**Performance**

**Report**

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| Name: | Aborigines Advancement League Inc |
| Commission ID: | 300520 |
| Address: | 2 Watt Street, THORNBURY, Victoria, 3071 |
| Activity type: | Quality Audit |
| Activity date: | 21 May 2024 to 22 May 2024 |
| Performance report date: | 17 June 2024 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

# Service included in this assessment

Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 8472 Aborigines Advancement League Inc  
Service: 25307 Aborigines Advancement League Inc - Community and Home Support

**This performance report**

This performance report for Aborigines Advancement League Inc (**the service**) has been prepared by M Waniczek delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Quality Audit 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 7 June 2023 which included a copy of their Plan for Continuous Improvement, Training Register, staff induction manual and CHSP Risk Management Plan.

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Not assessed** |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

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

# Areas for improvement

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

**Standard 6**

* Requirement 6(3)(a) implement strategies to encourage and support elders or others to provide feedback or make a complaint.
* Requirement 6(3)(b) implement strategies to ensure elders and their representatives are aware of and have access to advocates, language services and other methods for raising and resolving complaints.
* Requirement 6(3)(c) ensure the feedback and complaints register is updated and staff receive training in the principles of open disclosure.
* Requirement 6(3)(d) demonstrate monitoring, analysis and use of feedback and complaints data to continually improve the quality-of-care services provided.

**Standard 7**

* Requirement 7(3)(d) ensure staff training is provided and recorded.

**Standard 8**

* Requirement 8(3)(a) seek input from elders and their representatives to ensure they are engaged in the development, delivery and evaluation of care and services.
* Requirement 8(3)(c)
  + identify, and act upon, opportunities for continuous improvement
  + implement and or maintain a Plan for Continuous Improvement (PCI), training plan, incident reporting register, and feedback, compliments and/or complaints register.
  + manage regulatory compliance.
* Requirement 8(3)(d) implement an effective risk management framework.
* Requirement 8(3)(e) implement an effective clinical governance framework.

# Standard 1

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| Consumer dignity and choice | | CHSP |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected, and personal information is kept confidential. | Compliant |

Findings

I am satisfied based on the Assessment Team’s observations and recommendations that the service complies with the Requirements as outlined in the table above and as a result complies with this Standard.

Elders and representatives confirmed staff value their cultural identity and diversity and treat elders respectfully. Elders confirmed they are informed about their rights to respect, dignity, and inclusion via the elder welcome pack. Support workers demonstrated they are familiar with individual elder's cultural background. Support workers described how they greet elders using "Aunty" and "Uncle" with their preferred names as a sign of respect. Documentation was personalised and reflected elder needs and backgrounds, including their goals, preferences, and things of interest to them. The service does not provide cultural safety training to staff during onboarding but rather organises various cultural activities throughout the year to develop staff understanding of values and attitudes central to Aboriginal culture. The Site Audit report noted that documentation provided examples all staff attending an Aboriginal artwork exhibition and participation in ‘Kinship, talking of stories Kinchela Boys Home’.

Elders and representatives described feeling comfortable with staff as they share similar cultural identities. Support workers described and care documentation confirmed culturally safe care is provided to elders in line with their wishes and preferences. The service does not have a cultural and diversity plan or policy however in response to the Assessment Team’s feedback management advised this would be tabled for Board discussion and action.

Elders and representatives described communications with support workers to discuss their choices, decisions, and connections. Care documentation includes information about elders' relationships of significance and preferences regarding care. The CHSP welcome pack details the service approach to enabling elders to make choices during initial and subsequent care planning and includes the Charter of Aged Care rights.

Elders and representatives were satisfied with how the service supports elders in taking risks to live their best lives. Management described and documentation demonstrated risks are explained to elders and representatives during assessments, including how their rights to take risks are balanced with safety considerations. Care documentation identified risks and mitigation strategies. The service does not have a dignity of risk policy however in response to the Assessment Team’s feedback management advised the service will endeavour to work with the Aboriginal Community Elders service to ensure policies are alignment with Aged Care Standards.

Elders and representatives were satisfied they receive timely and clear information, including a welcome pack, schedule of services, and a copy of their care plan. They also confirmed support workers are in regular contact with them with a high level of verbal or informal communication provided. Management advised information is provided as per elder’s communication preferences.

Elders and representatives expressed confidence that the service maintains the privacy and confidentiality of their information. Management and staff described how they protect consumer privacy, including never discussing elders' personal information with others. Access to consumer electronic information is password-protected.

# Standard 2

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| Ongoing assessment and planning with consumers | | CHSP |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| 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. | Compliant |

Findings

I am satisfied based on the Assessment Team’s observations and recommendations that the service complies with the Requirements as outlined in the table above and as a result complies with this Standard.

Elders and representatives confirmed the services they receive help them to live safely in their own homes. Elders explained staff listen to them and plan care according to their individual social, emotional and physical needs. Care documentation demonstrated staff complete intake assessments which identify diagnoses, allergies, and functional needs. Management explained and the Plan for Continuous Improvement (PCI) confirms the 6 monthly care plan review includes risk management and occupational health, and safety, with elders surveyed to determine delivery of service effectiveness.

Elders and representatives explained they receive care and services relevant to their current needs. Management and support staff explained assessment and care planning identifies service delivery which is tailored to elders’ daily needs and preferences. Staff explained elders generally do not want to discuss end-of-life care planning. If and when they do staff listen and refer them to the community’s funeral service if they wish. Management advised there is currently no formal process for discussing advanced care directives, however if required they would do so in a culturally sensitive way.

Elders and representatives confirmed they are actively involved in the assessment, planning and review of the services they receive. They explained staff gain their consent before involving other service providers in their care. Staff described a collaborative approach to the assessment, planning and delivery of care. Documentation confirmed elders’ involvement in assessment and care planning including gaining their consent to share healthcare information with other services.

Staff and management explained, and documentation review confirmed, care plans are reviewed every 6 months or as needed following a change in their circumstances. They provide elders with a copy of their revised care plan; noting, most elders could not recall receiving a copy however said they were confident they could get one if needed. The Assessment Team observed care plans stored in secure filing cabinets which were accessible to staff.

# Standard 3

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| Personal care and clinical care | | 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. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | 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. | 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. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

I am satisfied based on the Assessment Team’s observations and recommendations that the service complies with the Requirements as outlined in the table above and as a result complies with this Standard.

Elders receiving personal clinical care were satisfied with the care provided. Staff described providing individualised care, that is culturally sensitive, to optimise elders’ health and wellbeing. Care documentation reflects staff use dementia appropriate, reablement strategies to encourage elders to maintain their own personal hygiene. This was supported by a representative account where staff were able to coax an elder into showering when the representative was having difficulties. Progress notes included individualised strategies staff use to engage the elders in personal care. Management demonstrated collaboration with a neighbouring residential aged care service to develop a culturally appropriate policy and procedure for the management of personal hygiene for their elders. They also plan to attend training facilitated by Dementia Support Australia (DSA).

Elders and representatives were satisfied staff support them to remain living safely in their own homes. Elders described how domestic assistance and property maintenance contributed to positive mental health and prevented falls. Support workers demonstrated knowledge of each elder they care for and described risks to their individual wellbeing including mobility issues, mental health, and carer stress. This was supported by an elders account whereby staff walk on her left-hand side because her right side is weak, and they will press her personal safety alarm for assistance if she falls. The service employs interventions to manage and mitigate risks to elders, including maintaining a vulnerable elders register. Management advised the Assessment Team they plan to establish regular meetings with support workers to develop a formalised process for identifying and supporting vulnerable elders. Documentation reviewed confirmed all staff are registered to undertake training in the Serious Incident Response Scheme (SIRS) and mandatory reporting.

The service assists families who are caring for elders nearing end-of-life. With consent they make referrals to appropriate health or palliative care and the Aboriginal funeral service. Support workers described assisting elders with end-of-life planning and supporting them to make their own decision, which often includes having the staff member hold the elder’s hand or sit with the family.

Elders and representatives are confident staff recognise when elders are not well and do something about it. Elders provided examples when support workers and management have extended their visit time to provide emotional support and extra services during times of hardship. Support workers explained they have accurate information about elders’ needs and they described working together to discreetly share information and strategies for supporting the elder’s they share responsibility for. Staff communicate concerns to family or management where appropriate. They record details of service delivery and any concerns in the paper file or electronic progress notes. Management advised they will be introducing team meetings with support workers to review elders’ care and support the vulnerable elders register.

Elders and representatives were satisfied that when needed the service makes appropriate and timely referrals to other culturally appropriate community organisations, allied health services and Aged Care Assessment Service (ACAS). Support staff and management provided examples of referrals, which included the referral pathways within the broader organisation and to external services. Management explained many referrals were made informally, without documentation being recorded in elders’ files or progress notes, and they advised the Assessment Team they would develop a more formalised, documented referral system.

Elders and representatives explained staff took care to prevent the spread of infection and said they would inform the service if they were sick, and services were rescheduled. Management explained support staff would undertake welfare checks by phone if they were unable to attend in person. Staff described providing elders with rapid antigen tests for them to use when they felt unwell. The Assessment Team observed stocks of gloves, rapid antigen tests and cleaning products in the service’s store and in cars used for travel to elders’ homes.

The service has an Infection Prevention and Control policy which outlines a range of procedures for the prevention and control of infection. The policy specifies staff will receive training in infection prevention and control however the service did not provide evidence of the mandatory training. Staff advised they had not undertaken hand hygiene refresher training in a couple of years. Following feedback from the Assessment Team management advised would establish mandatory training in hand hygiene and infection prevention.

The Assessment Team did not assess practices to promote appropriate antibiotic prescribing for this service.

# Standard 4

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| Services and supports for daily living | | CHSP |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Not applicable |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

I am satisfied based on the Assessment Team’s observations and recommendations that the service complies with the Requirements as outlined in the table above and as a result complies with this Standard.

Elders and representatives described how the services they receive contribute to their independence, self-worth, and safety. Support workers described, and elders confirmed they are encouraged to participate in decisions about how services are delivered. Staff and management explained they provide extra services to support elders through difficult times so they can continue to live in their own homes. Management said staff rostering is organised to support those elders who prefer care from specific support workers.

Elders and representatives provided examples that demonstrate how the services and supports they receive contribute to emotional, psychological, and spiritual wellbeing. Support workers explained, and documentation confirmed, support workers spend time ‘yarning’ with elders. Management described referring elders living with high levels of stress, due to financial and family circumstances, to culturally appropriate family support services to protect family relationships and well-being.

Elders and representatives confirmed the service enables them to maintain their connection with community, friends, and family. Support workers described encouraging elders to engage in the community and their preferred activities. The service supports elders to do the things they enjoy such as ‘yarning’ with other elders, shopping, and participating in art, craft, and dance activities, providing transport as needed.

Support workers demonstrated knowledge of elders’ life stories, family backgrounds and interests which was supported by examples provided by elders. There was evidence of documented condition, needs and preferences recorded and accessible to staff within the organisation, and with others where responsibility for care is shared, when elders have given consent for the sharing of information.

Elders and representatives provided examples that demonstrate the service connects elders with the range of culturally appropriate services to enhance their quality of life including housing services, food relief and social support groups. Staff described networking with staff within the organisation and external services to meet elders’ needs. The Site Audit noted referrals to housing services and social activity programs were evident. Management explained many referrals were made informally, without documentation being recorded in elders’ files or progress notes, and they advised the Assessment Team they would develop a more formalised, documented referral system.

Management explained that they do not regularly purchase equipment for elders to use in their homes but when they do it is based on recommendations from an allied health assessment. Support workers check in with elders to ensure equipment is working and suitable.

Elders described feeling safe when travelling in the services fleet cars, noting they are clean. Support workers confirmed the cars are reliable. The Assessment Team noted the cars were clean and there was evidence of regular maintenance and current insurance.

# Standard 5

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| Organisation’s service environment | | CHSP |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Not assessed |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Not assessed |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Not assessed |

Findings

This Quality Standard was not assessed as the requirements have been assessed as not applicable, noting transport services have been assessed under Standard 4.

# Standard 6

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| Feedback and complaints | | CHSP |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Not Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Not Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Not Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant |

Findings

I am satisfied based on the Assessment Team’s report and the approved provider’s response that the service does not comply with Requirements 6(3)(a), 6(3)(b), 6(3)(c) and 6(3)(d) and as a result does not comply with Standard 6.

Requirement 6(3)(a):

Elders described feeling uncomfortable providing feedback or making a complaint, especially in writing, as the service had not yet responded to their previous complaint.

Management and staff explained that elders and representatives can provide feedback verbally or in writing, via completion of a feedback form or email. Management advised the service receives feedback or complaints informally and resolves them without recording them on the register. The Site Audit report noted that staff confirmed that feedback and complaints are also not always recorded in consumer records. In response to the Assessment Team’s feedback management advised this would be tabled for Board discussion and action.

There was evidence of complaint submission information displayed as well as a complaints and feedback policy to guide staff practice.

The Approved Provider submitted a response which included a PCI and CHSP Risk Management Plan which includes information related to areas of non-compliance identified at the Site Audit. The PCI indicates the service has developed a plan of action to (1) advise elders of the complaints process and (2) encourage and support elders to provide feedback or express complaints, verbally or in writing, however, it is not clear how the outcomes will demonstrate actions taken are implemented, achieved, and evaluated. The risk management plan identifies client complaints as a risk and includes treatment action but does not include information regarding timeframes or staff accountability. As the response lacks the detail to assure clear processes will be implemented to support the implementation of improvements, I find this Requirement non-compliant.

Requirement 6(3)(b):

Elders were unfamiliar with information on advocacy services and confirmed they had not received relevant information. A review of the consumer pack did not reflect information regarding the Older Person's Advocacy Network (OPAN), the Australian Government National Aged Care Advocacy Program (NACAP) and the Aged Care Quality and Safety Commission (ACQSC). The Assessment Team observed no information on Aboriginal advocacy and interpreter services displayed at the service.

Management and staff were familiar with Aboriginal advocacy services they could refer elders to if required but confirmed they have not needed to refer an elder to an advocacy service. Management confirmed the service does not have a policy and procedure that supports consumers in accessing advocacy services as required.

Whilst the Approved Provider submitted a response which included a risk management plan that identifies policies and procedures as a risk it does not describe what actions will be taken to ensure elders are aware of and have access to advocacy and language services, as a result I find this Requirement non-compliant.

Requirement 6(3)(c):

The service does not have an open disclosure policy or procedure to guide staff practice, and the complaints and compliments policy does not reference open disclosure principles and process.

Management and staff were unfamiliar with open disclosure principles and confirmed they had not undertaken training on open disclosure.

Elders advised the Assessment Team they had provided verbal feedback and complaints about staff not turning up and the service had not resolved these issues promptly. A review of these consumer records showed no evidence of the complaint made, an apology provided, or actions implemented to resolve the issue.

The service does not maintain a current feedback and complaints register to monitor when appropriate and timely action is taken in response to when things go wrong. A review of the complaints register showed the service last recorded a complaint on 25 October 2022.

The Approved Provider submitted a response which included a PCI indicating the service recognises the need to regularly update their register of complaints. However, it does not contain any information regarding open disclosure, nor does it include any outcomes that would demonstrate actions taken are implemented, achieved, and evaluated, as a result I find this Requirement non-compliant.

Requirement 6(3)(d):

Management was unable to describe how feedback and complaints are monitored and trended to assist in improving care and services.

In response to the Assessment Team’s request for evidence, management advised the service conducts annual reviews of their performance. The Assessment team noted the service did not have a PCI and the organisations strategic PCI 2021 - 2024 demonstrated no evidence feedback and complaints are used to inform broader care and service continuous improvement actions.

The Approved Provider submitted a response which included a PCI and risk management plan. The PCI indicates the service recognises the need to regularly update their register of complaints and use the information to improve practice, however, it does not include any outcomes that would demonstrate actions taken are implemented, achieved, and evaluated. The risk management plan identifies client complaints as a risk and includes treatments. As the response does not provide reassurance a clear process will be implemented to ensure feedback and complaints information is used to improve the quality of care and services, I find this Requirement non-compliant.

# Standard 7

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| Human resources | | 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. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | 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. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

I am satisfied based on the Assessment Team’s report and the approved provider’s response that the service does not comply with Requirement 7(3)(d) and as a result does not comply with Standard 7. I am satisfied the service complies with Requirements 7(3)(a) 7(3)(b), 7(3)(c) and 7(3)(e).

Requirement 7(3)(d):

Management and staff confirmed, and documentation reviewed demonstrated, training is not provided in relation to outcomes required by the Aged Care Standards. This includes incident reporting, dementia support, abuse and neglect, restrictive practices, infection prevention, and Serious Incident Reporting Scheme (SIRS). Training records demonstrated support workers had not completed cardiopulmonary resuscitation (CPR) refresher training since 2022 and 3 out of 4 support workers, employed since 2021, have no records of training completed. Management advised staff had completed manual handling training however they were unable to provide evidence to support this. Two support workers confirmed completing manual handling training, but they were unable to provide evidence of completion.

The Approved Provider submitted a response which included a PCI, risk management plan and staff training register. The PCI identifies the need to ensure staff receive relevant training to ensure they suitably skilled and qualified. The risk management plan includes a risk regarding having relevant and appropriate staff training. I note that the staff training register provides information regarding completed courses and staff training due, including first aid update June 2024 for all staff, and infection control and indigenous health contract tracing for some staff. As the response is not clear on how the outcomes will demonstrate actions taken are implemented, achieved, and evaluated I find this Requirement non-compliant.

In relation to compliance with the remaining Requirements:

The service demonstrated the workforce is planned and able to fill planned and unplanned leave shifts with existing staff. The roster showed shifts cancelled by elders, which correlated with care documentation.

Elders and representatives confirmed staff are kind, caring and respectful. Management described examples of providing the right staff according to elders' requests and in support of cultural preferences and backgrounds. Management and staff spoke about elders in a kind and caring manner and knew elders' cultural identities and individual needs. Staff demonstrated a sound knowledge of elders’ background, needs and preferences. The Assessment Team observed staff referred to elders using respectful naming conventions of “Uncle” and “Aunty”. The service does not have a policy and procedure that guides staff practice in respecting diversity and providing inclusive care.

Elders and representatives were satisfied staff are competent and skilled to effectively perform their roles. Management described and staff confirmed the recruitment process which ensures staff employed have the appropriate skills and knowledge for care delivery. Management advised the service does not mandate certification for the support worker role. However, support workers are required to have a demonstrated knowledge and understanding of Aboriginal culture and lived experience caring for elders. The Assessment Team noted this information did not correlate with the service’s Orientation and Recruitment and Selection of Staff policies and the staff manual did not include minimal requirements for the support worker’s role. Position descriptions included minimum requirements or qualifications, conditions of employment, and police checks.

The service requires all actions to be signed off on the induction checklist before staff commence their role. Staff reported, and induction records confirmed, this includes completing and signing the organisation's code of conduct and policy and procedure manual. In addition, support workers are paired with experienced workers for buddy shifts during induction.

The service has a staff Annual Performance Review policy. Management described, and staff confirmed, staff are formally assessed, monitored, and reviewed at the 3, 6, and 12-month mark of their employment and then annually, noting informal discussions may occur. Documentation reviewed confirmed all staff performance appraisals were up to date. The policy requires staff to have a development plan however documentation reviewed confirmed no staff have a development plan in place. Management acknowledged this was not currently implemented and committed to tabling as part of Board discussions to determine remedial actions.

# Standard 8

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| Organisational governance | | CHSP |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Not 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. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Not Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Not Compliant |
| 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. | Not Compliant |

Findings

I am satisfied based on the Assessment Team’s report and the approved provider’s response that the service does not comply with Requirements 8(3)(a), 8(3)(c), 8(3)(d) and 8(3)(e) and as a result does not comply with Standard 8. I am satisfied the service complies with Requirement 8(3)(b).

Requirement 8(3)(a):

Documentation reviewed demonstrated that the feedback and complaints register was last updated on 25 October 2022. Whilst the Continuous Improvement policy references annual consumer reviews the service did not provide any evidence of consumer satisfaction reviews or surveys completed in the past 3 years. The organisation's strategic PCI 2021 to 2024 indicated feedback and complaints are to be actioned as per policy guidelines but no evidence demonstrating how this connects with service improvement was provided. The service does not have a consumer advisory body, nor has it initiated actions to establish one. Management was unfamiliar with relevant legislative requirements, including the requirements to offer elders and representatives the opportunity to start an advisory body.

Management advised, and elders confirmed, the service engages directly with elders during their 6 monthly care plan reviews, including discussing individual goals, needs, and preferences and associated budgets. This was evidenced in care records.

The Approved Provider submitted a response; however, it does not adequately address how the feedback and complaints register will be updated and consumer satisfaction surveys will be completed regularly. The response does not provide evidence of a process to utilise relevant information gathered from engagement with consumers, as a result I find this Requirement non-compliant.

Requirement 8(3)(c):

The Assessment Team noted the effective systems in place to support information management and financial governance. Staff can access information including elders needs, goals and preferences, as well as policies, procedures, and communications, through a password protected electronic system. The services’ financial management system includes a scheduled reporting process to obtain ongoing CHSP funding and additional funding through business planning, capital expenditure and Board approval.

Documentation reviewed confirmed the service is not identifying opportunities for continuous improvement and does not maintain a PCI. The organisation's strategic PCI 2021 - 2024 included general areas for improvement however they were not linked to the quality standards. The Assessment Team noted that management was unfamiliar with the organisation's strategic PCI.

The service does not maintain a training plan, management and staff confirmed they had not completed training in open disclosure, incident reporting, SIRS, and restrictive practice. Records reflected no evidence of staff completion of relevant training linked to the Aged Care Standards.

The organisation's strategic PCI 2021-2024 notes the CEO and Board manage regulatory compliance however management was unable to describe how the organisation tracks changes to aged care legislation or how information is relayed to elders, representatives and staff as required. The February 2024 CEO report notes an Aboriginal Development Officer role would commence working with CHSP to monitor and update staff regarding new reforms in aged care. No further evidence to support this was provided.

The service does not maintain a current incident reporting register. Management and staff were unfamiliar with SIRS and unable to describe SIRS reporting requirements or outline their responsibilities based. The Assessment Team was unable to view policies and procedures related to open disclosure, incident reporting, SIRS, and restrictive practice.

The service has a complaints and compliment policy and procedure to guide staff in the management of feedback and complaints. The Assessment Team noted the register did not reflect current information demonstrating appropriate current and or follow-up action, in a timely manner, nor does it not analyse relevant data trends to feed into a PCI.

The Approved Provider submitted a response however no evidence was provided to assure me that the service will take any action to ensure it has effective governance systems in place, therefore I find this Requirement non-compliant.

Requirement 8(3)(d):

The service does not have an effective risk management framework or policies and processes for managing high-impact or high-prevalence risks associated with elder care. The service was unable to demonstrate risk management practices including how risks are identified, reported, escalated, reviewed, monitored, actioned, and reported by staff.

The service does not maintain an incident management systems or SIRS register. The Assessment Team was unable to review documentation demonstrating analysis of incidents, and the identification of trends, nor reporting to the Board.

Management was unable to describe how they identify and respond to allegations of abuse or neglect of elders and the appropriate reporting requirements for SIRS. The service does not maintain records of staff training on incident reporting, including SIRS.

The Assessment Team noted the service's Critical Incident Management System policy has not been reviewed since July 2019 and did not reflect SIRS reporting requirements. The organisation’s risk register referenced risks relevant to CHSP, however the register was last updated on 28 April 2021 and does not reflect current risk.

The Approved Provider submitted a response, including a PCI, which notes a planned action for management and the CEO to report regulatory compliance and incident management to the Board, however, it does not include any outcomes that would demonstrate actions taken are implemented, achieved, and evaluated. Without the implementation of a risk management framework, policies and procedures, and risk and incident registers, that the governing body has oversight of I find this Requirement non-compliant.

Requirement 8(3)(e):

The service did not demonstrate an effective clinical governance framework is in place to support consideration to antimicrobial stewardship, restrictive practices, and open disclosure. The service does not have antimicrobial stewardship, restrictive practice or open disclosure policies and procedures to guide staff.

Antibiotics are not typically monitored or reported, and staff were generally aware of infection control. A review of the services Infection Control policy reflected no review date.

Management and staff were unfamiliar with the principles of open disclosure and confirmed they have not completed open disclosure or restrictive practice training. Information regarding restrictive practice is not included in the staff handbook. The Assessment team noted that the service complaints and compliments register, last updated on 25 October 2022, indicated open disclosure was not practised. This was supported by a review of consumer records which did not reflect staff completion of the open disclosure process.

The Approved Provider submitted a response, including a PCI and staff training register, however the information provided does not address the non-compliance with the requirement as it is not clear how the outcomes will demonstrate actions taken are implemented, achieved, and evaluated, I therefore find this Requirement non-compliant.

In relation to Requirement 8(3)(b):

Elders and representatives confirmed the care provided at the service is safe and based on individual needs and goals. The governing body, the Board, meets 4 times a year and consists of 9 community-based members, from a range of Aboriginal networks, of which none have a clinical background. The Chief Executive Officer (CEO) receives reports from each program, presents to the Board and then cascades decisions back to program managers and staff. Whilst the November CEO report did not reflect an analysis of care delivery, consumer feedback, complaints or incident trends, Board meeting minutes provided evidence of discussions regarding CHSP targets.

1. The preparation of the performance report is in accordance with section 57 of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)