**Performance**

**Report**

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| Name: | Barkly Regional Council |
| Commission ID: | 600259 |
| Address: | 41 Peko Road, TENNANT CREEK, Northern Territory, 0860 |
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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: 7656 Barkly Regional Council  
Service: 24632 Barkly Regional Council - Care Relationships and Carer Support  
Service: 24631 Barkly Regional Council - Community and Home Support

**This performance report**

This performance report for Barkly Regional Council (**the service**) has been prepared by M Glenn, 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 clients/representatives, staff and management; and
* the provider’s response to the assessment team’s report received 19 December 2023.

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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

* Review information sharing and communication processes to ensure information relating to clients’ personal and clinical care needs is documented and effectively communicated to others, including to clients and/or representatives.

Standard 7 requirement (3)(e)

* Ensure regular assessment, monitoring and review of the performance of each staff member is undertaken in line with organisational processes.

Standard 8 requirements (3)(b) and (3)(c)

* Ensure the governing body is aware of and accountable for the delivery of care and services through review of communication and reporting processes from the service to the governing body and vice versa.
* Review the organisation’s governance systems in relation to continuous improvement.

# Standard 1

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| Consumer dignity and choice | | CHSP |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

All clients said they are treated with dignity and respect, and their identity and diversity are valued. Care plans included details about clients’ background, language spoken, who they are in the community, such as Elder, Traditional owner or if they participate on any local community committees, important customs, interests, what makes them happy and what annoys them. All support workers are from clients’ local community which assists them to support clients’ identity, culture and diversity. Staff were familiar with clients’ backgrounds and described strategies which help maintain clients’ identity, culture and diversity.

Clients said staff understand them and their cultural needs and deliver care and services with this in mind. Management described how the local culture is respected, such as not verbalising or writing the name of a deceased person and closing the facility out of respect during sorry business and said local staff advise on any community business.

All clients confirmed they are supported to exercise choice and independence and said staff respect their choices. Clients are supported to choose the types of services they receive, and the day, time and duration services are delivered, and are involved in decisions regarding the way care and services are delivered. All staff interviewed confirmed clients are at the centre of decision-making and dictate how, where and when care and services are provided.

Clients are supported to take risks to support their independence and staff were able to describe who those clients are, and how they are supported. Clients interviewed did not consider they undertook activities involving any risk, however, said staff are always respectful of their choice to live the life they want and support them any way they can. The organisation has a choice and dignity of risk policy and procedure which outline the responsibilities of staff to ensure clients have received sufficient information on identified risks and any potential negative outcomes, and all staff assist clients to minimise risk. Dignity of risk posters were displayed in all five facilities referencing the importance of respecting each client’s autonomy to make choices, even if they involve an element of danger, and the importance of staff providing support to minimise risks to clients and other staff.

All clients said the service provides up to date and timely information which is presented in a way that is clear, easy to understand and helps them to make decisions. Staff said they mainly communicate to clients verbally in the local language and explain relevant information and adjust the words they use to suit clients’ needs. There are processes to ensure each client’s privacy is respected and personal information is kept confidential.

Based on the assessment team’s report, I find all requirements in Standard 1 Consumer dignity and choice compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | | CHSP |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

Care files sampled demonstrated risks to health and well-being are identified through screening assessment processes on entry, documented and reviewed at six months and then annually. Care files included clients’ needs and preferences and assessed risks, as well as management strategies to inform the delivery of safe and effective care. Staff were aware of the assessment and planning processes and clients confirmed the service contacted them and undertook a home visit, discussed care and services as approved for the CHSP program and discussed care plans.

Care files included clients’ personalised needs, goals and preferences identified for every assessment. Staff described how conversations with clients and/or their representatives about what is important to clients informs assessment and planning of care and services. Team leaders said clients do not like being asked questions regarding end of life and most prefer not to answer as it is not culturally appropriate. Management said the local community health clinic or hospital would ask these questions if the client was terminally ill and assist them to develop plans to manage care.

Clients said they can talk with staff about their personal care, services and supports, and staff do their best to meet their wants and needs. They said the team leader will come and talk to them about their services and supports regularly and if they need anything changed, and other organisations, such as the local community health clinic, are involved in their care. Management stated communication with some of the local providers and health clinics can be challenging, and even if they chase information, it is not always forthcoming, however, they are beginning to build relationships with the local community health clinics and update all client patient medical summaries.

Outcomes of the assessment and planning processes are communicated to clients in a daily consumer plan and documented in the service’s electronic systems to guide staff in the delivery of care and services, and care plan reviews are completed in consultation with clients and/or representatives. Staff said care plans are current and contain sufficient information to deliver safe and effective services to clients. Clients confirmed staff communicate outcomes of their care plan assessments to them and considered themselves to be knowledgeable of their assessed needs.

Care files demonstrated clients are regularly reassessed and care plans updated when circumstances changed. Clients are reviewed six monthly or annually, with review dates recorded and monitored. Support workers said they have input into clients’ review and clients confirmed staff had recently engaged them in a discussion regarding their care, services and supports and said staff are responsive to any changes in circumstances or needs.

Based on the assessment team’s report, I find all requirements in Standard 2 Ongoing assessment and planning with consumers compliant.

# Standard 3

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| Personal care and clinical care | | CHSP |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Not Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

The Quality Standard is assessed as non-compliant as one of the seven requirements assessed has been found non-compliant. The assessment team recommended requirement (3)(e) not met.

**Requirement (3)(e)**

The assessment team were not satisfied information about clients’ condition, needs and preferences is consistently documented. The assessment team’s report included evidence indicating care plans for two clients did not include current information relating to living arrangements, attendance at the facility, or service and personal care needs. Progress notes had not been completed at three of the five facilities for over 18 months. Staff confirmed information about each clients’ condition, needs and preferences is discussed daily at the start of the day, all staff meet to discuss any issues within the community and staff are advised of changes such as health, social or personal care needs.

The provider’s response consisted of an action plan directly addressing the deficits identified. Planned actions include reinforcing completion of progress notes at a minimum of fortnightly, with exception reporting, as required, and processes to monitor completion. Client files will also be reviewed and review dates set; education on progress notes, documentation, assessment, risk and planning will be provided; quarterly case conferences with local health services will be implemented to discuss clients’ health status and care needs, with adjustments to care plans made in response.

I acknowledge the provider’s response. However, I find information about clients’ condition was not current, nor effectively documented. I have considered that while there are processes to review clients’ care plans at regular intervals and as required, care plans for two clients were not congruent with their current needs and circumstances. I acknowledge staff feedback indicating daily information exchange processes relating to clients’ condition, needs and preferences. However, records of clients’ changing needs and preferences are not being maintained, with progress notes at three of the five facilities not recorded at all for at least a period of 18 months. I consider this does not ensure the workforce has access to accurate information to enable an informed care and service review process to be undertaken or coordination and delivery of safe and effective personal and/or clinical care.

I acknowledge the actions planned to address the deficits identified. However, I consider time will be required to establish efficacy, staff competency and improved client outcomes in relation to this requirement.

For the reasons detailed above, I find requirement (3)(e) in Standard 3 Personal care and clinical care non-compliant.

**In relation to all other requirements in this Standard**, none of the service’s five facilities provide clinical care and do not have clinical staff. All clients access the community health clinic for their health needs. Personal care for clients at the service involves showering assistance for a small number of the clients, with most clients remaining active and mobile in the community and showering independently. Staff were aware of clients’ specific needs and preferences, describing those who preferred assistance from male or female staff only, as well as those who preferred to have morning or afternoon showers. Information and best practice updates from the industry is disseminated to staff through toolbox training and discussed in staff meetings. All clients interviewed expressed satisfaction with the personal care provided and said care delivered was safe and right for them.

The service has minimal high impact, high prevalence risks, with falls considered the most likely risk. Care files evidenced effective management of risks relating to falls and included strategies to minimise these risks. Care files also evidenced involvement of medical officers and allied health professionals in clients’ care. Team leaders described the process of a daily discussion relating to incidents or changes to clients' circumstances, and fortnightly management meetings are held with zone managers to monitor incidents or changes in condition of clients and environmental issues. Staff said they are informed of any new and emerging risks through daily discussions and were knowledgeable of management strategies for sampled clients.

The service’s five facilities are not equipped to care for clients requiring palliative care. Clients are commonly transferred to hospital for palliative care or managed at home by family members. Staff described processes for supporting clients who choose to remain in the community to receive care and services and said they would maintain connections and provide cultural or spiritual support where required. Staff spoke of efforts made to support clients’ cultural needs, such as transporting clients to areas in the community during ‘sorry business’. The organisation has a death and funeral policy and acknowledges cultural protocols will be followed, where possible, to enable family and community members to demonstrate respect for the deceased person according to local tradition.

Care files demonstrated a range of assessments had been completed on entry and an ongoing basis to identify and evaluate changes to clients’ health, condition and abilities. Client assessments are reviewed as part of the care plan review process to identifying areas of deterioration. Staff described steps taken when clients are unwell or when their condition changes, such as reporting to the team leader, and care files demonstrated staff identify deterioration or changes in client's condition and take appropriate action. Staff also routine welfare checks are conducted on every client when delivering meals twice per day. All clients interviewed expressed satisfaction with the care received and they considered staff act promptly and manage any changes in their health condition well.

Clients confirmed they have regular input from the multidisciplinary team and have access to the medical officer and allied health professionals when required. Staff described processes for referring clients medical officers and allied health professionals and said this is usually arranged by the local health clinic, with aged care staff informed when visiting professionals are attending community.

The organisation implements standard and transmission-based precautions to prevent and control infection and practices, such as medication reminders and encouraging clients to drink fluids to reduce the risk of antibiotic resistance. Sufficient supplies of personal protective equipment are maintained for use in the event of an outbreak and staff were aware of where and how to access these supplies. A COVID-19 outbreak management plan is in place and staff were aware of their responsibilities in the event of an outbreak. In the event of an outbreak, services can access and consult with the local community health clinic where trained clinicians are available for support and guidance. Staff were knowledgeable of infection control practices and confirmed training in infection control, including hand hygiene, is provided.

Based on the assessment team’s report, I find requirements (3)(a), (3)(b), (3)(c), (3)(d), (3)(f) and (3)(g) in Standard 3 Personal care and clinical care compliant.

# Standard 4

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| Services and supports for daily living | | CHSP |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Staff described how they support clients to achieve their daily living needs, goals and preferences, ranging from the promotion of independence in hygiene and grooming activities, to providing transport to clients to attend medical appointments or activities in the community. Care files demonstrated each client has been assessed and reviewed annually or as required to ensure personal care services and supports meet their needs, goals and preferences. Clients described how the services provided supports their interests and said they are supported to maintain their independence, with staff only helping when required.

Information obtained on entry and through care plan reviews ensures clients receive services and supports for daily living which promote their emotional, spiritual, and psychological well-being. Staff described their approach to supporting clients’ by providing culturally appropriate care, services and activities. Clients are supported to go out into the bush to get bush medicine and collect ashes for chewing tobacco. Staff will take clients to activities of their choosing, such as fishing, hunting trips and picnics. Staff also help clients access community activities and appointments. Daily consumer plans were current, and individual social support, group and centre base outings activities observed were reflective of clients’ documented interests. Clients said they do activities of cultural and spiritual significance and are connected to family and community.

Clients interviewed said staff know what they like and need, and care and services are regularly delivered in line with these preferences. Care files sampled had been recently reviewed, were reflective of clients’ current needs and preferences and accessible to staff and evidenced appropriate and timely referrals to medical officers and allied health staff. Progress notes are also maintained to keep staff up to date of changes in the clients’ health or well-being. However, progress notes at three of the service’s facilities had not been kept up or date due to staff shortages and staff changeover. All facilities have ongoing relationships with other services, including allied health, the aged care assessment team and the community health clinics and information is shared electronically. Staff confirmed information about each clients’ condition, needs and preferences is discussed daily at the start of the day, all staff meet to discuss any issues within the community and they are advised of changes, such as health or social issues.

Meals are varied, of suitable quality and quantity. Each of the service’s five facilities provides breakfast and lunch to clients Monday to Friday, with hampers provide for the weekends. Clients have the option to visit the service for meals or have them delivered to their home or another venue, such as community or the art centre. Staff described how they accommodate clients’ needs and preferences and how they seek feedback regarding menu changes. Clients were happy with the food provided and said it meets their needs and preferences, and they have a variety of meals to choose from.

Equipment provided for the care and services of the clients is safe, suitable, cleaned and well maintained. Staff described how equipment is cleaned and maintained, as well as the purchasing of additional equipment when required. Vehicles used to transport clients are regularly maintained, including through weekly checks to ensure they are fit for purpose. Clients felt safe using equipment to assist with their showers and lifestyle activities, and said equipment used is always clean, well maintained and meets their needs.

Based on the assessment team’s report, I find all requirement in Standard 4 Services and supports for daily living compliant.

# Standard 5

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

Findings

All five of the service’s facilities are welcoming and easy to understand with a clear entrance and easy to navigate spaces. All clients interviewed said the service environment is welcoming and gives them a sense of belonging and they feel welcome when they attend the facilities. Service environments at all five facilities were clean, well maintained, and comfortable, and enabled clients to move freely both indoors and outdoors. Garden and outdoor areas were maintained, grassed areas were mowed, and paths were free of obstructions. Reactive and scheduled preventative maintenance programs, supported by contracted services are in place, and there are established systems to monitor environmental risks and hazards, and evacuation plans were displayed. Overarching organisational and disaster management procedures are in place to maintain staff and client safety. Staff interviewed were familiar with actions to take in the event of an emergency and said they had completed fire emergency training as part of their induction process. All clients confirmed they feel safe when attending the facilities for social activities, showers or meals, and said service environments are clean.

Furniture, fittings and equipment at all five facilities is safe, clean and well maintained and suitable for clients. Sufficient equipment is provided for staff to undertake all requirements of their roles. Clients said the facilities have everything they need on hand, and they find the furniture comfortable and suitable for their needs.

Based on the assessment team’s report, I find all requirement in Standard 5 Organisation’s service environment compliant.

# Standard 6

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| Feedback and complaints | | CHSP |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

All clients at the five facilities said they know how to provide feedback and make complaints. They said if they ever had an issue, they would tell staff or the team leader directly and are confident the issue would be resolved quickly. Clients said they participate in surveys about food and care and services in general. The client handbook encourages clients to provide feedback, compliments and complaints and provides details of other organisations clients can contact if they want to speak to someone outside the organisation. All staff said they always ask clients if everything is okay during provision of care and services. If clients provide feedback or make a complaint, these are usually rectified immediately, however, they inform the team leader who completes a feedback and complaint form.

Clients said they know how to access other services if they need more help, and staff said they would not hesitate to contact advocacy services if requested. Indigenous staff are employed at all services and can speak local dialects and often act as interpreters. Information encouraging clients to provide feedback or make complaints was displayed, including information relating to advocacy services and the client handbook includes details of other organisations clients can contact if they want to speak to someone outside the organisation, such as the Commission and advocacy services.

Clients said they do not generally need to make complaints, however, when they ask for something, it is usually provided. A complaints and feedback register is maintained and included an overview of each complaint made, the resolution put in place and the date this was actioned. The complaints register references apologies being made to clients where appropriate. Staff described complaint handling systems and were aware of open disclosure principles.

Feedback and complaints are reviewed and used to improve the quality of care and services for clients. Zone managers and team leaders from all five facilities attend fortnightly meetings where information on new complaints or feedback received, as well as updates on existing complaints and feedback is provided. Clients’ feedback, complaints and suggestions are captured and recorded on the centrally managed feedback and complaints register, as well as on survey documentation. All complaints are reviewed at head office and the information collated to ensure all complaints are evaluated. Management track complaints data to identify trends and improvement opportunities. Clients said feedback and complaints are primarily given verbally and actions implemented are reviewed in consultation with them to ensure satisfaction.

Based on the assessment team’s report, I find all requirements in Standard 6 Feedback and complaints compliant.

# Standard 7

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

Findings

The Quality Standard is assessed as non-compliant as one of the five requirements assessed has been found non-compliant. The assessment team recommended requirement (3)(e) not met.

**Requirement (3)(e)**

The assessment team were not satisfied regular assessment, monitoring and review of the performance of each member of the workplace was demonstrated. The assessment team’s report provided evidence to indicate the staff handbook states performance appraisals are conducted annually. Management said staff at all levels of the organisation have not completed any performance appraisals since June/July 2022 due to changes to senior management. There are no schedules in place or reports detailing the percentages of staff with completed performance reviews and/or follow up of those who did not take part. A current system for assessing and reviewing new staff performance during the probationary period was not demonstrated. Seven staff confirmed they do not have regular performance reviews and were unable to describe how ongoing assessment of their duties, responsibilities and performance happens, or how this links into their performance development.

The provider’s response consisted of an action plan directly addressing the deficits identified. Planned actions include conducting staff performance reviews as soon as possible; and implementing a performance review due reminder process.

I acknowledge the provider’s response. However, I find ongoing monitoring of the performance of each member of the workforce was not demonstrated. In coming to my finding, I have considered the intent of the requirement which expects the performance of all members of the workforce to be regularly evaluated to identify, plan and support any training and development they need. Staff performance appraisals have not been conducted since June/July 2022, which is not in line with the organisation’s related policy referenced in the provider’s response. Staff interviewed also confirmed they have not participated in regular review of their performance.

I acknowledge the actions planned to address the deficits identified. However, I consider time will be required to establish efficacy, staff competency and improved client outcomes in relation to this requirement.

For the reasons detailed above, I find requirement (3)(e) in Standard 7 Human resources non-compliant.

**In relation to all other requirements in this Standard**, 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. A roster is maintained and management ensure the right number and mix of staff by considering the types of services each client requires and how long it takes staff to complete those duties. Staffing levels are also discussed at team meetings. Whilst there are challenges with ensuring continuity of the workforce due to the remoteness of facilities, management said staff are able to manage the workload to mitigate any impact to clients. Clients are happy with the number of staff, and the support provided by staff delivering care and services.

All clients said staff are kind, caring, respectful. Clients said many of the staff are family and they understand community and their relationships are respectful. They said staff are respectful of their choices and support them to express their identity and diversity. Staff said whenever they have contact with clients, they always ask how their day is going, check if everything okay and ask if there anything they need. Clients’ satisfaction with workforce interactions is monitored.

Clients said staff know what they are doing, the care provided is of good quality and they get the supports they need. Additional staff support and training requirements are identified through monitoring of incident, survey, complaint and feedback data. There are processes to monitor police clearances and qualifications to ensure staff are suitably qualified for their roles. Support workers said they undertake initial induction training, buddy shifts and mentoring when they commence employment to ensure they are familiar with clients’ needs and organisational processes. Staff said throughout their employment they participate in toolbox learning sessions delivered by the team leader.

Clients felt confident in the ability of staff to deliver effective care and services and said staff are well trained. A thorough onboarding process is undertaken for all new staff which includes mandatory training, an induction and buddy shifts. Staff said they felt they could raise concerns with their team leader regarding their training and felt supported to do so. Staff said they have completed mandatory training modules which are supervised and signed off by the team leader. Completion of mandatory training is monitored to ensure staff are appropriately equipped to undertake their roles. Toolbox training sessions are delivered to staff by team leaders on an ongoing basis. However, not all team leaders are monitoring what and when sessions are delivered or which staff have received the training.

Based on the assessment team’s report, I find requirements (3)(a), (3)(b), (3)(c) and (3)(d) in Standard 7 Human resources compliant.

# Standard 8

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| Organisational governance | | CHSP |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | 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 |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

The Quality Standard is assessed as non-compliant as two of the five requirements assessed have been found non-compliant. The assessment team recommended requirements (3)(b) and (3)(c) not met.

**Requirement (3)(b)**

The assessment team were not satisfied the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for service delivery. The assessment team’s report included evidence indicating the governing body does not understand the requirements to ensure performance of the organisation against the Quality Standards, including ensuring there are effective monitoring processes for them to meet its responsibilities under this requirement. The ordinary council meeting minutes for September and October 2023 do not include any information or trending in relation to continuous improvement, incidents, feedback and complaints, or clients’ overall care and services. Information discussed at area managers’ meetings, and zone managers and team leader meetings is not provided to, or tabled at ordinary council meetings. Management acknowledged the governing body is not informed of information in relation to continuous improvement, incidents, feedback and complaints, or clients’ overall care and services due to the recent changes to governing body personnel, however, said now the official manager and a new chief executive officer have been appointed, this information will be provided.

The provider’s response consisted of an action plan directly addressing the deficits identified. Planned actions include, but are not limited to, development of a new reporting template for aged care to inform the governing body of compliance with the Standards, as well as incidents, feedback and complaints, continuous improvement and clients’ overall care and services. An information session to the new governing body is also planned regarding aged care and their role as a provider.

I acknowledge the provider’s response. However, in coming to my finding, I have considered that reporting processes from service management to the governing body are not sufficient to ensure the governing body is aware of and accountable for the delivery of care and services. While information exchange processes occur at a service level, relevant information relating to key areas is not provided to the governing body to ensure they are aware of and accountable for delivery of care and services or to enable them to make informed decisions and set directions for the organisation.

For the reasons detailed above, I find requirement (3)(b) in Standard 8 Organisational governance non-compliant.

**Requirement (3)(c)**

Effective organisation wide governance systems relating to financial governance and regulatory compliance were demonstrated, however, the assessment team were not satisfied information management, continuous improvement, workforce governance, and feedback and complaints governance systems were effective.

The assessment team’s report included evidence indicating many policies and procedures were in the process of being created, while others were being updated to ensure compliance with current legislation. Staff had not been engaged in which policies and procedures were current and meeting minutes did not demonstrate issues relating to incomplete or outdated policies and procedures had been discussed. The organisation did not demonstrate how they monitor the electronic care system to ensure staff receive accurate information, with the assessment team referencing deficits identified in Standard 3 Personal care and clinical care requirement (3)(e).

The plan for continuous improvement (PCI) was not current and did not include any recent improvement actions across the Quality Standards. Most issues identified were associated with the 2020/21 financial year, with no new initiatives identified since August 2020. Continuous improvement is not discussed at monthly council meetings and while continuous improvement forms part of the area managers’ meetings, there are no minutes available.

A designated or trained infection prevention control lead is not in place. Regular staff appraisals have not been occurring and adequate monitoring to gauge staff competency and ensure performance is being regularly reviewed is not undertaken. Feedback and complaints are not discussed at monthly council meetings, and management were unable to describe how feedback and complaints are used to inform improvement activities.

The provider’s response consisted of an action plan directly addressing the deficits identified. Planned actions include, but are not limited to, undertaking review of policies and procedures for currency and compiling a register identifying review dates; providing PCI training to staff and adding the PCI to the area managers’ meeting agenda; and including feedback and complaints reporting and trends in monthly council reporting.

I acknowledge the provider’s response. However, in coming to my finding, I have considered that effective organisation wide governance systems, specifically relating to continuous improvement, were not demonstrated. I have considered that while a PCI is available, the plan is not current with no new initiative on the plan identified since August 2020. I have also considered reporting from the service to the governing body is not sufficient to enable the governing body to identify at both a service and organisational level where quality and safety is at risk or to enable improvement opportunities to be effectively identified.

While I acknowledge policies and procedures are in the process of being created or updated, the lack of policies and procedures available has not impacted staffs’ ability to undertake their roles. The assessment team’s report demonstrates clients have access to information relating to the care and services they receive and there are effective, verbal communication processes to ensure staff receive the information they need to deliver safe and effective care and services.

In relation to workforce governance, while I acknowledge regular monitoring of staff performance has not been undertaken, and an infection prevention control lead is not in place, I do not consider these deficits to be reflective of poor workforce governance. I have considered outcomes of four of the five requirements in Standard 7 Human resources demonstrates the organisation has processes to ensure sufficient skilled and qualified staff to deliver quality care and services, and there are processes to monitor the sufficiency of staff. While a designated infection prevention control lead is not in place, the service does not deliver clinical care or employ clinical staff. Where required, the organisation can access and consult with the local community health clinic where trained clinicians are available for support and guidance.

While I acknowledge complaints data is not provided to the governing body, I do not consider this to be reflective of poor feedback and complaints systems overall. I have considered outcomes in requirements relating to Standard 6 Feedback and complaints demonstrating the organisation has effective processes to capture, action and monitor feedback and complaints, and to identify improvement initiatives.

For the reasons detailed above, I find requirement (3)(c) in Standard 8 Organisational governance non-compliant.

**In relation to requirements (3)(b) and (3)(c)**, I acknowledge the actions planned to address the deficits identified. However, I consider time will be required to establish efficacy, staff competency and improved client outcomes in relation to these requirements.

**In relation to requirements (3)(a), (3)(d) and (3)(e)**, clients are engaged in the development, delivery and evaluation of care and services through surveys, feedback processes and ongoing discussions to understand their needs. All clients from the service’s five facilities said the service is well run, and they have an opportunity to regularly engage with the service through communication with the team leader and feedback processes, such as providing compliments and complaints, and completing surveys.

Effective risk management systems and practices relating to managing high impact or high prevalence risks, identifying and responding to abuse and neglect, supporting clients to live the best life they can and managing and preventing incidents were demonstrated. Staff were aware of their reporting responsibilities in relation to abuse and neglect of clients. A choice and dignity of risk policy and procedure is in place and outlines the responsibilities of management, team leaders and support workers to ensure clients have received sufficient information on identified risks and any potential negative outcomes, and all staff assist clients to minimise risk. There are processes to report, investigate incidents and implement mitigation strategies. Client incidents discussed at fortnightly zone manager and team leader meetings. However, incidents are not trended or reported to or discussed at monthly council meetings. While an incident register is maintained, it does not include any incidents involving clients.

The service’s five facilities do not provide clinical care and do not have clinical staff. All community based aged care clients access the community health clinic for their health needs. The organisation maintains appropriate governance structures in relation to antimicrobial stewardship and open disclosure. However, there were no policies or procedures on minimising the use of restraint in place to guide staff practice.

Based on the assessment team’s report, I find requirements (3)(a), (3)(d) and (3)(e) in Standard 8 Organisational governance compliant.

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)