evaluation were inconsistently completed on the CIP.

Requirement 8(3)(c) needs sub requirements (i) through to (vi) to have evidence demonstrating compliance.

I am satisfied, having considered the information of the Assessment Team, that the approved provider has not demonstrated that all sub-Requirements of this Requirement have been complied with.

I have considered evidence in Requirement 8(3)(b) relating to a lack of information pathway between the operational team and the governing body in my compliance finding for sub-Requirement (i).

I have considered the lack of continuous improvement in regard to governance systems throughout the Assessment Team’s evidence in Standard 8, in my compliance finding for sub-Requirement (ii) including that improvements, such as governance meetings have not been sustained.

I am satisfied, having considered the information of the Assessment Team, that the approved provider has complied with sub-requirements (iii), (iv), (v) and (vi).

I find the provider, in relation to the service, non-compliant with Requirement 8(3)(b) as I am satisfied that sub-requirement (i) and sub-requirement (ii) are non-compliant.

Requirement 8(3)(d)

The approved provider was previously found non-compliant with this Requirement in assessments of performance in 2022 and 2023 due to a lack of an effective incident system.

At this assessment of performance the Assessment Team reported the service did demonstrate effective processes to identify and respond to abuse and neglect of consumers, and to support consumers to live their best life.

The Assessment Team reported the service did not demonstrate evidence of effective systems in relation to incident management and reported that:

* A staff member was not aware of the need to record incidents on the service’s incident register.
* The service could not confirm if near misses and unwitnessed incidents are reported, to ensure appropriate corrective actions are undertaken for consumers to ensure the risk of further incidents are being mitigated. The Assessment Team’s report gave three examples including a cancelled service due to ill health, a description of declining mental health, and an injury during a shopping trip for a brokered client.
* The Managing Director advised they are accredited under the Work, Health and Safety ISO45001 certification and have the appropriate systems and trained staff in place to manage incidents.

While not all incidents outlined in the Assessment Team’s report are required to be on the service’s incident register, as they did not all occur during the delivery of a service, there is an expectation that, however recorded, that any incident should be considered in the broader service needs of the consumer and that the service has a system for trending incidents to improve services.

While I am satisfied that individual incidents are managed, I am not satisfied that the service has met its previous commitment to the Commission to improve the governance of its incident management system.

I have reviewed the continuous improvement plan previously submitted by the approved provider in regard to this Requirement which outlines:

* The Incident and Emergency Accident Procedure will be reviewed with other Policies and Procedures in first quarter of 2023, and Program Manager will ensure that relevant policies and procedures provide guidance to office staff and support workers about reporting and managing consumer incidents.
* Reinforcing any changes to Policies and/or Procedures that affect support worker practice will be included in onsite training which is currently being arranged to be provided by the Program Manager in February 2023.
* The Program Manager has undertaken further work on our Incident Management Register, which will be used at monthly Management Meetings and fortnightly Team Meetings to analyse individual incidents and monitor trends, as well as to inform of requirements to change service delivery (PCI inclusion) and identify areas of concern with staff training.

I am not persuaded, having considered the Assessment Team’s report that the service has fully implemented the actions it advised to the Commission or that these actions have been sustained over time. Trending of incidents is not occurring and reporting of incidents to the governing body is not occurring.

I find the provider, in relation to the service, non-compliant with Requirement 8(3)(d) as I am satisfied sub-requirement (iv) is non-compliant.

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)