**Performance**

**Report**

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| Name: | Balwyn Evergreen Centre |
| Commission ID: | 300549 |
| Address: | 45 Talbot Avenue, BALWYN, Victoria, 3103 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 9 January 2024 |
| Performance report date: | 14 February 2024 |

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

# Service included in this assessment

Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 8399 BALWYN EVERGREEN CENTRE  
Service: 25158 BALWYN EVERGREEN CENTRE - Community and Home Support

**This performance report**

This performance report for Balwyn Evergreen Centre (**the service**) has been prepared by K Jarvie, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the Assessment Team’s report for the Assessment contact (performance assessment) – site report, which was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the Assessment Team’s report received 31 January 2024
* the performance report dated 15 August 2023 in relation to the Quality Audit undertaken from 28 June 2023 to 30 June 2023.

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |
| **Standard 8** Organisational governance | **Not Compliant** |

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

# Areas for improvement

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

Requirement 2(3)(a) and Requirement 2(3)(d)

* Ensure assessment and planning processes are embedded and include consideration of risk, risk mitigation strategies or any potential impacts to the consumer’s health and well‑being.
* Ensure consumer care plans are up to date and contain relevant information to guide staff in the delivery of safe and effective care and services.
* Ensure outcomes of assessment and planning are effectively communicated to the consumer and documented in a care plan.
* Ensure care plans are provided to consumers and are available where care and services are provided, including for use by volunteers and subcontracted staff.

Requirement 8(3)(d)

* Ensure the workforce is trained in identifying and responding to abuse and neglect of consumers.
* Ensure systems and practices are embedded to manage high impact or high prevalence risks, including identifying and documenting strategies for managing those risks.
* Ensure consumer care plans are up to date and contain relevant information to guide staff in the management of high impact or high prevalence risks.

# Standard 2

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| Ongoing assessment and planning with consumers | | CHSP |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | 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 |

Findings

Requirement (3)(a)

Requirement (3)(a) was found non-compliant following a Quality Audit undertaken from 28 June 2023 to 30 June 2023. The service did not demonstrate:

* assessment and planning considered risks to the consumer’s health and well-being to inform the delivery of safe and effective care and services.

The Assessment Team’s report for the Assessment Contact undertaken on 9 January 2024 included evidence of actions taken by the service in response to the non-compliance. These actions include, but are not limited to:

* development of a continuous improvement plan with actions to address the non-compliance including:
  + annual re-assessments of all consumers
  + implementation of assessment and planning processes to ensure staff can deliver safe and effective care and services, including a consumer alert summary sheet outlining medical consideration and associated risk assessments
  + staff risk assessment training
  + review of the organisation’s structure to have a dedicated case manager to undertake assessments, care planning and care plan reviews as required and as scheduled.

The Assessment Team was not satisfied the service has made adequate progress towards addressing the non-compliance. The Assessment Team recommended Requirement (3)(a) not met and provided the following evidence relevant to my finding:

* While 6 of 6 consumers advised the service and staff are aware of their health conditions, including considerations which would put the consumer at risk such as diabetes or falls, this information was ineffectively documented in care planning and assessments.
* While staff described the risks to each consumer and were aware of each consumer’s health conditions, staff were not consistently aware of risk mitigation strategies associated with those risks.
* Documentation did not contain adequate information on health condition, risk strategies or valid assessments. Three of 3 exercise care plans were either absent or incomplete and exercise assessment documentation was consistently outdated. The Assessment Team’s report included examples of 3 consumers whose documentation did not include care plans or guidance and strategies on how to respond to identified consumer risks.
* The service maintains assessment and care planning policies and processes. However, these do not specify how any potential risks to consumers are monitored or managed.
* Management explained weekly staff meetings provide staff an opportunity to collaboratively discuss any concerns regarding consumers. Management also described monthly staff meetings which provide opportunities for discussions including improving consumer assessments and care plans. Management acknowledged the service had previously focused on direct consumer engagement which impacted capacity to undertake care planning and assessment documentation and noted the intention to allocate additional resources to enable effective consumer documentation. However, at the time of the Assessment Contract, risk assessments remained incomplete and care planning documentation was insufficient.

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

* explanation that priority areas for improvement were developed in September 2023, on commencement of the new Chief Executive Officer
* explanation that the online information management system and regular staff meetings were implemented after commencement of the new Chief Executive Officer
* explanation that all services are provided onsite at the service’s centre except for outings once a week and transport to bring consumers to the centre for activities.
* explanation that the exercise program was added to the list of services in May 2023 and the service has received multiple referrals of CHSP consumers since that time, with management explaining the service needs to catch up with care plans for all consumers.
* management acknowledged the importance of having up to date assessment and care plans for consumers.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows the service is not undertaking assessment and planning and is not including consideration of risks to the consumer to inform the delivery of safe and effective care and services.

I acknowledge the service has a plan for continuous improvement with actions to address the non-compliance. However, at the time of my finding, these actions have not been fully implemented or embedded.

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

Requirement (3)(d)

Requirement (3) (d) was found non-compliant following a Quality Audit undertaken from 28 June 2023 to 30 June 2023. The service did not demonstrate:

* effective communication of assessment and planning through a readily accessible plan for consumers at the point of care provision.

The Assessment Team’s report for the Assessment Contact undertaken on 9 January 2024 included evidence of actions taken by the service in response to the non-compliance. These actions include, but are not limited to:

* development of a continuous improvement plan with actions to address the non-compliance including:
  + assessment and planning which are adequately documented in care plans that are readily available where care and services are provided, including the development of accessible consumer information folders for subcontractor staff
  + assessment and planning documentation and reviews are communicated to consumers, including providing care plans to consumers or their representative as appropriate.

The Assessment Team was not satisfied the service has made adequate progress towards addressing the non-compliance. The Assessment Team recommended Requirement (3)(d) not met and provided the following evidence relevant to my finding:

* Consumers stated they have not received a care plan and consumers generally could not recall having completed a care plan.
* Staff stated consumer documentation, including care plans, were unavailable to volunteers and subcontracted staff involved in service provision.
* Staff stated the incomplete transfer of consumer documentation to the electronic consumer management system has resulted in documentation inconsistencies and delays in staff being able to access consumer documentation.
* Volunteers providing unsupervised transport services reported receiving no consumer documentation.
* Management acknowledged the need for improvement in information sharing and committed to developing processes to enable access to relevant consumer information for all staff involved in care and service provision, including subcontractors and volunteers.
* The Assessment Team’s report included examples of 4 consumers who have not received copies of their care plans.

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

* explanation that priority areas for improvement were developed in September 2023, on commencement of the new Chief Executive Officer.
* explanation that the processes the service uses to inform subcontractors and volunteers is not adequate and the service needs to update the way it shares relevant information to mitigate risks and deliver safe services to consumers.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows the service is not effectively communicating the outcomes of assessment and planning with the consumer, assessment and planning is not documented in care and services plans and care plan information is not available to the consumer and where care and services are provided.

I have placed weight on consumers stating they have not received a copy of their care plan, the workforce stating care plans are not available to volunteers and subcontractors and staff stating the incomplete transfer of consumer documentation to the new electronic management system has resulted in delays in staff being able to access consumer documentation. I acknowledge the service has a plan for continuous improvement with actions to address the non-compliance. However, at the time of my finding, these actions have not been fully implemented or embedded.

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

# Standard 8

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

Findings

Requirement (3)(c)

Requirement (3)(c) was found non-compliant following a Quality Audit undertaken from 28 June 2023 to 30 June 2023. The service did not demonstrate:

* information management systems were in place to manage consumer documentation, with inconsistent use of information management systems resulting in consumer information being inaccurate and not available to all parties involved in the consumer’s care
* a continuous improvement plan was in place but, did demonstrate continuous improvement opportunities were identified.

The Assessment Team’s report for the Assessment Contact undertaken on 9 January 2024 included evidence of actions taken by the service in response to the non-compliance. These actions include, but are not limited to:

* development of a continuous improvement plan with actions to address the non-compliance including:
  + implementation of an electronic consumer management system and planned development of accessible consumer documentation for subcontracted staff.

The Assessment Team found these improvements were effective and recommended Requirement (3)(c) met. The Assessment Team provided the following evidence relevant to my finding:

* Information management
  + Staff explained they are supported to improve their capacity to use the electronic information systems, including using the system to maintain consumer records. Management confirmed the electronic information management system has been implemented to support consistent management of information throughout the organisation. The service is currently transitioning to consistent use of this system.
  + Policies and procedures are available to staff through the electronic information system. Management acknowledged the transitioning of all documentation to this system is not finalised and consumer lists were not up to date at the time of the Assessment Contact. However, the service is working to ensure consistency in consumer lists and CHSP reporting.
* Continuous improvement
  + The service has developed and is using a plan for continuous improvement. Opportunities for improvement are identified through staff meetings and feedback, consumer feedback and complaints, incidents and analysis of annual consumer survey feedback.
  + Although the Assessment Team identified gaps in the expected completion dates on the plan for continuous improvement, this is identified as an area for improvement on the plan for continuous improvement. Management confirmed the service is moving towards determining and recording expected completed dates for each continuous improvement item.
* Financial governance
  + Management discussed and documentation supported the organisation has improved financial sustainability to enable the service to break even following substantial losses in previous years.
  + Fee schedules are provided to consumers as part of the welcome pack and discussions are held with consumers to support them in accessing CHSP subsidised services.
  + The service reports CHSP consumer service provision to the Department of Health and Aged Care and has policies and processes to ensure effective management of consumer co-contribution payments.
* Workforce governance
  + Management described and documentation showed the organisation has improved oversight of subcontracted staff competency and compliance through updated subcontractor agreements.
  + Management described how program coordinators are supported to identify areas of workforce shortage and the skills required.
  + Documentation showed staff performance reviews are consistently completed and the plan for continuous improvement includes an action to review position descriptions to ensure accountabilities and responsibilities are assigned.
  + The organisation has developed an improved training matrix to provide training to ensure staff can provide the outcomes as required by the Quality Standards.
* Regulatory compliance
  + Staff demonstrated compliance with police certification and vehicle inspection, maintenance and insurance.
  + Management advised the organisation will seek to keep driving licence records for staff and volunteers providing transport.
  + Management advised the organisation ensures the service and staff remain up to date on regulatory requirements through monitoring and disseminating legislative updates.
* Feedback and complaints
  + Management described increased focus on seeking consumer feedback following service delivery, as well as providing opportunities for consumers to provide written feedback at the service outlet.
  + Documentation showed the training matrix includes training for staff on best practice feedback and complaints handling and open disclosure.
  + The organisation maintains a feedback and complaints register including information about the complaint or feedback and actions taken to address the issues raised. Trends identified in feedback and complaints are discussed at regular staff meetings and used to inform continuous improvement actions.

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

* explanation that priority areas for improvement were developed in September 2023, on commencement of the new Chief Executive Officer.
* explanation that online information management systems, online accounting software and regular staff meetings were implemented by the new Chief Executive Officer.
* explanation that prior to September 2023, the organisation’s systems were heavily paper based, and it will take time for staff to learn new software and technology and different systems and to transfer all paper files to the online systems so they are more easily accessible and searchable.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows the service has implemented improvements to ensure it has effective organisation wide governance systems.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements have been made to address the previous non-compliance. I acknowledge the service has a plan for continuous improvement with actions to address the non-compliance and the service is still implementing and embedding these changes. While these actions have not been fully implemented or embedded, it is reasonable to accept the provider will continue to make improvements and embed these improvements.

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

Requirement (3)(d)

Requirement (3) (d) was found non-compliant following a Quality Audit undertaken from 28 June 2023 to 30 June 2023. The service did not demonstrate:

* effective processes to manage and document high-impact or high-prevalence risks associated with the care of consumers such as falls risks or diabetes
* training or guidance to staff to enable them to identify and respond to elder abuse and neglect, with staff unaware of policies and procedures to guide the identification and response to concerns of abuse and neglect of consumers.

The Assessment Team’s report for the Assessment Contact undertaken on 9 January 2024 included evidence of actions taken by the service in response to the non-compliance. These actions include, but are not limited to:

* improved assessment and planning including a consumer alert summary sheet outlining medical considerations and associated risk assessments
* implementation of risk management systems and practices to manage high impact and high prevalence risks associated with the care of consumers and to respond to abuse and neglect of consumers.
* Implementation of risk management systems and practices to manage and prevent incidents, including the use of an incident management system.

The Assessment Team was not satisfied the service has made adequate progress towards addressing the non-compliance. The Assessment Team recommended Requirement (3)(d) not met and provided the following evidence relevant to my finding:

* Managing high impact and high prevalence risks
  + Documentation showed the social support group service is undertaking care planning and assessment which identifies risk. However, risk management strategies are not identified and recorded to manage identified risks, including for diabetes management.
  + Documentation showed care planning and assessment is not consistently occurring for consumer attending the exercise classes and risks and risk management strategies are not consistently identified or recorded.
  + Documentation showed the service maintains a risk management framework inclusive of a risk management policy and risk management plan. However, the lack of effective or up to date consumer documentation presents a risk to consumers in the provision of safe and effective care and services.
* Identifying and responding to abuse and neglect of consumers
  + Staff stated they were not equipped to respond to elder abuse and neglect.
  + The organisation has not provided training to staff in identifying and responding to elder abuse and neglect.
  + While the organisation maintains an elder abuse policy and procedure, staff have not reviewed this document.
  + Compliance staff advised elder abuse and neglect training will be provided to staff in 2024. Documentation showed the training matrix for 2024 includes serious incident response scheme related abuse and neglect training. However, further training to support staff with practical skills to identify and respond to abuse is not included.
* Supporting consumers to live their best life
  + The organisation provides social support and exercise services to CHSP consumers to support them to live the best life they can, through improved social connectedness, skills development and exercise programs for varying levels of mobility and physical capacity.
* Managing and preventing incidents, including the use of incident management system
  + The organisation maintains an incident management system and has provided serious incident response training to relevant staff.
  + Management reported the service will ensure the incident management policy is available to staff through the electronic information management system.
  + Documentation showed the service is consistently using an incident system for consumer falls and vehicle incidents and is maintaining information related to the incident, actions required, and dates completed and reported.

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

* explanation that priority areas for improvement were developed in September 2023, on commencement of the new Chief Executive Officer
* acknowledgement that improvements could continue to be made to address risk management.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows the service has made improvements to address the non-compliance. However, the provider has not implemented and embedded all required changes and consumer risk continues to be inconsistently identified and risk management strategies continue to be lacking. In addition, staff have yet to receive training to identify and respond to abuse and neglect.

I have placed weight on the evidence in the Assessment Team’s report which showed there remains deficits in risk identification and management. Further improvements including training for staff is yet to be implemented. I acknowledge the service has a plan for continuous improvement with actions to address the non-compliance. However, at the time of my finding, these actions have not been fully implemented or embedded.

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

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