**Performance**

**Report**

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| Name of service: | Aboriginal Elders - MILE END |
| Service address: | 1/67 Henley Beach Road MILE END SA 5031 |
| Commission ID: | 600145 |
| Home Service Provider: | Aboriginal Elders & Community Care Services Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 28 August 2023 to 29 August 2023 |
| Performance report date: | 27 November 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.

**This performance report**

This performance report for Aboriginal Elders - MILE END (**the service**) has been prepared by G. McNamara, 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.

# Services included in this assessment

**Home Care:**

* Aboriginal CDC Home Packaged Program - Metro North, 23381, 1/67 Henley Beach Road, MILE END SA 5031

**CHSP:**

* Community and Home Support, 24657, 1/67 Henley Beach Road, MILE END SA 5031
* Care Relationships and Carer Support, 24658, 1/67 Henley Beach Road, MILE END SA 5031

# Material relied on

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

* the assessment team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received 22 September 2023.

# Assessment summary for Home Care Packages (HCP)

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| --- | --- |
| Standard 2 Ongoing assessment and planning with consumers | Non-compliant |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Non-compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| --- | --- |
| Standard 2 Ongoing assessment and planning with consumers | Non-compliant |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Non-compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-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 2**

Requirement 2(3)(a):

* use validated assessment tools to assess the clinical needs of consumers
* ensure that identified risks to consumers captured within the assessment process are documented in consumer care plans, to provide guidance to staff in managing those risks.

Requirement 2(3)(b):

* ensure that, for consumers wishing to discuss advance care planning and end of life planning, that sufficient information and support is available
* demonstrate that information collected on consumers’ needs and preferences is consistently and sufficiently documented within the care plans, to inform and guide staff.

Requirement 2(3)(d):

* ensure that care and service plans include information on the outcomes of assessment and planning including the consideration of risks, and that these plans are readily available to consumers
* implement, embed and refine systems and processes to support reporting by and oversight of brokered care and services.

Requirement 2(3)(e):

* provide initial and ongoing training, instruction and guidance to staff on what circumstances and incidents prompt a review of care and services
* ensure that such reviews occur in a timely and appropriate manner
* ensure that care and services are regularly reviewed for effectiveness.

# Standard 3

Requirement 3(3)(a):

* ensure each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care by, including but not limited to:
  + demonstrating that care plans describe consumers current personal and clinical needs, and contain information detailing how care and services are expected to be delivered
  + documenting the provision of clinical care
  + using validated assessments.

Requirement 3(3)(b):

* effectively manage high impact or high prevalence risks associated with the care of each consumer by, including but not limited to:
  + documenting risks for consumers in their care plans
  + monitoring the care provided by sub-contracted organisations
  + providing adequate support and guidance to staff when managing risks associated with the care of consumers, including through policies and procedures
  + developing and maintaining an incident management system to capture incidents, and ensuring data from such a system, including high risk consumers or prevalent risks, is considered at an organisational level.

Requirement 3(3)(d):

* demonstrate that deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner by, including but not limited to:
  + implementing appropriate effective communication processes between your organisation and brokered services, and monitoring the effectiveness of same
  + implementing appropriate effective communication processes within your organisation; and
  + in both instances, ensuring such processes result in timely identification and effective escalation of changes in a consumer’s condition or state of health.

Requirement 3(3)(e):

* ensure that information about consumer’s needs, preferences, conditions and changes is consistently and effectively documented and communicated within the organisation, and with others where responsibility for care is shared by, including but not limited to:
  + implementing, monitoring and evaluating effective systems for the sharing of information
  + implementing appropriate effective communication processes between your organisation and brokered services, and monitoring the effectiveness of same.

**Standard 4**

Requirement 4(3)(g):

* demonstrate that the equipment provided to consumers is safe, suitable, clean, and well maintained by ensuring that needs are identified in a timely manner, and that prompt action taken to meet those needs.

**Standard 6**

Requirement 6(3)(c):

* show that appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong, by:
* providing guidance and training on open disclosure and monitoring the application of that process when resolving complaints
* documenting complaints and the resolution of such complaints
* ensuring all personnel understand the importance of respectful management of consumers and their concerns.

Requirement 6(3)(d):

* implement, monitor and evaluate processes and systems to ensure that feedback and complaints are tracked, reviewed and analysed to improve the quality of services for consumers.

**Standard 7:**

Requirement 7(3)(a):

* ensure that the workforce is planned, and the number and mix of members of the workforce enables the delivery and management of safe and quality care and services, by ensuring that the staffing model sufficiently supports the care and service needs of all consumers.

Requirement 7(3)(c):

* demonstrate that your workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles, by implementing processes for the review, monitoring and evaluation of staff competencies, including brokered staff, and taking expeditious action to remedy any identified concerns.

Requirement 7(3)(e):

* ensure that your workforce is regularly assessed or monitored, and that you review the performance of each member of the workforce, by implementation of processes and procedures to effectively monitor and review staff performance.

**Standard 8**

Requirement 8(3)(a):

* engage consumers in the development, delivery and evaluation of care and services, and support them in that engagement, beyond that associated with the informal feedback processes, through embedding and enhancement of current and planned improvements.

Requirement 8(3)(b):

* implement, monitor and evaluate processes and systems to ensure your governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery, in particular, that all relevant information is provided to that body and that that body considers that information in an appropriate manner.

Requirement 8(3)(c):

* establish, monitor and evaluate effective organisation-wide governance systems in relation to information management, continuous improvement, workforce and financial governance, regulatory compliance and feedback and complaints.

Requirement 8(3)(d):

* establish, monitor and evaluate effective risk management systems and practices to identify, assess, manage, and monitor risks to consumer’s safety and well-being; and prevent further risks or incidents.

Requirement 8(3)(e):

* implement an effective clinical governance framework, including systems and processes to enable delivery of safe and quality clinical care to consumers, in relation to but not limited to antimicrobial stewardship, minimising the use of restraint and open disclosure.

# Other relevant matters:

On 21 April 2022, arising out of a Quality Audit undertaken from 15 to 17 February 2022, a delegate of the Commissioner found the Home Service Provider, in relation to this service, Non-Compliant with 19 requirements across 6 of the 7 applicable Standards. Specifically:

* Standard 2 requirements 2(3)(a), 2(3)(b), 2(3)(d) and 2(3)(e)
* Standard 3 requirements 3(3)(a), 3(3)(b), 3(3)(d) and 3(3)(e)
* Standard 4 requirement 4(3)(g)
* Standard 6 requirements 6(3)(c) and 6(3)(d)
* Standard 7 requirements 7(3)(a), 7(3)(c) and 7(3)(e)
* Standard 8 requirements 8(3)(a), 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e).

# 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. | Non-compliant | Non-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. | Non-compliant | Non-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. | Non-compliant | Non-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. | Non-compliant | Non-compliant |

Findings

Based on the evidence cited in the Assessment Team’s Assessment Contact Report, summarised below, the Home Service Provider (HSP) is not, in relation to this service:

* utilising assessment and planning, including consideration of risks to consumers’ health and well-being, to deliver safe and effective services.
* identifying consumer needs and preferences or providing information about advanced care planning to consumers.
* ensuring that outcomes of assessment and planning are effectively communicated to consumers and documented within care plan.
* monitoring and reviewing consumers services regularly, including times when consumer circumstances change.

As to Non-compliant requirement 2(3)(a)

The service did not demonstrate that assessment and planning was effective. While consumer risks were captured within the assessment process, information including risks and service specific details were not documented within consumer care plans. The service did not demonstrate the use of validated assessment tools to assess the clinical needs of consumers. Therefore, staff did not have sufficient information to deliver safe, quality care and services.

While the service did complete assessments during initial onboarding to identify consumer risks, 8 of 8 consumer care files viewed demonstrated that relevant consumer information was not transferred to the care plan to inform staff delivering care and services. For example, one consumer’s assessment in September 2022 noted mobility issues, risk of falls and use of a walking stick at all times, however no information was included within the care plan to inform staff of their mobility. For another consumer, their representative described how they receive regular podiatry services for diabetic neuropathy and garden maintenance, however that consumer’s care plan does not document that they receive podiatry or provide any alerts for their type 2 diabetes, chronic back pain, or service specific information to guide staff.

The Assessment Team reported that management acknowledged the lack of information documented on the care plans to guide staff and notify them of the risk to consumers, and self-identified a common trend that care planning documentation does not include risks and alerts. Management described how the service is experiencing challenges due a lack of workforce training, knowledge and internal process surrounding assessment and planning. Management stated it was launching a new Client Management System (CMS) in September 2023 to improve the assessment and planning process.

The HSP provided information on a number of issues in its written response but did not challenge the findings of the Assessment Team in relation to these matters.

On the evidence available I find that the service was not able to demonstrate further actions undertaken to address the non-compliance identified at the Quality Audit in February 2022. While management described how they are launching a new Client Management System (CMS) in September 2023 to improve the assessment and planning process, this improvement was not visible at the time of this assessment contact, and I consider that once the CMS is implemented it will take time to produce tangible results.

As to Non-compliant requirement 2(3)(b)

The Assessment Team found that while the service demonstrated that it documents goals it could not demonstrate that needs and preferences, including advanced care planning, were considered within the care plans. Care planning documentation viewed for all sampled consumers did not identify individualised needs and preferences or provide instructions to staff on how to achieve these.

Management advised that needs and preferences are discussed during the initial intake assessments and included within service instructions of the care plan. However, the Assessment Team found that this information was not consistently and sufficiently documented within the care plans. For example, an assessment from June 2023 for one consumer documents then they have limited mobility and required assistance with mobility equipment for general walking, but this information was not reflected in the care plan to inform staff delivering services. Another consumer advised that they receive meals from an external provider. While an assessment from March 2023 identifies their need for meals, this information was not reflected in their care plan.

Management advised validated assessments are conducted by brokered services, however, care planning documentation did not demonstrate the use of clinical assessment to review falls risks for three consumers for whom falls risk was a relevant consideration.

Consumer assessments included brief summaries of consumer backgrounds, hobbies and interests. However, care plans viewed for all sampled consumers did not reflect this information to inform staff. For example, assessments for two consumers identified, variously, interest in watching television, reading, being outdoors and the importance of his friends and family in their life, however these matters were not reflected or included in their care plans.

Further, the service did not demonstrate that advanced care planning had been discussed with consumers. Five of 5 consumers and/or representatives interviewed advised advanced care planning was not discussed as part of the intake process at the service. While advanced care planning is included in the services assessment process, 7 of 8 care files reviewed by the Assessment Team demonstrated that no information was documented. Management advised that information about advanced care directives is provided in the introduction folder during onboarding, however evidence of these discussions were not documented within care planning files.

The Assessment Team reported that these concern where raised with management, who:

* acknowledged the lack of information provided on the care plans to inform staff of consumer needs and preferences.
* stated that while information is provided within the induction folder about advanced care planning, the service needs to improve on documenting these discussions with consumers.
* described how the service is experiences challenges due a lack of workforce training, knowledge and internal process surrounding assessment and planning
* advised how the implementation of the CMS will help to capture and document consumer needs and preferences within the care plan.

In its written response the HSP stated that Client Intake Folders contain information on advanced care planning, and that this is discussed with clients on intake. No additional information was given to support this statement, and I consider that the preponderance of evidence indicates that the organisation’s systems for including advance care planning and end of life planning, if the consumer wishes, are not mature.

The HSP did not challenge the other findings of the Assessment Team in relation to this requirement, and I consider that the HSP could not demonstrate that individualised needs and preferences are always identified or instructions provided to staff on how to meet these needs and preferences.

As to Non-compliant requirement 2(3)(d)

The Assessment Team found that the service did not demonstrate that outcomes of assessment and planning are effectively communicated to the consumer and documented within the care plan.

Four of 6 consumers interviewed indicated they did not receive a copy of their care plan or were unsure if the service had provided them a copy of their care plan. In addition, all care plans sampled did not include information on the outcomes of assessment and planning including the consideration of risks. When risks were identified through the assessment process this information was not documented within the care plan, as identified in additional detail under requirements 2(3)(a) and 2(3)(b) above.

Referral forms provided to brokered services did not consistently provide detailed information about the consumer and how their services are to be provided to support the workforce to deliver appropriate and safe services. For example, referral forms for a consumer provided information in relation to social support services such as a desire to go shopping each week, but it did not detail how the tasks are to be completed according to the consumer’s preferences and risks. No information was provided to inform the brokered services that the consumer has limited mobility and requires a walking stick for assistance.

The Assessment Team reported that these concerns were raised with management who was recorded as stating that:

* staff receive information about consumers by email or phone call
* care plans are mailed out to consumers so staff can access them, however, management acknowledged consumers do not have the care plan readily available for staff
* they lack oversight of brokered service as they do not receive regular information back. While they advised that they have attempted to update brokerage agreements to improve service oversight and reporting, they have not been successful in getting all contractors to fulfil their reporting obligations, as per their contractual arrangements.
* reporting and documentation is their biggest risk in relation to the sharing of information and completion of progress notes. They described how staff do not document consumer information effectively and how they require additional training and support.

In its written response the HSP challenged the Assessment Team’s findings in relation to brokerage. For the reasons stated below that information does not persuade me the findings of the Assessment Team were incorrect or that the HSP has rectified identified the issue since this Assessment Contact.

The HSP stated that Brokerage Agreements were sent to its Lawyers for review, and that information in the agreement had been updated and finalised. A copy of that agreement was provided, and I acknowledge that such an agreement is in place. However, the HSP’s response does not challenge its reported statement during this Assessment Contact that they had not been successful in getting all contractors to fulfil their reporting obligations.

The HSP also stated that a Client based audit was developed, and that it was conducting these monthly to gain feedback from clients on brokered services. It provided some feedback forms completed in May and July 2023. This is a positive step, and this process appears to have been commenced prior to this Assessment Contact. However, the Assessment team’s findings relate to evidence gained on 28 and 29 August 2023, which indicates this improvement requires further development. Further, the evidence regarding client audits does not challenge the reported statement of management during this Assessment Contact that they had not been successful in getting all contractors to fulfil their reporting obligations.

The HSP further stated that since this Assessment Contact follow up conversations and meetings have been held with contractors to ensure reporting obligations are met. This is also a positive step, however no evidence of this was provided.

While there is evidence of improvement actions, I am not satisfied that these actions are fully integrated into the HSP’s systems and processes, and that the HSP, in relation to this service, did not demonstrate that outcomes of assessment and planning are effectively communicated to the consumer and documented within the care plan. .

As to Non-compliant requirement 2(3)(e)

The service did not demonstrate that consumers are reviewed regularly, or when circumstances change after an incident or following discharge from hospital. The evidence indicated challenges with workforce capabilities and the management of staff workload were impacting the service’s ability to complete consumer reviews and identify a change in needs, goals and preferences.

Consumers and representatives interviewed described they had not been reviewed when circumstance had changed, or after an incident had occurred. For example, one consumer was hospitalised on a date in June 2023 and discharged two days later. The consumer stated that when they were discharged the service did not complete a review to reassess their needs despite the cause of their hospitalisation requiring an increase in relevant aspects of their clinical care. When this feedback was provided to the HSP, staff stated a review was not completed by the service after the consumer’s hospitalisation because it was not considered a change in circumstance.

Another consumer had falls on 25 May and 1 June 2023. That consumer indicated the service was notified and stated that it did not complete a reassessment or review. Another consumer stated they went to hospital to undertake x-ray scans following a fall from their bed, resulting in a bruise and lump on their head. They advised that while an Occupational Therapist (OT) appointment had been scheduled for 1 September 2023 to review their bed the service has not completed a review or reassessment of their services.

Review of documentation confirmed concerns raised by consumers regarding the service lack of regular review. A monthly review report generated at the time of Assessment Contact highlighted that 46 of 380 consumer had not undergone a review within the previous 12 months. This is considered in more detail in Standard 7, requirement (3)(a). The report highlighted that 5 CHSP consumers had not been reviewed since 2021.

The service’s assessment and planning policy states that agreed dates of care plan reviews, and undertaking additional reviews occur when the consumers condition changes, the situation regarding the services delivery changes or an incident occurs. As indicated in relation to two consumer examples cited, staff were not always aware of when consumers reviews are required.

The Assessment Team reported that these concerns were raised with management who was recorded as stating that:

* the reason for consumers not having a review is due to lack of consistency with training about when to review and how often
* Staff caseloads are too high and described how the service needs to hire additional staff and provide further training to the current workforce. This is considered in more detail at Standard 7, requirement (3)(a)
* the service should be delivering on expectations reflected within their policies and procedures.
* reviews are undertaken, however the documentation is not completed
* they would monitor the progress of reviews by generating a monthly report.

In its written response the HSP stated three consumers identified in the Assessment Team’s report, including in this and requirements in other Standards, were ‘not in scope’ for the services included in the assessment. However, all these consumers were listed as consumers of this service in a service consumer list given by the HSP to the Commission, and I do not accept that submission.

The HSP did not otherwise challenge the findings of the Assessment Team in relation to this requirement, and I am satisfied that service could did not demonstrate that consumers are reviewed regularly, or when circumstances change after an incident or following discharge from hospital

# Standard 3

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| --- | --- | --- | --- |
| Personal care and clinical care | | HCP | CHSP |
| 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. | Non-compliant | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant | Non-compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Non-compliant | Non-compliant |
| 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. | Non-compliant | Non-compliant |

Findings

Based on the evidence cited in the Assessment Team’s Assessment Contact Report, summarised below, the Home Service Provider (HSP) is not, in relation to this service:

* ensuring that consumers receive safe and effective clinical services that is tailored their needs and optimises their health and wellbeing.
* ensuring that high impact risks to consumers are effectively managed.
* recognising and responding to deterioration of consumers conditions in a timely manner.
* effectively communicating information about consumers’ condition within the organisation and with brokered service providers where the responsibility of care is shared.

As to Non-compliant requirement 3(3)(a)

The service was not able to demonstrate that each consumer gets safe and effective care that is best practice, tailored to their needs, and optimises their health and well-being. While most consumers and representative interviewed confirmed they receive care and service tailed to their needs, care planning documentation did not demonstrate that clinical care was safe, effective and delivered in a way that optimises consumer health and wellbeing.

As discussed in Standard 2, requirement (3)(a) care plans viewed by the Assessment Team did not describe consumers current personal and clinical needs. They did not contain information detailing how care and services are expected to be delivered. For example, one consumer described how they were diagnosed with type 2 diabetes and has had an ulcer on their ankle for 5 years. The consumer described that the wound is healing, however their care plan lacked information about the wound. The care plan states, 'wound care every second day', however there are no care and support instructions documented that detail how the wound care is being provided. Further, progress notes dated 23 August 2023 for that consumer highlight that they had requested a new drainage bag for their wound since the one they had was worn out. At the time of this Assessment Contact management confirmed no follow up or documentation was recorded regarding the purchase.

In its written response to the drainage bag aspect of these findings the HSP stated the consumer’s request for a new drainage bag on 23 August 2023 was followed up by the coordinator. When followed up the coordinator found that the consumer was requiring foot and leg protectors for their wounds when showering, this was purchased the very next day on 24 August 2023.

Documentation was provided to support that claim, however, I am unable to see on that documentation evidence of purchase of drainage bags. And even if such bags had been purchased as stated, I consider that the other information in relation to this consumer, which the HSP did not address in its written response, are of concern.

The representative of another consumer described how the has consumer has type 2 diabetes and receives regular podiatry to treat their diabetic neuropathy. Care planning documentation does not list podiatry as a service being delivered, nor does it document any information about the consumer’s clinical risks including chronic back pain, hip replacements and their diagnosis of type 2 diabetes. The HSP did challenge these findings.

Another consumer had been receiving wound care twice a week for an ulcer on their foot despite care planning documentation stating once weekly. On 7 June 2023 that consumer was admitted to hospital for a second degree burn on the same foot that occurred on 31 May 2023. The consumer was discharged from hospital with home supports until 16 June 2023. The service was then commenced providing wound care 3 times a week, however, care planning documentation dated 8 May 2023 was not updated and listed 'wound care - once weekly'. Further, there were no care and support instructions documented that detail how the wound care is being provided, and there was no documentation of any information about their clinical risks and alerts including limited mobility and medical diagnoses. The HSP did challenge these findings.

Additional detail on care plans not described consumers current personal and clinical needs is detailed under Standard 2, requirement (3)(a).

The Assessment team also found that the service did not demonstrate further actions undertaken to address the non-compliance identified at the Quality Audit in February 2022. For example, it did not show that validated clinical assessment are being undertaken to assess consumers clinical needs and risks. While management advised that the service refers to brokered providers to complete clinical assessments, the Assessment Team viewed care plans which demonstrated they were not completed. The HSP did challenge these findings.

The Assessment Team noted that another consumer with a level 4 Home Care Package (HCP) had a surplus in their funds of approximately $64,000.00 as at 31 July 2023. According to that consumers July 2023 statement no services had been delivered. In its written response the HSP stated that documentation showed that on 1 August 2023 a home visit for review took place and documented discussion on services where the consumer was open to ongoing meals and domestic assistance, however not at this time and they would inform the coordinator when these should start. The HSP also indicated that the consumer’s partner also received services in the home which may reduce the need for the consumer to access services through their funding. The HSP also stated that the consumer has utilised funding for allied health and equipment recommendations and services as they require, the HSP stating this is consumer choice. A copy of a file note set out some of that conversation, however I am not satisfied that the HSP’s response or that file note evidenced sufficiently detailed engagement with that consumer about use of funds.

The Assessment Team reported that these matters were raised with management who:

* acknowledged the lack of information documented on the care plans to guide staff and notify them of the risk to consumers.
* also acknowledged that validated assessments should be undertaken by referring to brokered services, however, staff lack the training and knowledge to know when an assessment is required and are therefore not referring.
* that it needed to recruit to clinical positions to support its delivery of clinical care

For the above reasons I am satisfied that the service was not able to demonstrate that each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care.

As to Non-compliant requirement 3(3)(b)

The service was not able to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. The service did not document risks for consumers in the care plans. The service did not demonstrate an effective process to assess, action and mitigate risks associated with the care of each consumer, to ensure safe and effective delivery of personal and clinical care.

Care planning documentation viewed by the Assessment Team for a consumer demonstrated the service did not safely manage their wounds. Care planning documentation confirmed that the consumer had been receiving wound care every second day by a brokered services for an ulcer on their left foot. The consumer was admitted to hospital due to a second degree burn on the same foot. The brokered service was providing wound care during this period to treat the ulcer on the left foot, however, did not notify the service of the burn. Following discharge form hospital the consumer received wound care three times a week by the same brokered provider, however the service did not reassess or review the consumer after their admission. The service did not receive any notes from the brokered service to provide updates on the management of the consumers wound for a period of approximately 6 weeks. The Assessment Team viewed the notes from the brokered service that stated that the consumer had further deteriorated and had developed a wound on their right foot. The consumer was admitted to hospital because their foot started to deteriorate and bleed. The subcontracted provider did not send any notification of the deterioration to the service while providing care during this period.

Another consumer described how they weighed 200kg and required a wheelchair assistance for their mobility and to prevent falls. The consumer advised that their current walking frame did not meet their needs since the service cannot supply one that is capable of holding their weight. The consumer described how they were currently using a wheelchair that is able to hold up to 180kg and they were hopeful it doesn’t break.

An assessment dated 21 June 2023 documented that the consumer had very limited mobility, requires physical assistance and support with equipment. It identifies that they have limited mobility due to weight, chronic pain and is susceptible to falls due to dizziness. However, that consumer’s care plan did not contain this information in alerts, provide care instructions to inform staff, or provide any risk mitigation strategies to prevent falls.

The Assessment Team noted that mobility, falls risks and mitigation strategies were not reflected on care plans for other consumers at risk of falls, details of which are considered in more detail in Standard 2 requirements (3)(a) and 3(b).

The Assessment Team noted that the service does not have policies and procedures to support staff when managing risks associated with the care of consumers including falls, wounds, pressure injuries, dementia, behaviours of concern, palliative care, pain, nutrition and hydration.

While the service did develop an incident management system to capture incidents, the Assessment Team reviewed multiple Team Meeting and Board Meeting minutes and noted that the service did not demonstrate that it discusses high risk consumers or prevalent risks.

The Assessment Team reported that these matters were addressed with management who was recorded as stating:

* they were currently investigating the incident regarding the issue of management of a consumer’s wounds
* they acknowledged the lack of information documented on the care plans to guide staff and notify them of the risk to consumers.
* they also acknowledged that the service does not have policies and procedure in clinical areas to support staff on the internal processes including when to refer for validated assessments.
* They further acknowledged that high impact or high prevalence risks are not reported to or discussed with the governing body.

In its written response the HSP provided some context on the management of a consumer’s need for equipment to manage some risks. The HSP also stated it had Clinical Policies and procedures to provide guidance to staff and provided copies of two documents entitled ACS-HC-Assessment and Planning with a date of 19 December 2022 and ACS-HC-Assessment with a date of 23 January 2023. However, this context and these documents did not strongly challenge or address the information detailed above. The HSP did not otherwise challenge the Assessment Team’s findings.

For the above reasons I am satisfied that the service was not able to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer.

As to Non-compliant requirement 3(3)(d)

The service did not demonstrate that deterioration or change in consumers mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. While the organisation had implemented new brokerage agreements to stipulate obligations for reporting deterioration, the Assessment Team found that at the time of the Assessment Contact this process was not effective.

As detailed in Standard 3 requirements (3)(a) and (3)(b), there was not sufficient escalation, evidence of monitoring or communication of concerns for a consumer who suffered a burn to their left foot and a subsequent ulcer on that same foot, particularly in relation to communication from and to the brokered service that was providing wound care to this consumer . At the time of the Assessment Contact management advised they were investigating the care given to this consumer.

In its written response the HSP did not challenge the Assessment Team’s findings detailed above, and did not submit any evidence to substantiate that new brokerage agreements were now effective.

For the above reasons I am satisfied that the service was not able to demonstrate that deterioration or change in consumers mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.

As to Non-compliant requirement 3(3)(e)

The service was not able to demonstrate that information about consumer’s needs, preferences, conditions and changes are consistently and effectively documented, and communicated within the organisation, and with others where responsibility for care is shared.

Brokered service providers are provided information about consumers through the completion of referral forms, care plans and other requested information. However, as detailed in Standard 3, requirement (3)(a) care plans viewed by the Assessment Team did not reflect consumers current personal and clinical needs, and also did not contain information detailing how care and services are required to be delivered.

The Assessment Team noted that information received from brokered services about consumers personal care and clinical needs was not consistently received, documented, or shared within the service. For example, as detailed in Standard 3 requirement (3)(d) and (3)(b) the service did not receive information from brokered services on two separate occasions regarding the deterioration of a consumer’s wound. One Care Coordinator, and progress notes dated 31 June 2023, confirmed how the service did not receive 2 months’ worth of wound management reports from brokered services caring for that consumer.

Although this information relates to one consumer, I consider that it indicates a significant deficiency in the service’s processes, and the HSP did not challenge the Assessment Team’s findings detailed above.

The Assessment Team reported that management acknowledged that oversight of brokered services is the organisation highest risk, and advised that the service had worked at improving oversight of brokered services, however, acknowledged the challenges associated with getting information back from brokered services providers. Management also stated that the new CMS will assist with accurate documentation and increase staff accessibility to information, whilst acknowledging it was due to be introduced in September 2023.

For the above reasons I am satisfied that the service was not able to demonstrate that 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. I acknowledge planned or current improvements in oversight and information sharing, however I am not satisfied that these actions are fully integrated into the HSP’s systems and processes.

# Standard 4

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| Services and supports for daily living | | HCP | CHSP |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Non-compliant | Non-compliant |

Findings

As to Non-compliant requirement 4(3)(g):

Based on the evidence cited in the Assessment Team’s Assessment Contact Report, summarised below, the Home Service Provider (HSP) did not, in relation to this service, demonstrate that the equipment provided to consumers is safe, suitable, clean, and well maintained.

The service had implemented some changes since the Quality Audit conducted in February 2022, however, they had not effectively communicated the changes to staff, and staff did not consistently follow the services policies and procedures in relation to the purchasing and maintenance of equipment for consumers.

Consumers sampled advised they had requested mobility equipment and/or home modifications but had not received equipment suitable for their needs. One consumer advised they had requested a bariatric 4-wheel walker with a seat to remain mobile; however, they were provided a walker without a seat. The consumer advised they continue to use an older 4-wheel walker that is not recommended for their weight range.

Management advised that the consumer had gained weight since the previous walker was purchased and they have been trying to locate a more appropriate 4-wheel walker. Management acknowledged that the consumer was utilising equipment that was not recommended for them, and despite the policies and procedures recommending a Dignity of Risk form to be completed, this had not been undertaken for the consumer.

The Assessment Team viewed care planning documentation for that consumer and observed they also required an electric bed suitable for their weight range. Case notes indicate the consumer had insufficient funds and this would be looked into when funds are available, noting there was no discussion documented regarding the risks to the consumer. The electric bed and mattress were recommended by the OT on 8 August 2023.

The HSP did not challenge the Assessment Team’s findings detailed above.

Staff interviewed advised they have consumers who have requested equipment, however, they were waiting on the consumer to be reassessed for a higher package before making any purchases. For example, the Client Services Coordinator for another consumer advised the consumer had requested mobility equipment, a personal alarm and a lock box, however, the staff member stated because they had requested a new ACAT via MAC they advised the consumer to await the outcome of their ACAT before looking into purchasing equipment. The Assessment Team was advised by the consumer they had requested a bathroom grab rail to assist with showering due to recent falls, and a personal alarm that would activate when they experienced a fall.

Management acknowledged the consumer’s case notes did not meet their defensible documentation requirements. They advised the Assessment Team that the staff member had met with the consumer on Friday 25 August 2023 without documenting the meeting, discussion or outcome. Management advised they will follow this up. Management confirmed the consumers Allied Health codes were with an alternate provider, and the process to have the codes allocated to them was difficult and it was easier for the consumer to await the outcome of the ACAT. The staff member did not mention the handrail during their interview and the consumers case notes also did not reflect recent falls and/or the request for a grab rail to be installed.

In its written response to this issue the HSP noted this consumer was not funded under its program to provide equipment or home modifications, and provided evidence that it had sought a referral to address this issue. However, while some steps were in place I am not satisfied that the documentation evidenced an accurate assessment and escalation of the consumer’s situation and needs.

Management acknowledged consumers are not being provided with safe and suitable equipment to assist consumers to remain mobile and/or independent within the community. Management advised they plan to make improvements in relation to this requirement. However, the Assessment Team viewed the Action Plan created after the previous Quality Audit in February 2022 and noted the 3 items in relation to equipment management were marked as completed, however, the Assessment Team did not observe any of the completed changes.

In its written response to this observation the HSP state that Individual clients have electronic folders and CIM files which between them contain all correspondence for purchases, allied health recommendations and dates of purchase. A screen shot of those folders was provided but no details were visible, hence it is not apparent to me that the Assessment team’s observation was incorrect.

For the above reasons I am satisfied that the HSP, in relation to this service, was not able to demonstrate that the equipment provided to consumers is safe, suitable, clean, and well maintained.

# Standard 6

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| Feedback and complaints | | HCP | CHSP |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Non-compliant | Non-compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Non-compliant | Non-compliant |

Findings

Based on the evidence cited in the Assessment Team’s Assessment Contact Report, summarised below, the Home Service Provider (HSP) is not, in relation to this service:

* Actioning and analysing feedback from consumers and implementing actions to improve the quality of services for consumers.
* Creating, encouraging, and promoting open disclosure when managing complaints.

As to Non-compliant requirement 6(3)(c):

The service did not demonstrate they take appropriate action in response to complaints or use an open disclosure process when things go wrong. The service also did not demonstrate they take an open disclosure approach when resolving complaints and acknowledged that complaints are not consistently documented, which impacts the service’s ability to resolve complaints.

Some staff and management spoke about consumer’s feedback in an adverse manner, with some case notes and the complaints register containing negative comments about consumers. One consumer who made a complaint had a case note that contained multiple comments in all capitals that ended with multiple exclamation points.

Consumers provided mixed feedback in relation to responses received following complaints. While some consumers said appropriate action occurred, not all consumers interviewed were satisfied those complaints raised are resolved to their satisfaction. This feedback included that there had been no apology or expression of regret provided and no reason given as to why the situation occurred.

While the service has an open disclosure policy, staff interviewed could not describe the meaning of open disclosure. Management did not provide any examples of open disclosure or learnings. Consumer complaints and incident documentation did not show appropriate and timely action is always taken and that open disclosure occurs.

Staff acknowledged they do not record all complaints on the required registers, and management confirmed they do not document all forms of feedback received.

Management advised whilst they have policies and procedures to capture feedback from their consumers, staff do not effectively record all feedback provided by consumers and this does not meet the threshold for defensible documentation or the services policies and procedures. Management stated they would create a further action item to address this deficiency.

Management advised it can be challenging to help resolve concerns with consumers, stating they can only work off the notes recorded within the system when the complaint relates to a staff member. For example, management described one consumer as difficult to contact and stated they do not respond to their contact attempts; the consumer only contacts the service when they need them to purchase something. Management advised they may need to suspend the consumers services to trigger contact from the consumer. Management advised there had been ongoing contact attempts by staff, however, case notes provided to the Assessment Team noted that the consumer was not contacted by staff between 16 February 2023 and 6 July 2023.

Case notes further evidenced when the consumer contacted the service on 21 August 2023 to explain they were dissatisfied with her current Care Support Worker (CSW), the manager advised the consumer that the CSW’s notes evidenced “there is significant documentation” by the staff member to verify their contact attempts, however, the consumer did not feel the same way. The Assessment Team, noted at the completion of the Assessment Contact, no contact or open disclosure process had been attempted with this consumer to address their concerns. The Assessment Team noted throughout the reported case notes there was no evidence of an apology being provided to the consumer, or consideration of the consumer’s voice.

The Assessment Team viewed the Feedback register which evidenced complaints are not resolved in a timely manner. Feedback was submitted by another consumer on 9 June 2022 in relation to the quality of the cleaning being provided and how equipment was purchased. The feedback stated this issue was impacting the consumer’s mental health. This complaint was resolved on 6 December 2022. No improvements were documented and there was no evidence of an apology or outcome provided to the consumer.

I have included additional details in relation to these matters in Standard 8, requirement (3)(c).

The HSP did not challenge the Assessment Team’s findings detailed above.

For the above reasons I am satisfied that the HSP, in relation to this service, was not able to demonstrate that it takes appropriate action in response to complaints or uses an open disclosure process when things go wrong.

As to Non-compliant requirement 6(3)(d):

The service does not have implemented processes that enables it to track, review and analyse feedback and complaint trends to improve the quality of services for consumers.

The Assessment team found that systemic issues previously identified at the Quality Audit in February 2022 remaining ongoing, despite improvements being marked as completed on the services Action Plan. Staff do not recognise complaints or record them on the complaints register, therefore, complaints are not able to be analysed, monitored, or reviewed to improve service delivery.

The service does not have a system that enables it to track, review and analyse feedback and complaint trends to improve the quality of services for consumers. For example, one staff member interviewed described an inconsistency in a consumer’s monthly invoices from a brokered service. The staff member reviewed the invoices and determined the consumer was having medication for his cognitive decline administered outside the required time, and was also being charged at a higher rate. The staff member resolved the issue.

A staff member for another consumer stated that a consumer contacted them because they had a brokered staff member attending their home for 3 hours a week and the consumer had not requested this service. The staff member followed up and determined that the brokered service was incorrectly sending a staff member out to the consumer’s home, and resolved the issue.

The staff member acknowledged they did not record the above concerns on the complaints register, however they raised the matter with management and for one of the 2 brokered services involved, all invoices would now be checked. The staff member identified a third discrepancy had now been found and they were still looking into the matter.

Management acknowledged they were aware of this billing issue and were currently looking into it. Management confirmed the brokered services involved had not been audited, however the service was investigating the incidents. Management confirmed they had made the decision not to notify the Board and, in line with their internal policies, both above complaints should have been added to the complaints register to identify the trend.

Multiple complaints had been raised by consumers in relation to taxi drivers not taking the most direct route and potentially overcharging consumers or asking them to sign blank cab-charges, and management advised that complaints about taxi’s was one of the services biggest complaint trends. However, there was only 2 complaints about taxis on the complaints register documented between 4 May 2023 and 2 August 2023.

The HSP did not challenge the Assessment Team’s findings detailed above.

For the above reasons I am satisfied that the HSP, in relation to this service, was not able to demonstrate that it has processes that enables it to track, review and analyse feedback and complaint trends to improve the quality of services for consumers.

# Standard 7

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| Human resources | | HCP | CHSP |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Non-compliant | Non-compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Non-compliant | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant | Non-compliant |

Findings

Based on the evidence cited in the Assessment Team’s Assessment Contact Report, summarised below, the Home Service Provider (HSP) is not, in relation to this service:

* regularly reviewing workforce planning to ensure there is enough staff and volunteers to deliver quality services that meet consumer needs and preferences.
* ensuring that staff are competent to perform their role through induction, guidance and supervision.
* monitoring and reviewing staff performance.

As to Non-compliant requirement 7(3)(a):

The service did not demonstrate the workforce is planned, and the number and mix of members of the workforce enables the delivery and management of safe and quality care and services.

The Assessment Team found that the service employs 9 care staff, one care coordinator and one care advisor, which it recorded was a reduction of the staff recorded during the February 2022 Quality Audit. The service has appointed a HR Manager and a Quality Manager, and advised they will continue to employ additional staff. Brokered services are utilised and the service advised there were no unfilled shifts in the last 30 days.

The Assessment Team reported that management acknowledged there was risk to the consumers with the current staffing model, noting some managers advised it was due to the competency of staff and others stated it was due to a complex workload and a lack of support and/or training provided to staff. Management acknowledged care planning reviews, case notes and consumer follow up was not meeting these Standards, and despite actions implemented over the last 18 months; there was no improvement.

Management advised they will create an action item and look at recruitment of additional staff. Management advised two care staff will be leaving the service by October 2023 and to date, they have not filled these positions.

The Assessment Team viewed documentation that evidenced 46 of 380 care plan reviews were outstanding, with 5 CHSP reviews overdue by more than 18 months. A review of staff caseloads identified that of 9-care staff; 4 care staff had 9 or more reviews outstanding.

Management acknowledged the outstanding reviews and the potential impact to consumers, advising one staff member recently had 30 reviews outstanding, however, they recently re-distributed the caseloads based on staff feedback that they were overwhelmed and could not effectively and safely manage their caseloads.

All consumers sampled in relation to this requirement advised they had experienced ongoing concerns with staff over the last 12 months and were aware of staff shortages and the heavy caseloads. Two of 6 consumers advised previous care staff had taken no action despite repeated requests for help, had not returned their calls and the consumer had not been contacted for weeks at a time, despite leaving multiple messages.

Staff interviewed described their caseloads as complex and advised there was not always the time to complete their administrative tasks. One staff member advised they do not have the time to have in person meetings with consumers and they rely on the brokered services to provide feedback via their progress notes because it is the brokered services that have their eyes on the consumers.

In its written response the HSP corrected some position titles and noted that the Aged Care Advisor role filled with the candidate starting on 4 September 2023. It also stated a second offer has been made and the new Client Services Coordinator would commence on 3 October 2023. It disputed the Assessment team’s finding there was a reduction in staff, stating that staff numbers in the Adelaide Metro Team have increased by two since the last Quality Audit in February 2022. It did not otherwise challenge the Assessment Team’s finding detailed above.

These improvements are positive, and I am unable to dispute the stated increase in staff. However, the evidence indicates that staffing concerns remain. Further, the recruitment in advisory and coordination is of recent origin and will take time to show improvements.

For the above reasons I am satisfied that the HSP, in relation to this service, was not able to demonstrate that the workforce is planned, and the number and mix of members of the workforce enables the delivery and management of safe and quality care and services.

As to Non-compliant requirement 7(3)(c):

The service did not demonstrate the workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

The Assessment team found that, as outlined in the Quality Audit dated February 2022, there was no documented process in place to monitor the competencies and capabilities of care staff. It found that new process implemented to monitor brokered staff has demonstrated systemic deficiencies throughout this contact assessment. For example:

* Brokered staff services were charging excessive consumers and no audit has commenced.
* Brokered staff are not notifying the HSP of case notes for multiple consumers. Whilst follow up for one agency has occurred, the HSP has identified a second brokered service, and is yet to complete an audit.
* Brokered staff are not completing work as requested by consumers, resulting in consumers following up with the brokered service directly, and this deficiency was not being captured.

Notwithstanding these concerns, no audit of the brokered services involved had been completed at the time of this Assessment Contact to investigate the identified deficiencies. The service did not demonstrate care staff and management are competent to perform their roles.

Consumers sampled advised staff received regular training, however, some consumers sampled advised the staff should not be in their roles because they are the wrong fit. Overall consumers were satisfied with brokered services, however they advised they liaised directly with brokered services due to the HSP not having the time to assist with those issues.

Staff described monthly training they received, however, when asked to provide details about policies and procedures, such as Open Disclosure, or writing and reviewing care plans, staff advised they could not elaborate on the processes. One staff member advised they received one hour’s induction and three buddying sessions on how to write a care plan prior to commencing in their role and they felt competent to perform all required roles and responsibilities.

Management provided documentation that verified staff attend regular training, however, confirmed there is no follow up to assess competency. Management acknowledged the staff were “working in silo’s” and this was creating risk for consumers as each staff member completed tasks in their preferred way. Management acknowledged the service did not provide guidance to their staff to ensure consistency in the delivery of care and services to consumers.

Management stated they would look at creating detailed training and checklists that provide staff with detailed instructions and guide staff in the delivery of care and services, acknowledging there is no mentoring and minimal staff oversight, excluding annual reviews. Management also acknowledged they had promoted staff within the organisation, however the policies and procedures created over the last 12 months did not provide the relevant guidance required to address this deficiency, first identified in the Quality Audit conducted February 2022.

Management advised and provided documentation confirming brokered staff are required to maintain their competencies and maintain the Quality Standards. Notwithstanding this, management advised there was one incident they are reviewing where a brokered organisation did not provide wound care progress notes or timely feedback over a 3-month period, and during this time the consumers situation deteriorated. Management advised at the time of the contact assessment, the investigation was not finalised, and they could not determine what had occurred with the consumers wound care, and what contributed to the consumers deterioration.

In its written response the HSP gave some clarity on recruitment processes, indicating staff were selected based on skills, qualifications and experience. It stated all staff receive an induction to the organisation on the first day they commence employment. It also stated that five new staff members have joined it since the induction process was implemented in May 2022, and that new staff members undergo buddy shifts in the form of home visits and assessments and sit with other staff to learn the processes involved. It did not otherwise challenge the Assessment Team’s finding detailed above.

These improvements are positive, however, the evidence indicates that concerns remain in relation to their being no documented process in place to monitor the competencies and capabilities of care staff, including but not limited to monitoring brokered staff. Further, the recruitment in advisory and coordination is of recent origin and will take time to show improvements.

For the above reasons I am satisfied that the HSP, in relation to this service, was not able to demonstrate that its workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

As to Non-compliant requirement 7(3)(d):

The service did not demonstrate their workforce is regularly assessed or monitored, and that they review the performance of each member of the workforce. The service does not have processes and procedures to effectively monitor and review staff performance.

A review of staff performance appraisals identified staff performance reviews had been conducted within the last 12 months, however, two staff members who participated in their 12-month performance review had received no indication or discussion of the consumer complaints that had been received by the service.

The Assessment Team viewed performance development reviews for both staff members and noted under the core competency to consistently demonstrating our value of respect, the staff are assessed as exceeding expectations. The performance review indicated in almost all core competencies and requirements the staff members were meeting operational requirements.

Management advised they have implemented changes and experienced resistance from staff who have identified the guidelines being set are not obtainable based on their current workload and staffing levels. Additional information relating to this has been detailed at Standard 8, requirement (3)(c).

Management advised there is currently no formal process to performance manage staff, and there have never been key performance indicators set for the care planning staff in relation to conducting reviews and/or maintaining care planning documentation. However, the Assessment Team viewed the Quality Audit conducted in February 2022 where management advised two staff members had been terminated due to their inability to undertake their roles and responsibilities.

Management advised they have undertaken recent discussions with two staff members who have demonstrated an unwillingness to work within the parameters set. Management acknowledged that whilst they had observed the care plan reviews outstanding, heard feedback from consumers, and self-identified these staff members were not meeting their key performance indicators, the manager stated they had no performance management process to refer to.

Management advised they have set a work plan to manage overdue reviews and administrative tasks and they have set expectations that need to be met for all staff to maintain. The Assessment Team viewed the work plan documentation provided to 2 staff and confirmed that whilst tasks are set there is no clear direction to assist or instruct staff on how to make the required improvements. Management and Board members acknowledged there was no informal or formal training for upper management, including mentoring or ongoing coaching within their role.

The Assessment Team viewed the minutes of Board meetings for February 2023 that indicated the Board proposed Senior Management positions have involvement from the Board to safeguard the organisation, however, since this meeting there has been no further discussion, and the Board is not provided with any feedback or information relating to the competency of staff, including Senior Management.

In its written response the HSP did not challenge the Assessment Team’s finding detailed above.

For the above reasons I am satisfied that the HSP, in relation to this service, was not able to demonstrate that its workforce is regularly assessed or monitored, and that it reviews the performance of each member of the workforce. The service does not have processes and procedures to effectively monitor and review staff performance.

# Standard 8

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| Organisational governance | | HCP | CHSP |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Non-compliant | Non-compliant |
| 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. | Non-compliant | Non-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. | Non-compliant | Non-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. | Non-compliant | Non-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. | Non-compliant | Non-compliant |

Findings

Based on the evidence cited in the Assessment Team’s Assessment Contact Report, summarised below, the Home Service Provider (HSP) is not, in relation to this service:

* engaging consumers in the development, delivery and evaluation of care and services.
* demonstrating that the organisation’s governing body effectively promotes a culture of safe, inclusive, and quality care and services, and is accountable for their delivery.
* demonstrating effective organisational wide governance systems relating to information management, continuous improvement, financial management, regulatory compliance, and feedback and complaints.
* demonstrating effective clinical governance framework.
* overseeing the management of consumer risks and incidents to ensure that the delivery of services is safe and effective.
* effectively monitoring and managing effective risk management systems and practices.
* documenting, analysing and trending incident outcomes, and using this intelligence to inform service improvements.

As to Non-compliant requirement 8(3)(a):

The service did not demonstrate that consumers are engaged in the development, delivery and evaluation of care and services or are supported in that engagement. Staff and management could not describe how consumers are actively engaged in the development, delivery and evaluation of care and services beyond that associated with the informal feedback processes. The organisation did not demonstrate they apply effective governance systems to meet the requirements of the Quality Standards to enable consumers to feel they are partners in improving the delivery of care and services.

Management advised they had recently asked consumers to complete the NAIDOC survey, and on 10 August 2023 consumers were mailed a survey containing 10 questions to seek their feedback. However, management acknowledged they had no plan or process to capture ongoing consumer feedback that would improve the services they delivered.

The Assessment Team reported that these concerns were addressed with management who was recorded as stating that:

* it acknowledged they do not have effective systems in place to engage with or seek feedback from consumers in relation to their experience or the quality of the care and services they receive.
* they were in the process of establishing a Client Advisory Group. The Assessment Team viewed an accompanying participation invitation dated 11 August 2023, citing 20 September 2023 as the date of the inaugural meeting.

The Assessment Team found that the implementation of a regular consumer survey to capture feedback and establish a client advisory group, foreshadowed at the Quality Audit in February 2022, had not occurred.

In its written response the HSP stated contractor audits are being conducted with consumers on a monthly basis regarding services that are delivered and the brokered contractors delivering those. It stated event feedback is analysed, and key themes are identified in the feedback and improvements are implemented commencing from the next event. It provided examples of how this feedback was being implemented to improve future events in a number of named areas.

It also stated that feedback forms are supplied at events with information being improved, and that a Client survey was sent out and responses so far received were being correlated and analysed for continuous improvement purposes.

These improvements are positive, however these improvements appear of recent origin and will take time to become embedded and to be seen as sustainable.

For the above reasons I am satisfied that the HSP, in relation to this service, was not able to demonstrate that consumers are engaged in the development, delivery and evaluation of care and services, and are supported in that engagement.

As to Non-compliant requirement 8(3)(b):

The HSP did not demonstrate that its organisation’s governing body effectively promotes a culture of safe, inclusive, and quality care and services, and is accountable for their delivery. While the organisation has an established governance framework, underpinned by policies and procedures, the organisation does not have effective data gathering, reporting, and monitoring systems and processes to enable effective governance, oversight and accountability.

The Assessment Team identified that the governing body has not implemented effective systems and processes to enable relevant data and information to be provided to, and discussed at, regular meetings to enable the governing body to effectively monitor care and services delivered to consumers and respond accordingly. The Assessment Team viewed Leadership Team meeting minutes from June, July and August 2023, which included standing agenda items regarding incidents, complaints, feedback, improvements and risks. The minutes did not capture and/or record specific consumer information and resolution of the above criteria.

Minutes of Board Meetings from April, May, and June 2023, failed to capture and report metrics associated with consumer incident management, risk, or issues that impact safe service delivery and organisational accountability captured and discussed at Leadership Team meetings.

Board representatives were reported as acknowledging they were unaware of specific incidents directly impacting safe, inclusive quality care and services. The Board representative stated they had not received any information in relation to consumer incidents or deterioration and acknowledged they had not requested this information. Management acknowledged that it had not communicated this information to the Board.

In its written response the HSP did not challenge the Assessment Team’s finding detailed above.

For the above reasons I am satisfied that the HSP, in relation to this service, was not able to demonstrate that its governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

As to Non-compliant requirement 8(3)(c):

The organisation did not demonstrate an established, documented, and effective organisation-wide governance systems in relation to information management, continuous improvement, workforce and financial governance, regulatory compliance and feedback and complaints.

The organisation did not demonstrate an established, documented, and effective organisation-wide continuous improvement system.

(i) information management

The organisation did not demonstrate effective information systems and processes to support staff in their roles or to meet the outcomes required by the Quality Standards.

The organisation also did not demonstrate assessment and care planning information regarding the consumers’ risks, needs and preferences is consistently documented and communicated within the service. Staff advised they do not have access to accurate and/or completed consumers’ information in one system. Service managers acknowledged that consumer information is held in multiple systems with a transition to a single platform underway.

Information I have detailed in Standards 2 and 3 shows that assessment, planning and reviews did not result in safe and effective care and services for consumers. The service did not demonstrate that outcomes of assessment, planning and review activities had been effectively documented and communicated to consumers and members of the workforce, and brokered services, to inform consumer care and services.

(ii) continuous improvement

The organisation did not demonstrate effective continuous improvement processes, at the service level, to improve the quality-of-service delivery for consumers accessing CHSP and HCP services.

The Assessment Team observed feedback, complaints and incidents recorded in the registers are not used to drive continuous improvement initiatives, with items often closed without resolution or changes being implemented. For example, the Assessment Team viewed the Continuous Improvements Register (CIR), with the service identifying 10 items for improvement, some relevant to the Quality Standards. The service outlined actions being undertaken by management to respond to and improve service delivery and meet the Quality Standards. Improvements documented included conducting contractor audits, however the CIR failed to identify how it will monitor contract audits.

(iii) financial governance

The organisation did not demonstrate effective financial governance processes for managing consumer HCP spent and unspent funds, nor identified reporting statement irregularities.

The Assessment Team reviewed existing consumer care package statements for a consumer who had previously been identified in the Quality Audit conducted in February 2022. During that Quality Audit that consumer had unspent funds of $59,424, without any documented direct care needs. That consumers July 2023 statement showed an unspent subsidy held by the HSP of $42,494.23 with services provided for the month of July 2023 as nil. The service’s consumer overdue review register identifies the consumer as having their annual review conducted on 1 August 2023 with no change to service type or support.

The Assessment Team viewed the Leadership Team meeting minutes (August 2023) which listed 2 complaints from Aged Care Quality and Safety Commission (ACQSC) regarding service delivery and lack of communication regarding pricing. The statement ended with ‘Both have been closed out with no further action required.’ The corresponding information regarding these complaints had not been captured in the services complaints register.

During the current Assessment Contact the Assessment Team wase made aware of identified irregularities with accounting and brokered servicing information provided to consumers, including, but not limited to inconsistencies with brokered services overcharging for services either not provided or overestimated in duration. For further information, see Standard 6, requirement (3)(d).

(iv) workforce governance, including the assignment of clear responsibilities and accountabilities

The organisation did not demonstrate effective workforce governance to ensure staff receive the ongoing support, training, professional development, and feedback they need to ensure staff are competent in order to meet the needs of aged care consumers and deliver the outcomes of the Quality Standards.

As detailed in Standard 7, requirement (3)(c), the organisation did not demonstrate how they consistently support staff with induction and ongoing training, and with policies and procedures to ensure safe and effective services are delivered to consumers, in line with their goals, needs and preferences, and the Quality Standards. The organisation acknowledged that care staff have on average 35 consumers on their caseload. As of 28 August 2023, 46 consumer reviews were outstanding from 380.

Two Coordinators were identified as leaving the service at the end of September 2023, with the Assessment Team viewing their respective workplans provided by management to manage overdue reviews as of 22 June 2023. The Assessment Team observed this was a list of requirements and did not provide guidance or instruction on how to achieve the required expectations. There was limited detail on guidance, tips or techniques a staff member could implement to achieve expected outcomes.

The organisation advised they do not have a specific clinical related role to provide support to case managers or other personnel, preferring to utilise brokered services to advise clinical, allied health and personal care requirements. Management was reported as acknowledging that although the services consumer delivery is predominately through brokered arrangements, the Assessment Team identified there have been lapses in accurate and timely case note recording by staff and brokered services to capture consumer information and respond appropriately.

(v) regulatory compliance

The service did not demonstrate effective systems and processes in place to support the service to meet regulatory requirements in respect of the HCP, CHSP funding arrangements and the Aged Care Quality Standards.

The organisation was unable to demonstrate regulatory compliance processes are in place including providing training and ensuring all staff are made aware of legislative updates and regulatory reforms related to consumer care and services. The Assessment Team acknowledged the service has commenced utilising a Legislation Compliance Monitoring Register to maintain oversight of legislative changes, however identified deficiencies included two of 4 service managers not being aware of the Banning Orders Register, nor its use. Both managers could not advise when this would be considered within the recruitment process. Multiple incidents from the services incident register were identified involving consumers funds, with no evidence of effective management of those issues.

In relation to two instances in particular there was no reference that staff had used the Serious Incident Response Scheme (SIRS) Decision Support Tool for further treatment under regulatory reporting requirements. Management was reported as acknowledging their misunderstanding of when to use the SIRS Decision Support Tool to determine its use, despite updated policies and procedures identifying its appropriate use and determination, in conjunction with documented SIRS training delivered 02 March 2023.

Management was reported as stating they were not aware of the Aged Care Learning Information Solution training available, and acknowledged they had not reported matters they should have due to their misunderstanding of the reporting requirements. Management advised, despite their lack of understanding, they created and delivered their own in-house training to staff.

(vi) feedback and complaints.

The organisation was not able to demonstrate effective systems and processes to capture, monitor, analyse and use feedback and complaint data to improve the quality of care and services.

As detailed Standard 8, requirement (3)(a), the organisation did not demonstrate effective systems regarding encouraging feedback and complaints, or consistent continuous improvements made to service delivery as a result of feedback and complaints. Management was reported as acknowledging a deficiency in capturing, analysing, trending and using feedback to improve service delivery. Feedback and complaint numbers were captured in Leadership Team meeting minutes, however, there was no content to assist with the trending or analysis of complaints. I have detailed additional information in relation to these matters in Standard 6 requirements 6(3)(c) and 6(3)(d).

In its written response to all these matters the HSP provided some clarity on documentation of feedback by staff member, and described actions taken to review all incidents and mentor staff using the SIRS decision tool. It did not otherwise challenge the Assessment Team’s finding set out above.

For the above reasons I am satisfied that the HSP, in relation to this service, was not able to demonstrate an established, documented, and effective organisation-wide governance systems in relation to information management, continuous improvement, workforce and financial governance, regulatory compliance and feedback and complaints.

As to Non-compliant requirement 8(3)(d):

The organisation did not demonstrate effective risk management systems and practices including to identify, assess, manage, and monitor risks to consumer’s safety and well-being; and prevent further risks or incidents. The organisation did not demonstrate effective consumer risk assessments and care planning is undertaken to inform safe and quality delivery of care and services, and the governing body does not have effective processes to monitor and have oversight of consumers’ high-impact or high-prevalence risks.

(i) managing high-impact or high-prevalence risks associated with the care of consumers

The organisation did not demonstrate effective systems and processes to identify, assess, manage and monitor risks to consumers. The organisation was not able to demonstrate staff were aware of clinical policies and procedures and their use in managing and responding to high-impact or high-prevalence risks. Supporting evidence regarding this is detailed in Standard 3, requirements (3)(a) and (3)(b).

The governing body does not have effective processes to monitor oversight of high impact, high prevalence incidents. Management and Board representatives acknowledged they do not receive or request specific information on individual consumer’s risks and vulnerabilities.

The services reliance on brokered care arrangements, in conjunction with multiple electronic platforms to record consumer information, and subsequent deficiencies in the accurate and timely recording of consumer care has resulted in the systemic failure to identify risk. This is set out in more detail under Standard 2 requirement 2(3)(a).

Management was reported as acknowledging systemic failures in staffing caseloads, staff retention, the accurate and appropriate recording of consumer risk and clinical information (both by internal staff and brokered services).

(ii) identifying and responding to abuse and neglect of consumers

The organisation did not demonstrate a procedure to recognise and report Elder Abuse with policies and procedures in place to guide staff. Deficiencies were identified in aspects of the services response to abuse and neglect of consumers, which was detailed by the Assessment Team.

(iii) supporting consumers to live the best life they can

The organisation did not demonstrate effective systems and processes in the identification and management to assist consumers to support their independence to enable them to live their best lives.

While the service provides policies, procedures, and information to inform care planning to identify risks or describe areas in which consumers are supported by the service to take risks. For some consumers, the focus on purchase of goods and equipment rather than provision of care and services tailored to assist continues to be a focus.

Management acknowledged there is a Dignity of Risk form and a process to ensure consumers are supported to make choices and to live their best life, however the organisation has not used this process or the forms.

(iv) managing and preventing incidents, including the use of an incident management system.

The organisation did not demonstrate comprehensive or effective documentation of incidents, including an effective incident management system (IMS). The governing body does not have effective processes to monitor or have oversight of consumer incidents. Minutes of Board meetings viewed by the Assessment Team documented the Board is not provided with examples of consumer related incidents to drive and shape continuous improvement.

One Board representative advised they had not been made aware of consumer incidents within the Board meetings they have attended, noting they have been a member of the Board since 2019.

Management acknowledged they were awaiting the implementation of their new CMS, and stated they believed this system will resolve a high number of the identified deficiencies, outlined in the Quality Audit of February 2022.

In its written response the HSP did not challenge the Assessment Team’s finding detailed above.

For the above reasons I am satisfied that the HSP, in relation to this service, did not demonstrate effective risk management systems and practices including to identify, assess, manage, and monitor risks to consumer’s safety and well-being; and prevent further risks or incidents.

As to Non-compliant requirement 8(3)(e):

The organisation did not demonstrate effective clinical governance framework including systems and processes to enable delivery of safe and quality clinical care to consumers. The organisation was not able to demonstrate effective consumer clinical assessment and care planning are undertaken to inform safe and quality clinical care, and the governing body does not have effective processes to monitor and have oversight of consumer’s clinical care.

(i) antimicrobial stewardship

The organisation has an Antimicrobial Framework document in place, including clinical governance roles and responsibilities. Oversight of clinical care is achieved through Leadership meetings. However, as detailed in Standard 8, requirement (3)(b), the organisation does not currently monitor and report to the governing body in relation to consumer clinical risks and/or incidents.

Management acknowledged that they do not have a dedicated clinical care advisor role on staff within home services to aid in aspects of clinical care or antimicrobial stewardship, relying instead on brokered parties to provide consumer information. Management advised they will seek clinical guidance from a member of the residential services clinical staff if they require guidance with antimicrobial stewardship or broader clinical matters.

(ii) minimising the use of restraint

The service provides a restrictive practices policy, in which it identifies the governing body is responsible for providing leadership and fostering a culture that minimises the use of restrictive practices. Management acknowledged it was responsible for monitoring implementation and compliance with this policy including ensuring completion of education and training and providing feedback and performance reviews were required.

The Assessment Team viewed the External Training Records register and confirmed that staff had not undertaken training in identifying and minimising the use of restrictive practice. The Adelaide Metro Training Matrix does not include training in identifying and minimising the use of restrictive practice.

At the time of this Assessment Contact management could not identify any consumers impacted by use of restraint practices. As previously identified by the Assessment Team, the governing body does not receive or request reported instances of the use of restraints.

(iii) open disclosure.

The organisation did not demonstrate it had an open disclosure approach to supporting consumer complaints, feedback and resolution. The Assessment Team viewed the last 3 Leadership and Board meeting minutes, none of which captured and applied the principles of open disclosure.

Staff could describe policies and procedures, such as Open Disclosure, however, could not elaborate on the processes to achieve open disclosure.

The services Clinical Governance Framework identifies roles and responsibilities of the governing body and leadership in responding to incidents, including.

* all incidents including relevant information, interactions related to open disclosure and cross reference/link to the incident management system.
* implementing a process for reporting incidents to the governing body.
* monitoring incident data as well as the effectiveness of this framework as part of continuous improvement activities.

The Assessment Team viewed Board meeting minutes for February, April and June 2023, which did not capture and report on incidents, despite data being captured in the incident register for April, May and June 2023. The Leadership meeting minutes, and the incidents register viewed by the Assessment Team did not document open disclosure in the relation to the outcomes of incidents. Incident numbers were captured in Leadership Team meeting minutes, however, only the numbers are reported and not the content or severity and impact of the incident.

In its written response the HSP did not challenge the Assessment Team’s finding detailed above.

For the above reasons I am satisfied that the HSP, in relation to this service, did not demonstrate effective clinical governance framework including systems and processes to enable delivery of safe and quality clinical care to consumers.

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)