**Performance**

**Report**

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Aurukun Community Aged Care Service |
| Commission ID: | 700261 |
| Address: | 39 Kang Kang Road, AURUKUN, Queensland, 4871 |
| Activity type: | Quality Audit |
| Activity date: | 6 October 2023 to 12 October 2023 |
| Performance report date: | 29 December 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.

# Service included in this assessment

Home Care Packages (**HCP**) included:  
Provider: 1912 Aurukun Shire Council  
Service: 18002 Aurukun Community Aged Care Service  
  
Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 7358 Aurukun Shire Council  
Service: 25170 Aurukun Shire Council - Care Relationships and Carer Support  
Service: 25169 Aurukun Shire Council - Community and Home Support

**This performance report**

This performance report for Aurukun Community Aged Care Service (**the service**) has been prepared by G. McNamara, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Quality Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives, and others
* the Home Service Provider’s response to the assessment team’s report received 24 and 27 November 2023
* Verbal information provided on 1 December 2023 to the Commission by the current Chief Executive Officer (CEO) of the Home Service Provider

# Assessment summary for Home Care Packages (HCP)

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

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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

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

# Areas for improvement

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

**Standard 1**

Requirement 1(3)(a)

Ensure each consumer is treated with dignity and respect and their identity, culture and diversity valued, through provision of relevant information, instruction and training to staff.

Requirement 1(3)(b)

Show that care and services are culturally safe, through provision of relevant information and training to staff, as well as through the collation and dissemination of cultural preferences and identity

Requirement 1(3)(c)

Support consumers to exercise choice and independence through, including but not limited to, accommodating nutrition preferences, providing sufficient activities and outings, and giving staff relevant training and assistance.

Requirement 1(3)(d)

Demonstrate that consumers are supported to take risks if they choose, and that steps are taken to mitigate the potential impact of risks when possible

Requirement 1(3)(e)

Ensure that your systems support provision of information on an individualised basis and in an appropriate manner.

**Standard 2**

Requirement 2(3)(a)

Demonstratethatassessment and planning includes consideration of risks to the consumer’s health and wellbeing and informs the delivery of safe and effective care and services for each consumer, by ensuring that care planning documentation is up to date and includes all relevant information.

Requirement 2(3)(b)

Ensure that assessment and planning consistently identifies and addresses consumers’ current needs, goals and preferences and that care planning documentation matches the actual services provided to consumers.

Requirement 2(3)(c)

Ensure that clinical service providers, allied health professionals, GPs and other providers of care and services are involved in both the care of consumers and in ongoing assessment and planning.

Requirement 2(3)(d)

Demonstrate that 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)

Implement a robust process for regularly reviewing care plans and ensuring timely review of care plans following changes in circumstances.

**Standard 3**

Requirement 3(3)(a)

Ensure that personal care needs are identified and are informed by clinical needs of consumers, including by implementing a process to ensure oversight of personal care and coordination of personal and clinical care

Requirement 3(3)(b)

Implement systems and processes to ensure management of high impact or high prevalence risks, at the individual level through personalised risk prevention or minimisation strategies, and systemically through the recording and analysis of incidents and adjustment of practices.

Requirement 3(3)(c)

Ensure that sufficient information is collected and recorded on the clinical or complex care needs of all consumers and make certain that engagement with consumers occurs when their health conditions change, so that a coordinated approach is taken to meeting the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, and that their comfort is maximised and their dignity preserved.

Requirement 3(3)(d)

Implement effective systems and processes to ensure that changes to a consumer’s function, capacity or condition is recognised and responded to in a timely manner, including undertaking risk assessments, taking and reviewing progress notes, adequate care plan reviews, and collecting and using feedback from staff, representatives, and consumers about the consumer’s condition.

Requirement 3(3)(e)

Implement processes in place to ensure relevant information about the condition of consumers is communicated between parties involved in their personal and clinical care.

**Standard 4**

Requirement 4(3)(a)

Ensure that each consumer gets services and supports for daily living that meet their needs, goals, and preferences, including provision of domestic care in the home and providing a sufficient number and variety of outings.

Requirement 4(3)(b)

Demonstrate an understanding of what is important to individual consumers and how the provision of a flexible service supports the well-being of the consumer, through ensuring care plans have sufficient detail to guide care staff in supporting a consumer’s emotional, spiritual, and psychological needs.

Requirement 4(3)(c)

Provide consumers with ample opportunity, based on their needs and preferences, to participate in their local community and do the things that are important to them.

Requirement 4(3)(f)

Implements systems to ensure that meals are varied and of suitable quality and quantity, and suitable for consumers individual requirements.

Requirement 4(3)(g)

Implement a system of monitoring and review of equipment to ensure ongoing safety, suitability, cleanliness, and maintenance.

**Standard 6**

Requirement 6(3)(d)

Implement an effective feedback and complaints system that improves the delivery of care and services.

**Standard 7**

Requirement 7(3)(a)

Ensure 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.

Requirement 7(3)(b)

Address identified deficits in both training and instruction for current and new staff and staffing levels, to support ongoing, positive interactions between staff and consumers.

Requirement 7(3)(d)

Ensure there is adequate recruitment, training and support given to your workforce to deliver the outcomes required by the Aged Care Quality Standards.

**Standard 8**

Requirement 8(3)(a)

Ensure that consumers are engaged in the development, delivery and evaluation of care and services by, including but not limited, acting on formal and informal feedback, and ensuring adequate staffing levels to promote individual and group engagement.

Requirement 8(3)(b)

Ensure that the organisation’s systems and processes for promoting a culture of safe, inclusive, and quality care and services and ensuring the governing body is accountable for their delivery are effective and being adhered to.

Requirement 8(3)(c)

Implement effective organisation wide governance systems related to information management, continuous improvement, financial governance, workforce governance, regulatory compliance, and feedback and complaints, and monitor and evaluate their effectiveness.

Requirement 8(3)(d)

Implement effective risk management systems and practices related to managing high-impact and high-prevalence risks, identifying the abuse and neglect of consumers, supporting consumers to live the best life they can, and managing and preventing incidents, and monitor and evaluate their effectiveness.

.

# Standard 1

|  |  |  |  |
| --- | --- | --- | --- |
| Consumer dignity and choice | | HCP | CHSP |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Not Compliant | Not Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Not Compliant | Not 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. | Not Compliant | Not Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Not Compliant | Not 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. | Not Compliant | Not Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant | Compliant |

Findings

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

* Ensuring each consumer’s identity, culture and diversity is valued
* Ensuring care and services are culturally safe
* Supporting each consumer to exercise choice and independence regarding their care and services
* Providing current, accurate and timely information to consumers about their services.
* Supporting consumers to take risks and discussing the potential outcomes of those risks.

The service is:

* Respecting each consumer’s privacy and keeping their personal information confidential.

**As to Non-Compliant requirement 1(3)(a)**

The Assessment Team found that the service did not demonstrate that each consumer’s identity, culture, and diversity is valued. While staff interacting directly with consumers spoke respectfully about consumers and showed an appreciation of each consumer’s identity, and consumers did not report any issues with how they were treated; the Assessment Team identified several deficiencies related to consumer culture and diversity not being valued.

For example:

* The Assessment Team observed that interactions between staff and consumers were limited due to the lack of staff available at the service.
* Care planning documentation did not show the individual cultural needs of consumers are captured. Please refer to Standard 2 requirement 2(3)(a) for further information.
* The service does not support the workforce to understand the culture and beliefs of the consumers they provide care and services to. For further information, please refer to Standard 1 requirement (3)(b), Standard 7 requirements (3)(b) and (3)(d).
* Orientation and workforce training records did not demonstrate that staff are supported to meet this Requirement. For further information, please refer to Standard 7 requirement (3)(d).
* The service did not demonstrate that all consumers are informed of their right to be treated with dignity and respect. Of the 37 consumers receiving services, only 4 have been provided with a copy of the Charter of Aged Care Rights.

Whilst the Assessment Team did not observe any disrespectful interactions between members of the workforce and consumers, the service has not taken appropriate steps to ensure the diversity and culture of each consumer is valued and reflected in care planning documentation. All 37 consumers identified as being Aboriginal or Torres Strait Islander.

On 1 December 2023 Chief Executive Officer (CEO) of the Home Service Provider (HSP) verbally advised the Commission that they did not believe that the HSP was equipped to deliver the required quality of care and services and address the concerns raised by the Assessment Team across all Standards and requirements. They felt that the issues stemmed from a lack of local staff and lack of accommodation for (outside) staff.

I acknowledge that these statements do not directly address the specific findings of the Assessment Team and I have given them minimal weight. However, these statements indicate the HSP has limited capacity to implement required improvements for this and all other Non-Compliant Standards and requirements.

The HSP also provided a document which set out the actions it proposed to address the issues identified in this and all other Standards and requirements (the ‘planned actions’). These improvements include implementation of new or improved processes and systems, training, policies and procedures, and engagement with various organisations, relevant to all requirements of this Standard, with various completion dates between December 2023 and June 2024.

I have reviewed these planned actions as they relate to each Standard and requirement. They are comprehensive and directed toward the concerns detailed throughout each Standard, however I note these matters are in progress, and once implemented will take time to inform improvements.

In its written response in relation to this requirement the HSP disagreed with the Assessment Team’s findings. It stated that some care plans were observed by Assessment Team to have individual cultural needs recorded and this was specifically praised by the Assessment Team onsite, that Cultural Training is provided to staff and that scheduled training is provided by a local Aurukun Cultural Elder, including for new staff, and that nearly all clients have a received a copy of the Charter, with a laminated copy located on the walls of the foyer of the Chivaree Centre. However, no documentary of these claims was provided. Further, many of the improvements identified appear to be occurring on future dates.

The HSP also stated that the Assessment Team only requested to see client files in the last hour of the onsite visit and about 15 were provided immediately. It also stated that the Assessment Team declined to look through these client files, saying that they did not have time to look through them.

I have considered that submission and note that in this and other requirements and Standards the Assessment Team reported that it had reviewed care files and other documentation, and that of the files and documents reviewed the stated deficits were commonly identified. I am satisfied that sufficient files were reviewed to indicate the identified deficits existed, and that the deficits were neither isolated nor minor.

Further, while no adverse interactions were observed, I have given weight to the Assessment Team’s observation that interactions between staff and consumers were limited due to the lack of staff available at the service. Further, I consider that the deficits in training and instruction for current and new staff do not support ongoing, positive interactions between staff and consumers.

**As to Non-Compliant requirement 1(3)(b)**

The Assessment Team found that the service did not demonstrate that care and services occur in a manner which is culturally safe and did not demonstrate an appropriate understanding of this Requirement. The workforce is not supported to understand and appreciate the unique cultural background of consumers.

For example:

* Several consumers expressed a desire to incorporate bush tucker into their care and services. The Assessment Team did not identify any evidence to show that the service knew about this or had made enough effort to accommodate the consumer requests.
* Staff advised that they do not receive any cultural awareness training when commencing with the service. Management is tasked to provide staff with a brief overview of some cultural considerations to be aware of within the community of Aurukun, however, this has not been occurring. Please refer to Requirement 7(3)(d) for further information.
* Staff interviewed advised they use their own knowledge and experience to deliver what they consider to be culturally safe care.
* Sampled consumer care plans contained little to no information about the cultural background of consumers.
* The service does not have sufficient staff to meet any gender preferences of consumers, should it be requested. Management noted to the Assessment Team that this is a factor that needs to be considered during interactions with the consumer cohort.
* Management acknowledged that the service is not currently providing staff with any specific cultural awareness training and that the induction provided on commencement with the service only provides a brief overview of cultural considerations to be aware of within the community. 37 of 37 consumers are identified as being Indigenous; however, staff are not being provided with any type of cultural safety or awareness training specific to the community.
* Management spoke of a training guide available to staff when commencing with the service, though staff advised they had not yet completed this guide. Please refer to Requirement 7(3)(d) for further information. Management acknowledged that it is important staff are provided with enough information about the culture of consumers and the community. Management stated the service is currently in the process of finding someone most appropriate to deliver this training to staff.

In its written response the HSP disagreed with the Assessment Team’s findings. It stated that training by a local Aurukun Cultural Elder is scheduled, together with other relevant training including for new staff, and that that nearly all client files have a validated cultural Assessment Tool that identifies relevant information. However, no documentary of these claims was provided, and some of the actions appear to be occurring on future dates. Accordingly, I accept the findings of the Assessment Team.

**As to Non-Compliant requirement 1(3)(c)**

The Assessment Team found that the service did not demonstrate that consumers are able to exercise choice and independence, including making decisions about their own care or communicating their decisions.

For example:

* Consumers advised they are only given limited options regarding their care and services. Several consumers said they are unsatisfied with the types of food they are currently receiving, stating they do not get enough variety and are limited in what is available to them. Please refer to Requirement 4(3)(f) for further information.
* Consumers advised they would like to be able to engage in more activities provided by the service, including arts and crafts and group outings like fishing. Consumers stated they have advised the service of their preferences. Staff advised that due to workforce shortages they have not been able to provide activities or outings for consumers. New staff are currently exploring ideas for future activities. Please refer to Requirement 4(3)(c) for further information.
* Documentation reviewed contained no evidence that consumer representatives are involved in the assessment and planning process.
* The workforce does not receive any training related to consumer choice and independence. Please refer to Requirement 7(3)(d) for further information.

Management was recorded as acknowledging that there were very few services on offer at the time of the Quality Audit due to staff shortages and that consumers' choices aren’t facilitated.

In its written response the HSP disagreed with the Assessment Team’s findings. It stated that the Assessment Team was provided with several meal surveys and meal reviews undertaken by a Dietician, and that clients were taken on a fishing trip the week before the Assessment Team arrived, with a Risk Assessment of this activity being presented to the Assessment Team, and that very few clients have nominated a representative.

No documentary of these claims was provided, and some of the actions appear to be occurring on future dates. I note that under Standard 8 requirement 8(3)(a) I identified that meal surveys had been undertaken but not acted upon.

Further, while a fishing activity may have been recently held there was clear consumer sentiment on the need for more activities to be provided by the service, including arts and crafts and group outings like fishing. While the HSP stated that very few clients have nominated a representative, the evidence indicates that across the board that consumers are not being supported to exercise choice and independence.

**As to Non-Compliant requirement 1(3)(d)**

The Assessment Team found that the service did not demonstrate that consumers are supported to take risks if they choose or that steps are taken to mitigate the potential impact of risks when possible.

For example:

* Consumers advised the Assessment Team that they used to go on regular outings to Weipa to do shopping. However, consumers stated that the outings were cancelled due to a singular event involving a consumer actions. There was no evidence demonstrating the service considered alternate ways to manage these risks.
* The Assessment Team did not identify evidence demonstrating the service actively reviews risks it has identified. As a result, the service does not utilise risk mitigation strategies to improve outcomes for consumers.
* The Assessment Team did not identify evidence in consumer files demonstrating dignity of risk forms are completed when risks are identified.
* There was no evidence in consumer files demonstrating that conversations had occurred with consumers or representatives about options for how to manage risks associated with consumer choices, where the choice may potentially be harmful to them.
* The service does not utilise appropriate risk mitigation strategies to improve outcomes for consumers. High-impact and high-prevalence risks are not appropriately identified and managed using an appropriate incident management system. Please refer to Requirements 3(3)(b) and 8(3)(d) for further information.
* Staff have not received any training to assist them in identifying and managing risks associated with consumer choice. Please refer to Requirement 7(3)(d) for further information.

Management could not demonstrate an understanding of the importance of allowing consumers to take risks. The Assessment Team advised management that several consumers expressed a desire to have bush tucker incorporated into their services. Management responded by stating that they do not provide this option due to kitchen regulation concerns. However, the Assessment Team could not locate documented evidence demonstrating the service has actively assessed the risk and considered alternative solutions.

In its written response the HSP disagreed with the Assessment Team’s findings. It stated the Assessment Team was told that the service was looking at Weipa trips but did not have suitable vehicle for this. It detailed its efforts to borrow a suitable vehicle, which was unsuccessful, and how it had approached other organisations to provide transport services. It stated that this was all communicated to the Assessment Team onsite. It stated that the Assessment Team was provided as an example the Risk Assessment and Mitigation Form for the Fishing Trip undertaken the week before the Assessment Team were onsite.

No documentary evidence of these claims was provided, and some of the actions appear to be occurring on future dates. While efforts appear to have been made to provide transport, and a fishing activity organised and assessed, the evidence indicates insufficient consistency of effort to support the taking of risks.

In addition, I am satisfied that the Assessment Team reviewed sufficient information to satisfactorily support its findings.

**As to Non-Compliant requirement 1(3)(e)**

The Assessment Team found that the service could not demonstrate that information provided to each consumer is current, accurate and timely. Consumers are not provided with the information they need to make informed choices and decisions about the care and services they receive.

For example:

* The Assessment Team requested monthly statements for the sample of consumers who attended the Chivaree Centre during the Quality Audit. This information was not provided. Please refer to Requirement 8(3)(c) for further information.
* Consumers are not provided with copies of their care plans, schedules, and monthly statements. When this was put to management, they stated they do not provide paper copies of documentation because it is likely the consumer will burn the information in bonfires. There was no evidence to suggest the service considered this on an individual basis.
* Consumers are not provided with menus communicating meals that will be provided. As a result, consumers are unaware of what meals they will receive until the day of and cannot exercise choice regarding meal preferences.
* The service could not demonstrate that information is combined and documented when multiple organisations provide care and services. As a result, each organisation does not have access to timely and accurate information to provide to the consumer.
* Care planning documentation did not consistently include signed copies of the Charter of Aged Care Rights for all 37 consumers.

The workforce described strategies used to help communicate with consumers, including printing information at the Chivaree Centre. The Assessment Team acknowledged some of the barriers associated with communication at the service. However, many consumers do not attend the Chivaree Centre. The Assessment Team could not identify how information is communicated to these consumers, other than relying on transport/delivery staff to deliver verbal updates.

In its written response the HSP disagreed with the Assessment Team’s findings. It stated that nearly all client files have Health Summaries provided by a related organisation. The HSP stated this was highlighted to the Assessment Team onsite. It indicated it had over the years worked very closely to jointly care for clients, and had Memorandums of Understanding (MOU) in place. It stated that verbal updates are an extremely effective communication method for our clients who cannot read in English, or read in their language spoken at home, and that this was communicated to the Assessment Team onsite.

While I acknowledge the HSP’ statement about the inclusion of Health Summaries and relationships in place, this was not supported by documentation. I also acknowledge the commentary on provision of information verbally, particularly in the setting in which the service operates. However, on balance I do not consider the system is individualised, or sufficiently strong, to identify that information is always adequate and communicated effectively.

**As to Compliant requirement 1(3)(f)**

The service demonstrated that each consumer’s privacy is respected and personal information is kept confidential. Staff stated consumer information is stored securely in a locked filing cabinet that requires a key to access. Information regarding the service’s privacy policy and principles is available on the Council’s website. All sampled consumers reported that the service respects their privacy, and a privacy policy is in place which contains appropriate information that enables consumers to understand how their personal information is collected and used.

# Standard 2

|  |  |  |  |
| --- | --- | --- | --- |
| Ongoing assessment and planning with consumers | | HCP | CHSP |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Not Compliant | Not 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. | Not Compliant | Not 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. | Not Compliant | Not 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 | 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 | Not Compliant |

Findings

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

* Considering risks to the consumer’s health and well-being to ensure the delivery of safe and effective services.
* Working in partnership with the consumer and others they wish to be involved in their care and services to ensure that assessment is effective in assessing individual consumers’ needs, goals and preferences.
* Collaborating with other organisations and providers of care, such as general practitioners and allied health professionals.
* Documenting consumer's care and services plan including regular reviews and risk assessments.

**As to Non-Compliant requirement 2(3)(a)**

The Assessment Team found that the service did not demonstrate that assessment and planning, including consideration of risks to the consumer’s health and wellbeing, informs the delivery of safe and effective care and services for each consumer.

While the service does not provide direct clinical care, Chivaree Centre staff are responsible for coordinating care and services for both Home Care Package (HCP) and Commonwealth Home Support Program (CHSP) consumers. Services that are funded to be provided to CHSP consumers include domestic assistance, personal care, individual and group social support, home maintenance, meals, and transport.

Management reported that there was a turnover of experienced staff last year which resulted in the Chivaree Centre being closed for a period. At the time of the Quality Audit, the service had a newly appointed Centre Manager and a Coordinator who had both commenced very recently.

The Coordinator reported that on commencement in the role, they recognised significant gaps in documentation, including missing and outdated care plans. Four HCP consumer and 1 CHSP consumer’s care planning documents that had been recently updated and signed were reviewed. Of the consumer files reviewed, sighted assessment documents were not completed thoroughly. A comprehensive assessment had not been conducted for each consumer that considered all relevant information. For example:

* For each consumer there is no evidence that a validated assessment tool was used to ascertain the level and nature of the risk to inform the delivery of care.
* There was no evidence that the service is using current information from other sources, such as My Aged Care (MAC) or General Practitioner (GP) patient health summaries or information from the clinic, to share and combine relevant information relating to the care of each consumer.
* Care planning documentation included an Aboriginal and Torres Strait Islander assessment form that contains specific cultural questions relating to outings, creative activities, lifestyle preferences, special days, special dietary customs, and religious practices. However, within the care plans reviewed, these sections were not completed.
* Assessment and planning was not effective in identifying or addressing the risks associated with chewing and swallowing difficulties, despite most consumers having compromised teeth, and 6 consumers being identified as requiring texture-modified meals.
* The Coordinator said they do not have oversight of those consumers who require continence aids. Currently, they are issued based on consumers requesting them.

The Assessment Team noted that key risks for each consumer were not consistently identified or assessed, therefore strategies to manage those risks were not documented. For example, one consumer on a HCP level 4 had a care plan signed on 5 October 2023. That care plan identified they have diabetes, continence issues, reduced mobility, pain in their left knee, and compromised teeth. The service was unable to demonstrate assessment of any risks that might be associated with mobility, pain, continence and swallowing.

While the service has referred that consumer for an OT assessment for replacement mobility aids, documentation did not include a falls risk assessment or contain strategies to minimise the risk of her falling. Other deficiencies were identified in relation to this consumer, such as their care plan noting soft foods are to be provided, but there was no further detail relating to their meal and dietary requirements, and no further information on how their diabetes is managed or whether there is any associated risk. Information in their care planning documentation included a GP patient health summary from 2020 and notes from a case conference including GP, RN, and specialists in 2021 relating to their chronic kidney disease and knee pain. This information was observed to be outdated, and there was no evidence that the service has been asking for input from relevant qualified practitioners about assessing and managing the specific risks related to that consumer’s health since 2021.

Another consumer had recently spent several weeks in respite care at Weipa Hospital. Their care plan dated 29 September 2023 did not document any health conditions or concerns, and management and staff were unsure of the reason they had been in respite care. Care planning documentation did not include hospital discharge paperwork or a recent patient health summary.

This information was given to management. The Centre Manager and Coordinator had identified that the current assessment and care planning process is not resulting in safe and effective care and services for each consumer. The Centre Manager explained how they plan to undertake new comprehensive assessments for all current consumers to ensure all needs and risks are identified and care plans inform safe and effective care, which would include use of validated tools, care planning documentation to include strategies for managing identified risks to consumers, and care planning documentation would include the MAC summary and GP health summary for each consumer where possible.

In its written response the HSP disagreed with the Assessment Team’s findings. In summary, it stated that over 15 files were given to the Assessment team which they did not review, that nearly all files evidenced thoroughly completed validated Assessment Tools has been completed for nearly all clients, using a tool developed for the Cairns Aged Care Assessment Team (ACAT), and that nearly all clients had Health Summaries in their files. It noted that the hospital discharge paperwork for the named consumer could not be located by the discharge RN at Weipa Hospital. However, no documentary of these claims was provided, and some of the actions appear to be occurring on future dates. While I acknowledge the plans that the Centre Manager and Coordinator plan to put in place to meet the outcomes of this requirement, they will take time to be implemented and to be effective.

In relation to the HSP’s comment that several files were given to the Assessment Team but were not reviewed, the Assessment Team reported that it had reviewed care files and other documentation, and that of the files and documents reviewed the stated deficits were commonly identified. I am satisfied that sufficient files were reviewed to indicate the identified deficits existed, and that the deficits were neither isolated nor minor.

**As to Non-Compliant requirement 2(3)(b)**

The Assessment Team found that assessment and planning has not consistently identified and addressed consumers’ current needs, goals, and preferences. For the consumers sampled, care planning documents were not reflective of their current care needs and were not tailored to consumers' cultural and personal preferences.

Management described some of the challenges associated with providing care in consumers’ homes, saying they have deemed it unsafe, due to various factors, for staff to enter consumer’s homes due to intermittent community unrest and vicious dogs. Additionally, the service does not currently have care staff, resulting in the centre being closed for a period. With the commencement of the new Coordinator the Chivaree Centre has reopened and is now offering a breakfast service.

At the time of the Quality Audit, the service was only offering meals and transport services, therefore, those consumers assessed as requiring personal care, domestic assistance and social support were not receiving the care and services they need to continue live at home. Consumers interviewed reported they did not always feel that their care and services are planned and delivered in line with their needs and preferences.

For example, one consumer expressed their disappointment that no one was helping them and for this reason was considering moving to another area. They stated they wanted help with cleaning her home and would also like to go on outings. Their care plan signed and dated 5 October 2023 notes personal care as a service being provided 7 days per week. However, the centre does not open on weekends and there are no care staff to provide personal care in the centre or in the consumer’s home.

Another consumer said they do not receive any care at home but they need help cleaning their house. They said the Centre could do with some more activities and outings. That consumer lives alone. There was no documented evidence in their home risk assessment to suggest that going into his home posed a risk to staff, other than the presence of dogs, however, this risk was captured as a generic note on all sampled consumers’ home risk assessments and was not specific to that consumer’s home

In relation to the identification of needs, goals and preferences for advance care planning and end of life planning, the service did not demonstrate that this is discussed with consumers during the assessment and planning stages. Given the cultural sensitivity in relation to this discussion, the Centre Manager explained they are aware of a support program for Indigenous people where they identify preferences such as going back to country and provide support in facilitating their requests. The manager said this will be considered further when reviewing assessment and planning procedures.

The Assessment Team provided feedback to management that services are not tailored to each consumer’s individual needs and preferences and care planning documentation did not evidence the service has considered different ways they can help each consumer to live a fulfilled, safe, and healthy life by trying to find a solution to the barriers faced in providing these services.

Management explained the challenges of providing the appropriate level of care due to not having care staff to deliver care in the home or at the centre. However, the service did not demonstrate that they have taken the appropriate steps to recruit care staff. Please refer to Requirement 7(3)(a) for further information.

In its written response the HSP disagreed with the Assessment Team’s findings. It stated that social support is provided at the centre and in the community, and that clients are taken shopping, to community events and to funerals. It also stated laundry and showering are also provided at the Centre for those clients who request this service. It further noted that several recruitment drives had taken place. I have considered this information and do not consider it shows that assessment and planning consistently identifies and addresses consumers’ current needs, goals and preferences as articulated by the Assessment Team.

**As to Non-Compliant requirement 2(3)(c)**

The Assessment Team found that the service did not demonstrate that assessment, planning and review of the consumer’s care and services are based on ongoing partnership with the consumers and others, including other organisations or individuals that are involved in the care of the consumer. Care planning documentation identified and management confirmed that clinical service providers, allied health professionals, GPs and other providers of care and services involved in the care of the consumer are not consistently involved in ongoing assessment and planning by the service.

For example, one consumer said they recently returned from Cairns after receiving a treatment, however their care plan did not contain documented evidence of recent communication with external services who are involved in their care.

Management said that a consumer had been away for weeks in respite in the Weipa hospital, and that QLD Health should have conducted an ACAT assessment as their health had declined. Management said that QLD Health have case management meetings but do not include the service in the meetings. However, the service did not provide evidence that they were partnering with QLD Health to understand that consumer’s needs.

While the service advised that some consumers go to the QLD Health Clinic every day for insulin administration, staff confirmed there is no diabetes management plan or monitoring information from the clinic in their care plans. These was no evidence of regular structured meetings with the service in the past with the Apunipima Health Clinic, and staff form this Clinic confirmed this.

The Assessment Team provided feedback to management who acknowledged the gaps identified. The Centre Manager and Coordinator have put arrangements in place with specialists at Apunipima Clinic to share and combine relevant information about any risks to consumer’s safety, health, and well-being.

In its written response the HSP disagreed with the Assessment Team’s findings. In summary, it stated that health summaries were on consumer files and that the service had made numerous attempts to be part of case meetings with the clinic and QLD Health. MOUs were in place. It felt that liaison between organisations is a joint responsibility, and that the QLD Health GP has been invited and has now joined the Quality Care Advisory Body that will commence in December 2023. It stated it has also had a consultation crew from Queensland Health to visit the to improve continuity of care for Chivaree clients, as well as two weekly RN clinics and monthly GP clinics and allied health clinics as required and available.

No relevant documentation was provided in support of these claims. Further, while I acknowledge these improvements, they will take time to be implemented and to be effective. In addition, I am not satisfied that these submissions demonstrate that other persons and organisations are consistently involved in ongoing assessment and planning by the service.

**As to Non-Compliant requirement 2(3)(d)**

The Assessment Team found that the outcomes of assessment and planning are not effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. The service did not provide evidence of a documented care plan for each consumer. Where a care plan was in place, the care plan did not always document outcomes of assessment, including assessment by the health clinic or other health professionals involved in the care of consumers.

Staff confirmed that not all care plans are current and said they are currently undertaking a review of care plans, and of the 37 consumers listed, the Assessment Team was provided with 5 consumer care plans that had been recently updated and signed by the consumer. The Assessment Team was unable to confirm if these updated care plans had been completed in partnership with the consumers, and the outcomes of the assessments discussed with the consumers.

The coordinator said they had updated approximately 20 single page care plans however; these were not signed by the consumers and were not provided to the Assessment Team. Management stated a documented plan is not provided to each consumer and/or their representative. Management also stated they do not provide outcomes of assessment and planning or documented care plans to other organisations, individuals or service providers who deliver care and services through brokerage arrangements.

In its written response to these matters the HSP stated that the Assessment Team did not request any client files until one hour before the closing meeting, and did not review those files, and that Client Care Plans and Client Agreements are in the client files. It also stated that the Chivaree Centre has only one subcontractor and they deliver meals to clients at their home.

No relevant documents were provided to support aspects of these claims. Further, in relation to the HSP’s comment that several files were given to the Assessment Team but were not reviewed, the Assessment Team reported that it had reviewed care files and other documentation, and that of the files and documents reviewed the stated deficits were commonly identified. I am satisfied that sufficient files were reviewed to indicate the identified deficits existed, and that the deficits were neither isolated nor minor.

In addition, the 5 consumer care plans that had been recently updated and signed by the consumer did not contain evidence they had been completed in partnership with the consumers, or that the outcomes of the assessments were discussed with the consumers.

**As to Non-Compliant requirement 2(3)(e)**

The Assessment Team found that the service did not demonstrate care and services are reviewed regularly for effectiveness when circumstances change or when incidents impact on the needs, goals, or preferences of the consumer. A review of care planning documentation did not demonstrate consistent regular reviews or services being adjusted in response to changes in the consumer’s condition changes, including when incidents occur. Not all care and services are reviewed on the agreed review date documented on the consumer’s care plan.

For example, the Coordinator said they had completed approximately 10 care plans when they commenced with the service. The Coordinator confirmed they had reviewed 5 consumers care plans that have been signed by the consumers and have completed single page plans for approximately 20 consumers that have not yet been signed by the consumers. The remaining consumer’s care plans are yet to be completed.

The Assessment Team was provided with one consumer’s care plan dated 29 September 2023. However, the care planning documentation did not contain information relating to that consumers recent change in condition or list their health conditions. There was no evidence of risk assessments or a comprehensive review being completed when that consumer returned to the community from respite care.

The manager explained how they plan to undertake new comprehensive assessments for all current consumers. Please refer to Requirement 2(3)(a) for further information.

Following feedback from the Assessment Team, management acknowledged the deficiencies identified. While management described the plan in place to ensure all consumer’s care and services are reviewed, at the time of the Quality Audit the service did not demonstrate the outcomes of this Requirement for HCP and CHSP services.

The HSP did not directly respond to these findings, however I have addressed the HSP’s response to the theme of these issues under other requirements. The evidence available to me indicates there is not a robust process for regularly reviewing care plans, or that there is timely review of care plans following changes in circumstances.

# Standard 3

|  |  |  |  |
| --- | --- | --- | --- |
| Personal care and clinical care | | HCP | CHSP |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Not Compliant | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant | Not 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. | Not Compliant | Not 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. | Not Compliant | Not 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. | Not Compliant | Not Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant | 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 | Compliant |

Findings

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

* Delivering personal care that is best practice and optimises the well-being of the consumer.
* Effectively managing high-impact and high-prevalence risks associated with the care of each consumer.
* Recognising and responding to deterioration or change of a consumer’s condition.

The service is:

* Ensuring timely and appropriate referrals to individuals, other organisations and providers of other care and services.
* Minimising infection-related risks through standard precautions to prevent and control infection, including COVID-19.

**As to Non-Compliant requirement 3(3)(a)**

The Assessment Team found that the service did not demonstrate that personal care provided to consumers is best practice, tailored to their needs, and optimises their well-being.

Clinical care, including nursing and allied health services, are provided by the Queensland Health Clinic and Apunipima Cape York Health Council. Management advised that the service has a Memorandum of Understanding (MOU) with these services and they are not subcontractors of Chivaree Centre.

While the service has consumers who are assessed as requiring personal care assistance, management confirmed that personal care was currently not being provided to consumers as there are no care staff to provide the care. The Coordinator did not understand how many consumers currently require assistance with personal care as face-to-face assessments had not yet been completed for all consumers.

One consumer’s care plan signed and dated 5 October 2023 notes personal care as a service being provided 7 days per week. However, the consumer stated they shower themself herself at home and does not require assistance with personal care.

The Chivaree Centre is equipped with 4 accessible showers. While the centre has reopened recently, personal care services have not resumed.

Management confirmed the service is not currently providing personal care for those consumers who need or prefer to receive care in their homes. Management stated this is due to the absence of care staff and due to the risks to staff entering consumer’s homes. For further information, please refer to Requirement 2(3)(b).

Care planning documentation did not contain input from relevant qualified practitioners about managing the specific risks to consumers' clinical care needs or evidence of regular communication with the health clinics regarding the care of the consumers.

Feedback was provided to management and staff highlighting concerns regarding the absence of face-to-face monitoring and a thorough understanding of consumers' current personal and clinical care requirements. In response to the feedback, the Centre Manager and Coordinator advised they planned to recommence providing personal care assistance at the centre, and had put arrangements in place with specialists at Apunipima Clinic to share and combine relevant information about consumers' clinical care needs.

However, Management did not accept the feedback provided by the Assessment Team, saying that the 2 health clinics in the community are responsible for communicating and sharing data with the service as part of their MOU. While the Assessment Team noted that the clinics are responsible for completing their own assessments of consumers' clinical needs, but stated there was no evidence that the service has adequately assessed the needs of each consumer, making sure the personal and clinical care is coordinated to reflect consumers’ individual needs and situations. This lack of oversight poses a risk to the health and safety of consumers and reduces their overall well-being and quality of life.

Given the absence of personal care being provided, the service did not demonstrate that consumers receive safe personal care that is tailored to their needs and optimises their health and well-being. The Assessment Team notes the deficiencies identified within this Requirement to be impacting both CHSP and HCP services.

The HSP did not directly respond to these findings, however I have addressed the HSP’s response to the theme of these issues under other requirements. The evidence available to me indicates deficits in the provision of personal care, including a lack of personal care being provided. I consider it is the responsibility of the HSP to ensure it adequately assesses the needs of each consumer, making sure the personal and clinical care is coordinated to reflect consumers’ individual needs and situations, and find there was a lack of oversight in this regard. And while I acknowledge the planned improvements, they will take time to become embedded and for the HSP to demonstrate their sustainability.

**As to Non-Compliant requirement 3(3)(b)**

The Assessment Team found that the service did not demonstrate all high-impact or high-prevalence risks had been identified or adequately assessed and as a result could not demonstrate how they are effectively managed. Care plans reviewed did not document individualised risk prevention or minimisation strategies to manage all high-impact and high-prevalence risks for consumers, including falls, diabetes management, choking, and cognitive decline. For example, one consumer was observed to have poor mobility and is awaiting an OT assessment for mobility aids. There was no evidence of a falls risk assessment being completed in their care plan dated 5 October 2023, or the identification of their being a high falls risk.

For consumers with risks associated with diabetes, there was no evidence of strategies documented to guide care staff in the management of those risks. The Coordinator acknowledged they do not have diabetes management plans for consumers living with diabetes. The Centre Manager and Coordinator identified that there is a risk for consumers with diabetes to have insulin administered after eating breakfast instead of prior to eating. However, the health clinic does not open until 9.00 am and consumers arrive at the centre for breakfast from 07.30 am.

Management said another consumer on a HCP L2 package has a regular routine of attending the centre for breakfast and then going to the health clinic for insulin administration. Their care plan did not evidence the service had considered the risks associated with diabetes. While the Assessment Team were not made aware of any incidents relating to that consumer’s diabetes management, the Centre Manager and Coordinator said they do not have the appropriate medical equipment available to help should the consumer experience hypoglycaemic and hyperglycaemic episodes. The Centre Manager and Coordinator said while they are both qualified to assist with medication, there is a challenge getting the medication from a pharmacy.

A review of care plans identified compromised teeth as a common condition among consumers, which can increase the risk of choking. Kitchen staff said they were aware of 6 consumers who required modified meals; however, the staff did not demonstrate an awareness of the risks associated with texture modified foods. Kitchen staff said they do not follow professional guidance when preparing texture modified meals and will generally make meals that are softer in texture for all consumers.

Kitchen staff said they were advised the week prior to the Quality Audit that another consumer now required pureed meals. The staff reported they blend the prepared meals for that consumer. The Assessment Team was not provided with care planning documentation for that consumer. The Assessment Team indicated that on this basis it was unclear whether this information had been updated in that consumer’s file. This evidence is equivocal and I have given it no weight.

Management said the service does not have specific strategies to help staff to provide care to consumers living with dementia and reported that details could be more specific in consumer notes. Management and staff described a named consumer as having cognitive decline. There was no documentation demonstrating that the service actively considered and assessed that consumer’s potential cognitive decline or identified strategies to manage risks associated which may impact on their safety in the community.

A review of the incident register found that not all incidents such as falls or hospitalisations were reported through incident reporting processes. For example, one consumer’s recent hospitalisation was not reported in the incident register. The service was not aware of the reason for that consumer’s decline in health or when they had been discharged from the hospital. Whilst that consumer’s care plan had been reviewed 9 days after her hospital discharge, there was no evidence of risk assessments being undertaken to understand and reduce their risks on returning to her home.

The Coordinator said the service does not maintain a consumer risk register to monitor consumers' risk status, any changes to this, actions taken and ongoing management strategies. The Assessment Team noted that without the identification of specific risks to consumers, the service is not able to demonstrate how they monitor and adjust practice in relation to high impact and high prevalence risks to achieve positive outcomes for consumers.

Following feedback, management acknowledged that there are areas for improvement in relation to strengthening the assessment and care planning processes, including improving the identification and management of risks associated with the care of each consumer. The Centre Manager identified improvements that will commence following the Quality Audit, including providing education to staff regarding incident reporting, the Serious Incident Response Scheme (SIRS), manual handling, and risk management, putting processes in place for delivery staff to report changes in consumer’s condition, and identifying incident trends and using the data to drive continuous improvement and implement strategies to minimise risks to consumers.

In its written response the HSP disagreed with the Assessment Team’s findings. It stated the Care Plan has a section on the individualised risk identification and management, and these were completed and included in the client files shown to the Assessment Team. It also stated that the Assessment Team mentioned these client risk assessments and suggested an improvement, which was accepted by Management, to improve the layout of the section to identify the mitigation strategies more clearly for each identified risk. No documentation was submitted to support this contention and I accept the Assessment team’s finding that care planning documentation reviewed did not evidence the documentation of risk or strategies to manage them.

The HSP also stated that the Assessment team did not request the file for a consumer whose dietary needs had changed to a pureed diet. As I stated above, the evidence in relation to this consumer is equivocal and I have given it no weight.

However, there is sufficient other evidence to indicate high impact or high prevalence risks are being effectively managed at the individual level as personalised risk prevention or minimisation strategies were not documented, or systemically as incidents were not being recorded or practices adjusted to achieve positive outcomes for consumers. And while I acknowledge the planned improvements, they will take time to become embedded and for the HSP to demonstrate their sustainability.

**As to Non-Compliant requirement 3(3)(c)**

The Assessment Team found that whilst the service does not provide direct end-of-life or palliative care, management and staff were not able to describe how care and services are adjusted for consumers nearing the end of life. Care planning documentation was not completed for each consumer, and where it was it did not include the consumer’s cultural, spiritual, or religious preferences relating to end of life care.

While the service was not aware of any consumers who required palliative or end of life care, this understanding was in the context of a general lack of information on the clinical or complex care needs of all consumers. For example, management and staff were unaware of a consumer’s health condition following their return from respite care in Weipa Hospital. Management said that consumer’s health had declined and QLD Health should have completed an ACAT review prior to her returning to them home. Management advised they were not invited to any meetings or case conferences and staff reported they were unaware of the reason that consumer was hospitalised or the risks to their health since returning to the community. They could not demonstrate that they took any other actions to inform themselves of her requirements, for example, speaking to the consumer or representatives or requesting a discharge summary.

The Centre Manager described strategies to manage possible cultural challenges and ensure that the wishes of consumers who may be nearing end-of-life are established. The manager said they planned to engage Community Connectors who facilitate monthly meetings with aged care service managers, and they offer support in palliative care, training, and education.

The HSP did not directly respond to these findings, however I have addressed the HSP’s response to the theme of these issues under other requirements. The evidence available to me indicates a lack of information on the clinical or complex care needs of all consumers and limited engagement with consumers when their health conditions change, and that these deficits inhibit the ability of the HSP to identify and address the needs, goals and preferences of consumers nearing the end of life. And while I acknowledge the planned improvements, they will take time to become embedded and for the HSP to demonstrate their sustainability.

**As to Non-Compliant requirement** **3(3)(d)**

The Assessment Team found that the service did not demonstrate changes to a consumer’s function, capacity or condition is recognised and responded to in a timely manner. Care planning documentation did not reflect the identification of and response to deterioration or changes in a consumer’s condition in a timely manner. There was no evidence of risk assessments, progress notes, adequate care plan reviews, and feedback from staff, representatives, and consumers about the consumer’s condition.

The Assessment Team considered that due to the current lack of in-home care provided to consumers, staff were not positioned to identify and respond to changes in the condition of consumers. The service could not provide direct examples of when it had responded to a deterioration.

For example, the service had noted the deterioration of a consumer who had recently spent several weeks in the Weipa hospital as their health had declined, however, issues associated with communication between the service and the local health clinic resulted in delayed notification. Management was not aware that the consumer had returned to the community, further demonstrating a breakdown in communication. In general, there was no evidence demonstrating members of the workforce document routine observations of consumer health and wellbeing.

The HSP did not directly respond to these findings, however I have addressed the HSP’s response to the theme of these issues under other requirements. The evidence available to me indicates that the systems and processes to respond to changes in health are limited and not effective.

**As to Non-Compliant requirement 3(3)(e)**

The Assessment Team found that while the service does not provide clinical care to consumers, it did not demonstrate consumers’ conditions, needs and preferences relating to personal care are documented and communicated within the organisation and with others where responsibility for care is shared.

A review of care documentation did not demonstrate effective communication processes in place so that those involved in the care of the consumer have information about delivering safe and effective personal care. There are no processes in place to ensure relevant information about the condition of consumers is communicated between parties involved in their personal and clinical care. For example, care plans did not evidence accurate, up-to-date, and relevant information is shared with others as consumers move between care settings, such as between home and hospital. Consumer files did not include dated notes and progress notes. One consumer’s care planning documentation did not include hospital discharge paperwork or a recent patient health summary. Changes in personal care needs were not clearly documented in their updated care plan which notes they use a commode for personal care but does not specify if assistance by the service is required.

In its written response the HSP disagreed with the Assessment Team’s findings. It stated progress notes are stored electronically on the ROCS software program and that the Assessment Team was advised of this while on site. No documentation or other evidence was submitted to support this contention and I accept the Assessment team’s finding that consumer files did not include dated notes and progress notes.

The HSP also stated the consumer’s care planning documentation did not include hospital discharge paperwork, and that it had requested it but it was not provided. I accept there were issues with securing this information from the discharging hospital, however I am not satisfied there were sufficient efforts expended in sourcing this important documentation.

**As to Compliant requirement 3(3)(f)**

The service demonstrated that timely and appropriate referrals are made to individuals and providers of other care and services. The Coordinator described the processes in place for making referrals and for the consumers sampled, they have been referred to other health professionals and service providers as appropriate. Whilst not present in consumer files, the Assessment Team observed email communication demonstrating that referrals to allied health professionals and other service providers occur when appropriate and in a timely manner.

**As to Compliant requirement 3(3)(g)**

The service demonstrated that it adheres to infection mitigation measures in relation to COVID-19, such as wearing Personal Protective Equipment (PPE). Staff and management described actions taken by the service to ensure the risk of consumers or staff contracting COVID-19 is minimised.

If a consumer chooses not to receive services due to the risks posed by infection, this will be respected. The Chivaree Centre has hand sanitisers throughout the centre and all visitors are required to sign in and out of the centre. Management advised that all staff are fully vaccinated against COVID-19. The service has a COVID-19 Plan in place and supporting policies and procedures related to infection control. During an outbreak, the Council put restrictions on visitors coming to the community to reduce the spread of infection.

# Standard 4

|  |  |  |  |
| --- | --- | --- | --- |
| Services and supports for daily living | | HCP | CHSP |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Not Compliant | Not Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Not Compliant | Not 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. | Not Compliant | Not 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 | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Not Compliant | Not Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Not Compliant | Not Compliant |

Findings

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

* Ensuring 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.
* Providing a wide range of services for consumers to support them to live the life they choose and remain connected to their community.
* Promoting consumers’ emotional and psychological well-being through compassion and connection between consumers and the workforce.
* Demonstrating that it supports the nutritional needs of consumers through assistance with meal delivery services if required
* Showing that where equipment is supplied, that it was clean, safe, suitable,

The service is:

* Communicating information about the consumer’s needs and preferences regarding assistance for daily living within the organisation and with others where appropriate
* Ensuring timely and appropriate referrals to individuals, other organisations, and providers of other services.

**As to Non-Compliant requirement 4(3)(a)**

The Assessment Team found that the service did not demonstrate that each consumer gets services and supports for daily living that generally meet their needs, goals, and preferences. The service is currently limited to providing meals in the centre and delivered to consumer’s homes, laundry services at the centre and transport services only. Yard maintenance is available through a subcontracted provider. The service is not providing any domestic assistance in the home and was not currently providing social outings.

Breakfast is served at the centre for those consumers who wish to attend and a breakfast and lunch delivery service is offered 5 days per week. Weekend meal packs are delivered on Fridays as the centre is not open on the weekend. For those consumers who do not attend the centre for breakfast, they receive meal delivery services and/or transport only.

The Assessment Team spoke with consumers who attended the Chivaree Centre for breakfast during the Quality Audit. Most of the consumer feedback indicated that services did not meet their preferences or were inadequate to meet their needs. For example, one consumer said they need help with cleaning her home, would like to go on shopping trips to Weipa and would like to go fishing. That consumer stated they had lived in Aurukun their whole life and used to go out hunting and fishing, and would like a bit more variety with activities and outings.

Another consumer said they get transport to the centre to have meals. They said they would like to be taken out fishing and would also like some help in the home. Another consumer said they would like to receive some care at his home.

Staff said they recently took some consumers out fishing, but this is not a regular occurrence. They said feedback from consumers was they would like to go fishing regularly and on bus outings and shopping trips.

Management said that when the service has enough staff, they would still be providing services in the centre rather than in consumer’s homes due to safety concerns. They were not able to substantiate that an assessment has been undertaken to determine risks and identify any potential controls for these risks, to improve their ability to provide services to consumers that are consistent with their needs, goals, and preferences.

In its written response the HSP disagreed with the Assessment Team’s findings. It stated that social support is provided at the centre and in the community. It stated that clients are taken shopping, taken to community events, and taken to funerals, and that laundry and showering are also provided at the Centre for those clients who request this service. It also stated that clients were taken on a social outing to go fishing in the week before the Assessment Team arrived and a risk assessment completed for the outing, and that this Risk Assessment was presented to the Assessment Team while onsite. I have noted this information but no documentary evidence of this was provided.

The HSP also stated the assessment of the safety of providing services in client homes is undertaken by Council and this is taken extremely seriously for the safety of staff and other clients. It stated that the Assessment Team did not request Management to substantiate that an assessment has been undertaken. It further stated services in client homes would recommence when care staff are employed. The Assessment Team were advised and shown the vehicle at the Centre in the garage that has been purchased and fitted out to provide services in client homes (including domestic assistance and personal care).

I acknowledge this information but it does not evidence that required or requested services in consumer’s homes was being provided.

**As to Non-Compliant requirement 4(3)(b)**

The Assessment Team found that the service did not demonstrate that services and supports for daily living promote each consumer’s emotional, spiritual, and psychological well-being. Care plans for the consumers sampled did not have sufficient detail to guide care staff in supporting a consumer’s emotional, spiritual, and psychological needs. While staff were observed to interact kindly with consumers, they did not consistently demonstrate an understanding of what is important to individual consumers and how the provision of a flexible service supports the well-being of the consumer.

For example, the care plan for a consumer identified they are unable to leave the house without assistance as they are an amputee and required assistance transferring to their wheelchair. Their care plan identifies they can be lonely because they cannot get out of the house on their own, and to encourage them to come to the centre. Staff said that consumer does not come to the centre as their house does not have a ramp, requiring their family to carry them down the 3 steps and place them into their wheelchair. Staff said it would be nice to see that consumer at the centre. The Coordinator said they would be discussing the need for a ramp for that consumer in their meeting the with QLD Government Department of Housing. For further information, please refer to Requirement 4(3)(e).

The Assessment Team observed the breakfast delivery run for that consumer noted there was no staff interaction with them as a carer met the staff at the gate to collect his meal. The Assessment Team found that the service was not taking any other actions to understand or address that consumer’s psychological or emotional needs.

The Assessment Team referenced another consumer whose care plan noted they tend to get in bad moods due to family problems and for staff to ensure they can relax throughout the day at the centre. The consumer stated they did not sleep well the night before and left her home due to issues in her neighbourhood. The Assessment Team spoke to and observed that consumer at the Centre, as well as staff interactions with that consumer and formed the view that limited support of the type required was provided.

The Centre Manager and Coordinator have plans to have the centre open throughout the day with the options of activities and rest areas, and the Coordinator has a meeting with the Department of Housing regarding the home modification process.

The HSP did not directly respond to these findings, however I have addressed the HSP’s response to the theme of these issues under other requirements.

The evidence available to me indicates that care plans for the consumers sampled did not have sufficient detail to guide care staff in supporting a consumer’s emotional, spiritual, and psychological needs, and that while staff were observed to interact kindly with consumers, they did not consistently demonstrate an understanding of what is important to individual consumers and how the provision of a flexible service supports the well-being of the consumer. Further, planned improvements will take time to enhance services and supports for consumers.

**As to Non-Compliant requirement 4(3)(c)**

The Assessment Team found that the service did not demonstrate that the services and supports provided to consumers enable their participation in the community, maintain social and personal relationships and do things of interest. Most of the consumer feedback indicated that they are not provided with an opportunity to participate in their local community and do the things that are important to them. Most consumers interviewed said they would like to be taken out fishing, go on bus outings and go shopping. One consumer said a lady at the centre used to take them fishing all the time but that does not happen anymore.

There are currently no activities running during the day and most consumers interviewed at the centre said they go home after breakfast as there is nothing to do there. When asked what they will do at home, most consumers said they have nothing to do.

Staff said the delivery drivers will continue to encourage consumers to attend the centre for breakfast when driving through the community. The Assessment Team observed staff delivering one consumer’s breakfast to the local art centre. Staff said that consumer is there most days so they always deliver their meal to the centre.

Feedback was provided to staff and management who acknowledged the gaps identified and provided examples of steps they are taking to provide opportunities for consumers to do things they enjoy and that they find meaningful, including:

* The Coordinator said, and the Assessment Team observed, they had cleaned up a room at the centre to start craft activities. The Coordinator has spoken to the local art centre coordinator about volunteering at the centre and bringing some tools and equipment for consumers to use.
* The Coordinator had other suggestions including having consumers visit the local school to talk with the children about dreamtime and local history.
* The service has recently engaged a sports and recreation officer who works in conjunction with a physiotherapist in Weipa to start chair exercises after breakfast. The Assessment Team observed the officer attempting to engage consumers in the activity however the consumers chose to leave the centre. The Coordinator said they will continue to schedule the activity to provide consumers with an opportunity to stay at the centre for longer.

Management said the local sub-contracted service provider has recently received funding for a bus that will be used for day trips and outings and the service would consider providing this as an option for consumers who wish to go on group social events.

In its written response the HSP disagreed with the Assessment Team’s findings. It stated there had been a fishing trip on the week before the assessors arrived and the Assessment Team were provided with this activity Risk Assessment. It also noted that The Assessment Team observed a staff member attempting to engage consumers in the activity however the consumers chose to leave the centre.

I acknowledge these matters which indicate some services and support are provided. However, these supports appear to be limited, and I have considered overwhelming consumer feedback suggesting further supports are required. And I while acknowledge improvements identified these are yet to be fully implemented.

**As to Non-Compliant requirement 4(3)(f)**

The Assessment Team found that the service did not demonstrate it supports the nutritional needs of consumers through assistance with meal delivery services if required. Assessments did not include discussions on the consumer’s nutritional and hydration needs and capacity to maintain overall health and well-being. For consumers sampled, assessments and care plans did not consistently reflect dietary needs and preferences and the assistance required by staff to support the consumer with managing their meals. Whilst a dietician provided a list of consumers who required texture modified meals and nutritional supplements to kitchen staff, this information was not included in care plans.

On the last day of the Quality Audit kitchen staff were observed to be busy and consumers were alone for periods of time with no staff to serve their meals. Some consumers called out to the Assessment Team for assistance with the meal service. The Centre Manager advised they understand the risk for consumers to be left unattended during meal service and confirmed they had discussed the importance with kitchen staff of maintaining a presence in the dining room while consumers are eating to identify and minimise any risks of consumers choking or falling.

During the meal delivery service, staff were observed delivering meals to consumers in their homes, or to family or representatives outside the homes. Staff did not have direct contact with all consumers when delivering meals.

Some of the consumer feedback indicated that there was not enough variety of meals and that breakfast items did not meet their meal preferences or were inadequate to meet their needs. Staff said the menu has not changed in 12 months, and consumers are not provided with choice or flexibility. Instead, consumers receive whatever meal is on the menu. Kitchen staff said they would not be able to accommodate all consumer preferences or specific dietary restrictions to ensure goals and preferences can be met.

Based on feedback from consumers who told the Assessment Team that they would like bush tucker, the team asked management if they have considered offering bush tucker on the menu. Management said they have not considered this option as this may not meet kitchen regulations.

The dietician from Apunipima Health Clinic said there is a high proportion of people in the community who are underweight and the risk for consumers is undernourishment. The dietician said that the meal service is adequate, however there is room for improvement of the menu. The dietician said the Coordinator recently provided a copy of the menu and weekend pack for review and input and felt the weekend packs are inadequate nutritionally. The dietician said the packs have not changed or improved since 2018.

The Assessment Team provided feedback to management relating to the feedback received about the meals and weekend packs. Management described the difficulties in sourcing and providing ingredients for the weekend pack, stating they know the packs are going into homes where they may not have power, so they provide non-perishable ingredients only due to consumers potentially not having the capacity to reheat or cook meals. However, the Assessment Team did not sight evidence in home risk assessments identifying the risk of consumers having the capacity to reheat or cook meals.

Management also described the challenges relating to the costs of ingredients and the staff requirements to pack the bags each week. Management said they have an arrangement in place with the local supermarket that pack the bags each week.

Management advised they had recently conducted a consumer survey relating to the meal service; however, they had not reviewed the results at the time of the Quality Audit. For further information, please refer to Requirement 8(3)(a).

In its written response the HSP disagreed with the Assessment Team’s findings. It stated that there are NOVOSOURCE drinks provided by the clinic and are delivered by Chivaree to client homes to supplement meals where required. Chivaree Centre has had several reviews of the meal service by dieticians, and that these reviews were presented to the Assessment Team.

It also stated that the Assessment Team was advised by Management that the Weekend Packs have changed many times over the years. It also stated that verbal evidence was provided to the Assessment Team that power is an issue in client homes. One client spoke with the Assessment Team themselves and said that they were out of power, this interaction was observed by Chivaree Centre staff.

I acknowledge some of the clarity provided but no documentary evidence was submitted to verify a number of these matters.

I am not satisfied that the HSP’s systems for ensuring meals are varied and of suitable quality, and suitable for consumers individual requirements are sufficiently developed.

**As to Non-Compliant requirement 4(3)(g)**

The Assessment Team found that while the service was able to demonstrate that equipment is provided, it was not able to adequately demonstrate how they ensure it is clean, safe, suitable, and well maintained for the consumer to use. Care planning documentation reviewed did not evidence a system of monitoring and review of equipment to ensure ongoing safety, suitability, cleanliness, and maintenance.

One consumer told the service that their scooter was 5 years old and needed repair. They said the seat is falling apart and parts of the scooter were moving and offered to bring it to the service to be reviewed. Staff at the service said they agreed with that consumer that they noticed the seat on his scooter was torn and needed repair however they could not describe what they were doing about this.

The Assessment Team observed 2 broken mobility scooters requiring repair or replacement. The Coordinator said there is currently no system or process to record and monitor equipment provided to consumers or repairs that are required. The Centre Manager said assessment and documentation of equipment will be included when they conduct comprehensive reviews of all consumers care and services.

In its written response the HSP disagreed with the Assessment Team’s findings. It stated that the Assessment Team were advised that the issue in relation to a named consumer’s scooter was investigated on the morning the Chivaree Staff were advised and that there was a similar broken scooter in storage that would allow the seat to be replaced and the front bumper to be replaced. No evidence was provided regarding when this occurred or where this was up to.

The HSP also stated that the recording and monitoring of equipment provided to clients occurs and is documented in a file and in clients’ progress notes, and that the recently employed Coordinator would not have been aware of this. No documentary evidence of this was provided, and in the absence of this evidence I accept the Assessment Team’s findings.

**As to Compliant requirement 4(3)(d)**

Staff could describe how they are informed of any changes about the consumer, relevant to their responsibility, such as changes to delivery instructions. Kitchen staff described the process for being informed of any updates to required meals, for example if texture modified meals are required. The Assessment Team observed delivery staff, the kitchen staff and the office staff sharing information prior to, and following, the daily meal delivery service.

Whilst care plans and the run sheet did not list identified risks or strategies, this is discussed further in Requirement 2(3)(a). Information about a consumer’s condition, needs and preferences for the limited services that were currently being provided were effectively documented and communicated within the service and with others where responsibility for care is shared.

**As to Compliant requirement 4(3)(e)**

The Assessment team found that the service did not demonstrate that referrals to individuals or other organisations occur, including providers of other services that can deliver services and supports to better meet consumer choices.

For example, management said the service has engaged a local subcontractor to clean the Chivaree Centre, and in the past has used this service to deliver meals to consumers’ homes when they did not have adequate staff or transport. However, there was no evidence to support that the service has considered using this subcontractor to provide domestic assistance in consumers’ homes.

In response to feedback provided by the Assessment Team, management said they had recently contacted the subcontractor to enquire about providing domestic assistance in consumers’ homes. At the time of the Quality Audit management said they were still waiting for a response to this enquiry.

The Coordinator identified that three consumers that had steps in their homes and required ramps. The Coordinator said they had arranged a meeting with the Department of Housing to understand the process for referring consumers for home modifications.

In its written response the HSP stated the subcontractor had been approached to undertake domestic assistance in clients’ homes, however they did not have the staff to undertake this service and said this was communicated to the Assessment Team.

I accept this submission and find this requirement Compliant. I have considered issues in relation to lack of domestic assistance under other requirements.

# Standard 5

|  |  |  |  |
| --- | --- | --- | --- |
| Organisation’s service environment | | HCP | CHSP |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant | Compliant |

Findings

Based on the evidence cited in the Assessment Team’s Assessment Contact Report, summarised below, the Home Service Provider (HSP) is, in relation to this service:

* Providing an environment that is clean, comfortable, well maintained and welcoming for consumers.
* Supporting consumers to feel welcome and safe and connect with others to the extent they wish.

**As to Compliant requirements**

The service environment was welcoming, with a layout that enables consumers to move around freely in a comfortable space. The service environment ensures that consumers feel welcome and optimises their sense of belonging. Consumers confirmed that the service environment is welcoming and clean and that chairs are comfortable. The Assessment Team observed the environment and corroborated the feedback provided by consumers. The Assessment Team observed that the service has various facilities available to consumers, however, as activities for consumers are not currently running these areas are not being utilised by consumers at the service. For further information, please refer to Requirement 4(3)(c).

The service demonstrated the environment is clean, well maintained, and comfortable, with appropriate noise levels, natural light, and temperature control. Consumers and other visitors can move freely around the environment, including indoors and outdoors, with easy access for those with mobility issues. Processes are in place to ensure the environment is clean and well maintained, with identified issues reported promptly and addressed to minimise hazards and potential risks.

Furniture, fittings, and equipment were observed to be safe, clean, suitable for use and well maintained. Staff described the processes in place to ensure the space remains suitable for consumers.

Staff and management explained that maintenance is monitored and addresses any emergent issues or required repairs. Repairs and professional services are engaged where qualified tradesmen are required.

Emergency management procedures are in place for the service to guide response, including evacuation options and coordination, fire, localised area flooding and severe weather, along with other emergencies or incidents such as building damage, air conditioning contamination, medical emergency, and lockdown (shelter in place).

# Standard 6

|  |  |  |  |
| --- | --- | --- | --- |
| Feedback and complaints | | HCP | CHSP |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant | 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 | 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 | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant | Not Compliant |

Findings

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

* Ensuring all feedback and complaints are recorded to enable appropriate analysis and support continuous improvement efforts.
* Responding to service-wide feedback regarding the provision of care and services.

The service is:

* Encouraging consumers to provide feedback about care and services delivered.
* Providing consumers with appropriate information to access advocates and other methods for raising and resolving complaints.
* Responding to individual complaints raised by consumers.

**As to Non-Compliant requirement 6(3)(d)**

The Assessment Team found that the service could not demonstrate that feedback and complaints are reviewed and used to improve the quality of care and services. The service could not demonstrate a best practice feedback system that improves how it delivers care and services.

The Assessment Team received a significant amount of feedback from consumers regarding the provision of care and services. Feedback generally discussed the services that they would like to receive, in addition to feedback about the meals provided at the Chivaree Centre. During the initial meeting for the visit, the Assessment Team asked management whether there were any identifiable trends regarding feedback. In response, management stated consumers have ‘high expectations’ regarding the provision of domestic assistance and yard maintenance however they did not articulate any themes or trends in the matters raised by consumers.

Despite the apparent quantity of feedback being provided to the service regularly from consumers, the issues raised by consumers and identified by the service as a common area of feedback did not appear in the complaints and feedback register. The Assessment Team provided feedback to the service that feedback being received was not being appropriately recorded for follow-up and higher-level analysis. As a result, management could not completely analyse and trend the most common areas of feedback on a regular basis. Further evidence listed below indicates that the service does not actively review feedback and use it to improve the quality of care and services:

* Consumers did not specify any service improvements made in the months preceding the Quality Audit relating to feedback provided from consumers, and the Assessment Team did not identify any evidence of the service sharing changes made in response to feedback with consumers.
* The service’s training register contained no evidence that staff are trained in using feedback and complaints to continuously improve the service. Please refer to Requirement 7(3)(d) for further information.
* The service’s induction policy did not contain any indication that staff are provided with information about complaints and how the service manages feedback.
* The service conducted a survey in September 2023 regarding meals provided by the service. At the time of the Quality Audit, the service had not instituted any changes recommended by the survey results and no summary documentation could be located by the Assessment Team. Notes on the complaints and feedback register indicate that the service was waiting for the new Chivaree Centre Manager to start before making any changes. In addition, management stated they were not aware of the results from the survey as they had not had time to review them.

The Assessment Team provided feedback to the service that valuable feedback was not being appropriately captured in the complaints and feedback register. Additionally, the Assessment Team communicated the importance of said feedback to allow analysis and shape continuous improvement efforts. Management and staff acknowledged the feedback and stated that more efforts would be made to capture all feedback received.

The HSP did not directly respond to these findings, however I have addressed the HSP’s response to the theme of these issues under other requirements. The evidence available to me indicates the service does not have an effective feedback and complaints system that improves how it delivers care and services.

**As to Compliant requirements 6(3)(a), 6(3)(b) and 6(3)(c)**

The service demonstrated that consumers are encouraged to provide feedback and make complaints.

The service advised that consumers are provided with a ‘client handbook’ that contains information about how to make a complaint and the consumer's rights in doing so. The handbook contains appropriate guidance for consumers to consider.

The information in the ‘client handbook’ is written in plain English and easy to understand. Members of the workforce could describe the steps associated with the complaints process and discuss the importance of receiving feedback. The new Coordinator recently conducted a survey shortly after commencing with the service to encourage feedback. However, the Assessment Team identified gaps associated with the recording of feedback received and ongoing consumer engagement at the service. For further information, please refer to Requirements 6(3)(d) and 8(3)(a).

Despite the gaps identified regarding the recording of feedback and consumer engagement, the Assessment Team considers that the service has taken appropriate steps to encourage feedback from consumers at a service level.

The service demonstrated that consumers are made aware of and have access to advocates, language services, and other methods for raising and resolving complaints.

The service advised that consumers are provided with a ‘client handbook’, which contains relevant information.

Staff provided the Assessment Team with additional information about how they ensure consumers are aware of how to make a complaint. This includes reminding them of their right to an advocate during recent assessment and planning discussions. Members of the workforce knew how to contact local advocacy and language services if required. The service employs a staff member who can speak the native language of the consumers and communicate their desire to make a complaint or contact an advocate if required.

The service demonstrated that when a complaint is received, appropriate action will be taken and that an open disclosure process will be used when things go wrong.

Members of the workforce demonstrated an appreciation for receiving feedback and knew what steps to take should a complaint be received. This includes utilising an open disclosure process when things go wrong. The Assessment Team was not provided evidence of an individual complaint occurring, and as a result could not observe these processes in practice. Despite this, staff demonstrated a sound understanding of what steps to take in the instance that a complaint is received.

The Assessment Team identified gaps associated with the appropriate recording of all feedback received and the service’s responses to group feedback such as the survey results. However, these gaps are primarily associated with complaints and feedback governance at the management level and service-wide issues. Given the statements provided by the new Coordinator and Chivaree Centre Manager, I am satisfied that future individual complaints will be appropriately managed and responded to. Therefore, the deficiencies associated with feedback and complaints are discussed further in Requirements 6(3)(d), 8(3)(a), and 8(3)(c).

**Standard 7**

|  |  |  |  |
| --- | --- | --- | --- |
| Human resources | | HCP | CHSP |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Not Compliant | Not Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Not Compliant | Not 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 | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Not Compliant | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant | Compliant |

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

* Providing appropriate training and support for staff to deliver the outcomes required by these Standards.
* Ensuring workforce interactions are respectful of each consumer’s culture and identity.
* Planning the workforce to enable the delivery and management of safe and effective care and services.

The service is:

* Monitoring and reviewing the performance of members of the workforce who have been with the service for an extended period.
* Ensuring members of the workforce are competent and have the experience necessary to perform their roles effectively.

**As to Non-Compliant requirement 7(3)(a)**

The Assessment Team found that the service could not demonstrate that the workforce is planned and that the number and mix of members of the workforce enables the delivery of safe and effective care.

Management stated that due to the remote location of the service and other local issues, employing and retaining new staff had proven difficult. Management advised of several steps

taken to recruit new staff to the service, however considering the care and service provision concerns identified these efforts were not considered to be sufficiently comprehensive. Evidence was cited in support of this contention and included:

* Management acknowledged that no Care Staff have been employed by the service for all of 2023. Management acknowledged that no in-home services have been provided throughout the entire year. Management stated no interviews have been conducted in 2023 to fill vacant Care Staff positions.
* The service did not provide any evidence of concerted efforts made to recruit Care Staff throughout 2023. The service acknowledged that no in-home services have been provided throughout the entire year.
* The Director’s monthly report to the Council provides no recurring updates regarding staffing levels or the need for recruitment at the Chivaree Centre.
* Consumers provided a significant amount of feedback that they wished to receive additional services in the home and would like additional activities to be run.
* The Assessment Team observed low staffing levels at the centre whilst present on site.
* Consumers stated that nearly every staff member was new and confirmed that they were not receiving any assistance in their homes.
* Members of the workforce confirmed that staffing levels at the service are insufficient.

The Assessment Team provided feedback to management that the workforce was insufficient to meet the needs of consumers. Additionally, the Assessment Team noted that there was no evidence demonstrating the service had made concerted efforts to recruit urgently needed Care Staff. Management disagreed with the feedback and believed that no more could be done to hire additional staff.

The service noted the challenges associated with delivering in-home care to members of the community due to local concerns. Management stated consumer homes can present an unsafe environment for staff to work in. The Assessment Team acknowledged that the issues raised can pose a challenge to the provision of in-home care, however, there was no evidence demonstrating the service had conducted thorough risk assessments of consumer homes. The Assessment Team found that any risk assessments observed were generic in nature and did not capture the individual risks of each consumer’s living environment. Management also stated efforts would be made in the weeks following the Quality Audit to employ new staff, however at the time of the Quality Audit, these efforts had not commenced.

In its written response the HSP disagreed with the Assessment Team’s findings. It provided details of positions that had been filled, stating that all such positions undertake caring services. It stated that the Assessment Team was advised that Care staff should preferably be local to be allowed in client’s homes and for housing, and that care staff vacancies were posted on the Council Vacancy Notice Board at Council, which it stated is the most proven and effective strategy for recruitment.

I have considered this submission and acknowledge the recruitment difficulties for this location. However, I am concerned about the evidence regarding limited care and service provision and related consumer feedback. I am not satisfied that the identified recruitment and recruitment processes are sufficiently robust or have fully addressed the staffing needs identified.

**As to Non-Compliant requirement 7(3)(b)**

The Assessment Team found that the service could not demonstrate that workforce interactions with consumers are respectful of each consumer’s identity and culture.

Whilst no negative interactions were observed between the workforce and consumers, several gaps identified at the service have created barriers to delivering safe and inclusive care that respects the culture of consumers. These included:

* The service could not demonstrate that new members of the workforce are trained in the history and culturally significant aspects of the remote community.
* Members of the workforce felt that new staff being brought in from outside the community were not sufficiently trained on cultural considerations and how to appropriately interact with the Indigenous consumers. This is discussed further under Requirement 7(3)(d).
* The current staffing model at the service does not support a culture of care and respect. The service does not employ sufficient staff to meet the individual needs of each consumer. Please refer to Requirement 7(3)(a) for further information.
* The Assessment Team did not identify any position descriptions for the staff employed by the service.

The Assessment Team provided this feedback to management. Management stated more efforts would be made to include cultural training in staff inductions.

In its written response the HSP disagreed with the Assessment Team’s findings. This included a statement that training is scheduled to be delivered by a local Aurukun Cultural Elder and that management was not asked to provide Position Descriptions for any position at Chivaree Centre. Further, the HSP stated that the Performance Review of one staff member who has been at Chivaree Centre for 12 months included feedback from the staff member regarding areas they would like training. It also stated that Management was not asked to provide the Position Descriptions for any position at Chivaree Centre, and that all Position Descriptions are available and would have been provided if requested from Management.

No documentary of these claims was provided. No position descriptions were submitted in the HSP’s response. In addition, many of the improvements identified appear to be occurring on future dates. Therefore, I accept the findings of the Assessment Team.

In addition, while no adverse interactions were observed, I have given weight to the Assessment Team’s observation, detailed in Standard 1 requirement1(3)(a) that interactions between staff and consumers were limited due to the lack of staff available at the service. Further, I consider that the deficits in training and instruction for current and new staff do not support ongoing, positive interactions between staff and consumers.

**As to Non-Compliant requirement 7(3)(d)**

The Assessment Team found that the service could not demonstrate that the workforce is recruited, trained, and supported to deliver the outcomes required by these standards.

The service provided its training and competencies register during the Quality Audit. From this register, the Assessment Team noted that only 5 training topics are noted (including first aid, cardiopulmonary resuscitation (CPR), food supervisor training, food handling, and fire drills), and that not all staff had completed all or some of these courses.

The Assessment Team found that the service has not provided sufficient support and training for staff to support their continued success and development. The 2 staff noted to have completed first aid and CPR training do not provide direct care. Staff providing direct care had not been trained or had not provided certification proving competency in these areas. Further, the service’s induction policy specifies that staff must be introduced to several Council policies, including but not limited to code of conduct, community disturbance, computer use, and workplace health and safety (WHS). In addition, an introduction to Indigenous culture is required. Sampled staff confirmed that this induction did not occur when starting at the service.

In addition, the induction policy stipulates that a record of the induction completion must be documented. The service did not provide any documentary evidence demonstrating that recently employed staff had completed the full induction, including training on Indigenous culture.

The service does not deliver or arrange training on important aged care related topics, such as manual handling, cultural awareness, and incident management. The Assessment Team provided feedback to management that the training and support provided to staff at the service was insufficient. The new Centre Manager provided the Assessment Team with a training calendar that showed intended training sessions to be conducted in the future. The future training session topics were relevant and appropriate to assist staff in delivering the outcomes expected by these standards.

The HSP did not directly respond to these findings, however I have addressed the HSP’s response to the theme of these issues under other requirements. The evidence available to me indicates there is inadequate recruitment, training and supported given to deliver the outcomes required by the Aged Care Quality Standards. I acknowledge planned improvements, but note these will take to engender improvements.

**As to Compliant requirement 7(3)(c)**

The service demonstrated that members of the workforce are competent and have the experience required to effectively perform their roles. The service’s processes for assessing and testing the competency of prospective staff showed that criminal histories are checked that staff recently employed by the service have appropriate work experience in aged care settings, and that the new Centre Manager has appropriate qualifications, including being an RN.

Deficiencies were identified in relation to the ongoing support and training of new staff at the service. However, staff who have been employed by the service have appropriate background experience and have undergone necessary competency checks. For further information regarding ongoing training and support, please refer to Requirement 7(3)(d).

**As to Compliant requirement 7(3)(e)**

The Service demonstrated that the performance of staff members who have been with the service for more than a year has been reviewed and assessed.

Members of the workforce noted that new staff are reviewed 6 months after initially starting employment with the service. The member of the workforce who has been with the service for longer than 12 months had their most recent performance appraisal in May 2023.

The structure for conducting performance appraisals was reviewed. The appraisal provides staff with the opportunity to discuss their performance, areas they would like to improve in, and clarify any questions they have about the role.

Management noted that the 6 monthly review of new staff is not used as a disciplinary tool, but rather an opportunity to discuss ongoing development of the staff member.

Identified gaps regarding staff training, support, and workforce governance are discussed in Requirements 7(3)(d) and 8(3)(c).

# Standard 8

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

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

* Demonstrating effective organisation-wide governance systems in relation to information management, continuous improvement, financial governance, workforce governance, regulatory compliance, and feedback and complaints.
* Ensuring the governing body promotes a culture of safe, inclusive, and quality care.
* Engaging and supporting consumers in the development, delivery, and evaluation of care and services.
* Implementing effective risk management systems and processes, including but not limited to managing high-impact or high-prevalence risks.

**As to Non-Compliant requirement 8(3)(a)**

The Assessment Team found that the service could not demonstrate that consumers are engaged in the development,delivery and evaluation of care and services.

At the time of the Quality Audit, consumers were receiving limited services due to a lack of staff at the service. Consumers were predominantly receiving meals and transport only, with no services being provided in the home. In relation to consumer engagement in the evaluation and delivery of services, the Assessment Team noted that the recommendations of a meal survey undertaken in September 2023 had not yet been implemented. Management stated they were unaware of the results of the 2023 meal survey. Further, it was not apparent that an external dietician’s recommendation from a meal survey in 2022 had been implemented.

Internal reports indicated that consumers had expressed an interest in pottery activities, however it was apparent no group activities were being conducted at the service. Desires for other activities, such as fishing, had not been fully met. In addition, a significant amount of feedback from consumers was provided which indicated they would like to receive additional assistance in the home and more variety in meals, however there was no indication in the complaints and feedback register that this feedback was being effectively captured and analysed.

The HSP did not directly respond to these findings, however I have addressed the HSP’s response to the theme of these issues under other requirements. The evidence available to me indicates that consumers are not engaged in the development, delivery and evaluation of care and services.

**As to Non-Compliant requirement 8(3)(b)**

The Assessment Team found that the service could not demonstrate that the organisation’s governing body promotes a culture of safe, inclusive, and quality care and services and is accountable for their delivery.

The Chivaree Centre Manager reports to the Director of Community Services, who is responsible for providing regular updates regarding the quality of care and services to the Chief Executive Officer (CEO), the Mayor, and elected Council members. Regarding the governing body’s promotion of a culture of safe, inclusive, and quality care, the Assessment Team noted that the Aurukun Shire Council’s Operational Plan for the 2022/2023 financial year contained no information relating to aged care or the Chivaree Centre. In its Corporate Plan 2020-2025, the only focus related to aged care is to provide a subsidised care facility to support elders in the community. There is no information regarding how the Council will measure the success of this focus and it does not specify what actions will be taken to meet this goal.

No documentary evidence was available to indicate the governing body requests information related to the performance and continuous improvement of the service. Reports to the Council regarding the operations of the Chivaree Centre are brief and do not provide sufficient information to enable appropriate monitoring of care and services.

Consumer surveys were not seen to be reported to the governing body. As a result, the outcomes sought and feedback provided by consumers did not appear to be appropriately communicated.

The Assessment Team provided feedback to management that information provided to the governing body regarding the operations of the Chivaree Centre is insufficient. Management did not directly address these matters.

The HSP did not directly respond to these findings, however I have addressed the HSP’s response to the theme of these issues under other requirements. The evidence available to me indicates that the organisation’s systems and processes for promoting a culture of safe, inclusive, and quality care and services and ensuring the governing body is accountable for their delivery are either not effective, or not being adhered to.

**As to Non-Compliant requirement 8(3)(c)**

The Assessment Team found the service could not demonstrate effective organisation wide governance systems related to information management, continuous improvement, financial governance, workforce governance, regulatory compliance, and feedback and complaints.

Information Management

The Assessment Team reported that throughout the Quality Audit it requested various pieces of documentation, which were provided after a long delay, not at all or incomplete.

Members of the workforce discussed difficulty accessing the information needed to provide care and services. Documentation surrounding care plans and consumer files could not be located easily. The Assessment Team reviewed the handover documents provided to the new Coordinator and found that much of the contact information listed was inaccurate.

The HSP did not directly respond to these findings. In relation to other requirements, it stated it had provided information to the Assessment Team. I have considered that submission under those other requirements, and find that sufficient information was reviewed to substantiate the findings of the Assessment Team.

Continuous Improvement

The service provided the Assessment Team with its continuous improvement plan, which contained appropriate entries relevant to the provision of aged care. However, the service could not demonstrate that progress of the continuous improvement items is reported through regular governance structures.

The Assessment Team reviewed the Director of Community Services reports provided to the Council for 2023 and could locate no reporting on the progress of continuous improvement efforts. As a result, the governing body is not informed of the progression of targets.

Financial Governance

The service could not demonstrate appropriate governance systems related to financial governance. Throughout the Quality Audit, the Assessment Team requested copies of financial documentation provided to the governing body and senior management of the service. The service utilises the assistance of a consultant who reportedly assists with Data Exchange reporting and end-of-financial-year figures. Several of the documents requested by the Assessment Team had not been provided.

The Assessment Team reviewed reports provided to the Council regarding the ongoing operations of the service. Monthly reports are prepared by the Director of Community Services which are then published on the Council’s website. Recent iterations of the report only provide the Council with the number of consumers currently receiving services. Since June 2023, no further information has been provided in writing. No iterations of the report in 2023 contain any financial information related to the operations of the Chivaree Centre. CHSP funding targets against outputs are not reported through this function.

Management stated that because the report is published on the Council’s website, sensitive financial information should not be included. In addition, management noted that the Council does not want the report to have more information than can be absorbed during the general meetings. However, it was noted by the Assessment Team that no confidential reports had been prepared concerning the Chivaree Centre or aged care.

Workforce Governance

The service could not demonstrate appropriate governance systems related to workforce governance. The service does not have a sufficient mix of skilled staff to ensure the delivery of safe and effective care and services. See requirements 7(3)(a) (recruitment of staff) and 7(3)(d) (not supporting and developing its workforce to deliver safe and quality care and services) for further details.

In addition, whilst on site, consumers were observed to be sitting alone and had to call out for assistance. Due to the lack of staffing, only kitchen staff were available to assist. No Care Staff were present. Further, the governing body is not informed regularly of staffing levels at the Chivaree Centre.

Regulatory Compliance

The service did not demonstrate effective governance systems related to regulatory compliance. Management of the service relies on the assistance of consultants to advise when changes to legislation may affect the ongoing operations of the service. The consultants advised the Assessment Team that when changes occur, training takes place to inform staff of the effect it may have on their roles. However, the Assessment Team could not find evidence demonstrating that this occurs.

The Assessment Team reviewed Director of Community Services reports in the lead-up to December 2022. Reports provided to the Council contained no information regarding the introduction of the SIRS or the Code of Conduct for Aged Care on 1 December 2022. There was no documentary evidence to support these statements. The service’s training register did not contain any entries related to SIRS or the Code of Conduct for Aged Care. Staff confirmed training related to SIRS and the Code of Conduct for Aged Care has not occurred.

Feedback and Complaints

The service did not demonstrate effective governance systems related to feedback and complaints. The service maintains a complaints and feedback register; however, deficits were identified regarding the recording of feedback and subsequent reporting to the governing body. In relation to feedback and complaints governance, see Standard 6 for additional details.

Further, the governing body is not informed of current feedback and complaints through regular reporting structures. Recent Director of Community Services reports contain no information related to the complaints and feedback register.

Management stated that reports intentionally withhold large amounts of information due to them being public and a desire not to over-encumber the governing body with information. However, this information could be summarised. Management acknowledged the Assessment Team’s feedback and stated more information would be included in future reports to try and increase oversight of the services provided at the Chivaree Centre.

In its written response the HSP stated that at no point were files requested during the first and/or second day, and that this only came until one hour before the closing meeting, which the Assessment Team declined to review.

I have considered that submission am satisfied that sufficient files were reviewed to indicate the identified deficits existed, and that the deficits were neither isolated nor minor.

**As to Non-Compliant requirement 8(3)(d)**

The Assessment Team found that the service could not demonstrate effective risk management systems and practices related to managing high-impact and high-prevalence risks, identifying the abuse and neglect of consumers, supporting consumers to live the best life they can, and managing and preventing incidents

Managing high-impact or high-prevalence risks associated with the care of consumers

The Assessment Team reviewed the service’s risk register, which identified a number of the aspects of its operation as high risk, including consumer falls, elder abuse and consumers not responding to a scheduled visit. However, the risk register contained little information demonstrating what the service is doing to mitigate these risks. Further, the Assessment Team found no evidence to indicate that high prevalence and high impact risks are reported to the governing body through regular reporting structures. In addition, the Assessment Team identified several examples of risks not being appropriately managed or responded to. Please refer to Requirement 3(3)(b) for further information.

Identifying and responding to abuse and neglect of consumers

The service identified elder abuse as a key risk associated with the provision of care at the service due to living circumstances, however the service has not undertaken risk assessments of all consumer living circumstances. Staff have not received any training in identifying and responding to the abuse and neglect of a consumer, and despite living circumstances and elder abuse being identified as a high recurrence risk to consumer wellbeing, there were no entries on the services incidents register regarding these instances.

Supporting consumers to live the best life they can

The Assessment Team identified that risks to consumer health and wellbeing are not always identified or appropriately managed. Furthermore, organisation-wide issues such as staffing deficiencies do not support consumers to exercise choice over their care and services. Please refer to Standards 1, 3, and 4 for further information.

Managing and preventing incidents, including the use of an incident management system

Whilst the service provided the Assessment Team with its incident register, only 4 incidents were recorded during the previous 12 months. Of the 4 incidents, only 1 involved a consumer. There was no evidence demonstrating incident data is analysed or used to drive continuous improvement efforts. Since June 2023, the subheading related to incidents in the Director of Community Services report has been removed. Further, the service could not demonstrate that staff had been trained on the service’s incident management system. In addition, the service could not demonstrate that staff had received training related to SIRS and their responsibility for identifying reportable incidents.

The HSP did not directly respond to these findings, however I have addressed the HSP’s response to the theme of these issues under other requirements.

The evidence available to me indicates that the service could not demonstrate effective risk management systems and practices related to managing high-impact and high-prevalence risks, identifying the abuse and neglect of consumers, supporting consumers to live the best life they can, and managing and preventing incidents.

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