**Performance**

**Report**

**1800 951 822**

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| Name of service: | Aunty Grace Home Care |
| Service address: | Level 4/405-407 Collins Street MELBOURNE VIC 3000 |
| Commission ID: | 600475 |
| Home Service Provider: | Aunty Grace Clients Pty Ltd |
| Activity type: | Quality Audit |
| Activity date: | 7 July 2023 to 12 July 2023 |
| Performance report date: | 15 September 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 Aunty Grace Home Care (**the service**) has been prepared by F.Nguyen, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Services included in this assessment

**Home Care:**

* Aunty Grace Clients Pty Ltd, 26187, Level 4/405-407 Collins Street, MELBOURNE VIC 3000

# 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 2 August 2023.

# Assessment summary for Home Care Packages (HCP)

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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 | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Not Applicable** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

# 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 3(3)(a)*

Improve processes to guide staff in providing safe and effective personal and clinical care that is best practice and tailored to the consumer’s needs. Clinicians do not have appropriate oversight of the delivery of clinical care and sub-optimal care has been delivered in relation to wound management and skin integrity.

*Requirement 3(3)(b)*

Improve assessment and planning that better identifies risks and strategies to support consumers. Improve validated risk assessment tools to identify and monitor risks to consumers. Management is not actively considering alternative strategies to mitigate the risk to consumers’ health and wellbeing when delays in sourcing services or equipment are occurring.

*Requirement 3(3)(e)*

Improve documentation and communication within the service regarding consumer’s needs, preferences, conditions and changes. Communication to and from others involved in the consumer’s care is not always occurring and care is not always optimal as a result.

*Requirement 8(3)(e)*

Embedding of the Clinical Governance Framework to provide overarching direction, planned consumer/organisational outcomes and performance measures. Employment of the Clinical Care Manager to occur to provide advice and reinforce care practices and focus primarily on consumers with complex care needs.

# Standard 1

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| Consumer dignity and choice | | HCP |
| 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

Requirements 1(3)(a)(b)(c)(d)(e)(f)

The service was able to demonstrate that each consumer is treated with dignity and respect, with their identity, culture and diversity valued. Consumers and representatives sampled described staff as kind, caring and respectful. Staff advised they receive training in treating consumers with dignity and respect and ensuring identity and diversity are valued. Management advised of the ways they support their staff to ensure consumers are treated with dignity and their identity, culture and diversity are valued.

The service was able to demonstrate services are culturally safe. Consumers and representatives interviewed said that staff understand their needs and preferences and deliver services with this in mind. Staff demonstrated understanding of consumers’ cultural backgrounds and described how they ensure services reflect consumers’ cultural needs and diversity. Management described how they have recruited care managers and concierge staff who speak different languages, including Italian, Greek and Mandarin, to support effective communication.

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 and representatives sampled confirmed the service involves them, and others if they choose, in making decisions about the services they receive. Staff described how they support consumers and their representatives to exercise choice and make decisions about the services they receive. Documentation showed consumers are supported to make choices as part of the assessment and planning process, while services are being delivered.

The service was able to demonstrate consumers are supported to take risks to enable them to live the best life they can. Consumers and/or their representatives described undertaking activities they enjoy safely and with appropriate supports. Staff and management were able to describe the concept of dignity of risk and demonstrated how consumers are supported to safely take risks. This was confirmed through documents viewed by the Assessment Team.

The service demonstrated that 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. Most consumers and representatives sampled advised that their monthly statements are accurate and easy to understand. Care planning documents showed that consumers are provided verbal and written information to enable them to exercise choice. This includes a care plan following assessment and review processes, at the commencement of services and as required. Management described implementing additional layers of oversight to address any inaccuracies in monthly statements, and advised they are expanding the service's library of translated documents to support communication and reduce language barriers.

The service was able to demonstrate each consumer’s privacy is respected and personal information is kept confidential. Consumers and representatives interviewed stated staff and volunteers were respectful of personal information and the service demonstrated they have effective systems in place to protect each consumer’s privacy and personal information. Most consumers and/or representatives interviewed said that the service is respectful of the consumer’s privacy and personal information.

# Standard 2

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| Ongoing assessment and planning with consumers | | HCP |
| 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

Requirement 2(3)(a)

In respect to Requirement 2(3)(a) the Decision Maker notes the service responded to the Assessment Team’s report and has provided a detailed plan for continuous improvement (PCI). Outlined below is a summary of the Assessment Team's report and the approved provider’s response to that report.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that assessment and planning, including considerations of risk to consumer’s health and well-being, informs the delivery of safe and effective care and services.

The service does not use validated assessment tools to identify the initial needs of consumers and/or inform strategies to support risks to the consumer’s health and wellbeing. Validated risk assessment tools are used at the service, but their use is limited to when an incident occurs, such as when a consumer falls or becomes unwell.

The service’s response outlines a number of actions which have been implemented post the Quality Audit. For example:

* The Plan for Continuous Improvement notes improvements to the functions of the service’s consumer management system including embedding validated assessment tools such as the Psychogeriatric Assessment Scale and Carer Strain Index and Quality of Life Measures into the system. While this project is being completed, interim measures to improve existing assessment questions and steps to ensure clarity of information specific to risk are being embedded.
* The service has added the Falls Risk for Older People in the Community as a mandatory part of the initial assessment process that is conducted during the onboarding of consumers. The outcomes of this assessment will inform a formal Falls Risk Assessment and/or additional service recommendations.
* The Care Management Team have received additional training on actions required in response to an identified concern, referrals for assessment that may be required and actions and documentation that must be completed.
* The Assessment and Care Planning Policy and Guidance documentation has been updated.
* The development and implementation of a suite of risk management guidance including tools to aid the Care Managers in managing identified risk.

On review of the evidence provided by the Assessment Team and the PCI provided by the service, the Decision Maker deems Requirement 2(3)(a) to be compliant. The immediate actions taken by the service address the issue outlined by the Assessment Team and the service’s continuous improvement plan outlines an ongoing commitment to embed a risk-based approach to assessment and planning.

Requirements 2(3)(b)(c)(d)(e)

The service was able to demonstrate that assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advanced care and end of life planning if the consumer wishes. Consumers and/or representatives interviewed confirmed in various ways that assessment and planning processes identify consumer’s current care and service needs, goals and preferences. Care Managers described how onboarding assessments with consumers and/or their representatives identifies what services are important, including advanced care directives. Care plans for sampled consumers demonstrated that consumer’s needs, goals and preferences are discussed and documented.

The service was able to demonstrate assessment and planning is based on ongoing partnership with the consumer, and others who are involved in the care and services of consumers. Consumers and/or representatives confirmed they were involved in decision making regarding the care and services they received. Care Managers explained the involvement of consumers and/or representatives in assessment and planning of care and services, including the option to elect a representative to be present during assessments and reviews. Care planning documents viewed for sampled consumers demonstrated the inclusion of consumers and/or their representatives, as well as others involved with assessment and planning such as health professionals or specialists.

The service was able to demonstrate the outcomes of the assessment and planning process are communicated to consumers and documented in a care plan, readily available to consumers and where care and services are provided. Most consumers and/or representatives confirmed that they received a copy of their care plan and get adequate information about their care and services. Management described how consumers receive copies of their care plans, and relevant documentation was provided to contracted suppliers to ensure they receive the information required to deliver care and services. Care planning documents viewed for sampled consumers confirmed that recommendations for services are discussed with the consumers and recorded within their care planning documentation.

The service was able to demonstrate care and services are reviewed regularly for effectiveness, including when circumstances changed or following incidents. Most consumers and/or representatives confirmed that services were reviewed regularly. Care Managers advised that consumers were regularly reviewed and demonstrated the processes used to schedule and monitor for upcoming review dates. In some instances, the service could demonstrate more effective review of consumers when a consumer experienced a change in health or circumstance.

# Standard 3

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| Personal care and clinical care | | HCP |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-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. | Non-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

Requirement 3(3)(a)

In respect to Requirement 3(3)(a) the Decision Maker notes the service responded to the Assessment Team’s report and has provided a detailed plan for continuous improvement (PCI). Outlined below is a summary of the Assessment Team's report and the approved provider’s response to that report.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that each consumer receives safe and effective care that is best practice, tailored to their needs, and optimises their health and well-being. Most consumers and/or representatives sampled confirmed they receive care and services tailored to their needs. While Care Managers and management described how the personal and clinical care provided to consumers is tailored to their needs and optimises the consumer’s health and well-being, this was not evidenced in practice. For example:

* Wound care is occurring without the oversight of a registered nurse :
  + Consumer A was receiving weekly nursing services for the management of a wound on their right hip.
  + Progress notes confirmed that the wound was initially identified by a subcontracted support worker in May 2023.
  + While progress notes were documented by the supplier, the service was not notified of the wound until ten days later when a Care Manager completed a care plan review.
  + In the interim period, prior to the service becoming aware of the wound, email correspondence confirmed that the support worker sought advice and recommendation from a local pharmacy and was treating the wound outside of their scope of practice, without a nursing review or consultation from a wound specialist.
  + In response to feedback provided by the Assessment Team during the Quality Audit, management acknowledged that wound management undertaken by a support worker, without consultation from nursing staff does not demonstrate best practice or safe clinical care. Management confirmed that personal and clinical care services provided by this subcontracted provider have been placed on hold.

In response to Assessment Team report, the service acknowledged that the supplier did not follow the agreed process as the subcontracted staff did not report the wound through the appropriate lines of escalation.

* A consumer’s health status has not been proactively monitored while awaiting nursing review.
* Care planning documentation viewed for Consumer B demonstrated that safe clinical care was not provided due to the timeliness of a nursing review for the management of a rash.
* The incident register documented that Consumer B developed a rash on their chest. Management advised how a booking request was placed within the system for multiple nursing suppliers, however, the scheduled review was not arranged until 10 days had passed.
* Management advised how the service does not usually experience issues organising nursing services and expects a nursing review to occur within approximately 2 days.
* In response to feedback provided by the Assessment Team during the Quality Audit, management acknowledged that 10 days for a nursing supplier to review the management of a rash was not timely and effective to meet the needs of the consumer.

In response to the Assessment Team’s report, the service acknowledged that the subcontracted provider reported the wound via an incorrect email address, the supplier has been reminded of the correct email address for consumer notifications. The service has suspended the supplier from receiving new consumers for personal care related services until such time the service is confident that the supplier understands their obligations around consumer care.

Although the service did coordinate for a nurse to review Consumer B’s rash the day after being made aware of the concern, the Decision Maker was not able to evidence that any further actions to ensure that other parties involved in Consumer B’s care were also notified of the rash and it was not demonstrated that staff were actively monitoring the consumer’s skin integrity while waiting for the nursing assessment to occur.

The service’s response outlines a number of actions which have been implemented and/or planned post the Quality Audit. For example:

* Subcontracted providers appropriately educated and reprimanded where a failing existed.

On review of the evidence provided by the Assessment Team and the PCI provided by the service, the Decision Maker deems Requirement 3(3)(a) to be non-compliant. Clinicians have not had appropriate oversight of the delivery of clinical care and sub-optimal care has been delivered in relation to wound management and skin integrity.

Requirement 3(3)(b)

In respect to Requirement 3(3)(b) the Decision Maker notes the service responded to the Assessment Team’s report and has provided a detailed plan for continuous improvement (PCI). Outlined below is a summary of the Assessment Team's report and the approved provider’s response to that report.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that effective management of high impact or high prevalence risks associated with the care of each consumer. While the service actively documented risks for consumers in their personal assessments, the service does not have an effective process to assess, action and mitigate risks associated with the care of each consumer, to ensure safe and effective delivery of personal and clinical care. For example:

* A consumer’s risk of subsequent falls has not been effectively managed.
  + Care planning documentation confirmed that Consumer C had a fall with injury, down the steps at the entrance of their home in April 2023.
  + Progress notes confirmed that an occupational therapist’s assessment occurred with recommendations for grab rails and minor house modifications to assist Consumer C to remain independently at home in a safe manner.
  + Progress notes documented that Consumer C’s representative contacted the service to follow up the installation of the rails and home modification in June 2023.
  + The Assessment Team noted that at the time of the Quality Audit, the assessed rails and home modifications still had not been implemented to effectively manage Consumer C’s decline in mobility and reduce their risk of falls.
  + In response to feedback provided by the Assessment Team during the Quality Audit, management described challenges associated with procuring tradespeople to Consumer C’s regional location and acknowledged the failure to implement alternative strategies to reduce Consumer C’s falls risk whilst sourcing a supplier for the installation of rails.
* A consumer’s wound has deteriorated as risk mitigation strategies have not been effectively managed.
  + Care planning documentation viewed by the Assessment Team for Consumer A demonstrated the service was not able to safely manage their wound through the implementation of assessed equipment.
  + Consumer A underwent an occupational therapist’s assessment in May 2023 which reported that they are at a high risk of pressure injuries The occupational therapist recommended items including a new bed, pressure relieving mattress, a new chair and a gel cushion.
  + The Nursing Report dated 3 June 2023 documented that the wound was chronic noting a lack of pressure relief when in bed. Nursing staff attempted to relieve the pressure by laying layers of blankets under the sheets to cushion / protect the wound.
  + The Nursing Report dated 11 June 2023 noted that the wound had not improved Furthermore, the report noted Consumer A’s frustration with the delay in the new bed being delivered.
  + Care planning documentation confirmed that the equipment had been ordered, however, at the time of the Quality Audit, the equipment had still not arrived.
  + Despite Nursing Reports documenting no improvement to the wound, the service was unable to demonstrate that alternative strategies were implemented to improve the management of Consumer A’s risk of the wound deteriorating further.

In response to Assessment Team report, the service acknowledged that risk management was not completed effectively for both Consumer A and Consumer C.

The service’s response outlines a number of actions which have been implemented and/or planned post the Quality Audit. For example:

* The development and implementation of an organisational risk management framework, risk appetite statement, policy, procedure, and tools for identifying and managing risk for consumers.
* Risk registers.
* A Dignity of Risk decision making process is in place.
* The service responded that although this work is in progress, a number of these documents are still in draft form.

On review of the evidence provided by the Assessment Team and the PCI provided by the service, the Decision Maker deems Requirement 3(3)(b) to be non-compliant. Management are not actively considering alternative strategies to mitigate the risk to consumers’ health and wellbeing when delays in sourcing services or equipment are occurring.

Requirements 3(3)(e)

In respect to Requirement 3(3)(e) the Decision Maker notes the service responded to the Assessment Team’s report and has provided a detailed plan for continuous improvement (PCI). Outlined below is a summary of the Assessment Team's report and the approved provider’s response to that report.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that information about consumer’s needs, preferences, conditions and changes are consistently and effectively documented and communicated within the organisation, and with others where responsibility for care is shared. The Assessment Team noted that information received from contracted suppliers about consumer’s personal care and clinical needs is not consistently documented, communicated, or shared within the service. For example:

* Consumer E had a hospital admission and is under the care of the hospital’s neurology team. Their care plan documented their cognitive decline and the involvement of the neurology team in managing this risk. Management confirmed that they had not undertaken an independent cognitive assessment, stating that the neurology team was involved in managing the consumer’s condition. However, the service was not able to demonstrate any communication or information has been sought or obtained from the neurology team regarding the consumer’s change in cognition or any assessments that team has completed.
  + In response to Assessment Team report, the service acknowledged that at this stage there is no specific documented communication from the neurology team relating to completed assessments and cognitive status for Consumer E.
* Consumer F is experiencing pain in their hands and back and since October 2022 has attended weekly physiotherapy session to assist with pain management. The service was unable to provide any information or communication from the physiotherapist in relation to the consumer’s current pain status or mobility needs.
  + In response to Assessment Team report, the service acknowledged that there are no reports from the physiotherapist on record for Consumer F in reference to their treatment for arthritis and pain management.
* Consumer G is at risk of choking, however, the Assessment Team noted, and management confirmed that work instructions for staff providing meal preparations did not include information about the consumer’s chocking risk.
  + Management said although Consumer G is supported to choose their preferred foods and their GP is supporting the consumer to manage their condition, however, information in relation to their risk of choking should be reflected in the work instruction in their care plan.
* Consumer H requires oxygen therapy. The work instruction notes this, however, the service did not provide information to care staff to highlight the risks associated with oxygen therapy when providing the consumer’s personal care.
  + In response to Assessment Team report, the service acknowledged that it was noted on the work instructions that home oxygen therapy was in place, the service agrees that the risks associated with oxygen therapy could have been listed in Consumer H’s care plan.

The service’s response outlines a number of actions which have been implemented and/or planned post the Quality Audit. For example:

* Deliver small group training with participants required to write examples in the training environment in response to hypotheticals.
* Add training to the induction process.

On review of the evidence provided by the Assessment Team and the PCI provided by the service the Decision Maker deems Requirement 3(3)(e) to be non-compliant. Communication to and from others involved in the consumer’s care is not always occurring and care is not always optimal as a result.

Requirements 3(3)(c)(d)(f)(g)

The service was able to demonstrate they would respond appropriately to support the needs, goals and preferences of consumers nearing end of life to maximise their comfort and preserve their dignity. Care Managers and management described the service’s process to ensure that consumers receive the appropriate end of life supports when required. Care planning documents showed that advanced care directives are discussed with consumers and outcomes are documented within their care plans.

The service was able to demonstrate 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. Consumers and/or representatives sampled stated that staff would recognise change in their health and would respond appropriately. Care Managers and management described the various avenues utilised by the service to identify consumer deterioration. Documents viewed demonstrated how deterioration or change in consumer health was identified and how the service generally responded in a timely manner.

The service was able to demonstrate timely and appropriate referrals to individuals, other organisations and providers are made for consumers. Most sampled consumers and/or representatives confirmed consumers had been referred to health professionals when required. Management described the processes of referring consumers to contracted health professionals or external organisations such as My Aged Care (MAC). Care planning documentation for most sampled consumers confirmed the service’s process when referring consumers for care and services.

The service was able to demonstrate they minimise infection related risks through the implementation of standard and transmission-based precautions to prevent and control infections. Consumers and/or representatives advised that staff use Personal Protective Equipment (PPE) and hygiene techniques to minimise the transmission of infection. Care Managers and management described the service’s processes for minimising risks of infection including policies, procedures, training and monitoring for mandatory vaccination requirements.

# Standard 4

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| Services and supports for daily living | | HCP |
| 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. | Compliant |

Findings

Requirement 4(3)(g)

In respect to Requirement 4(3)(g) the Decision Maker notes the service responded to the Assessment Team’s report and has provided a detailed plan for continuous improvement (PCI). Outlined below is a summary of the Assessment Team's report and the approved provider’s response to that report.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that where equipment is provided, it is safe, suitable, clean and well maintained. Sampled consumers and representatives advised that following an OT assessment, there can be significant delays in acquiring suitable equipment. Documentation viewed by the Assessment Team showed that where equipment had been identified as not suitable or damaged, repair or replacement had not been prioritised to ensure consumer safety. Staff and management confirmed delays in both OT assessments and sourcing suitable equipment for consumers. Management advised the service is looking into annual OT and physiotherapy assessments for consumers, however, this has not yet been implemented at the time of the Quality Audit.

The service’s response shows a 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:

* Care managers described check-in calls with consumers to ensure that equipment received is suitable and fitted to consumers.
* Staff and management advised maintenance of equipment is managed through monthly check-in calls with consumers and annual reviews.
* The service has clarified the process for monitoring and following up for equipment and subscription purchasing with development and implementation of a documented process for guidance and reference.

On review of the evidence provided by the Assessment Team and the PCI provided by the service to remediate the deficiencies identified in the Assessment Team report, the Decision Maker deems Requirement 4(3)(g) to be compliant. The service was able to demonstrate that where equipment is provided, it is safe, suitable, clean and well maintained.

Requirement 4(3)(a)(b)(c)(d)(e)(f)

The service was able to demonstrate 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. Most consumers and/or representatives were satisfied that the services provided optimised the consumer’s independence, well-being and quality of life through the provision of in-home services. Staff described what is important to consumers and how they adapt services according to consumers’ needs and preferences such as additional in-home services when required. Care planning documents confirmed that the service had identified and documented what is important to the consumers, their goals and preferences for daily living.

The service was able to demonstrate that services and supports for daily living promote consumer’s emotional, spiritual and psychological wellbeing. Consumers and/or representatives advised that staff know consumers well and described in various ways how the services provided enhance their emotional and psychological wellbeing. Management and Care Managers demonstrated their knowledge of consumers and described strategies to support consumers emotionally, spiritually and promote their psychological wellbeing. This was confirmed through care planning documents viewed for sampled consumers.

The service was able to demonstrate that services and supports for daily living assist consumers to participate in their community, have social and personal relationships, and do things of interest to them. Consumers and/or representatives confirmed that in-community services enable consumers to do things of interest and maintain social relationships, such as going shopping, respite services and social groups. Staff and management described, and care planning documents confirmed, how the service actively supports consumers to access and participate in their community.

The service was able to demonstrate that information about consumers’ needs, conditions, goals and preferences is documented and communicated within the organisation, and with other organisations where responsibility for care is shared. Consumers and/or representatives confirmed provision of daily living support and services was consistent, with staff who know them well. Management described how relevant information about consumers are documented and communicated through detailed work instructions provided to the supplier. Care planning documents viewed for sampled consumers showed that information was shared and communicated to the appropriate staff and suppliers through care plans, work instructions and progress notes.

The service was able to demonstrate timely and appropriate referrals to individuals, other organisations and providers are made for consumers. Consumers and/or representatives confirmed that consumers were generally timely and appropriately referred as required, for example, to allied health professionals and/or for purchase of mobility equipment. Staff and management advised the service refers all services to external suppliers, and additionally refer to MAC where required. Care planning documentation confirmed referrals to external providers were generally timely and appropriate.

The service was able to demonstrate that, where meals are provided, they are varied and of suitable quality and quantity. Consumers interviewed confirmed they are satisfied with the meals provided, and they meet their nutritional needs and preferences. Staff demonstrated they know consumer’s dietary needs, preferences and identified risks relating to consumer’s nutritional status. Care planning documents showed that consumer’s dietary needs and preferences are documented and communicated.

# Standard 5

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| Organisation’s service environment | | HCP |
| 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 applicable |
| 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 applicable |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Not applicable |

Findings

All individual requirements within Standard 5 are not applicable, therefore standard 5 is not applicable and was not assessed as part of the Quality Audit.

# Standard 6

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| Feedback and complaints | | HCP |
| 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

Requirement 6(3)(c)

In respect to Requirement 6(3)(c) the Decision Maker notes the service responded to the Assessment Team’s report and has provided a detailed plan for continuous improvement (PCI). Outlined below is a summary of the Assessment Team's report and the approved provider’s response to that report.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that appropriate action is taken in response to feedback and complaints, and that an open disclosure process is used when things go wrong. Three consumers and representatives interviewed said they are not satisfied their issues raised with the service had been followed up and actions taken to their satisfaction. A further two consumer representatives stated that the service had not taken appropriate action in a timely manner following incidents. They had brought these delays to the service’s attention but did not receive a response. While the service actively documents feedback, the service does not have an effective process to ensure consumer feedback is consistently followed up and actioned appropriately, including the use of open disclosure when relevant, to ensure a satisfactory resolution is obtained for the consumer. For example:

* The representative for Consumer I advised that they had made a serious complaint regarding the conduct of a subcontracted support worker in June 2023. While the subcontracted support worker had initially been removed from Consumer I’s schedule, the service had not been back in touch with the representative since the day after the complaint was made.
  + During the Quality Audit, management advised, and documentation showed that the service had lodged a Serious Incident Response Scheme (SIRS) report in June 2023. The service had interviewed the supplier to obtain a statement regarding the shift in question, and the Care Manager had contacted both the consumer and representative the day after the complaint was made to provide support and an apology. No further contact had been made with the representative regarding this matter following the investigation. Management provided an update on day three of the Quality Audit to advise that a discussion had been held with the representative to discuss a range of solutions to their ongoing concerns.
    - In response to the Assessment Team’s report, the service evidenced that follow up with Consumer I and their representative had also occurred three days after the complaint was made as evidenced in a feedback note and an incident note.
    - Additionally, the service was able to evidence that communication with the representative also occurred six days after the initial complaint was made, following a separate complaint relating to a missed shift. Additional documentation noted that the service had met the representative’s needs around the complaint. It was evidenced by the Decision Maker that the service communicated this to the supplier and that the feedback and complaints system used by the service also prompts staff to utilise an open disclosure approach when managing consumer complaints.
* Consumer G stated they had lodged two complaints and have ongoing issues with the service that continue to be unresolved and had decided to transfer to another provider. Consumer G advised that following their complaints, the service’s response was to change their Care Manager without resolving their issues.
  + During the Quality Audit management described steps they had undertaken to manage Consumer G’s complex complaints.
  + In response to the Assessment Team’s report, the service has demonstrated that Consumer G’s complaint has since been raised with the Commission and was closed by the Commission in August 2023.
  + In response to Consumer G’s request for the Care Manager to resign, the service changed Consumer G’s Care Manager as a resolution to one of their complaints around a specific Care Manager.
* While the service has a Feedback and Complaints policy, a management process, a quick reference guide, and an Open Disclosure Policy to provide staff guidance on effective complaint management, elements of open disclosure was not consistently evidenced on complaint documentation to ensure actions that are undertaken are communicated to the complainant. Furthermore two staff members interviewed were not conversant with the concept of open disclosure.
* During the Quality Audit management advised they have been prevented from accessing the Aged Care Learning Information System (ALIS) until such time as their Quality Audit has been completed and will ensure that staff access modules regarding effective complaint management and open disclosure, moving forward.
  + In response to the Assessment Team’s report, the service has demonstrated that an open disclosure process is utilised as evidenced in both Consumer I and Consumer G’s examples above.

On review of the evidence provided by the Assessment Team and the PCI provided by the service to remediate the deficiencies identified in the Assessment Team report, the Decision Maker deems Requirement 6(3)(c) to be compliant. The service has demonstrated that appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

Requirements 6(3)(a)(b)(d)

The service demonstrated consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. Consumers and representatives know how to provide feedback or make a complaint and staff were aware of what to do when a consumer or representative raised issues or concerns. Management described their process to ensure consumers and representatives are supported to access feedback mechanisms and this was confirmed through the Feedback, Compliments and Suggestions register viewed by the Assessment Team.

The service demonstrated consumers are made aware of, and have access to advocates, language services and other methods for raising and resolving complaints. Staff and management discussed processes to ensure consumers have access to advocates and language services if required, and consumers are made aware of other methods for raising and resolving complaints. Staff interviewed stated how they are encouraged to utilise the face-to-face or telephone interpreter service for any consumers with language barriers to ensure consumers are supported to communicate with them effectively regarding their care and services.

The service was able to demonstrate feedback and complaints are reviewed and used to improve the quality of care and services for consumers. Some consumers and/or representatives interviewed described improvements to service delivery because of their complaints. Staff and management described how feedback and complaints are analysed and trended, and the information is used to make service improvements. The Assessment Team viewed documentation that evidenced feedback provided had positively impacted service delivery.

# Standard 7

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| Human resources | | HCP |
| 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

Requirement 7(3)(a)

In respect to Requirement 7(3)(a) the Decision Maker notes the service responded to the Assessment Team’s report and has provided a detailed plan for continuous improvement (PCI). Outlined below is a summary of the Assessment Team's report and the approved provider’s response to that report.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that the workforce is planned and the number and mix of members of the workforce deployed enables the delivery and management of safe and quality services. Some consumers and/or their representatives sampled, and care documentation showed the service did not consistently meet the assessed needs of consumers due to supplier availability. Commercial and Service Coordination Managers described their efforts to onboard new suppliers and work with current suppliers to ensure that all requested consumer care and services are matched with a suitable supplier. Management demonstrated their oversight of unfilled shifts for consumers, however, acknowledged that they are limited in their ability to deliver care and services for consumers due to limited availability of contracted staff. For example:

* Management advised that, on day one of the Quality Audit, 93% of care and services for consumers had been booked by the Service Coordination team for the month of July 2023. Following some analysis of their scheduling system, the Assessment Team and management investigated the unfilled shifts for June 2023 which showed 316 appointments had not been accepted by suppliers to provide care and services to consumers.
* In response to the Assessment Team report, the service clarified that of the 6,625 appointments planned for the service in June 2023, only 316 appointments were ‘unfilled’ at the time of the Quality Audit, representing less than 5% of all appointments. However, after the removal of appointments from the system that were cancelled by consumers that still read as ‘open’, the number of appointments missed in June was 200, or 3% of all appointments.
* Further to this, of the 200 appointments that were not delivered in June 2023, 65 were for outdoor maintenance:
* 46 gardening services
* 9 for window cleaning
* 3 for gutter cleaning
* 7 for other home maintenance
* The service also stated that the fulfilment rate of personal care, respite services and nursing services are, respectively, 99.7%, 98.9% and 95.5%.
* Consumer L did not receive their monthly monitoring of their blood pressure in June 2023. Management advised the service had attempted to fill the nursing service multiple times with the scheduled services showing as expired or declined.
  + In response to the Assessment Team’s report, the service states that Consumer L was called by their Care Manager in June 2023, the nurse had provided an update on Consumer L’s health and well-being. The nursing appointment has now been booked for Consumer L.
* The schedule showed Consumer M did not receive three appointments of wound care in June 2023 to attend to a wound that had become infected. Following management investigation of these missed shifts, the unfilled appointments were entered with an incorrect start date for this series of nursing wound care services and the consumer had received the required wound care prior to her hospitalisation on before the scheduled wound care visits. Whilst there was no impact to the consumer as the service had met the consumer’s needs, documentation on Consumer M’s file was insufficient to understand what actions the Care Manager had undertaken to meet Consumer M’s wound care needs.
  + In response to the Assessment Team’s report, the service states that no nursing services were missed/unfilled. Unfilled nursing appointments were allocated in the consumer’s schedule in June 2023. While these booking requests could have been cancelled/removed from the system, there was no risk to Consumer M in having these left in their schedule. The service states that the nursing service in question was aware of Consumer M’s hospitalisation at the time and that there were no direct or potential risks for Consumer M that the nursing services had been booked.
    - The Decision Maker notes that in relation to Consumer M, the deficiency correlates directly to the lack of documentation and communication around their care and services and not unfilled shifts, this deficiency is addressed in Requirement 3(3)(e).

On review of the evidence provided by the Assessment Team and the PCI provided by the service to remediate the deficiencies identified in the Assessment Team report, the Decision Maker deems Requirement 7(3)(a) to be compliant. The service is demonstrating that 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.

Requirements 7(3)(b)(c)(d)(e)

The service was able to demonstrate the workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture, and diversity. Overall, consumers confirmed staff treat consumers with respect and are responsive to their needs. Documentation showed and management described, how the service ensure staff employed meet their organisational values and expectations.

The service was able to demonstrate the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. Overall, consumers described confidence in staff knowledge and competence to perform their roles. Management described having recruitment, initial onboarding and monitoring processes to ensure that the workforce and suppliers are competent to perform their roles. Most consumers interviewed advised, in various ways, they have confidence in the knowledge and skills of staff and subcontracted staff, and said they knew what they are doing.

The service was able to demonstrate that the workforce is recruited, trained, equipped, and supported to deliver the outcomes required by the Quality Standards. The service has human resources and related policies to guide management in the initial selection, and the onboarding process, annual mandatory schedule of training identified based on job roles, and regular staff meetings to provide information and support. Staff confirmed they have participated in an induction program and confirmed they complete mandatory education and training, and ongoing targeted training, as part of their monthly office days and described how this helps them in their role.

The service was able to demonstrate the workforce performance is regularly assessed, monitored, and reviewed. The service has a performance appraisal and development process for staff. Staff interviewed confirmed they were supported in their ongoing performance through regular meetings with their managers and through the performance review process. Management described their process for regular assessment and monitoring of staff and supplier performance and this was confirmed through interviews with suppliers.

# Standard 8

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| Organisational governance | | HCP |
| 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. | 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. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Non-compliant |

Findings

Requirements 8(3)(c)(iv) and (vi)

In respect to Requirement 8(3)(c)(iv) and (vi) the Decision Maker notes the service responded to the Assessment Team’s report and has provided a detailed plan for continuous improvement (PCI). Outlined below is a summary of the Assessment Team's report and the approved provider’s response to that report.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that it has effective organisation wide governance systems in place for managing and governing all aspects of care and services in relation to workforce governance, and feedback and complaints.

Workforce governance

* Evidence analysed by the Assessment Team showed the service was not able to demonstrate that effective workforce governance is in place to ensure that the external workforce has the capacity to deliver care and services to consumers. As discussed by the Assessment Team in Standard 7, requirement (3)(a) the service did not have effective systems in place to ensure the sufficiency of suppliers, thus enabling the inconsistent delivery of safe and quality care and services to consumers. Onboarding for new suppliers was not prioritised to ensure care and service are being scheduled, delivered in a timely manner and for continuity of care.
  + The Decision Maker deems that the service has provided sufficient information as demonstrated in Standard 7 to remediate the deficiencies stated in the Assessment Report relating to Standard 8, requirement (3)(c)(iv).

Feedback and complaints

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that there is an effective complaints management system that ensures complaints are addressed in a timely manner to a satisfactory outcome for consumers and that an open disclosure process is used when things go wrong. For example:

* While the service reports on complaint trends and complaints received from the Commission at the Quality and Care Operational, Executive and Steering committee meetings, review of meeting minutes did not evidence actions to address the identified trends to improve the service experience for consumers. However, management said that additional staff were recently recruited, and processes and system improvements will positively impact on complaints received.
* As discussed in Standard 6, requirement (3)(c), while the service monitors if complaints remain open or have been resolved, the service does not have implemented processes in place to quality assure the resolution of complaints to the satisfaction of consumers.
* The Decision Maker deems that the service has provided sufficient information as demonstrated in Standard 6 to remediate the deficiencies stated in the Assessment Report relating to Standard 8, requirement (3)(c)(vi).

On review of the evidence provided by the Assessment Team and the PCI provided by the service to remediate the deficiencies identified in the Assessment Team report, the Decision Maker deems Requirement 8(3)(c)(iv) and (vi) to be compliant.

Requirements 8(3)(d)(i) and (iv)

In respect to Requirement 8(3)(d)(i) and (iv) the Decision Maker notes the service responded to the Assessment Team’s report and has provided a detailed plan for continuous improvement (PCI). Outlined below is a summary of the Assessment Team's report and the approved provider’s response to that report.

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

High impact or high prevalence risks

Evidence analysed by the Assessment Team showed the service was not able to demonstrate effective risk management systems to manage and monitor high impact or high prevalence risks to inform the delivery of safe and effective care for each consumer. For example:

* The Assessment Team noted that consumer risks are inconsistently identified in assessment processes, and while some information informs care planning, information on the work instruction that subcontracted staff receive was not consistently sufficient to enable them to mitigate the risks for consumers at point of care. This is discussed at Standard 2, requirement (3)(a) and Standard 3, requirement (3)(e).
* As described in Standard 3, requirement (3)(b) and in Standard 4, requirement (3)(g), mitigation strategies had not been implemented for consumers’ complex care needs in relation to falls, skin integrity and cognitive decline.
* However, the Assessment Report also notes that staff and management described processes including fortnightly Better Practice and monthly Clinical meetings, monthly trainings, and resources to ensure that staff respond to high impact and high prevalence risks for consumers. Operations management and Clinical Management stated they provide additional support, guidance and oversight of these consumers.
* Documentation viewed showed the service has a vulnerable consumer list with 242 consumers identified as either living alone with no informal supports, homelessness, mental health issues, or at risk of flood and fire.

The service’s response shows a 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 development and implementation of an organisational risk management framework.
* A risk appetite statement, risk registers (enterprise and operational), the development of policy, procedures, and tools for identifying and managing risk for consumers.
* A Dignity of Risk decision making process is in place.
* There is documentation in place to guide staff members with the identification of and management of high impact and/or high prevalence risks such as mobility and falls, identifying and responding to consumer deterioration, delirium, and skin management. Care Managers have also received training in these areas.
* Incidents and complaints are reported for review and discussion at operational, executive and director levels.
* Identified improvements are actioned for the individual consumers and/or systemically or processes.

Managing and preventing incidents

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that it has an effective incident management system to ensure a systemic approach is taken to minimise the risk of incidents occurring. While the service demonstrated they record individual incidents, they were unable to demonstrate how they consistently respond to consumer incidents, including undertaking investigations and analysis to ensure corrective actions are implemented for the consumer to mitigate their risks and prevent incidents from reoccurring. For example:

* As outlined in Standard 3, requirement (3)(b), the service did not respond in a timely manner to arrange home modifications for a consumer following a fall. In addition, there was an OT assessment completed that recommended rails at the steps that he subsequently fell.
* As outlined in Standard 4, requirement (3)(g) following an incident recorded on 5 May 2023 where a pressure injury has occurred due to a consumer’s bed and mattress, no timely action has occurred to hire a bed in the interim while the service awaits the back order for the ordered bed, thus minimising ongoing aggravation to the wound site. The Assessment Team noted that the incident reporting process was prematurely closed for the consumer prior to ensuring all mitigation strategies had been fully implemented and evaluated for effectiveness.
* A consumer stated that they advised the service of their fall, however, advised that their GP implemented actions following the incident to respond to their injuries. The consumer had been privately paying for allied health support separately and did not receive a review or follow up from the service.
* However, the Assessment Report also notes that the service has incident management policies and procedures that provides detailed guidance on actions staff are required to follow. Management reported that at the time of the Quality Audit there were 41 open incidents, and they would not be closed until all actions are completed or until the Commission advises of closure for the SIRS reports.
* The Assessment Team viewed incident data in the Executive and Steering committee presentations and the May review of incidents undertaken by the Clinical and Quality Manager and found these to be comprehensive in nature.
  + In response to the Assessment Team’s response, the service confirmed that when individual incidents are initially reviewed, the Clinical and Quality Manager may set tasks for the Care Manager (or other incident managers) in relation to required follow up actions that must be done. Through a compilation of the monthly report, if themes are identified, systemic improvements are suggested through the Continuous Improvement (CI) system. Items raised in the CI system are presented by the Head of Quality and Practice each month at the Progress and Outcomes Meeting where they are discussed, and a decision made in relation to the approval for the PCI or other actions.

Additionally, a consultant has been engaged to work with executive and directors to develop and guide on implementation of risk management suite of documents and tools including dignity of risk.

On review of the evidence provided by the Assessment Team and the PCI provided by the service to remediate the deficiencies identified in the Assessment Team report, the Decision Maker deems Requirement 8(3)(d)(i) and (iv) to be compliant.

Requirements 8(3)(e)

In respect to Requirement 8(3)(e) the Decision Maker notes the service responded to the Assessment Team’s report and has provided a detailed plan for continuous improvement (PCI). Outlined below is a summary of the Assessment Team's report and the approved provider’s response to that report.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that systems and processes are fully implemented and effective to maintain the reliability, safety and quality of the clinical care consumers receive. The PCI showed an action entered on 5 May 2023 that the service needs to have a Clinical Governance Framework in place that provides overarching direction, planned consumer and organisational outcomes and performance measures. This action is still in progress with a planned completion date of 6 July 2023.

The service’s response shows a 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 service now has a Clinical Governance Framework in place, with guidance documentation for the management of common medical conditions that require clinical care. Training in the clinical care processes had been delivered via online Better Practice Sessions as each document was developed and implemented, the group face to face training and was delivered the week following the Quality Audit.
* The service has a Clinical and Quality Manager and a Registered Nurse who has oversight for clinical and complex care. As part of their monitoring, they undertake consumer file reviews providing recommendations about clinical care responses and provides reports, via the Head of Quality and Practice, to the executive team for the Monthly Review and the Progress and Outcomes meetings and to key operations members at the Quality Care Operational Meeting. The information in the reports is reviewed by the two directors monthly. At the meetings, emerging themes are discussed as are actions to be undertaken in response to incidents and complaints.
* The service is currently advertising for a Clinical Care Manager who will work across the Care Management Team to provide advice and reinforce care practices. This role will carry a reduced case load primarily of consumers with complex care needs and report to the Operations Team Manager working closely with the Clinical and Quality Manager.
* The current risk indicators relate to consumers with dementia, vulnerable persons and those who are at risk of falls, additional fields for various clinical and health conditions to allow for ease of monitoring and reporting at a higher level will also be added. Other indicators are informed by trends from logged incidents relating to infection, wounds, falls etc.
* Anti-microbial stewardship
  + The service provides a fact sheet about antimicrobials in their welcome kit, promote infection control practices such as coughing, sneezing and hand hygiene etiquette, and social distancing from infected persons as management strategies for consumers in their home. In winter, the service encourages consumers to have a Covid-19 vaccination booster, an influenza vaccination and maintain good infection control practices. The service still requires Care Managers to wear N95 masks when visiting consumers and encourage subcontracted support workers to continue the use of masks with consumers.
* Minimising the use of restraint
  + Staff received training in identifying and reporting instances of restraint when SIRS training commenced in 2022, however, no instances or restraint have been identified by Care Managers or reported by staff. Reports are to be raised as Serious Incidents and reported for discussion at all levels, particularly at executive and director levels.
  + A Restrictive Practice Policy and Restrictive Practice Process provides guidance for the minimisation of restraint. A restrictive practice fact sheet has been added to the service’s PCI to provide education to consumers and their representatives. The development and implementation of a ‘restrictive practice register ‘ has also been added to the PCI and staff received updated training in relation to restrictive practice on the 3 August 2023.
* Open disclosure
  + The service has an Open Disclosure Policy and an Open Disclosure training video from the Commission’s website is part of the induction process. The service promotes the approach of open disclosure around all activities at the organisation and highlight this requirement in the incident and complaint management systems. As an improvement, the service will enable a link to the Open Disclosure Policy for staff as an additional reminder.

On review of the evidence provided by the Assessment Team and the PCI provided by the service to remediate the deficiencies identified in the Assessment Team report, the Decision Maker deems Requirement 8(3)(e) to be non-compliant. The service has now established a Clinical Governance Framework to provide overarching direction, planned consumer and organisational outcomes and performance measures, however, these critical actions have yet to be embedded into the organisation’s systems and processes.

Requirements 8(3)(a)(b),(c)(i)(ii)(iii)(v),(d)(ii)(iii)

The service was able to demonstrate consumers are engaged in the development, delivery and evaluation of care and services. Consumers and representatives said they have input about services provided to consumers and are encouraged to provide feedback. Staff described how consumers have input about their experience and services through feedback processes and management described the recent consultation with a representation of their Chinese cohort of consumers and their planned actions for the establishment of the Client Advisory Body.

The service was able to demonstrate that effective systems in relation to information management, continuous improvement, financial governance, and regulatory requirements. The service was able to demonstrate the organisation promotes a culture of safe, inclusive, and quality care and services and is accountable for their delivery. The service has a range of reporting mechanisms to ensure the service’s governing body is aware and accountable for the delivery of care and services. Management discussed the governance structure, reporting processes, and continuous improvement processes implemented to ensure they are accountable for the delivery of safe, inclusive, and quality care and services.

Information management

The service could demonstrate effective information management systems and processes are in place to support staff in their roles or to meet the outcomes required by the Quality Standards. Management described the development of their bespoke consumer management system which they continue to refine with their software engineers to ensure it is intuitive, and provides tasks, prompts and flags for service delivery staff to consider and action. Staff interviewed stated they can readily access the information they need through the electronic system and have access to policies and procedures, staff communications and resources to inform service delivery.

Continuous improvement

The service was able to demonstrate an effective continuous improvement system and processes in place to assess, monitor and improve the quality and safety of care and services provided by the service. The service’s continuous improvement plan includes improvements informed by staff feedback, actions identified for system improvements, policy and procedure review, and opportunities to upskill staff. The service provided a comprehensive Self-Assessment which identified additional actions to continue to improve care and services for consumers.

Financial governance

The service demonstrated effective financial reporting processes to give the governing body the assurance they require to be satisfied of compliance with their obligations as an Approved Provider of HCP services. Management advised the organisational finances are managed by the CEO, Business partner and an external Accountant, with a requirement of two approvers for bank account transactions. Management confirmed, and the Executive and Steering committee meeting minutes and presentations viewed, demonstrated the service reviews their financial position monthly and they have a quarterly meeting where fees and charges are discussed.

Regulatory compliance

The service was able to demonstrate that an effective system and process is in place to ensure regulatory compliance requirements are met. The service has systems and processes in place to ensure they are complying with all relevant legislation, regulatory requirements, professional standards, and guidelines. Information regarding any changes is received through various methods including memberships with aged care peak bodies and industrial relations, human resource and legal subscriptions, and monitoring of Australian Government websites, correspondence and media releases.

Recognising and responding to elder abuse

The service demonstrated processes are in place to identify and respond to abuse and neglect of aged care consumers, and that staff had been provided education, including elder abuse to enable the workforce to identify, assess and manage risks to consumers.

Supporting consumers to live their best life

The service has effective processes to assess and consult with consumers regarding their dignity of risk when consumers refuse to implement risk management strategies and provide evidence of examples of this process being implemented with consumers. Management and staff described how they deliver services to support consumers to access the community and have social interactions for consumers to live the best life they can and provide individualised choices and preferences.

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)