**Performance**

**Report**

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| Name: | Bathurst Seymour Centre |
| Commission ID: | 200323 |
| Address: | 3/55 Seymour Street, BATHURST, New South Wales, 2795 |
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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

Home Care Packages (**HCP**) included:  
Provider: 9573 Bathurst Seymour Centre Incorporated  
Service: 27459 Bathurst Seymour Centre  
  
Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 7677 Bathurst Seymour Centre Inc  
Service: 24900 Bathurst Seymour Centre Inc - Care Relationships and Carer Support  
Service: 24901 Bathurst Seymour Centre Inc - Community and Home Support

**This performance report**

This performance report for Bathurst Seymour Centre (**the service**) has been prepared by J Durston, 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 provider’s response to the assessment team’s report received 27 February 2024

# Assessment summary for Home Care Packages (HCP)

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

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| 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 | **Compliant** |
| **Standard 5** Organisation’s service environment | **Not 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.

* Requirement 1(3)(c) – the approved provider is to provide opportunities and support for consumers, including those requiring support with communication such as those with cognitive impairment, to exercise choice in the care and services they receive, such as the day centre program.
* Requirement 1(3)(e) - the approved provider is to ensure effective measures are implemented for consumers to receive timely, accurate and current information that is easy for them to understand and that can adequately inform their decisions about their care and services.
* Requirement 2(3)(a) - the approved provider is to ensure consumer care plans are updated and reflect of consumers’ current and assessed needs and preferences and risks to enable staff to provide safe, quality care and services.
* Requirement 2(3)(b) - the approved provider is to ensure consumers and their representatives have access to information on palliative and end of life care support and planning.
* Requirement 2(3)(d) - the approved provider is to ensure consumer care and support plans include sufficient information to guide staff in the delivery of safe and effective care to meet consumer needs, goals and preferences, and consumers and relevant representatives are aware they can access their consumer care plans if they wish.
* Requirement 2(3)(e) - the approved provider is to implement systems and processes to ensure care plans are regularly reviewed for effectiveness and when incidents occur or there are changes/deterioration in a consumer’s condition, and these systems and processes are effectively communicated to and understood by staff.
* Requirement 3(3)(a) - the approved provider is to ensure consumers receive safe and effective clinical and personal care, including administration of medication by staff who are trained and hold the required certification.
* Requirement 3(3)(b) - the approved provider is to ensure consumer documentation identifies high impact, high prevalence risks associated with their care, provides risk management guidance to care and support staff, and there is an effective system and process to analyse and document incident causation and mitigation strategies, and to review consumer care and support plans when incidents occur.
* Requirement 3(3)(e) - the approved provider is to ensure there is a system and process in place that records information about consumers’ condition, needs and preferences in a timely manner that is accessible to staff delivering care and services.
* Requirement 5(3)(b) - the approved provider is to implement processes and support strategies to minimise the use of restrictive practices such as environmental restraint.
* Requirement 6(3)(d) - the approved provider is to implement a system and process to ensure consumer/representative feedback and complaints are documented, trended, analysed and responded to in a timely manner and are used to inform continuous quality improvement of care and service delivery.
* Requirement 7(3)(c) - the approved provider is to implement an education program, and an effective training completion tracking system, to ensure staff and management have the competence to effectively perform their roles in line with legal and regulatory care and service delivery requirements, to effectively manage high impact, high prevalence risks to consumers, and to deliver safe, effective and quality consumer care and support.
* Requirement 7(3)(e) - the approved provider is to implement a performance assessment, monitoring and review process to ensure that all staff and management have annual performance reviews, and performance issues are managed in a timely manner to ensure safe and effective care and service delivery.
* Requirement 8(3)(a) - the approved provider is to implement effective measures to ensure consumers are supported to and engaged in the development, delivery and evaluation of care and services.
* Requirement 8(3)(b) - the approved provider is to implement an organisational reporting system and process to ensure the Board receives timely and accurate information regarding trends in consumer incidents and risk, regulatory compliance, feedback and complaints, workforce management, continuous improvement and service quality data, to ensure the Board can effectively monitor and provide direction and input on areas for improvement to ensure a culture that promotes safe, inclusive quality care.
* Requirement 8(3)(c) - the approved provider is to review and improve the effectiveness of key organisational governance systems including information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints.
* Requirement 8(3)(d) - the approved provider is to implement effective risk and incident management systems and processes and ensure these are effectively communicated to and understood by staff.
* Requirement 8(3)(e) - the approved provider is to implement an effective clinical governance framework to ensure the provision of safe and quality clinical care, and the minimisation of restrictive practices.

# Other relevant matters:

The service is currently only delivering services under the CHSP funded programs. The organisation is registered as a provider of home care packages (HCP), but does not currently have any HCP consumers and is not delivering HCP services. Hence the Assessment Team was unable to assess delivery of HCP care and services for this provider. The Assessment Team determined that the organisation was providing clinical care through its CHSP services.

# Standard 1

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| 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 Applicable | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Not Applicable | 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 Applicable | Not Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Not Applicable | 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 Applicable | Not Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Not Applicable | Compliant |

Findings

This Quality Standard has been assessed as non-compliant and as two of the five specific requirements are non-compliant for the service.

**Findings of non-compliance**

Requirement 1(3)(c)

The Assessment Team found the service did not demonstrate each consumer is supported to exercise choice and independence, in making decisions and communicating their choice about their care. Consumers and their representatives stated they do not have choice in programming of the service or meals. Programming at the day centre is created by staff and the meals available to consumers are based on what the Meals on Wheels service provides to the service that day. Consumers are given a choice regarding service payment options. Management and staff said the service uses picture cards to assist a consumer who is non-verbal due to advancing Alzheimer’s disease, to exercise choice. However, the Assessment Team did not observe the cards being used in communications with the consumer and management were unable to locate the picture cards during the visit.

Another consumer was observed by the Assessment Team to sit on the same chair at the respite day program for about 5 hours, except at mealtimes. The consumer advised they enjoy and want to talk with others and mentioned several times that staff walked past and did not acknowledge him. When this was raised with staff by the Assessment Team, staff responded that the consumer does not like to participate in activities and likes to watch them. The Assessment Team observed the consumer to look out towards staff attempting to engage with them.

In their response to the Assessment Team report the service did not refute the Assessment Team’s findings and outlined planned improvements to address the issues identified in this requirement. I commend the Approved Provider’s planned improvements to address the areas of non-compliance identified in this requirement. However, I consider it will take time for the improvements to be embedded and sustained in practice.

* Accordingly, I find the service non-compliant in Requirement 1(3)(c).

Requirement 1(3)(e)

The Assessment Team found the service did not demonstrate consumers receive information that is current, accurate and timely, that they can understand to enable them to make choices. Two out of four consumers/representatives interviewed said they were unsure of what information they received from the service. One consumer said staff tell them what’s coming up during informal chats, but they do not happen frequently. However, three of four sampled consumers/representatives said they understood their invoices.

The Assessment Team was unable to locate information on the client contribution amount, or how this information is provided to consumers. When asked about this, service management advised this was explained when completing the service agreement. However, the Assessment Team found six out of six sampled consumers did not have a service agreement. When asked about this, service management said some things have not been actioned due to the high workload of the acting manager. The client service agreement also includes information and a consent for media release and sharing of information to third parties. For consumers who do not have service agreements this means they have not specified their choice in relation to their privacy in this area

Staff were unable to explain how they know consumers understand the information provided to them and said they may check the consumer’s support plan to see if that person has any communication difficulties, although they do not have time to do this.

In their response to the Assessment Team report, the Approved Provider did not refute the Assessment Team’s findings and provided evidence of improvements already made to address the issues identified in this requirement, including all staff have been provided with a copy and how to access translation services, a new whiteboard with details of daily activities, meals and meal photographs, announcements daily at Morning Tea - each day relating to what’s on for people who may be unable to read the white board. The Bathurst Seymour Centre website has been launched and has accessibility features to support consumers and representatives to access information about the service. The features support consumers living with dyslexia, blindness, motor impairment, visual impairment, colour blindness, cognitive and learning impairments, epilepsy and attention deficit hyperactivity disorder, Daily contribution pricing for coffee mornings. A new CHSP service Agreement has been implemented and includes information on daily service costs covering when they will and won't be charged these fees. Respite/hospital and consumers are now informed of gated access and how to obtain a code for access.

In addition, the Approved Provider outlined several planned improvements. While I acknowledge the extensive improvements the approved provider has implemented and planned, I consider these actions will require time to demonstrate effectiveness and sustainability.

* Accordingly, I find the service non-compliant in Requirement 1(3)(e).

**Compliance findings**

Requirement 1(3)(a)

The Assessment Team found the service demonstrated it treats consumers with dignity and respect, valuing their identity and cultural diversity. Sampled consumers said they felt respected. Staff could describe what it means to treat a consumer with dignity and respect. The service does not have a policy to guide staff in treating consumers with dignity and respect, but consumers and representatives interviewed felt the service meets this requirement through everyday interactions.

Requirement 1(3)(b)

The Assessment Team found the service demonstrated that care and services are culturally safe. All sampled consumers and representatives confirmed staff knew what was important to them, including their background, culture and values. The organisation does not have policy or procedures on culturally safe services. However, management have organised cultural safety training for staff.

Requirement 1(3)(d)

The Assessment Team found each consumer is supported to take risks to enable them to live their best life. Staff advised they encourage consumers to do what they can for themselves and take mitigated risks when appropriate. A staff member said staff mitigate the risks to consumers who prefer not to use their mobility aids when they attend the ‘men’s shed’, by supervising them there and checking with them if they appear unsteady. The service has care planning policies to guide staff on partnering with consumers to take mitigated risks and maintain independence.

Requirement 1(3)(f)

The Assessment Team found the service demonstrated each consumer’s privacy is respected and their personal information is kept confidential. Staff said that they do not disclose consumers’ private information outside the service. Consumers’ information is mainly kept on the electronic care management system, accessed using two factor authentication. Older consumer files are kept in a locked compactor filing cabinet. Paper records are placed in a confidential locked bin to be confidentially destroyed offsite. The service has a privacy and confidentiality policy.

* Accordingly, I find the service compliant in Requirements 1(3)(a), 1(3)(b), 1(3)(d) and 1(3)(f).

# Standard 2

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| 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 Applicable | 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 Applicable | 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 Applicable | 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 Applicable | 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 Applicable | Not Compliant |

Findings

This Quality Standard has been assessed as non-compliant as four of the five specific requirements are non-compliant for the service.

**Findings of non-compliance**

Requirement 2(3)(a)

The Assessment Team found the service did not demonstrate 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 CHSP consumers.

The Assessment Team reviewed support plans for 11 sampled consumers and noted the service did not consistently identify risks to their health and wellbeing, such as falls, medical conditions and cognitive decline. The support plan was last reviewed on 4 July 2023 for a consumer who attends the day respite centre for social engagement, stated they live with intellectual disability, mental health issues and the risk of falls and seizures. However, the Assessment Team found that critical information on incidents that occurred since the review was not added to the support plan, including multiple choking incidents at the centre and their home. The consumer also had unwitnessed falls at the centre. The service was unable to demonstrate that review and assessments were undertaken following these incidents to further inform the management of risks to the consumer in relation to choking, falls and possible seizures, and the support plan was not updated with risk mitigation strategies or evidence of risk monitoring.

The support plan of another consumer who attends the day centre, dated 19 July 2022 identified the services to be provided whilst at the day centre. Their plan was not reviewed after the consumer experienced a stroke in their left occipital lobe in January 2024 which resulted in blindness on the right side of their visual field. The consumer was reported to have chewing and swallowing difficulties after the stroke. Neither the support plan nor the service’s electronic file records documented what impact the loss of vision had on the consumer’s participation at the centre-based activities, their chewing and swallowing risk and mitigation strategies for support workers to assist them when delivering services.

In their response to the Assessment Team Report the Approved provider noted, the Assessment Team report incorrectly indicated the support plan for consumer was not updated following their return to the service after the stroke. The Approved provider advised this was undertaken at the time of the audit and was available in hard copy (but had not been entered into the care management system), including a transport re-assessment, activities of daily living re-assessment, and head-to-toe reassessment covering the client’s needs post-stroke. However, I note that in the consumer document register supplied by the Approved Provider in evidence, there were no entries indicating the consumer had any of the 12 care documents listed, including the support plan; and on the supplied client reassessment document register the consumer is not marked as a vulnerable client. The Approved Provider did not supply further evidence of the consumer records referred to in their response.

The Approved Provider also noted in their response a speech pathology review has been arranged to develop a mealtime management plan for the consumer who had multiple choking incidents. There is now a COPD management plan in place provided by his GP including a Ventolin management plan and a seizure management plan for the consumer; and the service will provide education to staff on the use of these plans. The consumer’s care plan has been updated to inform support workers about the assessed risk faced by the consumer when eating. The client is supervised when eating and supported with alternate meal options if he requests.

The Approved provider outlined several planned improvements to address the identified areas of non-compliance in this requirement, such as strengthening the intake and assessment policy and process, and implementation of a new a procedure for re-assessment and reviews to be updated and a client review schedule.

I acknowledge the actions the Approved Provider has taken to mitigate the risks of the consumers noted in its response, and its planned improvement actions. However, I consider there is a clear systemic issue regarding lack of timely care and support plan review and documentation resulting in significant risk to consumers’ health safety and wellbeing. I consider it will take some time for the improvements to be sustained in practice.

* Accordingly, I find the service non-compliant in Requirement 2(3)(a).

Requirement 2(3)(b)

The Assessment Team found the service did not demonstrate that assessment and planning identify and address the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. Most consumers and representatives confirmed that goals are discussed at the commencement of services and when things change, they inform the service. One representative said they discussed their consumer’s needs, goals and preferences when they joined the program, but had not been asked since to engage in care planning discussions, but noted the consumer appeared happy when they return from the day centre. Care plans for 3 consumers were not updated following serious medical episodes or deterioration in their health. Support plans for another three consumers were overdue, and their current needs, goals, and preferences were not updated, including two consumers’ whose falls risk had increased and one requiring mobility support due to a health condition.

Management advised the service does not have a welcome pack and information booklet nor a link to a website containing information for consumers regarding advanced care planning.

In their response the Approved Provider did not refute the Assessment Team’s findings. The Approved Provider supplied evidence of improvements made since the Quality Audit, including the implementation of a new CHSP service agreement that includes advanced care planning, and an information on advance care planning fact sheet has been added to the new welcome pack for consumers.

I acknowledge the Approved Provider’s response, actions taken, and their commitment to continuous improvement in relation to this requirement. However, as the improvements were implemented after the Quality Audit, I consider time is required to demonstrate their effectiveness and sustainability.

* Accordingly, I find the service non-compliant in Requirement 2(3)(b).

Requirement 2(3)(d)

The Assessment Team found the service did not demonstrate the outcomes of assessment and planning are effectively communicated to consumers and consistently documented in a care and services plan that can be accessed by consumers and staff at the point of care delivery.

Care and service documentation showed, a review assessment was completed for one consumer in September 2023, but had not been finalised and was not signed. The plan did not detail the level of supervision and assistance the consumer required with their mobility and incontinence to guide support workers in their care delivery

The consumer’s representative said they enjoy going to the centre but could not recall receiving a support plan which detailed the services they receive. Seven sampled consumers and representative said they could not recall receiving a support plan which outlined their services and preferences for service provision.

The clinical care supervisor displayed a detailed knowledge of each consumer within their program areas including their individual needs, goals and preferences. However, they said this information is not documented within the support plan or shared with staff and volunteers providing support and services.

Sampled consumers’ support plans, did not include information on the outcomes of assessment and planning including the consideration of risk, and when risks were identified, they were not documented within the support plan. Management acknowledged these gaps but said that some plans did provide an action plan to guide support workers under a section in the plan called ‘assistance information’.

However, I place more weight on the risk to consumer health safety and wellbeing associated with the clinical care supervisor’s advice that their knowledge of consumers’ needs are not shared with staff or documented for support worker access and the number of sampled consumers/representative who provided feedback that they do not receive copies of their consumer’s support plan. In their response to the Assessment Team report the Approved Provider did not refute the Assessment Team’s findings and supplied a range of planned improvements relevant to the requirement. I acknowledge the Approved Provider’s commitment to implement the planned improvements. However, I consider it will take time for the improvements to be implemented and sustained in practice.

* Accordingly, I find the service non-compliant in Requirement 2(3)(d).

Requirement 2(3)(e)

The Assessment Team found the service did not demonstrate care and services are regularly reviewed for effectiveness, when circumstances change or when incidents impact on consumers’ needs, goals and preferences. Six sampled consumers could not recall reviews being conducted by the service. Care planning documentation showed when reviews were completed, they did not consistently identify risks to consumers following incidents or when circumstances changed. One sampled consumer said they were injured by a fall in November 2023.The consumer did not recall that their plan had been reviewed and noted they would like do activities and exercises to increase their strength. The consumer’s support plan was dated 19 July 2022. It did not contain a record of their unwitnessed fall, and their needs, goals and preferences were not updated.

The Assessment Team found other consumers’ support plans were not reviewed following significant incidents including multiple choking incidents for one and a stroke resulting in partial blindness in one eye and swallowing difficulties for the other. This was considered in Requirement 2(3)(a).

The clinical care supervisor confirmed that validated risk assessment and planning tools are not used to inform the planning of safe and effective services. The clinical care supervisor advised she discusses a ‘return to centre plan’ with a consumer and representatives when a major incident has occurred such as a fall or medical episode. The clinical care supervisor said one named consumer agreed to a return strategy which was discussed with the support workers following a stroke, but their support plan was not updated with the information. Staff and management interviewed acknowledged the service’s assessment and planning processes were not effective at identifying risks to a consumer’s health, safety and wellbeing.

Management and staff described how they contact consumers after a change in circumstance or an incident to see how they are. However, they confirmed a review of care and services is not conducted and these conversations were not consistently documented for sampled consumers. The service has engaged a support worker with the specific purpose of reviewing overdue support plans to assist the clinical care supervisor to catch-up with the overdue support plans.

In their response to the Assessment Team Report the Approved Provider did not refute the Assessment Team’s findings and outlined several planned improvements to address the identified deficits, such implementation of an updated procedure for re-assessment and reviews to be updated to include review schedule and reviews to occur after incidents, change in consumer condition and circumstances, and a request for review by the client and a client review schedule.

While I acknowledge the Approved Provider’s commitment to making improvements in relation to this requirement, I consider the Assessment Team’s findings to be more compelling in relation to non-compliance with this requirement, and further time is needed to ensure the improvements are effective when implemented.

* Accordingly, I find the service non-compliant in Requirement 2(3)(e).

**Compliance findings**

Requirement 2(3)(c)

The Assessment Team found the service demonstrated assessment and planning is based on an ongoing partnership with consumers and representatives, and there input from other care and service providers involved in the consumer’s care. Consumers and representatives advised they are involved in deciding on their care and services. While the Assessment Team found 5 out of 11 consumer files did not have a current support plan, the dated care notes showed the clinical care supervisor was in regular contact with the consumers and representatives for consumer views on their care and services. One consumer who attend the centre said they enjoyed coming to the centre and the staff involved them in discussions about their needs including accommodating their motorised wheelchair and making provisions for their oxygen concentrator. Overall, consumers’ care notes showed ongoing collaboration with their family and HCP provider in relation to care planning and assessment even though their support plan was last reviewed on 1 August 2022. Although there are significant gaps in the documentation and of care/support plans, this was considered in requirements 2(3)(a) and 2(3)(b).

* Accordingly, I find the service compliant in Requirement 2(3)(c).

# Standard 3

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| 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 Applicable | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Applicable | 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 Applicable | 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 Applicable | 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 Applicable | Not Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Not Applicable | 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. | Not Applicable | Compliant |

Findings

This Quality Standard has been assessed as non-compliant as three of the seven specific requirements are non-compliant for the service.

**Findings of non-compliance**

Requirement 3(3)(a)

The Assessment Team found the service did not demonstrate each consumer gets safe and effective personal care and clinical care. CHSP consumers and representatives advised they are receiving safe and effective clinical care. The Assessment team found clinical care including administration of medication and personal care are provided at the day respite centre. Some staff were found to be administrating medication to 2 consumers without the required medication administration certification and training posing a risk to consumer health and safety. Also, medication charts for October and part of November 2023 could not be located. Management noted these charts may be held on hard copy files pending upload to the consumers’ electronic files.

The Assessment Team found the clinical care supervisor is a registered nurse and undertakes all assessment and planning of consumer care and services. The service recently engaged a support worker with nursing background to review overdue support plans. However, the Assessment Team found support plans did not consistently contain current information in areas such as recent consumer incidents, deterioration and changed condition and risk, to inform the delivery of safe and effective care and support services. This was considered in Requirement 3(3)(e).

In their response to the Assessment Team report the Approved Provider did not refute the Assessment Team’s findings and supplied a range of planned improvements relevant to the requirement. I acknowledge the Approved Provider’s commitment to implement the planned improvements. However, I consider it will take time for the improvements to be implemented and sustained in practice.

* Accordingly, I find the service non-compliant in Requirement 3(3)(a).

Requirement 3(3)(b)

The Assessment Team found the service did not demonstrate effective management of high-impact or high-prevalence risks associated with the care of each consumer. Sampled consumers and their representatives advised that risks associated with their care are managed when they are being transported to and while they are at the centre. Staff were able describe risks associated with the care of consumers, including falls, cognitive impairment and social isolation; and they explained the ways they mitigate and minimise risks, including walking and standing beside consumers, prompting consistent use of mobility aids and being available to assist when needed. Management advised high impact, high prevalence risks to consumers mainly relate to dementia, cognitive impairment and falls are now captured in their incident and accident register to improve incident analysis to and prevention strategies.

However, when requested the service was unable to provide the Assessment Team with a list of consumers who were regarded as being at high impact high prevalence risk. Consumer documentation showed high impact, high prevalence risks associated with the care of CHSP consumers are not identified and documented and further consideration of risks are not further assessed. This was considered in Requirement 2(3)(a).

In their response to the Assessment Team report the Approved Provider did not refute the Assessment Team’s findings and provided evidence of their newly implemented register containing alerts for reassessment of vulnerable consumers. The Approved provider also provided a list of a planned improvements relevant to the requirement. I acknowledge the Approved Provider’s action and planned improvements to respond to the issues of non -compliance in this requirement. However, I consider it will take time for the improvements to be implemented and sustained practice.

* Accordingly, I find the service non-compliant in Requirement 3(3)(b)

Requirement 3(3)(e)

The Assessment Team found the service did not demonstrate 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. Most consumers and representatives said staff and others generally have current information about consumers’ needs. All sampled consumers and representatives advised that overall, they were satisfied with the communication of information about consumers’ health and personal care needs and preferences. Support workers said they were satisfied with the way they receive information through daily morning briefings about the needs, goals and preferences of consumers attending on the day. Care documentation showed communication with others including general practitioners and HCP package providers supporting consumers.

The Assessment Team noted the service relies on the clinical care supervisor, responsible for intake and review of consumer support plans, to keep staff updated on the care and support needs of consumers. However, five out of 11 sampled support plans were found to be overdue for review and three additional consumer support plans were not updated following serious incidents and evidence of deterioration. This increases the risk that the briefings delivered to staff by the clinical care supervisor and consumer records the may access at other times to inform care delivery contain information that is not up to date.

The support workers said they relied on the clinical care supervisor for information and directions to tailor services, but acknowledged if the clinical care supervisor was not available, there would be other support workers with some knowledge, which would not be adequate in event of a critical incident like allergic reaction, fall or choking.

In their response to the Assessment Team report the Approved Provider did not refute the Assessment Team’s findings and supplied a list of planned improvements relevant to the requirement. I acknowledge the Approved Provider’s commitment to implement the planned improvements. However, I consider it will take time for the improvements to be implemented and sustained in practice.

* Accordingly, I find the service non-compliant in Requirement 3(3)(e).

**Compliance findings**

Requirement 3(3)(c)

The Assessment Team found on balance the service demonstrated that when a consumer’s health changes or they experience functional deterioration, the clinical care supervisor conducts an assessment and where appropriate refers the consumer to appropriate support services, which could include palliative or end of life support services if required. Sampled consumers and representatives advised they did not want to discuss advanced care directives and end of life planning with the service. Service management said their day centre is not geared towards consumers nearing palliative or end of life care, and that the CHSP consumers attending their services are high functioning and independent. Staff demonstrated an understanding of the escalation process to the care supervisor if they observe deterioration in the consumer’s condition.

Requirement 3(3)(d)

The Assessment Team found on balance the service demonstrated 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. All staff were familiar with the process of recognising when a consumer may need re-assessment due to deterioration and the need to inform the clinical care supervisor for further action to determine if the consumer can continue to benefit from attending the centre, and/or requires referral to a more appropriate support service/s. Care documentation showed that changes in a consumer’s health or condition are reported and actioned. However, some care documentation did not contain consumers’ most recent or updated information. This was considered in Requirement 2(3)(a).

Requirement 3(3)(f)

The Assessment Team found the service demonstrated timely and appropriate referrals to individuals, other organisations and providers of other care and services. Overall, consumers and representatives interviewed were positive about the outcomes of referrals made by the service. Staff were able to describe referral processes to a range of service s, general practitioners, and M Aged Care. Care documentation showed the service makes referrals when a need is identified in consultation with consumers and representatives.

Requirement 3(3)(g)

The Assessment Team found that on balance the service demonstrated minimisation of infection-related risks through implementing standard and transmission-based precautions and practices to promote effective antimicrobial stewardship, based on the level of personal care and clinical care it delivers as a provider of CHSP services. Consumers and representatives advised they were satisfied with the infection control measures taken by staff to protect consumers. Staff said they wear personal protective equipment, participate in infection control training, have required vaccinations and do not work when unwell. Training records confirmed the service delivered staff training on infection control. The clinical care supervisor is the infection control lead coordinator, and there was evidence that vaccination records are maintained. Staff demonstrated a general awareness of the consequences of over-use and over prescribing of antibiotics.

* Accordingly, I find the service compliant in Requirements 3(3)(c), 3(3)(d), 3(3)(f) and 3(3)(g).

# Standard 4

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| 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 Applicable | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Not Applicable | 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 Applicable | 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. | Not Applicable | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Not Applicable | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Not Applicable | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Not Applicable | Not applicable |

Findings

This Quality Standard has been assessed as compliant as five of the six specific requirements are compliant, and one requirement 4(3)(g) was not applicable for the service.

**Compliance findings**

Requirement 4(3)(a)

The Assessment Team found the service demonstrated each consumer gets services and supports for daily living that meet their needs, goals and preferences and optimise their independence, health, wellbeing and quality of life. Consumers and representatives advised the service listens to them and provides them with the services and supports they need, in a way that helps them to continue to do things independently, noting examples such as exercise classes, activities and yoga to improve. Staff described how they support consumers to access the community including social support services and planned activity groups.

Requirement 4(3)(b)

The Assessment Team found the service demonstrated services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. Sampled consumers and representatives said staff and support workers recognise when they consumers are feeling low. One consumer noted staff recognise when they are feeling low and have a little joke with them. Management, staff and volunteers described strategies to support consumers emotionally, spiritually and psychologically. Some support plans contained information on consumers’ unique emotional, spiritual, and psychological needs, such as religious affiliations. More than half the sampled support plans reviewed did not contain this information. However, staff said they obtained this information in their interactions with consumers and representatives. On balance I consider the service has met this requirement.

Requirement 4(3)(c)

The Assessment Team found the service demonstrated services and supports for daily living assist each consumer to participate in their community within and outside the service, have social relationships and do things of interest to them. Consumers interviewed described how the service supports them in maintaining their personal relationships and one representative described how their consumer is happy when they are dropped off after attending the centre for the day. Staff interviewed showed they were familiar with the consumers’ interests and provided examples of ways consumers are supported to do things of interest to them.

Requirement 4(3)(d)

The Assessment Team found the service generally demonstrated information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others involved in consumer’s care. Consumers and/or representatives advised staff know the consumer and their care needs well, and that information about their services is shared within the service and with others involved in their service provision. Staff, volunteers and management said information about consumers is communicated verbally in the morning briefing, and staff and volunteers advised changes to consumers’ condition would be promptly identified and reported by the clinical care supervisor.

Requirement 4(3)(e)

The Assessment Team found the service demonstrated timely and appropriate referrals are made to individuals, other providers of care and services. Overall, consumers and their representatives were unable to recall many referrals for services and supports made by the service or that they were not interested in referrals. Sampled consumers said they felt confident the service would assist them by referring them to My Aged Care or another service if the need arose. The clinical care supervisor was able to describe a range of service networks and supports, and confirmed referrals were made as needed.

Requirement 4(3)(f)

The Assessment Team found the service demonstrated meals provided are varied and of suitable quality and quantity. One representative said their consumer attends the centre respite program five days per week and the service asked about their food likes and dislikes including any allergies This was confirmed by sampled consumers and representatives. The Assessment Team reviewed a consumer diet list documented located on an electronic tablet in the kitchen. The information detailed each consumer’s food requirements, including allergies, dislikes, food and beverage choice and any other special dietary requirements, such as those related to diabetes management and alerts to prevent choking hazards including food consistency requirements. The kitchen staff member referred to the consumer dietary information during the visit. The Assessment Team noted there had been previous choking incidents for two consumers, who now have appropriate instructions on their dietary requirements list.

Requirement 4(3)(g)

This requirement was not applicable as the service does not provide equipment.

* Accordingly, I find the service compliant in Requirements 4(3)(a), 4(3)(b), 4(3)(c), 4(3)(d), (4(3)(e) and 4(3)(f), with Requirement 4(3)(g) not applicable.

# Standard 5

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| 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. | Not Applicable | 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. | Not Applicable | Not Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Not Applicable | Compliant |

Findings

This Quality Standard has been assessed as non-compliant as one of the three specific requirements is non-compliant for the service.

**Findings of non-compliance**

Requirement 5(3)(b)

The Assessment Team found the service demonstrated the service environment is safe, well maintained, comfortable and enables consumers to move freely both indoors and outdoors and that all sampled consumers and representatives confirmed this. The service has a maintenance log where staff record maintenance and safety issues. However, not all staff interviewed were aware of the maintenance log. Staff were able to describe the procedure for securing an unsafe area and/or equipment. The Assessment Team observed several items with evidence to show they were maintained within required/recommended time frames, including fire extinguishers and the electrical equipment test and tagging log.

The Assessment Team found that three consumer bathrooms at the centre are not wheelchair accessible. One consumer was unable to move into the bathroom using their wheelchair. The consumer was supported to stand up and walk with manual handling support from the support workers.

The Assessment Team observed consumers could move freely between indoor and outdoor spaces within the service. However, they also found that consumers and representatives are not given the access code to the service gate leading to the outside car park. Management explained the intention is to prevent absconding or wandering of consumers into the carpark The Assessment Team noted this was not a restrictive practice because the carpark was not considered part of the service environment. However, on further consideration according to the legislation, this is a form of environmental restraint according to the Quality of Care Principles 2014, under Section 96-1 Aged Care Act 1997, Part 4A Division 2 Subsection 15E(3) that states:

*‘Environmental restraint is a practice or intervention that restricts, or that involves restricting, a care recipient’s free access to all parts of the care recipient’s environment (including items and activities) for the primary purpose of influencing the care recipient’s behaviour.’*

I consider the gate which is part of the service environment restricts consumer movement outside the service environment to the car park, for the primary purpose of influencing the care recipients’ behaviour; to prevent them from ‘absconding’ or ‘wandering’ from the service to the car park. There was not sufficient evidence that this restrictive practice has been used as a last resort, following consideration, trialling and evaluation of additional support and supervision strategies by the service.

On balance, I consider the service environment does note enable consumers to move freely both indoors and outdoors, based on the demonstrated environmental restraint and the consumer unable to independently access a bathroom using their wheelchair.

* Accordingly, I find the service non-compliant in Requirement 5(3)(b).

**Compliance findings**

Requirement 5(3)(a)

The Assessment Team found the service demonstrated the service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. Sampled consumers and representatives expressed they feel the service is safe and welcoming. Management said the service has purchased new chairs which have colourful prints, to make the space more inviting. The Assessment Team observed toilet icons on doors to assist consumer recognition and independence and the service environment has a clear open layout to minimise consumer confusion. Also, the ‘men’s shed’ has a pool table. Some consumers said they enjoy playing pool because it brings them together and they can use a skill they have had for decades. Some areas of the service look like a home and are welcoming, such as the lounge room that has a television, music and homely lounges and lounge chairs.

Requirement 5(3)(c)

The Assessment Team found the service demonstrated furniture, fittings and equipment are safe, clean, well maintained and suitable for consumers. Consumer feedback confirmed this. Staff were observed by the Assessment Team cleaning tables and chairs after shared activities and the service buses were cleaned on return from transporting consumers. Maintenance records showed equipment was regularly cleaned and serviced. The maintenance list did not include the hydraulic lift on the bus. However, records were provided to show it was serviced in line with the servicing manual. Management informed the Assessment Team that the external cleaners attend the service three times per week.

* Accordingly, I find the service compliant in Requirements 5(3)(a) and 5(3)(c).

# Standard 6

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| --- | --- | --- | --- |
| 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. | Not Applicable | 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. | Not Applicable | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Not Applicable | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Applicable | Not Compliant |

Findings

This Quality Standard has been assessed as non-compliant as one of the four specific requirements is non-compliant for the service.

**Findings of non-compliance**

Requirement 6(3)(d)

The Assessment Team found that overall, the service did not demonstrate feedback and complaints are reviewed and inform improvements to the quality of care and services. The quality improvement plan did not include items that had been identified as a result of consumer feedback or complaints in the complaints register or consumer survey. Because not all complaints and feedback are recorded on the compliments and complaints register, it cannot be determined how they are reviewed and utilised for quality improvement of the service. The Assessment Team found the service conducted an anonymous survey for consumers and representatives and has acted on two of the eleven suggested improvements.

In their response, the Approved Provider did not refute the findings of the Assessment Team report, and provided evidence the service has added an agenda item of ‘Complaints and Compliments’ to the Board meeting agenda. The Approved Provider also submitted an outline of planned actions to address the non-compliance in this requirement. However, I consider it will take time for these actions to be implemented and sustained in practice.

* Accordingly, I find the service non-compliant in Requirement 6(3)(d).

**Compliance findings**

Requirement 6(3)(a)

The Assessment Team found the service demonstrated consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. All consumers and representatives stated they know how to provide feedback or make a complaint to the service. They said they felt encouraged to provide feedback in several ways including calling the manager, telling their support worker, writing an email and visiting the manager’s office. Staff were able to describe how consumers can provide feedback and make complaints. Staff at the day centre advised consumers and representatives are encouraged to provide feedback in several ways, including calling the manager, telling their support worker, writing an email and visiting the manager’s office. Management explained they undertook a de-identified survey of consumers.

Requirement 6(3)(b)

The Assessment Team found the service demonstrated consumers are informed about and have access to advocates, language services and other methods for raising and resolving complaints. Consumers and representatives advised they had been informed about advocacy and language services. However, staff said they were not aware of how to access advocacy or language services or where they could locate information resources, to support the consumer and their representatives. Management stated if they needed to use interpreting services, they would use the Translating and Interpreting Service (TIS), although they said there was not a current need for this service. Management demonstrated a knowledge of advocacy services they can share with consumers. Management stated they do not have policies to support or guide staff and management on this. The Assessment Team observed pamphlets at the service covering a range of information on making complaints and advocacy services.

Requirement 6(3)(c)

The Assessment Team found the service demonstrated complaints are actioned appropriately and an open disclosure process is used when things go wrong. Review of complaint documentation for one consumer showed their complaint had been addressed and they were happy with the outcome. Staff could describe how they use open disclosure and how they talk to consumers when things so wrong. Staff explained complaints are not always recorded if they can be actioned promptly. The service does not have an open disclosure policy. However, staff could describe how they use open disclosure and how they talk to consumers when things go wrong.

* Accordingly, I find the service compliant in Requirements 6(3)(a), 6(3)(b) and 6(3)(c).

# Standard 7

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| --- | --- | --- | --- |
| 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 Applicable | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Not Applicable | 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. | Not Applicable | Not Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Not Applicable | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Not Applicable | Not Compliant |

Findings

This Quality Standard has been assessed as non-compliant as three of the five specific requirements are non-compliant for the service.

**Findings of non-compliance**

Requirement 7(3)(c)

The Assessment Team found the service did not demonstrate that all its workforce are competent and have the qualifications and knowledge to perform their roles effectively. Sampled consumers and representatives advised they felt the workforce was competent. However, the Assessment Team found that some support workers were providing services outside their scope of practice such as signing medication administration sheets where consumers medication is stored and administering medication to consumers at the day centre. Limited evidence of medication competency was found during the assessment.

The Assessment Team found clinical care is being provided by the service’s clinical care supervisor, who has a role description that does not specify the provision of clinical services. The Assessment Team found limited evidence to suggest the workforce is trained to deliver the level of care provided. The Assessment Team was informed that staff participate in two days of training at the beginning of the year outlining areas such as elder abuse and information on the quality standards.

In their response, the Approved Provider did not refute the findings of the Assessment Team report, and noted improvements it has implemented including, recruitment for additional support workers and a catering assistant is underway to support staff working within their scope long-term. The Approved Provider also submitted an outline of planned actions to address the non-compliance in this requirement. However, I consider it will take time for these actions to be implemented and sustained in practice.

* Accordingly, I find the service non-compliant in Requirement 7(3)(c).

Requirement 7(3)(d)

The Assessment Team found the service demonstrated the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. Management described how staff training needs are assessed and identified through staff appraisals and when performance gaps are identified. The Assessment Team was unable to obtain consistent training records to determine training completed by the workforce. For example, the Assessment Team attempted to locate staff competency records for medication management, but was unable to locate evidence of this. Management noted the services needed a training matrix and education plan to guide and monitor training needs for the workforce. The service has not provided training regarding Serious Incident Response Scheme (SIRS) requirements and provided limited details on education delivered on incident management. Management advised the workforce is updated and informed, about changes to aged care legislation through email and team meetings. The service has a debrief meeting each afternoon where certain topics are discussed based on support worker intertest. The Assessment Team noted that not all workforce files consisted of national criminal history checks.

On balance, when I consider all information before me, I am not satisfied that the provider demonstrates compliance with this requirement. The service does not have a consistent record keeping system to track and ensure compliance with staff training requirements. There are gaps in training in key areas of risk, including SIRS requirements and incident management training. There are numerous examples in the report that indicate a lack of training and/or competence in incident management. Requirement 2(3)(a) noted the lack of review and assessment following unwitnessed falls and choking incidents experienced by one consumer, to further inform the management of risks and include mitigation strategies in the support plan. Requirement 3(3)(a) noted some staff did not have medication administration certification, but were administrating medication to 2 consumers, placing consumers health at risk.

In their response the Approved Provider did not refute the findings of the Assessment Team report, and submitted an outline of planned actions to address their non-compliance with this requirement. However, I consider it will take time for these actions to be implemented and sustained in practice.

* Accordingly, I find the service non-compliant in Requirement 7(3)(d).

Requirement 7(3)(e)

The Assessment Team found the service demonstrated regular assessment, monitoring and review of the performance of each member of the workforce. Staff provided detailed descriptions of their participation in performance review. Management advised feedback from consumers is informally provided to staff in day-to-day meetings and at team meetings. The Assessment Team viewed workforce documentation and found some evidence of performance reviews being completed but was unable to locate all staff performance reviews. There was documentation that showed a new staff member’s probation assessment process including review points at week 3 and then at 3 and 6 months, which was consistent with feedback about the process provided by new staff.

However, management advised the clinical care supervisor has not had a performance appraisal for some time and limited oversight is being provided over their role. Review of staff files showed the clinical care supervisor’s last performance review was completed in May 2022. The governing body they provided a mixed response when this was raised by the Assessment Team. They advised the board has oversight over the service’s management, but due to recent structure changes the governing body typically would not review the clinical care supervisor’s performance. The governing body further advised that support occurs on an informal basis due their close communication with the clinical care supervisor The governing body explained how they observe the clinical care supervisor’s efforts and performance and said they were doing an excellent job.

In their response the Approved Provider did not refute the findings of the Assessment Team. However, I have considered the Assessment Team’s findings in relation to this requirement and information elsewhere in the Assessment Team’s report, which does not demonstrate sufficient assessment, monitoring and review of staff performance has occurred to minimise risk to consumers. The Assessment Team was unable to locate all staff performance review records, management advised there was limited oversight of the clinical care supervisor, and the governing body provided conflicting information regarding how it monitors their performance their performance.

The organisation confirmed the clinical care supervisor, who is a registered nurse, undertakes all assessment and planning of consumer care and services. This role is pivotal to ensuring consumers’ receive the services and supports required to ensure their health safety and wellbeing. Lack of adequate performance review of this role has resulted in sustained systemic gaps in consumer risk management. Requirement 3(3)(b) noted almost half of sampled consumer support plans were overdue for review and a quarter were not updated following serious incidents and/or deterioration. Requirement 2(3)(a) noted the clinical care supervisor advised their knowledge of consumer individual needs, goals and preferences is not documented within support plans or shared with staff and volunteers to guide them in providing safe, quality, services and support.

* Accordingly, I find the service non-compliant in Requirement 7(3)(e).

**Compliance findings**

Requirement 7(3)(a)

The Assessment Team found the service did not demonstrate workforce planning enables the right number and mix of staff to deliver safe and quality care and services. the Assessment Team found that the workforce structure is not sustainable for long term operations to provide safe care and services. Consumers and representatives advised support workers turn up on time and their care and service delivery is not rushed.

The team found support workers advised volunteers and the casual pool is used when support workers have a rostered day off. The service’s roster for the week of 22 January 2024 showed there were 12 workforce members in attendance with no casual staff listed.

Management advised they currently do not have casual staff to replace staff when shortages occur, but said they use other staff such as the centre coordinator. The service has recently advertised to recruit more casual support workers and volunteers and has recruited a new chief operating manager. In addition, the service is currently training all staff to support in the kitchen when needed, though advised if the kitchen hand were on leave, the service would make arrangements to provide meals for consumers in an alternative way such as ordering lunch in or taking consumers out for lunch.

In their response, the Approved Provider did not refute the findings of the Assessment Team report, and provided evidence that the new operations officer commenced in early February 2024, and recruitment of additional support workers and a catering assistant is underway. In addition, the Approved Provider noted several planned improvements to address the identified non-compliance with this requirement While the Assessment Team report identified the Approved Provider’s challenges with recruitment, it did not identify any negative impact to the service’s consumers as a result. On balance I consider the Approved Provider to be compliant with this requirement, based on the planned and actual workforce measures the provider has put in place to address staff shortages and the lack of identified consumer impact.

Requirement 7(3)(b)

The Assessment Team found the service demonstrated workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. Consumers and/or representatives interviewed felt that staff are kind, gentle and caring when providing care and services. Staff working with the social support group were observed interacting with consumers in a kind and respectful manner, and care and support staff spoke about consumers respectfully. One consumer advised they can talk about their past with staff and the service is working with them on a book about their life story.

* Accordingly, I find the service compliant in Requirements 7(3)(a) and 7(3)(b).

# Standard 8

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| --- | --- | --- | --- |
| 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 Applicable | 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 Applicable | 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 Applicable | 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 Applicable | Not 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. | Not Applicable | Not Compliant |

Findings

This Quality Standard has been assessed as non-compliant as five of the five specific requirements are non-compliant for the service.

**Findings of non-compliance**

Requirement 8(3)(a)

The Assessment Team found the service did not demonstrate consumers are supported to and are engaged in the development, delivery and evaluation of care and services. The Assessment Team acknowledged the size and unique small structure of the service, but found consumer feedback is mainly obtained through informal conversations with staff, and there was no evidence provided to confirm outcomes from consumer involvement in service development and evaluation.

Management advised a consumer survey had previously been conducted, and noted the service has an outreach forum. Sampled consumers and representatives said they would feel comfortable to provide input to the service to inform delivery of care and services. Management advised a former carer and member of the outreach forum became an associate member of the Board in December 2023. Two Board members advised they were unaware of previous attempts to engage consumers in Board meetings and one said their involvement would not work. Management said the recent annual general meeting (AGM) was advertised on the local radio station, and was attended by one outreach member and one consumer.

In their response the Approved Provider did not refute the findings of the Assessment Team report and noted improvements it has implemented, including modifications made to the board of management agenda template to include complaints and compliments. On balance, when I consider all information before me, I am not satisfied that the provider demonstrates compliance with this requirement as it currently does not have a formal system and process in place for engaging consumers and representatives to provide input to care and service delivery and for capturing, recording and trending and analysing the feedback they provide.

* Accordingly, I find the service non-compliant in Requirement 8(3)(a).

Requirement 8(3)(b)

The Assessment Team found the service did not demonstrate the organisation’s governing body promotes a culture of safe, inclusive and quality care and services, and is accountable for their delivery. The Assessment Team found the governing body is responsible for the oversight of the organisation’s strategic direction for delivering care. Management advised the Board does not receive information on the provision of clinical care nor clinical data to monitor whether care and services are being delivered safely, effectively and in line with best practice. Documentation reviewed did not show that the board receives information on consumer incidents for oversight of consumer safety and input to mitigation strategies. When asked by the Assessment Team, the Board was unable to recall any incidents that had occurred in the last 12 months. The Board confirmed it had not received any training on the Serious Incident Response Scheme or the aged care reforms.

In their response the Approved Provider did not refute the findings of the Assessment Team report, and noted planned and actual improvements made including modification of the board of management agenda template to include a clinical update and incidents. However, I have placed considerable weight on the evidence provided by the Assessment Team. Which shows the governing body is not provided with adequate information to monitor, make decisions about and be accountable for the quality, safety and effectiveness of care and services.

* Accordingly, I find the service non-compliant in Requirement 8(3)(b).

Requirement 8(3)(c)

The Assessment Team found that the service has sufficient and effective systems in information management and financial governance, but did not demonstrate effective organisational workforce governance, and governance systems for continuous improvement, regulatory compliance and feedback and complaints.

**Information management**

The service uses a password protected electronic client management system. Staff said they had enough information to perform their roles effectively and they can access policies and procedures on the service’s electronic shared drive. However, I note that the service demonstrated insufficient information governance in relation to ensuring systems and processes were in place to monitor that consumer records were current and complete, as there were gaps in records regarding changed consumer condition, deterioration, risk and guidance for staff to effectively manage changed care and support needs of consumers. The Assessment Team found consumer files showed information was not consistently saved in the client management system or shared drive for consumers. Although verbal daily briefings are provided by the clinical care supervisor at the centre, there is a risk that consumer care information critical to consumer health, safety and wellbeing is not available staff to access at all times, when needed, such as when the clinical care supervisor is unavailable/uncontactable. This was considered in Requirement 3(3)(e).

**Financial governance**

The service has a finance officer and a treasurer on the board who oversee the financial aspects of the services. Management advised that the treasurer briefs the Board monthly on the service’s profit and loss statement.

**Continuous improvement**

The service has a plan for continuous improvement which is outlined in their continuous improvement register. However, the Assessment Team found management was unable to provide evidence of service improvements resulting from consumer and representative feedback, and incident analysis.

**Workforce governance**

The service did not demonstrate robust workforce governance in relation the assignment of clear responsibilities and accountability’s for some management and care and service delivery roles; including the clinical care supervisor performing clinical duties not included in their job documentation and care staff managing medication without the required certification. This was considered in Requirements 7(3)(a) and 7(3)(c). The service does not have mandatory staff training system in place to ensure staff complete training in key areas including, SIRS, the incident management system and Code of Conduct.

**Regulatory compliance**

The service has regulatory compliance systems in place such as police checks and first aid qualifications. Management advised these are monitored by the centre coordinator. However, the Assessment Team found police checks for several staff had expired. The chief operations manager did not have a valid police check, but advised they have the paperwork and will complete the application. The Assessment Team were unable to obtain evidence that all staff had valid and current first aid certificates.

**Feedback and complaints**

The Assessment Team found the service did not demonstrate effective governance in relation to feedback and complaints. Review of documentation did not show that monitoring occurs to ensure complaints are reviewed to make improvements to the quality of care and services. The feedback and complaints policy does not include open disclosure.

I have considered the evidence in the Assessment Team report regarding areas of ineffective organisational governance, and I acknowledge the Approved Provider has not refuted this evidence in their response. The Approved Provider’s response outlines several planned improvements to return to compliance in this requirement. However, I consider it will take time for these actions to be implemented and sustained in practice.

* Accordingly, I find the service non-compliant in Requirement 8(3)(c).

Requirement 8(3)(d)

The Assessment Team found the service did not demonstrate effective risk management systems. Management identified there were gaps in the organisation’s processes for identifying risks and putting risk management strategies in place. The Assessment Team found that although the organisation has an accident/incident report register, it does not have effective management systems and processes to manage high impact and high prevalence risks. The register for 2023 contained incidents records noting staff were unaware of how to support consumers and did not have access to incident management processes when incidents occurred. Staff advised they had completed elder abuse training but were unable to describe SIRS reporting requirements.

Based on the evidence provided, the organisation does not have a clinical governance framework to ensure the quality and safety of its CHSP clinical care and support services. In their response the Approved Provider did not refute the findings of the Assessment Team report and noted planned improvements to return to compliance in this requirement. However, I consider it will take time for these actions to be implemented and sustained in practice.

* Accordingly, I find the service non-compliant in Requirement 8(3)(d).

Requirement 8(3)(e)

The Assessment Team found the service did not demonstrate an effective clinical governance framework is in place. Both the governing body and management advised the service does not have a clinical management framework that includes antimicrobial stewardship, minimising the use of restraint and open disclosure. Clinical issues and incidents are required to be reported to the Board, but the Assessment Team did not find any information to corroborate this has occurred. Staff and management demonstrated an understanding of the basic principles of open disclosure including acknowledging when things go wrong, being transparent and offering an apology.

The organisation does not prescribe medications. However, management and staff demonstrated an awareness of the effect of overuse of antibiotics. They advised they do not have any consumers who have been identified as subject to the use of restraint, but noted the organisation strives to minimise restrictive practices. However, the environmental restraint of consumers at the day centre was considered in Requirement 5(3)(b).

Based on the evidence provided, I consider that the organisation does not have a clinical governance framework to ensure the quality and safety of its clinical care and services provided by its CHSP service. In their response the Approved Provider did not refute the findings of the Assessment Team report and noted planned improvements to return to compliance in this requirement. However, I consider it will take time for these actions to be implemented and sustained in practice.

* Accordingly, I find the service non-compliant in Requirement 8(3)(e).

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