**Performance**

**Report**

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| Name: | Adelaide Day Centre Home Support Services |
| Commission ID: | 600143 |
| Address: | 32 Moore Street, ADELAIDE, South Australia, 5000 |
| Activity type: | Assessment contact (performance assessment) – non-site |
| Activity date: | on 4 April 2024 |
| Performance report date: | 10 May 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: 7397 Adelaide Day Centre For Homeless Persons Incorporated  
Service: 23877 Adelaide Day Centre For Homeless Persons Incorporated - Community and Home Support

**This performance report**

This performance report for Adelaide Day Centre Home Support Services (**the service**) has been prepared by Peter Frangiosa, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Assessment contact (performance assessment) – non-site report was informed by a review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 23 April 2024

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| Standard 2 Ongoing assessment and planning with consumers | 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.

* **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.
* **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.
* **Requirement 8(3)(d)** - Effective risk management systems and practices relating to managing high impact or high prevalence risks associated with the care of consumers.

# 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. | Not 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. | Not Compliant |

Findings

Requirement (3)(d)

Requirement (3)(d) was found non-compliant following a Quality Audit undertaken from 4 April to 6 April 2023. The service did not demonstrate:

* The outcomes of assessment and planning were effectively communicated to the consumer and documented in a care and services plan that was readily available to the consumer, and where care and services were provided.

The Assessment Team’s report for the Assessment contact undertaken on 4 April 2024 includes evidence of actions taken by the service in response to the non-compliance. These actions include, but are not limited to:

* Development and implementation of a new assessment process.
* Creation of guidance material for staff to guide assessment processes.

While the Assessment Team acknowledged improvements have been made, they were not satisfied outcomes of assessment and planning were communicated to consumers or available at the point of service delivery. The Assessment Team recommended Requirement (3)(d) not met and provided the following evidence to support their assessment:

* Care plans viewed did not include sufficient detail regarding consumer risks, needs, goals and preferences to effectively guide service delivery.
* Management acknowledged the care plans lack detail and practical instruction for staff and volunteers delivering services.
* Management advised the service will use the upcoming review schedule commencing May 2024 to increase the level of detail surrounding consumer risk, needs, goals and preferences and develop a more effective process for documentation.

The provider provided information in response to the Assessment Team’s report, including:

* An explanation advising despite limited staffing and servicing impacts, the election to start reviewing Client Care and Service Plans ahead of the annual cycle (May 2024). Although these were initiated ahead of the Assessment Contact, none were completed, resulting in the inability to demonstrate an annual review had been completed.
* Evidence of an updated Assessment Form, and corresponding Assessment Procedure. This form is used to determine the needs and goals of the participant and as such drive the creation of the care plan.
* Evidence of updated Client Care and Service Plans specific to consumers identified in the Assessment contact undertaken on 4 April 2024.
* Evidence including previous, and the reviewed Client Care and Service Plans for sampled consumers. The previous iterations of which were viewed in the assessment contact, these reviews include additional points requested by the auditor on risk.
* An explanation that the review of participant’s circumstances and transitioning them to the new Assessment Form and Care Plan constitutes a review as required under the standard.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows care plans are consistently available where care and services are provided.

* As acknowledged in the Assessment Team’s report, Consumers stated they had a copy of their care plan, with all sampled consumers advising they could ask staff to see their care plan at any time.

However, in examining the 4 updated Care and Service Plans provided by the provider in response to the findings of the Assessment Contact, it is noted that:

* One consumer is identified with Type 2 Diabetes. Within the nutrition overview section, it is identified that it is not well managed by the consumer and indicates that the consumer eats lunch at the centre. The support section advises that ‘we continue to provide meals as we know that what we provide is nutritionally balanced and in suitable amounts to help him manage their diabetes.’
  + The nutrition or relevant medical history section’s do not contain any medical or dietary restriction guidance, nor further risk mitigation strategies.
* One consumer is identified within the transport and community access section that their walking ‘is not too good’.
  + No further information is provided regarding risk mitigation or support strategies to assist this consumer regarding their mobility.
* One consumer is identified as using a walker to assist with their mobility. Further information advises that they use the walker at all times.

One updated Care and Service Plan, however, contained comprehensive detail regarding risks, goals, and the services support mechanisms. Further detailed guidance is provided including nutrition, communication, and relevant medical history.

The intent of this requirement is to ensure a care and services plan is to be documented and reflect the outcomes of assessment and planning for each consumer, ensuring accurate and up-to-date care and services are delivered. Relevant risks to a consumer’s safety, health and well-being need to be documented in the care and services plan to make sure their safety isn’t compromised. This includes things such as allergies and other risks relating to the consumer’s needs.

Whilst I acknowledge that the service is implementing updates to their processes for reviewing consumer Care and Service Plans, not all evidence provided supports that care and services plans are consistently accurate and reflect the outcomes of the most up-to-date assessments and reviews of consumer needs, goals or preferences.

I have considered the provider’s response which demonstrates proportionate and practical actions for the type of services delivered, however, at the time of my finding, these actions have not been fully implemented or embedded.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement (3)(d) in Standard 2 Ongoing assessment and planning with consumers.

Requirement (3)(e)

Requirement (3)(e) was found non-compliant following a Quality Audit from 4 April to 6 April 2023. The service did not demonstrate:

* 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.

The Assessment Team’s report for the Assessment contact undertaken on 4 April 2024 includes evidence of actions taken by the service in response to the non-compliance. These actions include, but are not limited to:

* Development and implementation of a new assessment process.

While the Assessment Team acknowledged improvements have been made, they were not satisfied care and services are reviewed on a regular basis, or changed when incidents or circumstances impact needs, goals or preferences of the consumer. The Assessment Team recommended Requirement (3)(e) not met and provided the following evidence to support their assessment:

* Sampled consumers advised they have not had their services reviewed.
* The service did not demonstrate services are reviewed after incidents occur. Documentation showed the service had one incident since the Quality Audit (4 April to 6 April 2023), where dehydration exacerbated an existing health condition for a consumer, resulting in hospitalisation.
  + While documentation demonstrated follow up with the consumer, and instructions for staff regarding hydration, it did not result in an immediate review with the consumer.
* Management advised the service intends commencing reviews in May 2024, however, at the time of the Assessment Contact, the service did not demonstrate regular reviews are conducted with consumers, nor did the service demonstrate reviews are conducted after incidents or changes of circumstances.

The provider provided information in response to the Assessment Team’s report, including:

* An explanation advising despite limited staffing and servicing impacts, the election to start reviewing Client Care and Service Plans ahead of the annual cycle (May 2024). Although these were initiated ahead of the Assessment Contact, none were completed, resulting in the inability to demonstrate an annual review had been completed.
* Evidence of an updated Assessment Form, and corresponding Assessment Procedure. This form is used to determine the needs and goals of the participant and as such drive the creation of the care plan.
* Evidence of updated Client Care and Service Plans specific to identified consumers identified in the Assessment contact undertaken on 4 April 2024.
* Evidence including previous, and the reviewed Client Care and Service Plans for sampled consumers. The previous iterations of which were viewed in the assessment contact, these reviews include additional points requested by the auditor on risk.
* An explanation that the review of participant’s circumstances and transitioning them to the new Assessment Form and Care Plan constitutes a review as required under the standard.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows care and services are not reviewed regularly for effectiveness, or when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

Though I appreciate the provider’s explanation regarding impacts on service delivery, and staffing limitations, it is reasonable all care and services plans are expected to include an agreed review date. How often a review is done depends on the needs of each consumer and on the nature and type of services the organisation is providing. However, it is appropriate in addition to the reviews that are scheduled, a consumer’s care and services plan should be reviewed when:

* The consumer’s condition changes (for example, physical or mental health)
* Incidents or accidents happen (for example, if a consumer has fallen).

The Assessment Team acknowledged enhancements made to care plan inclusions, now including an updated assessment procedure. I acknowledge previously sampled consumers have had updated Client Care and Service Plans provided to evidence improvements to capturing changes, risks and response. However, I also acknowledge the services own admission that although these were initiated ahead of the Assessment Contact, none were finished and as such the service could not demonstrate an annual review had been completed.

I have considered the provider’s response which identifies proportionate and practical actions for the type of services delivered, however, at the time of my finding, these actions have not been fully implemented or embedded.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers.

Requirements (3)(a), (3)(b), and (3)(c) were found non-compliant following a Quality Audit undertaken from 4 April to 6 April 2023, as the service did not demonstrate:

* 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.
* 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.
* Assessment and planning 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 includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.

The Assessment Team’s report for the Assessment contact undertaken on 4 April 2024 includes evidence of actions taken by the service in response to the non-compliance. These actions include, but are not limited to:

* The service developed and implemented a new assessment process.
* The service created guidance material for staff to guide assessment processes.

The Assessment Team was satisfied these improvements were effective and recommended Requirements (3)(a), (3)(b), and (3)(c) met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers confirmed the service engages with them, updates and reviews their circumstances when they change, and assists in referring to other services available.
* Management advised the service created a new assessment process and associated guidance material in May 2023 in response to the Quality Audit in April 2023. Management described how assessments were previously done verbally and informally, and this new process creates consistency and a baseline to assess from at reviews.
* Staff described how the new assessment process provides a more formal and consistent assessment process than the service previously used.
* Though assessments and care plans viewed did not consistently contain sufficient detail regarding consumer risk, needs, goals and preferences, all staff and volunteers demonstrated an intimate knowledge of the risks, needs, goals and preferences of all consumers.

Based on the information summarised above, I find the provider, in relation to the service, compliant with these Requirements in Standard 2, Ongoing assessment and planning with consumers.

# Standard 8

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| Organisational governance | | CHSP |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | 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. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Not Compliant |

Findings

Requirement 8(3)(d)

Requirement (3)(d) was found non-compliant following a Quality Audit undertaken from 4 April to 6 April 2023. The service did not demonstrate:

* Effective risk management system and practices, including managing high impact or high prevalence risks associated with the care of consumers. The service did demonstrate effective risk management system and practices, including, but not limited to identifying and responding to abuse and neglect of consumers, supporting consumers to live the best life they can, and managing and preventing incidents.

The Assessment Team’s report for the Assessment contact undertaken on 4 April 2024 includes evidence of actions taken by the service in response to the non-compliance. These actions include, but are not limited to:

* Daily staff briefings to ensure staff have up to date information regarding consumer risk.
* Increased levels of training for all staff and volunteers.

While the Assessment Team acknowledged improvements have been made, they were not satisfied effective risk management systems and practices relating to managing high impact or high prevalence risks associated with the care of consumers was evident. The Assessment Team recommended Requirement (3)(d) not met and provided the following evidence to support their assessment:

* The service does not have an effective system to document consumer risk, nor to review consumers regularly or when incidents occur.
* Strategies to manage these risks are not documented for staff, nor are they reviewed regularly or after an incident occurs.

The provider provided information in response to the Assessment Team’s report, including:

* Evidence of an updated Assessment Form, and corresponding Assessment Procedure. This form is used to determine the needs and goals of the participant and as such drive the creation of the care plan.
* Evidence of updated Client Care and Service Plans specific to identified consumers identified in the Assessment contact undertaken on 4 April 2024.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows effective risk management systems and practices relating to managing high impact or high prevalence risks associated with the care of consumers was not evident.

Whilst I acknowledge enhancements made to care plan inclusions, now including an updated assessment procedure, I note within this document the following information under the titles:

* Are there any barriers to your participation? (Page 2)

‘This section will inform us of potential risk factors for our clients. If the participant is known to ADC, some of these may be known already but it is important that this section is completed every time and new risk factors considered. Health conditions and disabilities must be recorded but other issues must also be considered.’, and

* Are there any barriers to your participation? (Page 3)

‘This section identifies the risks present for each individual CHSP participant. When specific risks have been clarified, a risk assessment is required. We will need to consider whether training, management, supervision equipment or some other preventive action can be put into place to minimise the risks likelihood of occurring. Details of these are to be recorded in the Operational level risk register and should there be any trend around a particular risk it should be escalated to the board level risk register.’

In considering compliance of this requirement, I refer to my findings in Standard 2, Requirement 2(3)(d) regarding the exampled updated Client Care and Service Plans. Whilst the service has initiated updates to their assessment process, the updated Client Care and Service Plans provided do not capture a comprehensive array of risks and detailed mitigation strategies. Furthermore, in the absence of the services operational level risk register, which was not supplied in the provider response, I am unable to determine these consumers risks are recorded within it, or actions taken which manage the risk in a timely manner.

The intent of this requirement is to ensure organisations have systems and processes that help them identify and assess risks to the health, safety and well-being of consumers. If risks are found, organisations are expected to find ways to reduce or remove the risks in a timeframe that matches the level of risk and how it’s affecting consumers. It is expected that the organisation’s risk management system identifies and evaluates incidents and ‘near misses’ (both clinical incidents and incidents in delivering care and services).

I have considered the provider’s response which demonstrates practical responses and actions for the type of services delivered, however, at the time of my finding, there is no evidence before me that demonstrates these actions have been fully implemented or embedded.

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

Requirements 8(3)(b) and 8(3)(c) were found non-compliant following a Quality Audit undertaken from 4 April to 6 April 2023, as the service did not demonstrate:

* The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.
* Effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, including the assignment of clear responsibilities and accountabilities, regulatory compliance, and feedback and complaints.

The Assessment Team’s report for the Assessment Contact undertaken on 4 April 2024 includes evidence of actions taken by the service in response to the non-compliance. These actions include, but are not limited to:

* Increased frequency of reporting to the Board and improved the quality of reports.
* Allocated resources to developing a new assessment process and training staff and volunteers.
* The introduction of online backup for the paper filing system, which is consolidated fortnightly.
* Development and introduction of a documented assessment process.

The Assessment Team was satisfied these improvements were effective and recommended Requirements (3)(b), and (3)(c) met. The Assessment Team provided the following evidence relevant to my finding:

* Management advised, and documents confirmed, the service has increased frequency of Board meetings to quarterly, including unifying the set agenda for all meetings at staff, management and Board meetings so information flows smoothly at all levels.
* Management described, and documents confirmed, the service reviewed and updated the Board Charter and Strategic Plan to provide clarity on roles and responsibilities for Board members, including monitoring aged care reforms.
* The Board has installed a staff representative and is looking to install a consumer representative to the Board.
* The updated Continuous Improvement Register which showed several actions derived from consumers, staff and external organisations.
* Viewed training records which showed staff have completed training in topics including, but not limited to, SIRS, Open Disclosure, Minimising Restrictive Practices, Code of Conduct and Obtaining Consent.

Based on the information summarised above, I find the provider, in relation to the service, compliant with these Requirements in Standard 8, Organisational governance.

1. The preparation of the performance report is in accordance with section 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)