**Performance**

**Report**

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name of service: | Adelaide Day Centre Home Support Services |
| Service address: | 32 Moore Street ADELAIDE SA 5000 |
| Commission ID: | 600143 |
| Home Service Provider: | Adelaide Day Centre For Homeless Persons Incorporated |
| Activity type: | Quality Audit |
| Activity date: | 4 April 2023 to 6 April 2023 |
| Performance report date: | 8 May 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 Adelaide Day Centre Home Support Services (**the service**) has been prepared by A. Grant, 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

**CHSP:**

* Community and Home Support, 23877, 32 Moore Street, ADELAIDE SA 5000

# Material relied on

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

* The assessment team’s report for the Quality Audit; 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 28 April 2023.
* A letter from Mr Steve Georganas MP Federal Member for Adelaide to the Hon Anika Wells MP, Minister for Aged Care.

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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

|  |  |  |
| --- | --- | --- |
| 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** |
| 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** |
| 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. | **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** |
| 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** |
| 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** |
| 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** |
| 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** |

# Standard 1

|  |  |  |
| --- | --- | --- |
| 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

Compliant Evidence

Evidence analysed by the Assessment Team showed the service was able to demonstrate each consumer is treated with dignity and respect, with their identity, culture and diversity valued. Consumers when interviewed described staff and volunteers as kind, caring and respectful. Staff and volunteers described how they ensure each consumer's identity and culture is valued, and they are treated with dignity and respect. This was substantiated through Assessment Team observations.

Evidence analysed by the Assessment Team showed the service was able to demonstrate services are culturally safe. Consumers when interviewed stated that staff understand their needs and preferences and deliver services with this in mind. Staff and volunteers demonstrated understanding of consumer’s cultural backgrounds and described how they ensure services reflect consumers’ cultural needs and diversity. This was substantiated through Assessment Team observations.

Evidence analysed by the Assessment Team showed the service was able to demonstrate how each consumer is supported to exercise choice and decisions about their services, including when others should be involved, communicate their decisions; and make connections with others. Consumers interviewed stated the service sometimes involved them in making decisions about their services, they attended the site and were just grateful for any assistance and support. Staff and management described how they support consumers and their representatives to exercise choice and make decisions about the services they receive.

Evidence analysed by the Assessment Team showed the service was able to demonstrate consumers are supported to take risks to enable them to live the best life they can. Consumers during interviews spoke about taking risks, and advised the Day Centre offers activities they enjoy. Staff and management demonstrated how they supported consumers to make choices and decisions on the activities offered, enabling them to live the best life they can. This was substantiated through Assessment Team observations.

Overturned Recommendations

In respect to Requirement 1(3)(e) the Decision Maker notes the service responded proactively to the Assessment Teams findings and already implemented corrective action. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response did meet and exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendation of “not met”. Documented below will be a summary of the Assessment Teams findings and a summary of the services corrective action.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate information provided to consumers is current, accurate and timely, and communicated clearly in a way that enables them to exercise choice. Consumers confirmed they are not provided with timely and relevant information when they first commenced at the service, and ongoingly with information about the service’s offerings. Staff and management described how they provide information to consumers verbally. Management described the methods used to communicate information to each consumer in an understandable format, including face to face discussions and asking for a support person to be present. This was confirmed through Assessment Team observations.

The services response shows a significant number of actions have been implemented post Quality Audit to remediate the deficiencies identified by the Assessment Team during the Quality Audit. Evidence has been provided by the service to substantiate these claims. A few key examples are documented below.

* New feedback forms have been developed to obtain information on a more frequent basis, with this information filling the feedback register and continuous improvement register (as required). These forms have been placed in various places within the centre to enable clients to complete at any time and will be given to home clients on a quarterly basis to obtain their views.
* The agenda for client, staff and board meetings have been updated with additional standing items to ensure all requirements are raised each meeting.
* The welcome booklet has been updated and will be provided to all CHSP clients (new and existing) in May 2023.
* The client assessment paperwork has been updated and will be utilised.

The Decision Maker deems Requirement 1(3)(e) to be compliant.

In respect to Requirement 1(3)(f) the Decision Maker notes the service responded proactively to the Assessment Teams findings and already implemented corrective action. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response did meet and exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendation of “not met”. Documented below will be a summary of the Assessment Teams findings and a summary of the services corrective action.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that each consumer’s privacy is respected, and personal information is kept confidential. Minimal consumer information is maintained in paper-based files, and accessible to the coordinator. Staff and volunteers demonstrated an understanding of their responsibilities in relation to maintaining privacy, however, no documentation was viewed by the Assessment Team in relation to consumers who provided or declined to provide consent.

The services response shows a significant number of actions have been implemented post Quality Audit to remediate the deficiencies identified by the Assessment Team during the Quality Audit. Evidence has been provided by the service to substantiate these claims. A few key examples are documented below.

* A media release document has been created. This form is to obtain the authority for photography and publication of images.
* The Confidentiality Policy has been updated to provide greater detail for staff and volunteers as requested by the auditors.
* Where a client is unwilling or unable to sign a form, the Adelaide Day Centre commits to having a verbal authority recorded on this form and witnessed by two staff members.
* The Adelaide Day Centre commits to transitioning paper records to secure storage.

The Decision Maker deems Requirement 1(3)(f) to be compliant.

# Standard 2

|  |  |  |
| --- | --- | --- |
| 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. | **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** |
| 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. | **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** |
| 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** |

Findings

In respect to Requirements 2(3)(a), 2(3)(b), 2(3)(c), 2(3)(d), and 2(3)(e) the Decision Maker notes the service responded proactively to the Assessment Teams findings and already implemented corrective action. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendation of “not met”. The Decision Maker is confident if the corrective action is followed through in its entirety the service should return to compliance upon its next assessment.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that assessment and planning, including consideration of risks to the consumer’s health and wellbeing, informs the delivery of safe and effective care and services. Care planning documentation analysed for sampled consumers showed that the service does not complete assessments, including related to risks to consumers’ safety, health and wellbeing, to inform delivery of safe and effective care. For some of these consumers, although risks had been documented in care plans, the risks had not been assessed by the service, which resulted in a lack of consideration for risk management strategies.

Management when interviewed advised the service does not have a formal assessment process and does not have a proforma assessment document to follow. They advised the service gathers relevant information from consumers verbally, which is documented in the consumer’s care file, to inform their care and services. However, sampled consumer’s care files viewed by the Assessment Team did not provide evidence of such conversations with consumers being documented.

Care planning documentation for three sampled consumers showed risks related to mobility, falls, communication and cognitive impairment had been documented. However, the service could not demonstrate that risk assessments had been completed and documented, and/or risk management strategies considered to guide safe care and services delivery, as required under the Aged Care Quality Standards and the service’s CHSP Grant Agreement with the Department of Health and Aged Care.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that 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. Care planning documentation analysed for sampled consumers did not evidence discussions with consumers as part of the intake and/or annual review process to identify and address their needs, goals and preferences to inform their care and services.

As previously identified, management advised the service gathers information from consumers verbally, which is documented in the consumer’s care file, to inform their care and services. However, sampled consumer’s care files analysed by the Assessment Team did not provide evidence of such conversations with consumers being documented.

Consumers sampled were satisfied with the care and services provided, however, none could recall the service involving them in an assessment or review process where their services’ goals, needs and preferences were discussed.

The service did not provide evidence that advanced care or end of life planning is discussed with consumers if they wished, and/or that information is provided to them, as expected under this requirement of the Quality Standards.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that assessment, planning and reviews are completed based on ongoing partnership with consumers and others that the consumer wishes to involve. The Assessment Team noted the service does not have an established and systematic process to carry out assessment, planning and reviews. While the Assessment Team analysed some evidence of consumer involvement, it was mostly related to the delivery of care and services, and did not inform assessment, planning and reviews of services.

Management when interviewed advised that, due to the service’s cohort of consumers, information about consumers is gathered over time, and did not systematically involve consumers and/or others in the identification of their risks, needs, goals and preferences to inform development of their care plans.

Care planning documentation analysed for six sampled consumers did not provide evidence that consumers had been supported and encouraged to take part in assessing and planning their own care and services, or that others were involved in the process on their behalf if they wished.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that 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. The Assessment Team noted care planning documentation for sampled consumers showed that individual care plans had been documented, however, these were not informed by assessment, planning and/or reviews in consultation with consumers and/or others if they wished. Consumers interviewed by the Assessment Team could not recall being offered a care plan. Furthermore, staff, volunteers and management interviews confirmed that information about consumers is communicated within the service verbally, and staff and volunteers do not have access to consumer’s relevant documented information to guide them in the safe and effective delivery of care and services.

Care planning documentation analysed for six sampled consumers did not provide evidence that consumers had been offered to view, and/or a copy of, their care plan if they wished, as expected under this requirement of the Quality Standards.

Staff, volunteers and management interviews demonstrated that information about consumers is communicated within the service verbally. The service did not provide evidence that documented information about consumers, including overview of the consumer’s care and services to be delivered, had been made available to staff and volunteers to support safe and effective care and services, as expected under this requirement of the Quality Standards.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that 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. Care planning documentation for sampled consumers indicated their care and services were reviewed annually as per the service’s process, however, the service could not provide any documented evidence of the actual review process, or how it had informed the consumer’s care and services delivery. Consumers sampled could not recall a review of their care and services.

Care planning documentation viewed for six sampled consumers indicated their care plan had been reviewed in 2022. However, the service did not provide documented evidence of the actual review process including if consumers were involved in the process, consideration of consumers’ needs, goals and preferences, consideration of consumers’ risks including risk assessments if required, and how the review informed changes to the consumers’ care and services when applicable.

# Standard 3

|  |  |  |
| --- | --- | --- |
| 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. | **Not applicable** |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | **Not applicable** |
| 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. | **Not applicable** |
| 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. | **Not applicable** |
| 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. | **Not applicable** |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | **Not applicable** |
| 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. | **Not applicable** |

Findings

All individual requirements within Standard 3 are not applicable, therefore Standard 3 is not applicable, and as a result was not assessed during the Quality Audit.

# Standard 4

|  |  |  |
| --- | --- | --- |
| 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. | **Compliant** |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | **Not applicable** |

Findings

Evidence analysed by the Assessment Team showed the service was able to demonstrate each consumer gets safe and effective services and supports for daily living that meet the consumers’ needs, goals and preferences and optimise their independence, health, well-being, and quality of life. Consumers were satisfied that the services provided support their independence and quality of life. Staff, volunteers and management described what is important to consumers, and how they support consumer’s independence, health and wellbeing through care and services in the consumer’s home and in the community. Observations conducted at the day centre confirmed that social activities support consumers to maintain their wellbeing and quality of life.

Evidence analysed by the Assessment Team showed the service was able to demonstrate that services and supports for daily living promote consumers’ emotional, spiritual and psychological wellbeing. Consumers interviews, and observations conducted throughout the audit confirmed that, consumers attending the day centre expressed in various ways their sense of belonging and connection with others, and that services enhance their wellbeing.

Evidence analysed by the Assessment Team showed the service was able to demonstrate services and supports for daily living assist consumers to participate in their community, have social relationships, and do things of interest to them. Consumers confirmed that social support and transport services enable them to participate in their community, maintain social connections and do things of interest to them. Staff, volunteers and management described how they encourage and support consumers to access and participate in their community.

Evidence analysed by the Assessment Team showed the service was able to demonstrate that information about consumer’s condition, needs, goals and preferences is generally communicated within the organisation and with others where responsibility for care is shared. Consumers confirmed that staff and volunteers know them, and they do not need to repeat information about their needs and preferences. Staff, volunteers and management advised relevant information about consumers’ services are communicated verbally over time, and they document the daily activities in the service’s day books.

Evidence analysed by the Assessment Team showed the service was able to demonstrate timely and appropriate referrals to individuals, other organisations and providers are made for consumers. Consumers sampled confirmed they were referred as required. Staff and management described, and provided examples, of consumer referrals to other organisations.

Evidence analysed by the Assessment Team showed the service was able to demonstrate that, where meals are provided, they are varied and of suitable quality and quantity. Most consumers interviewed confirmed they enjoy the meals provided at the day centre and prepared meals delivered to their home. Staff, volunteers and management described how breakfast and lunch is prepared at the day centre and provided to consumers attending the centre, and consumers unable to attend the centre are delivered prepared meals at home. Observations conducted at the centre confirmed that meals are prepared fresh on site and enjoyed by consumers attending the centre if they wished.

# Standard 5

|  |  |  |
| --- | --- | --- |
| 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. | **Compliant** |
| 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. | **Compliant** |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | **Compliant** |

Findings

Compliant Evidence

The service was able to demonstrate the service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. Consumers confirmed they feel welcome when the attend the centre-based group sessions. Coordinators and volunteers described how they ensure consumers feel welcome and observations confirmed the social group environment was easy to understand, welcoming and functional. The Assessment Team observed posters and some brochures in multiple languages available to consumers, and a clean and tidy reception area and various rooms and gardens for consumers to freely socialise.

The service was able to demonstrate fittings and equipment are safe, clean, well maintained, and suitable for the consumer. Consumers expressed satisfaction with the fittings and equipment provided. Management described processes to ensure tools and equipment are clean and well maintained, this was confirmed through observations. Consumers interviewed in relation to this requirement confirmed furniture and equipment are safe and suitable for their needs. Staff described the safety requirements for use of tools within the upstairs workroom, for consumers and volunteers who attend to plants, and harvest fresh fruit and vegetable crops from the Community Garden.

Overturned Recommendation

In respect to Requirement 5(3)(b) the Decision Maker notes the service responded proactively to the Assessment Teams findings and already implemented corrective action. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response did meet and exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendation of “not met”. Documented below will be a summary of the Assessment Teams findings and a summary of the services corrective action.

Evidence analysed by the Assessment Team showed whilst the service was able to demonstrate the environment was relatively clean, the service did not demonstrate a well-maintained and safe environment where consumers could move freely around the building. The service was able to demonstrate the vehicles making up the service environment were well maintained, comfortable, safe, and clean and enable consumers to move freely. Care staff and management described the process to ensure vehicles are regularly cleaned and maintenance is addressed immediately.

The services response shows a significant number of actions have been implemented post Quality Audit to remediate the deficiencies identified by the Assessment Team during the Quality Audit. Evidence has been provided by the service to substantiate these claims. A few key examples are documented below.

* New ramps have been purchased and placed at sliding doors to remove and risk of a trip from the small sliding door frame.
* The auditors identified an element of mould in the walk-in fridge / freezer. The Adelaide Day Centre has a cleaning and servicing contract for this unit with an external provider. This servicing provided reports on each service the unit was clean and fit for use. Upon the auditor making staff aware, this provider was recalled to undertake a thorough clean. Photos have been provided to demonstrate the clean. To ensure this does not happen again, the Adelaide Day Centre is tendering for a new cleaning provider.
* The Adelaide Day Centre acknowledges the unfortunate instance of a food handling error in the kitchen during the period of the audit. Food Handling training is being provided to all staff in accordance with our training plan.

The Decision Maker deems Requirement 5(3)(b) to be compliant.

# Standard 6

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

Findings

Compliant Evidence

The service was able to demonstrate that consumers are made aware of, and have access to advocates, language services and other methods for raising and resolving complaints. Consumers advised they did not require this service and management advised that information is provided to consumers verbally if it is required. Staff interviewed advised if anyone had a concern, they would assist to resolve their concern immediately or raise the complaint with management to resolve. One staff member advised they are fluent in 3 languages, and other staff members also stated they were bilingual, each staff member advised they assist consumers to communicate/translate with others if required

The service was able to demonstrate appropriate action is taken in response to feedback and complaints, and an open disclosure process is used when things go wrong. Consumers interviewed said they were satisfied with the care and services they receive and have not had to provide feedback or make a complaint. Management described, and provided documentation showing, how they address consumers’ feedback and complaints. Documentation provided to the Assessment Team confirmed the providers open disclosure approach when complaints are raised and documented with the provider as per the Quality Standards.

Overturned Recommendations

In respect to Requirement 6(3)(a) the Decision Maker notes the service responded proactively to the Assessment Teams findings and already implemented corrective action. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response did meet and exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendation of “not met”. Documented below will be a summary of the Assessment Teams findings and a summary of the services corrective action.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that consumers, their family, friends, carers, and others are encouraged and supported to provide feedback and make complaints. Staff and volunteers described their processes and how they would communicate any issues or concerns raised by consumers. The Assessment Team observed there are no effective systems in place to encourage or capture feedback, suggestions, and complaints.

The services response shows a significant number of actions have been implemented post Quality Audit to remediate the deficiencies identified by the Assessment Team during the Quality Audit. Evidence has been provided by the service to substantiate these claims. A few key examples are documented below.

* The Adelaide Day Centre has developed and implemented two new methods of feedback forms. These forms are available in various locations around the services premises. This will enable clients to complete feedback at any time, both at sought times and at the discretion of the client.
* The Feedback Register will be populated through these documents, along with any other feedback provided. This register in turn will populate the reporting to staff and board meetings in accordance with the updated agendas.
* Where feedback identifies an element of improvement, it will be included in the continuous improvement register.

The Decision Maker deems Requirement 6(3)(a) to be compliant.

In respect to Requirement 6(3)(d) the Decision Maker notes the service responded proactively to the Assessment Teams findings and already implemented corrective action. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response did meet and exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendation of “not met”. Documented below will be a summary of the Assessment Teams findings and a summary of the services corrective action.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate feedback and complaints are reviewed and used to improve the quality of care and services. Staff and management were not able to describe key areas of complaints for the service or describe any continuous improvement actions they may have implemented as a result of feedback from consumers and/or staff.

The services response shows a significant number of actions have been implemented post Quality Audit to remediate the deficiencies identified by the Assessment Team during the Quality Audit. Evidence has been provided by the service to substantiate these claims. A few key examples are documented below.

* Complaints will continue to be handled under the Grievance policy which has been updated in accordance with feedback from the auditors.
* A separate complaint form exists where a client or representative wishes to make a complaint.
* The Adelaide Day Centre commits to deliver training to all staff on complaints and feedback and this will occur in the training plan.
* The Adelaide Day Centre also commits to implementing the first of the quarterly feedback rounds in May 2023, in accordance with the updated policies and forms.

The Decision Maker deems Requirement 6(3)(d) to be compliant.

# Standard 7

|  |  |  |
| --- | --- | --- |
| 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. | **Compliant** |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | **Compliant** |

Findings

Compliant Evidence

Evidence analysed by the Assessment Team showed the service was able to demonstrate 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. Consumers stated they are satisfied with the number of staff and volunteer available to provide support during the care and delivery of services. Management described the processes to ensure there is adequate staff to deliver care and services.

Evidence analysed by the Assessment Team showed the service was able to demonstrate workforce interactions with consumers are kind, caring and respectful of each consumer’s identify, culture and diversity. All consumers stated staff are kind, caring and respectful. Staff and management spoke about consumers in a kind and respectful manner when talking with the Assessment Team about their services.

Evidence analysed by the Assessment Team showed the service was able to demonstrate that the workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles. All consumers described staff delivering care and services as competent. Staff and volunteers advised they are provided support which enables a competent workforce at the point of service delivery. Management described the services process to assess and monitor the competency of its workforce.

Evidence analysed by the Assessment Team showed the service was able to demonstrate regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. Most staff and volunteers confirmed they have undergone a performance review to support them in their roles. Management described their process for regular assessment and monitoring of staff performance.

Overturned Recommendations

In respect to Requirement 7(3)(d) the Decision Maker notes the service responded proactively to the Assessment Teams findings and already implemented corrective action. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response did meet and exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendation of “not met”. Documented below will be a summary of the Assessment Teams findings and a summary of the services corrective action.

The service was not able to demonstrate the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these Standards. Staff and volunteers confirmed that they have not received ongoing training to support them in their roles. Management was unable to provide documentation that demonstrated how they train staff and monitor the workforce as per this requirement. While staff and volunteers stated they receive informal on the job training, they advised in various ways that they have not received formal training to support them in their roles.

The services response shows a significant number of actions have been implemented post Quality Audit to remediate the deficiencies identified by the Assessment Team during the Quality Audit. Evidence has been provided by the service to substantiate these claims. A few key examples are documented below.

* The Adelaide Day Centre has created a training plan to begin in May 2023 for all staff. This training plan covers induction and ongoing training areas for all staff. A confirmation of a training booking by the provider substantiates this statement. As demonstrated within the training plan, any identified gaps will be remedied through the delivery of this plan.
* A copy of the updated training competency matrix was provided by the service.
* A copy of the Staff Clearance matrix was provided by the service. The Adelaide Day Centre confirms no staff (inclusive of volunteers) will work with CHSP clients until a valid clearance is on file.
* In accordance with the new matrices and training plan, the Adelaide Day Centre commits to completing a review of the existing training policy by 30-05-2023.

The Decision Maker deems Requirement 7(3)(d) to be compliant.

# Standard 8

|  |  |  |
| --- | --- | --- |
| 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. | **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** |
| 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** |
| 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** |
| 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 applicable** |

Findings

Overturned Recommendation

In respect to Requirement 8(3)(a) the Decision Maker notes the service responded proactively to the Assessment Teams findings and already implemented corrective action. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response did meet and exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendation of “not met”. Documented below will be a summary of the Assessment Teams findings and a summary of the services corrective action.

Evidence analysed by the Assessment Team showed the organisation was not able to demonstrate consumers are engaged in the development, delivery and evaluation of care and services. Consumers described how they have minimal input about services provided to them. Management and staff described how daily activities are planned and all daily tasks are recorded on a whiteboard. This was confirmed through observations.

The services response shows a significant number of actions have been implemented post Quality Audit to remediate the deficiencies identified by the Assessment Team during the Quality Audit. Evidence has been provided by the service to substantiate these claims. A few key examples are documented below.

* As documented within Standard 1 and 2, the service has developed and implemented processes to ensure it can readily document the engagement of clients in the development, delivery and evaluation of their services.
* As documented within Standard 6, the Adelaide Day Centre has developed two new forms for feedback and implemented processes to ensure this feedback is readily fed to management to meet the needs of clients.
* It is noted the Assessment Team stated they did not witness client choice in activities undertaken during the audit. This may have been due to the time they attended the centre, and as they did not view the whiteboard of activities as documented in Standard 1. Further, as the clients often only provide a verbal wish or agreement, the Adelaide Day Centre undertakes to note this preference or agreement within each client file.
* The Adelaide Day Centre commits to the development of a new strategic plan with targets and monitoring periods specific to our CHSP service and for this to be in place by 30-06-2023.

The Decision Maker deems Requirement 8(3)(a) to be compliant.

Non-compliant Evidence

In respect to Requirements 8(3)(b), 8(3)(c) and 8(3)(d) the Decision Maker notes the service responded proactively to the Assessment Teams findings and already implemented corrective action. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendation of “not met”. The Decision Maker is confidant if the corrective action is followed through in its entirety the service should return to compliance upon its next assessment.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate the organisation’s governing body promotes a culture of safe, inclusive, and quality care and services, and is accountable for their delivery. The organisation has an established governance framework including a constitution document outlining the Management Committees’ role and responsibilities, the delegation of day-to-day activities to the Centre Coordinator, and regular Management Committee and Sub-Committee meetings. However, the service did not demonstrate the governance framework was effective to enable the governing body to maintain oversight of CHSP services provided to consumers, promote safe and quality care and services, and be accountable for their delivery as required under the Aged Care Quality Standards.

Evidence analysed by the Assessment Team showed organisation’s governing body has not identified, documented and implemented systematic processes to guide the Centre Coordinator on key performance indicators to be monitored and reported at service management level, and escalated to the governing body as required to enable effective oversight and monitoring of care and services delivered to CHSP consumers. The Assessment Team identified that the governing body has not implemented effective systems and processes to enable relevant data and information to be gathered, reported, and provided to, and discussed at, quarterly Management Committee meetings to enable the governing body to effectively monitor services delivered to CHSP consumers.

*Information Management:*

Evidence analysed by the Assessment Team showed organisation did not demonstrate effective information management systems and process to ensure consumers have access to relevant information to support them to make decisions about their care and services when they first commenced at the service and ongoingly, including the Charter of Aged Care Rights, feedback and complaints avenues, outcome of assessment, planning and reviews, and access to their care plan; and give appropriate members of the workforce access to information relevant to their role including policies and procedures, and relevant documented consumer information at the point of service delivery.

Management advised that, due to the consumer’s cohort, most information is paper-based, and the service has limited use of electronic technology. The Assessment Team noted this was documented in the organisation’s Constitution. However, the service did not demonstrate effective record keeping, and that relevant information was documented and communicated, as required by the Aged Care Quality Standards and Records Principles 2014.

As documented within Standard 2, the service did not demonstrate that assessment, planning and review activities had been undertaken, and included consumer’s input. The service did not demonstrate that outcomes of assessment, planning and review activities had been documented and communicated to consumers and members of the workforce to inform consumer care and services. For example, consumers could not recall being involved in assessment and reviews or being offered a copy of their care plan. Members of the workforce advised information about consumers is communicated verbally and they do not have access to consumers’ care plans at point of care and services. – *End Information Management heading.*

Evidence analysed by the Assessment Team showed service was not able to demonstrate effective risk management systems and practices, including but not limited to managing high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers, supporting consumers to live the best life they can, and managing and preventing incidents.

Management described the risk of mental health, homelessness and addiction as having a higher impact on the health and well-being of its consumer; however, the organisation was unable to demonstrate how they monitor and support consumers to prevent harm from these risks. While Management stated that staff undertake mental health training to observe for signs of deterioration, the organisation was not able to provide any form of documentation to confirm that staff or volunteers have undergone said training. Furthermore, staff and volunteers confirmed that no training had been provided in this area to support their management of high-risk consumers.

Evidence analysed by the Assessment Team showed organisation was not able to demonstrate how consumers’ incidents data is used to identify, analyse and report trends, and inform continuous improvements to prevent similar incidents from reoccurring. Management advised that incidents are discussed at board meetings, however, meeting minutes viewed by the Assessment Team confirmed that 3 incidents that occurred within the previous quarter and were not discussed at the most recent board meeting. An additional 2 board meeting minutes were viewed to further confirm that incidents are not addressed with the governing body.

Management stated, and staff/volunteers confirmed that the workforce has not received training in SIRS or elder abuse and neglect. Management advised that specific training was not required since SIRS updates are reflected in the organisation’s current incident management policy and in the event of an incident staff are guided by the documentation. The Assessment Team viewed the incident management policy which failed to mention SIRS. The document referenced the NDIS Quality and Safeguards Commission, however, made no specific mention of reporting legislation required by the Aged Care Quality and Safety Commission.

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)