**Performance**

**Report**

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| Name: | Bay & Basin Community Resources Limited |
| Commission ID: | 200230 |
| Address: | 16 Sanctuary Point Rd, SANCTUARY POINT, New South Wales, 2540 |
| Activity type: | Quality Audit |
| Activity date: | 14 May 2024 to 16 May 2024 |
| Performance report date: | 3 July 2024 |

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

# Service included in this assessment

Home Care Packages (**HCP**) included:  
Provider: 883 Bay & Basin Community Resources Limited  
Service: 17328 Baycare - Bay & Basin Community Care Service

Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 7332 Bay & Basin Community Resources  
Service: 24903 Bay & Basin Community Resources - Care Relationships and Carer Support  
Service: 24902 Bay & Basin Community Resources - Community and Home Support

**This performance report**

This performance report for Bay & Basin Community Resources Limited (**the service**) has been prepared by P.Frangiosa, 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 25 June 2024.

# Assessment summary for Home Care Packages (HCP)

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| --- | --- |
| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **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 | **Compliant** |
| **Standard 8** Organisational governance | **Compliant** |

# 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 | **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 | **Compliant** |
| **Standard 8** Organisational governance | **Compliant** |

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

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# 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. | Compliant | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant | 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 | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant | 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 | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant | Compliant |

Findings

Consumers and representatives stated consumers are treated with respect by staff. Staff described how they treat consumers with dignity and respect. Documentation showed detailed recognition of consumers’ identity, culture and diversity, with each consumer’s background, social, cultural, language and family composition recorded.

Consumers confirmed care and services are culturally safe. Staff confirmed they consider the consumer’s cultural background when providing care and services. Management stated all staff have a cultural understanding or commonality between staff and consumers. Survey results confirmed consumers agree the service respects their religious or cultural beliefs.

Consumers and representatives confirmed the service supports consumers to exercise choice and independence, with staff ensuring the consumer is provided opportunities to decide on services and care provided. Staff described how they support consumers to make day-to-day choices. Management discussed how the service has ongoing communication with consumers to support consumer choice and independence. Documentation showed the service captures details about whom the consumers wish to be involved in decisions.

Consumers and representatives confirmed consumers feel confident to take risks around mobilising in the community. Staff confirmed they encourage consumers to undertake challenging tasks. Documentation showed the service has a dignity of risk procedure and waiver process for consumers undertaking higher risk activities.

Consumers and representatives confirmed consumers receive information about the care and services provided. Staff described strategies used to assist consumers with communication barriers, including using body language and written cues. Management described how the service translates information for consumers and arranges face-to-face meetings with consumers with hearing difficulties. Documentation showed the service routinely provides information on how to access language services for assistance with interpreting or translation if required.

Consumers and representatives confirmed staff respect and protect the consumer’s privacy. Staff described how they maintain consumer privacy and confidentiality by not sharing information with others who are not authorised to receive it. Management described the process for sharing personal and sensitive information only with those who require the information. Documentation confirmed the service uses a privacy consent process prior to sharing information with others.

Based on the information summarised above, I find the provider, in relation to the HCP and CHSP service delivery, compliant with all Requirements in Standard 1, Consumer dignity and choice.

# 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. | Compliant | 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 | 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 | 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 | 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 | Compliant |

Findings

Requirement 2(3)(a) was found non-compliant following a Quality Audit undertaken from 14 to 16 May 2024. The service did not demonstrate:

* 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.

The Assessment Team was not satisfied the service is analysing risk to consumer’s health and well-being, and not utilising validated tools to inform the delivery of safe and effective services, across all services. The Assessment Team provided the following evidence to support their assessment:

* Staff advised they had not received training on falls, wound care, skin integrity specific to any one consumer and the consumer file alerts do not provide risk mitigation strategies in responding to these.
* Documentation reviewed by the Assessment Team identified the capture of risks to consumers, such as a falls risk, or environment impacting the delivery of service, but no mitigation strategies or risk assessments.

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

* Specific responses to sampled consumers, and broader responses to requirement deficiencies, including:
  + Introduction of the following validated tools: Falls Risk for Older People Community Setting (FROP-COM); Older American Resources (OAR); Multi-Dimentional Functional Assessment Questionnaire - Complete Activities of Daily Living Section (OARS-ADL-IADL). Other tools added to assessment processes are: Cognitive Screening Tools (AD8/RUDAS/PAS); Epworth Sleepiness Scale; Nutrition - MNA; Pain Assessment Tools - Abby Pain Scale/Brief Pain Inventory; Continence - Revised Urinary and Faecal Incontinence Scales.
  + Planned actions and current roll outs:
    - currently reviewing all high risk - high prevalence CHSP clients to assess whether they should be allocated to a dedicated HCP Care Manager (funded by BCR as no Care Manager funding applies under CHSP).
    - Training on the Care Guide Fact Sheets including identifying and responding to risk of falls, wound care, and skin integrity is being included in the BCR Training Calendar.
    - Review all high-risk high prevalence clients including CHSP clients to ensure mitigation strategies and risk assessments are completed. High-risk high-prevalence CHSP clients will be transferred to dedicated BCR Care Managers to ensure risk management is consistent.
    - All clients will have a Falls Risk for Older People Community Setting (FROP-COM) screen and based on the outcome, relevant clients will receive a clinical review or BCR will refer CHSP clients for a MAC re-assessment.
    - The BCR Intake Checklist will be updated to include the Falls Risk for Older People Community Setting (FROP-COM) screen.
    - Introduction of Care Guides (fact sheets) for care staff which will be accessible through their mobile device as it will be uploaded to client files with the Support Plan when a risk is identified.
    - BCR Intake Checklist has been updated to include the Falls Risk for Older People Community Setting (FROP-COM) screen

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate and comprehensive introduction of risk mitigation and assessment tools, with further training to be introduced as part of the 2024-2025 Training Plan.

I appreciate the provider’s acknowledgement regarding identified gaps and proposed timeframes and methods in responding to them. The intent of this requirement is about making sure that assessment and planning are effective. To assess, plan and deliver care and services that are safe and effective, members of the workforce need to have the relevant skills, qualifications and knowledge to assess individual consumers’ needs and to understand their needs, goals and preferences.

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

Requirement 2(3)(b) was found non-compliant following a Quality Audit undertaken from 14 to 16 May 2024. The service did not demonstrate:

* 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.

The Assessment Team was not satisfied the service has guiding policies and processes in place, and consumer files reviewed showed inconsistencies in documenting current assessment and planning, across all services. The Assessment Team provided the following evidence to support their assessment:

* Sampled consumer care plans viewed did not always capture current needs, for example, one consumer has a wheelchair, pressure cushion, vital call and shower chair which are not identified in the care plan.
* One consumer is identified as being palliative on the service’s risk grouping, but it is not mentioned in her care planning documentation.
* An incomplete care plan for one consumer who had transferred back to CHSP with recommendations from a dietician, occupational therapist and physiotherapist not updated in either the STRC or CHSP care plan.
* Sampled consumer care plans do not have current planning documentation, with a number two to three years out of date, demonstrating a lack of currency.
* Management acknowledged assessment methodology is conducted on an ad hoc basis with care managers or staff providing reviews.
* Management advised the service has a draft quality management, continuous improvement and internal audit procedure which is yet to be implemented.

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

* The service had in place prior to the audit, processes and checklists for assessment and planning. These were provided to the assessors in hard copy over the three days. These tools were embedded as they had been in use for years at BCR.
* One consumer sampled had been provided with the NSW Health Advanced Care Planning document in June 2024, with care plan review completed.
* In February 2024, the service had run a report to identify outstanding CHSP Plan Reviews. The subsequent development of a strategy and process to have these reviews completed by December 2024 was communicated during the quality audit. The services Continuous Improvement Plan has been updated to progress monthly reporting by the CHSP Operations Manager to the Executive Manager Aged Care.
* 3 remaining sampled consumer care plans have been reviewed and updated to include needs, goals and preferences, including advanced care directives (where applicable).
* 1 consumer care plan was reviewed and updated by the palliative care team, reflecting the consumers declined ongoing palliative care support. The client does not consider herself palliative so respecting client choice she was removed from the group and that information was not added to her Care Plan. The notes had been captured for internal use.
* The service will continue to provide each CHSP and HCP client with end-of-life planning information at intake, during each Care Plan review and at least annually within the client newsletter.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate and comprehensive response to deficiencies identified.

I appreciate the provider’s acknowledgement regarding identified gaps and proposed timeframes and methods in responding to them. The intent of this requirement is about ensuring organisations do everything they reasonably can to plan care and services that centre on the consumer’s needs and goals and reflect their personal preferences.

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

Requirement 2(3)(e) was found non-compliant following a Quality Audit undertaken from 14 to 16 May 2024. The service did not demonstrate:

* 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.

The Assessment Team was not satisfied the service has current policies to inform care reviews for effectiveness (noting that the service had an in-draft aged care client documentation audit procedure). The Assessment Team provided the following evidence to support their assessment:

* One consumer was subject to an incident as documented in the provider’s incident management sheet; however, a review was not conducted after the finalisation of the incident in April 2024.
* One consumer was identified in the providers ‘SIRS report 27’ as being subject to an event, however a consumer review had not occurred.
* Another consumer care planning documentation was observed as being completed in 2021, with no additional plans available on the services organisational drive or the client management system implying a lack of regular review.
* Management acknowledged care plans are not reviewed for effectiveness, such as asking the consumer if they felt their goals have been realised, this includes for short term restorative care (STRC). In addition, management identified in some instances CHSP care plans are nine months out of date.
* The 2024 consumer survey included the following question: ‘Have your needs changed over the last 12 months?’ 67% of respondents responding that their needs have changed over the past year demonstrating the need of an effective monitoring method for reviewing care plans and responding to changes.

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

* Advising Policies and Procedures had been reverted to draft documents so the service could undertake a full review of all documentation prior to it being uploaded to the new service Intranet. The services Client Documentation Audit Procedure is being updated to include a review for effectiveness and quality of documentation.
* In response to one consumer identified as a SIRS event, and care review not conducted.
  + This consumer is an HCP client and was receiving Social Support Group (SSG) activities through CHSP funding. The assessment team looked in the CHSP notes, however the information regarding the SIRS and review was captured in the HCP Care Manager notes within the same system which the assessment team did not review.
  + An assessment had been completed in April 2024 and the incident occurred on 5 May 2024 where Community Transport did not pick the consumer up from home as planned, however service staff were made aware of the issue and were in contact with the consumers carer on the day of the incident. On the 9 May 2024, client attended SSG group activity, and the Lifestyle Activities Officer checked on his wellbeing which was captured in case notes.
* In response to one consumer identified as a subject of an identified incident and documented in the services incident management sheet.
  + The consumer had a support plan review in person on 20 May 2021. On 9 September 2023 the consumer was contacted, and a phone review was completed, and a MAC review submitted. The consumer received follow up from the service regarding the review. An in-person Support Plan review was conducted 18 June 2024. The support plan review process now includes a trigger to complete a review if there has been a complaint or incident that has been investigated.
* One consumer identified as not having an updated care plan or review since 2021.
  + This consumer became a client with the service on 24 January 2024. All documents were on file. This appears to be an assessor error.
* Plan effectiveness: the service have now added to the Support Plan document: meeting / not-meeting columns for all client goals.
* The service conducts surveys at least annually to seek feedback on our services and support. All clients who responded to the 2024 client survey noting that their needs have changed have been contacted and/or a review has been scheduled.
* Policies and Procedures are being approved and rolled out via the service intranet - this has been ongoing prior to the audit. The service will be developing an audit schedule based on feedback from the Quality & Safety Sub-Committee and Care and Clinical Governance Sub-Committee, including reporting requirements and schedules to meet Governance requirements.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a comprehensive response to deficiencies identified, both to specific examples, and organisational responses and proposed actions.

The intent of this requirement is to ensure organisations are regularly reviewing the care and services they provide to consumers.

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

Requirement 2(3)(c) and Requirement 2(3)(d).

Consumers and representatives confirmed the service involves them, and others they wish involved, in the care planning and assessment process. Staff and management demonstrated how assessment and planning occurs in partnership with consumers, the service and other health care professionals where necessary. Documentation showed assessment and planning involves the consumer and others the consumer agrees to be involved, including other organisations, individuals and other providers.

Consumers and representatives confirmed they receive assessment and care planning information and documentation, and staff know what they are doing. Staff confirmed they have access to care planning documentation to guide the care and services they provide for consumers.

Based on the information summarised above, I find the provider, in relation to the HCP and CHSP service delivery, compliant with Requirements 2(3)(c) and 2(3)(d) in Standard 2, Ongoing assessment and planning with consumers.

# 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. | Compliant | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant | 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 | 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 | 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. | Compliant | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant | Compliant |

Findings

Requirement 3(3)(a) was found non-compliant following a Quality Audit undertaken from 14 to 16 May 2024. The service did not demonstrate:

* Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice; and is tailored to their needs; and optimises their health and well-being.

The Assessment Team was not satisfied the service did not demonstrate that each consumer in receipt of all STRC, HCP and CHSP services receives care that is best practice, tailored to their needs and optimises their health and wellbeing. The Assessment Team provided the following evidence to support their assessment:

* One consumer care planning documentation did not consider clinical and personal care with matters such as oxygen flow rate, the frequency of filter changes in the oxygen concentrator and the frequency of nasal tubing changes. Further information omitted included consideration of skin integrity of the nasal cavity, nursing or allied health assessment, or who is responsible for monitoring the oxygen flowrate given the consumers failing eyesight.
* Another consumer recently transitioned from CHSP after completing the STRC program.
  + The Assessment Team was not able to find the care plan on the services client management system, resulting in the inability of staff to see the plan at the point of care. The care plan was saved on the services organisational drive, it did not include details of clinical assessments such as nursing, occupational therapy (OT), and dietician.
* One consume with a diagnosis of dementia, requiring extensive supports when their representative and family is not available. The Assessment Team could not locate a care plan on the services client management system and the care planning documentation for the consumer on the provider’s organisational drive was dated 2021, resulting in a lack of services that are best practice, tailored for the individual and optimise wellbeing.
* Management confirmed the use of clinical resources by the service, and how they are not validated tools, with the exception of the psychogeriatric assessment scales in use for the purpose of providing evidence for a dementia supplement with Services Australia.

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

* Management confirmed that the service uses a tool (OARS-ADL-IADL) which is a validated tool, however as one additional question was added to the tool to meet the services need for information gathering, this tool (called internally multidimensional functional assessment tool) was no longer considered a validated tool.
  + The service has now changed to the OARS-ADL-IADL tool and the FROP-COM screen at initial assessment with a number of validated tools being identified and added in our Clinical Review Form to be attended by the clinical team. Supporting evidence sighted confirms this.
* The service have developed an Oxygen Care - Fact Sheet as part of their Care Guides which will be uploaded to Care Workers mobile devices via TRACCS CRM alongside the Support Plan for clients using oxygen.
  + The service are reviewing clients to ensure all clients using oxygen have been identified and will check if the equipment is on the Support Plan and add to Support Plans if not.
  + Training will be provided in using fact sheets (Care Guide Training). Care Workers who do not have experience in managing oxygen will be provided coaching by the services Care Coach.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate response to deficiencies identified.

The intent of this requirement sets out the expectation that organisations do everything they can to provide safe and effective personal and clinical care. This means organisations make sure that the personal and clinical care they provide is best practice, tailored to consumer needs and optimising consumers health and well-being. In responding to the deficiencies identified, the service has provided evidence to support wholesale changes via the introduction of further validated tools (with complimentary training), resulting in consumer centric action.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 3(3)(a) in Standard 3 Personal care and clinical care.

Requirement 3(3)(b) was found non-compliant following a Quality Audit undertaken from 14 to 16 May 2024. The service did not demonstrate:

* Effective management of high impact or high prevalence risks associated with the care of each consumer.

The Assessment Team was not satisfied the service did not demonstrate effective management of high impact, high prevalence risks associated with the care of each consumer across STRC, HCP and CHSP. The Assessment Team provided the following evidence to support their assessment:

* Management self-identified that best practice was not in used for wound care such as use of rulers to measure the diameter of the wound, however the service will commence the practice.
* The representative for one consumer advised they administer psychotropic as prescribed by their medical officer to assist with behaviours.
  + The service confirmed they were not aware of the restrictive practice and had not requested medications from the representative to monitor for restrictive practices or polypharmacy, including training to support staff to be alert to side effects such as dizziness or drowsiness.
* Management advised the service utilises groups within the client management system to collate consumers with similar conditions, but it is not extensive and does not allow the service to monitor high impact and high prevalence conditions.
* The service does not have a high impact - high prevalence register.
  + Furthermore, the service does not provide training on restrictive practices or other high impact incidents, and currently the clinical and monitoring forms in use are not guided by a policy or procedure.
* Documentation for one consumer identifies and documents potential risks, however risk mitigation strategies were not documented within the care plan.

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

* Advising that the service does not use the terminology *high prevalence, high impact risks* with our care staff – the service support their team's understanding using more general terms and real examples of how to support clients safely while respecting client choice. HCP Care Managers have always used a meeting format to identify high impact-high prevalence clients which is conducted and minuted fortnightly. The assessment team were provided with this evidence at the time of audit.
* In response to one consumer receiving psychotropic medication. This medication is administered by his carer. This consumer is currently in respite care; however, a full clinical review will be conducted on his return home, with care workers provided with suitable instructions.
* The service implemented the STOP AND WATCH methodology along with our Make a Report form for Care Workers to alert Care Managers to changes in a client's condition including increasing pain and pressure injuries.
* The services new Training Calendar includes restrictive practices training, and the intranet will include restrictive practices information for care workers. There has been training and mentoring on the management of high impact incidents including for the Senior Care Manager and CHSP Operations Manager.
* The clinical assessment and monitoring forms and processes have been developed. The Policy and Procedure is in draft and once approved will be shared through the service Intranet.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate response to deficiencies identified.

The intent of this requirement ensures organisations need to do all they can to manage risks related to the personal and clinical care of each consumer. This means following best practice guidance and applying measures to make sure the risk is as low as possible whilst supporting a consumer’s independence and self-determination to make their own choices, including to take some risks in life.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 3(3)(b) in Standard 3 Personal care and clinical care.

Requirement 3(3)(c) was found non-compliant following a Quality Audit undertaken from 14 to 16 May 2024. The service did not demonstrate:

* The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved.

The Assessment Team was not satisfied the service did not demonstrate the needs, goals, and preferences of HCP, CHSP or STRC consumers nearing the end of life are recognised and addressed, their comfort is maximised, and their dignity is preserved. The Assessment Team provided the following evidence to support their assessment:

* Management and staff advised how end of life supports and advanced care planning for consumers is not something that the service has proactively considered. The service works with palliative care teams and often talk to consumers, however not proactive in providing any information to consumers to alert them to options or keep information on hand so that they are able to access it quickly.
  + Management confirmed and provided a sample of the new consumer pack which includes information on end-of-life planning.

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

* All clients are asked about Advanced Care Directives on intake, and the question is included in Care Plan reviews. HCP Care Managers are very aware of Advanced Care Directives and have those directives for the HCP clients who are willing to discuss/share that information with care workers.
* NSW Advanced Care Plans are provided for all new clients as part of our document pack. The service is developing a plan to roll these out to existing clients. All clients will be provided with information about advanced Crae Directives (ACDs) in the next client newsletter. ACD will also be added to the Care Plan reviews to capture preferences or changes to ACD.
* The service partnered with a recognised software provider, to support our clients with their end-of-life planning. This was promoted in client newsletters including a feature on a client who had used this software.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate response to deficiencies identified.

The intent of this requirement focuses on how personal and clinical care is delivered at the end of a consumer’s life. Organisations are expected to recognise the needs, goals and preferences of consumers who are nearing the end of their life. Communication with the consumer and a care and services plan that reflects to their needs, goals and preferences will support this requirement. The service has responded with evidence relating to ACDs, communication to consumers, improvements to training and service delivery, and inclusions at commencement of service.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 3(3)(c) in Standard 3 Personal care and clinical care.

Requirement 3(3)(d) was found non-compliant following a Quality Audit undertaken from 14 to 16 May 2024. The service did not demonstrate:

* Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.

The Assessment Team was not satisfied the service did not demonstrate deterioration or change in a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. The Assessment Team provided the following evidence to support their assessment:

* Documentation reviewed showed a lack of documented evidence in responding to consumers changing and emerging needs and documenting routine observations and displaying critical information.
  + Staff alerted the care manager on two instances about deterioration of one consumer in September of 2023 and January of 2024. File reviews did not show evidence of the service responding to the deterioration.
  + Care planning documentation for one consumer was evidenced as incomplete. This consumer participated and exited the care program with no update to the care plan with such information as nursing, dietician and Occupational therapy recommendations and the care plan was labelled as an interim care plan.
* The service has a workflow in place for recognising and responding to deterioration including various steps to be completed. The Assessment Team could not find evidence of various stages such as feedback to the staff member, representatives and others who have recognised changes.

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

* The examples provided by the assessors includes those where the service had demonstrated timely responses to deterioration or change, however we accept that there were instances where this was not the case.
* Care Workers currently use the Make a Report process to identify changes in clients. These are reported to their Care Manager. The process of response is documented in our flowchart.
* In response to one CHSP consumer, a review had been submitted to My Aged Care with client consent on 11 March 2024 suggesting a Home Care Package. A Support Plan review is trying to be coordinated with their representative present as requested by the client, however this matter is still in progress.
* Deterioration - Clinical Review form has been reviewed and audits will be conducted on these as part of a reviewed audit documentation schedule.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate response to deficiencies identified.

The intent of this requirement explains how organisations are expected to respond to deterioration or change in a consumer’s mental health, cognitive or physical function, capacity or condition.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 3(3)(d) in Standard 3 Personal care and clinical care.

Requirement 3(3)(g) was found non-compliant following a Quality Audit undertaken from 14 to 16 May 2024. The service did not demonstrate:

* Minimisation of infection-related risks through implementing: standard and transmission-based precautions to prevent and control infection; and practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.

The Assessment Team was not satisfied the service did not demonstrate the minimisation of infection related risks through implementing precautions to prevent and control infection and reduce the risk of increasing resistance to antibiotics for consumers across all HCP, CHSP and STRC funding. The Assessment Team provided the following evidence to support their assessment:

* One consumers representative stated the consumer was on several medications, including a psychotropic for mood stabilisation.
  + The service was not aware of the restrictive practice and confirmed that no medications were on file.
  + Management acknowledged the need to document consumers medications and provide training to staff on such things as side effects and restrictive practices. These had been included in the services plan for continuous improvement.
* The services medication management policy does not include consideration for the use of antibiotics, and the policy does not clearly outline the responsibility for the monitoring of medication.
  + Management advised the service had previously captured the medication of consumers, but no longer does so. Adding that it has been included in the plan for continuous improvement. Medications will be documented and analysed to inform quality care.
* Management advised that the service does not have an outbreak plan for gastro or covid but are aware of what should be done.
  + Management have included an outbreak plan in the services plan for continuous improvement.
* The service does not have a policy on antimicrobial stewardship and processes to support appropriate administration of antibiotics.

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

* The service seek current medication lists from clients considered high risk of use of psychotropic medications and develop a process for clients to keep the service informed of changes in medication.
* When clinical reviews are conducted current medications will be requested and documented with a review of polypharmacy and antimicrobial stewardship.
* Policy and Procedures will be updated or developed to document these processes.
* The service is currently updating its Medication Management policy to include consideration for the use of antibiotics and responsibility for the monitoring of medication.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate response to deficiencies identified.

Under the intent of this requirement Organisations are expected to assess the risk of, and take steps to prevent, detect and control the spread and severity of infections. Furthermore, ideal use of antibiotics means treating consumers ‘with the right antibiotic to treat their confirmed condition, the right dose, by the right route at the right time and for the right duration based on accurate assessment and timely review.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 3(3)(g) in Standard 3 Personal care and clinical care.

Requirement 3(3)(e) and Requirement 3(3)(f).

Consumers and representatives expressed satisfaction that the consumer’s condition, needs and preferences are communicated within the service and with others where care is shared. Management discussed how information and recommendations to other health practitioners are received, reviewed and implemented and documented. Documentation showed the service communicates with others to ensure the provision of personal and clinical care for consumers.

Consumers and representatives expressed satisfaction the service will refer the consumer to other organisations and providers when required. Management demonstrated an understanding of referral networks and described internal and external referral processes used by the service. Documentation showed the service makes referrals to other organisations and providers where the need is identified.

# 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. | Compliant | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant | 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 | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant | Compliant |

Findings

Requirement 4(3)(g) was found non-compliant following a Quality Audit undertaken from 14 to 16 May 2024. The service did not demonstrate:

* Where equipment is provided, it is safe, suitable, clean and well maintained.

The Assessment Team was not satisfied the service did not demonstrate that equipment purchased through HCP and STRC funding for consumers is safe, suitable and well maintained. Equipment provided by the service for CHSP consumers such as chairs, bedding and vehicles are safe, suitable and well maintained. The Assessment Team provided the following evidence to support their assessment:

* One consumer was identified as using a wheelchair, a lift and shower chair, and a pressure cushion. Not all are documented on the care plan and ongoing and periodic maintenance has not been a considered, such as documenting or checking the pressure of the cushion or the tyres on the wheelchair.
* Another consumer identified has an electric scooter in place. Though management were able to discuss maintenance of the scooter, it was acknowledged it was consumer led and no register of regular maintenance or warranty is kept. Additionally, the consumer has a hospital style bed with rails, and it has not been identified in the consumers care plan.

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

* The introduction of an individual Equipment Register on client's support plans which incorporates maintenance and cleaning. For annual maintenance for individual equipment (e.g. Scooter) reminders will be captured on our TRACCS system.
* In response to one consumer identified as using a wheelchair, a lift and shower chair, and a pressure cushion.
  + This consumer has had a Support Plan review completed which now includes the new maintenance schedule. Pressure cushion will be checked by a physio monthly; client will manage tyres on wheelchair and will escalate as required to Care Manager (documented on Support Plan).
* In response to one consumer identified as using a hospital style bed with rails.
  + The service has investigated the bed rail, and the client can remove the bed rail themselves, however, keeps the bedrail in place as it is used to assist them with moving on/off the bed. This is not a restrictive practice, however if the consumer deteriorates, they have been informed that the rail may be considered a restrictive practice and the service will provide the consumer with alternative best practice options to consider.
  + The bed has been added to the Client Support Plan Equipment Register.

Requirements 4(3)(a), 4(3)(b), 4(3)(c), 4(3)(d), and 4(3)(e)

Consumers and representatives confirmed the services and supports for daily living the consumers receive support the consumers to optimise their independence and well-being. Staff described how individualised and effective services and supports for daily living meet each consumer’s needs, goals and preferences. Management stated feedback from consumers on activities would be part of the service’s activities calendar. Documentation showed assessments and care plans identify services and supports for daily living which promote individual consumer’s independence and enhanced quality of life.

Consumers and representatives expressed satisfaction with the supports for daily living received by consumers. Staff described how they recognise and support consumers’ emotional, spiritual and psychological well-being and how services provided meet those needs. Management demonstrated an understanding of supporting consumers in their emotional, spiritual and psychological well-being. Documentation showed evidence of support strategies to meet individual consumer’s emotional, spiritual and psychological well-being.

Consumers and representatives confirmed consumers participate in activities of interest to them in their homes and in the community. Staff stated they access information about consumers to guide them on how to support the consumer in their personal relationships. Management described processes used by the service to meet the social and personal needs of consumers. Documentation showed services and supports for daily living support consumers to participate in the community, do things of interest to them and have social and personal relationships.

Consumers and representatives confirmed the consumer’s needs and preferences are communicated during the assessment process. Management advised consumer care plans are available to staff. Documentation showed care plans include clear directives about the consumer’s condition, needs and preferences.

Consumers and representatives confirmed the service supports consumers to access other services, including other lifestyle services where appropriate. Staff stated they will document concerns about consumers for management to review and make referrals where necessary. Management discussed processes used to refer consumers for additional care and higher-level packages. Documentation demonstrated the service refers consumers to organisations and providers for additional services and supports when necessary.

Consumers confirmed the food provided is satisfying and nutritious. Staff described how the service ensures appropriate meals are provided based on consumer needs and preferences, including allergies and likes and dislikes. Documentation showed the service has a documented emergency plan which identifies allergies, likes and dislikes of consumers and there are special directives for consumers with diabetes.

# 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. | Compliant | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant | Compliant |

Findings

Consumers confirmed they feel comfortable and welcome in the service environments. Staff described how they support consumers to interact and use the service environment to suit their needs. Management described how they know consumers feel welcome by assessing attendance and participation in activities. Consumers were observed participating in activities in the service environment.

The service environment was observed to be clean, accessible and fit for purpose. Staff stated the environment is rearranged for the needs of consumers on the day and there is a cleaning process in place to ensure the environment is clean and ready for use by the consumers.

Staff and management described the processes for cleaning equipment and escalating issues with furniture. The service environment was observed to be clean and well-maintained.

Based on the information summarised above, I find the provider, in relation to the HCP and CHSP service delivery, compliant with all Requirements in Standard 5, Organisation’s service environment.

# 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. | Compliant | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant | Compliant |

Findings

Consumers and representatives confirmed they are aware of how to provide feedback and raise complaints and feel safe to do so. Staff stated they seek feedback from consumers during service delivery and emphasise to consumers the importance of giving feedback. Management stated the complaint procedure is explained to consumers. Documentation showed complaint mechanisms and procedures are included in consumer agreements and consumer information manuals.

Consumers and representatives confirmed they are aware other methods for raising and resolving complaints, including knowing how to contact the Commission. Management described how the service supports consumers to access advocates and other services and methods for raising and resolving complaints. Documentation showed the service’s complaints procedure offer consumers diverse internal and external feedback, complaints and advocacy options.

Consumers and representatives confirmed the service resolved issues or informal complaints they had made. Staff described processes for escalating complaints from consumers. Management described how the service responds to complaints and how it uses open disclosure when issues are identified. Documentation showed the service uses an open disclosure approach to resolve issues, even though the service does not have an open disclosure procedure.

The service’s complaints policy states complaints will be addressed promptly, treated confidentially, and used as an opportunity for improvement. The service’s complaints register is used to trend complaints and improve service, with strategies implemented to avoid the same issues occurring again. Documentation showed complaints are actioned and finalised and, if necessary, improvements to services are implemented.

Based on the information summarised above, I find the provider, in relation to the HCP and CHSP service delivery, compliant with all Requirements in Standard 6, Feedback and complaints.

# 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. | Compliant | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant | Compliant |

Findings

Requirement 7(3)(a) was found non-compliant following a Quality Audit undertaken from 14 to 16 May 2024. The service did not demonstrate:

* 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.

The Assessment Team was not satisfied the service is assessing, planning and coordinating care and services to meet the needs of consumers and deliver safe and quality care and services, at all times. This could not be demonstrated in practice, across all services. The Assessment Team provided the following evidence to support their assessment:

* Management reported they have had 77 unfilled shifts in May 2024, although added this was a bad month for staff leave and not the typical number of unfilled shifts.
* Reviewed shift data from the past 5 months to May 2024, found the service consistently had unfilled shifts between 10-20 for the month. The service responded to this by saying they have a limited casual pool and do not have sufficient layers/mitigation strategies for multiple types of leave.

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

* The “master roster” feature in the services Customer relationship management (CRM) software establishes the care services required, effectively calculating the ongoing staff numbers and range of skills required. The rostering system identifies the type of service required on each occasion and there is a clear staffing model outlining what skills and qualifications are required for the various types of services. This model, along with many activities and strategies implemented to grow, develop and retain our workforce were outlined in the Self-Assessment Tool provided to the assessment team. The service prides itself on its unwavering commitment to active communication and consultation with clients regarding their service scheduling and firm commitment to adhering to required competencies and qualifications amongst our staff in accordance with our staffing model.
* The service employed a lead scheduler who works on the master rosters for the whole of the services to ensure services are planned to optimize the care workforce whilst continuing to meet client preferences. This role ensures any gaps or roster openings are identified proactively and forms part of the services many strategies to address and respond to workforce shortages being experienced in the aged care sector. Any service that requires replacement is clearly identified in the master roster as an unfilled service whilst awaiting re-allocation. This ensures client services are not lost track of and that communication and consultation can occur with clients.
* The service holds fortnightly workforce planning meetings to consider continuity of care and services for clients and to identify short and long-term shortages in the capacity or skills of its workforce, along with how we intend to address any shortages or emerging demand areas. Service leaders provide updates to this meeting including changing client needs, gaps or opportunities, client leave, exits and intakes. Workforce, Scheduling and People & Culture representatives discuss planned staff leave, workforce challenges, recruitment actions across the required mix of skills and geographical locations identified by the HCP and CHSP service leaders. This planning meeting results in actions for the next fortnight and beyond, taking into consideration forecasted growth.
* The service request part time and casual staff to extend availability and work additional hours wherever possible to either avoid shortages for planned leave or in response to unplanned leave. However, we do limit the amount of daily or weekly overtime is incurred to ensure staff health and wellbeing. We also strike a balance with the flexibility in hours and work schedules typically sought by home care workforce members. With the geographical spread of our services and relatively long distances between towns and villages, it is incredibly challenging to achieve the ability to have multiple layers of back up contingent workforce in every single locale in our service delivery areas. We were asked by the Assessment team how it is we could have care workers supporting support plan reviews when we had unfilled services occurring. Our response to that question was to consider the fact that an unfilled service may have occurred 150 km away from where our care worker was available and instead rostered to perform a support plan review. Whilst many of our staff are agreeable to working across regions, and we do incentivise this where we can, the reality is that even if a care worker has capacity in their roster, once travel time and distance is factored in, a worker invariably can only travel certain distances before their available time in a day for supporting clients is eroded by excessive travel times. This is a very real and pressing issue for regional home care providers in the context of thin markets.
* The assessment team were provided with additional unfilled shift reports which confirmed that there were an average of between 10-20 unfilled shifts per month which was less than 1% of total shifts delivered. In the context of sector wide workforce challenges and our evidenced process for prioritisation we believed there would be a small tolerance level for unfilled services where we were able to demonstrate risks were mitigated and client communication occurred. When management asked the assessment team this question it was indicated there was no clear threshold but rather the tolerance level or compliance would be based on prevalence of risk. With this in mind, we believe we have adequately monitored for and mitigated risk to clients within the context of the workforce challenges described and have and continue to implement sound and effective workforce management strategies in an effort to plan, grow, and retain a sufficient workforce.
* The service does not agree that unfilled shifts would result in regular SIRS reports for neglect, as it prioritises personal care and high-risk vulnerable clients when filling unfilled shifts. The service assesses SIRS based on the ACQSC guidelines and submits accordingly.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate response to deficiencies identified.

The intent of this requirement expects organisations to have a system to work out workforce numbers and the range of skills they need to meet consumers’ needs and deliver safe and quality care and services at all times. This system needs to be in line with current legislation and guidance where it applies. The system for managing the workforce may be different for each type of care and service. It’s expected that an organisation uses a structured approach for rosters and schedules, hiring and keeping members of the workforce, managing different types of leave and the use of contracted staff. In responding to the deficiencies identified, the service has provided evidence to support balanced responses based on numerical evidence provided, as counter to the assessment teams findings.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 7(3)(a) in Standard 7 Human resources.

Requirement 7(3)(c) was found non-compliant following a Quality Audit undertaken from 14 to 16 May 2024. The service did not demonstrate:

* The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

The Assessment Team was not satisfied staff could not describe regular professional development or training (beyond annually, to improve their knowledge, so they can effectively perform their roles. The provider utilises a third party ‘Conserve’ to conduct some compliance checks like qualifications of third parties, although this is not a consistent practice. The Assessment Team provided the following evidence to support their assessment:

* The provider could not demonstrate they have systems in place to ensure staff have the qualifications and knowledge to perform their roles.
  + Registered Nurses do not undertake competencies for nursing skills, like wound dressings.
  + Staff were asked to provide competencies for 3 selected care workers, this was not on the care workers file. Staff members provided contradicting statements as to who is responsible to monitoring staff’s competencies. The provider could not demonstrate which competencies staff have and how they are followed up.
  + Staff explained qualifications are uploaded onto the CRM, and it sends automatic reminders for updates. Although in reviewing the report provided it did not include up to date information.

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

* The services Clinical Team have been scheduled for training in wound care to occur in September and October 2024 through the Australian College of Nursing.
* A training matrix and 2024/2025 Training Plan has been completed for all staff and volunteers in aged care. This matrix and plan takes into consideration need areas identified at the time of the assessment.
* A single training register has been established, consolidating all training that is known to have occurred since approximately 2020. This register will continue to be populated and refined in order to integrate with CRM and individual training records to ensure it is an effective tool for monitoring all learning.
* This new consolidated register enables our organisation to more efficiently demonstrate which competencies each staff member has. The aged care leadership and People & Culture teams will review at the next Training meeting to ensure roles, responsibilities, and definitions in the identification and monitoring of training are clear.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate response to deficiencies identified.

This requirement is intended to make sure the workforce has the skills, qualifications and knowledge they need for their role to provide care and services. The requirement covers an organisation’s systems to regularly review the roles, responsibilities and accountabilities of their workforce. If personal or clinical care is provided, it’s expected that the organisation has systems to monitor whether staff are working within the scope of their practice, responsibilities and skills. The way staff delivering clinical care work needs to be in line with current legislation, guidance and the organisation’s clinical governance framework in accordance with relevant public health orders.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 7(3)(c) in Standard 7 Human resources.

Requirement 7(3)(d) was found non-compliant following a Quality Audit undertaken from 14 to 16 May 2024. The service did not demonstrate:

* The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

The Assessment Team was not satisfied the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. The Assessment Team provided the following evidence to support their assessment:

* Reviewed contracts between the service and third-party provider, did not specify the need to check for Banning orders when assessing their compliance. The provider could not demonstrate all staff have been check against the Banning Order list.
* The provider could not demonstrate the monitoring of staff compliance with training requirements. This was explained as being due to having multiple independent training systems.
* The provider could not demonstrate the monitoring of staff compliance with training requirements. This was explained as being due to having multiple independent training systems.

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

* It is our understanding that the assessment team asked a member of our volunteer administrative team about banning orders, to which she replied she was not aware. This staff member's role is not responsible for the compliance matters in recruitment of volunteers and therefore had no reason to be aware of banning orders.
  + The two People & Culture team members involved in recruitment of staff and volunteers and all matters of their compliance are fully versed in the aged care banning orders, had checked all employees and volunteers at the introduction of the banning orders and subsequently checked every time a new staff member is being recruited.
  + A hard copy recruitment workflow was provided to the assessment team clearly showing the checking of banning orders was a step in our recruitment process. Management did acknowledge that the recording the banning orders checks in to individual employee files in the database had not been occurring even though the People & Culture team asserted the banning orders file was being checked routinely for staff and volunteers using the search functionality in the CSV file.
* The assessment team were provided with evidence of checks for Banning Orders being in place for all service staff and volunteers.
  + A requirement for our Contractors to implement Banning Order checks is being included in the updated Contractor Agreement to be forwarded to all current and future contractors. All individual contractors (e.g. sole traders) have been checked against the Banning Orders by the service.
    - An updated Contractor Agreement will be forwarded to all contractors. In the interim, a Variation to Contract letter is being emailed to current contractors informing them of the requirement to check Banning Orders.
* The assessment team were provided with the records of the volunteer training days in 2023, outlining the agenda and the content. They were also provided evidence by way of an attendance sheet for Food Safety training.
* The People & Culture Manager stated the Driving policy was being drafted and that final decisions were being considered in relation to the procedure and timelines. Request and review of driving records now form part of the recruitment process and have been received for all new staff and volunteers who drive in the course of their employment.
  + This is in addition to the long-standing collection of evidence from all staff and volunteers as proof they hold the appropriate license class (and subsequent renewals) along with review of any driving restrictions noted.
    - Finalised draft of Motor Vehicle (Driving) policy and procedures for approval at next Workforce & Remuneration Sub-Committee.
  + Once the policy and procedures are approved at the next Workforce and Remuneration Sub Committee all existing staff and volunteers will then be asked to supply evidence of their driving record.
  + The service implemented this step-in response to the incident noted believing it demonstrated best practice.
* Learning and Development policy is under review based on the audit feedback and Quality Standards.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate response to deficiencies identified.

The intent of this requirement covers the organisation’s support for the workforce to deliver the outcomes for consumers in line with the Quality Standards. Meeting this requirement will support the workforce in their day-to-day practice and can protect against risk and improve the care outcomes for consumers.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 7(3)(d) in Standard 7 Human resources.

Requirement 7(3)(e) was found non-compliant following a Quality Audit undertaken from 14 to 16 May 2024. The service did not demonstrate:

* Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

The Assessment Team was not satisfied the provider could not demonstrate across all services, how they regularly assess, monitor and review the performance of each member of staff including volunteers, paid and brokered staff members. The Assessment Team provided the following evidence to support their assessment:

* Management had identified gaps in performance reviews of office staff prior to the Quality Assessment. Management had added this item to their plan for continuous improvement.
  + Staff will produce a monthly report to the Executive Aged Care Manager inclusive of performance against key performance indicators in their position description. This was not demonstrated as an embedded practice.
* Management did not have records or schedules which detail the percentage of office staff with completed performance reviews and follow up of those who don’t take part.

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

* All clients are asked to provide feedback about staff performance during our annual client survey and are encouraged to provide feedback if they have any complaints. This was evidenced to the assessors through our survey results and is further evidenced in the service receiving a Met for Standard 6 Feedback and Complaints.
* Implementing a new process takes time to embed. The recently updated performance review tool includes a format for one: one catch ups throughout the year. The leadership team will be supported to ensure this / or similar tool is embedded to support members of the workforce to monitor their own work.
* Management are not involved in how the Board performance is reviewed. Management do however support performance management by providing relevant information at relevant Sub-Committees and by generating Board Reports which highlight Governance matters including risks. The whole Executive team attend the bi-monthly Board meetings to ensure that Board members have the opportunity to ask questions regarding Executive and Sub-Committee reports.
* The service does conduct performance reviews for office staff. Although not every staff member has an up-to-date review, multiple examples could have been provided as evidence during the audit. Any outstanding performance reviews are being scheduled for all office staff.
* Evidence of management performance reviews provided to the assessors included 360 Performance Reports for the service’s Executive members. The CEO is reviewed by the Board of Directors. It was identified at March 2024 Workforce and Remuneration sub-committee that performance reviews would be completed on an annual basis by July/August every year. This is reflected in the newly created register and is identified in the Performance policy which is due to be approved at the next Executive Management meeting.
* Volunteer performance had not been reviewed formally in writing. It was explained to the assessment team that paid staff and volunteer procedures were being consolidated and that volunteer performance reviews would become formalised to align with processes for paid staff.
  + To that end, a revised performance policy has been completed along with a performance review tool for volunteers. All volunteers involved in service delivery will have a formal performance review completed by 31 August 2024.
* A Performance Review register has been created to clearly evidence those that have been completed and scheduled for those outstanding. Additional evidence provided in support of this included.
  + Performance Review Register for non-field staff
  + Performance Policy
  + Performance Review forms for volunteers.
  + Performance Procedure
  + Performance Review 1:1

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate response to deficiencies identified.

The intent of this requirement ensures that all members of the workforce are expected to have an appropriate person regularly evaluate how they are performing their role, and identify, plan for and support any training, and development they need. This requirement looks at how organisations need to regularly assess the performance and the capabilities of the workforce as a whole. Performance reviews can also support continuous improvement and development of the members of the workforce.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 7(3)(e) in Standard 7 Human resources.

Requirement 7(3)(b) Consumers and representatives confirmed consumers feel respected. Staff described how they relate to consumers respectfully. Results from a survey conducted by the service showed consumers feel they are treated with integrity and respect.

# 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. | Compliant | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant | 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 | 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 | Compliant |

Findings

Requirement 8(3)(c) was found non-compliant following a Quality Audit undertaken from 14 to 16 May 2024. The service did not demonstrate:

* Effective organisation wide governance systems relating to workforce governance, including the assignment of clear responsibilities and accountabilities.

Although the provider could demonstrate effective organisational-wide governance systems to monitor processes for information management, financial governance, continuous improvement, regulatory compliance and feedback and complaints, across all services, the service could not demonstrate effective organisational-wide governance systems for workforce governance. The Assessment Team provided the following evidence to support their assessment:

* Documentation viewed confirmed 3 board members who have conflict of interests (undeclared), with the chairperson declaring 1. Though the provider has drafted a conflict-of-interest policy, it does not have a conflict of interest register and could not demonstrate how these conflicts of interest are managed.

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

* Board Conflicts of Interest: Conflicts of Interest is a standing agenda item for every Board meeting (Board meeting minutes were provided to assessors). The service had a draft Conflicts of Interest, Gifts and Benefits Policy which was under review at the time of the audit. The Policy has now been approved by the Board and uploaded onto the service Intranet. The Policy includes a Conflicts of Interest Register which the three (3) identified Board Members has updated with their relevant conflicts of interest. The following evidence was provided to support these changes.
  + BCR Conflicts of Interest, Gifts and Benefits Policy
  + Conflicts of Interest Register Template - Board
  + Conflicts of Interest Register Template - Operations
  + Conflicts of Interest Procedure
  + Conflict of Interest Declaration

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a prompt response to deficiencies identified.

The intent of this requirement ensures workforce governance systems and process make sure workforce arrangements are consistent with regulatory requirements.

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

Requirement 8(3)(d) was found non-compliant following a Quality Audit undertaken from 14 to 16 May 2024. The service did not demonstrate:

* Effective risk management systems and practices, including but not limited to the following: managing high impact or high prevalence risks associated with the care of consumers; identifying and responding to abuse and neglect of consumers; supporting consumers to live the best life they can, and managing and preventing incidents, including the use of an incident management system.

The Assessment Team was not satisfied the service demonstrated effective risk management systems and practices. The Assessment Team provided the following evidence to support their assessment:

* Data in support of demonstrating effective system and process in managing high impact or high prevalence risk associated with the care of consumers was viewed. However, this data did not demonstrate how these risks are managed.
* Staff including volunteers could not recall training in identifying and responding to abuse, even though management stated this was provided at the annual training day for care workers.
* The Assessment Team identified that there may be restrictive practices in consumers’ homes which services were not aware of. As staff do not receive training in restrictive practices to identify what actions could be considered restrictive practice, consumers may be subject to them without recommended supports for them to live the best life they can.
  + When staff were interviewed, they stated they engaged in restrictive practices, agreeing with prompt examples, although could not elaborate on details.
* The provider supplied the incident and complaints register, it is currently on an excel spreadsheet limiting the services ability to monitor, trend and respond to incidents. The Assessment Team found not all incidents are recorded in the system and therefore cannot be reviewed for identifying training needs, preventing and managing the reoccurrence of incidents.
  + The representative of one consumer told the Assessment Team an incident occurred the week prior the Quality Assessment. The consumer received domestic assistance and the staff member used high amounts of bleach, causing the consumer to vomit twice. The staff member notified the registered nurse who was acting in the coordinator position and submitted a ‘make a report’, although this was not transferred into the incident register, and escalation and follow up had not occurred. Once the Assessment Team notified management of this incident, they began to review it and prior to the exit meeting notified the Assessment Team this is a SIRS and a notification would be submitted as soon as practicable.

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

**Risk management systems.**

* The service have a Care and Clinical Governance Commitment Statement (Framework) which we currently operate to, however will be also developing a policy underpinned by this framework/commitment statement.
* The service had been using assessment and mitigation strategies using a tool that combined two validated tools. This has been replaced with the following validated tools: Falls Risk for Older People Community Setting (FROP-COM); Older American Resources (OAR); Multi-Dimentional Functional Assessment Questionnaire - Complete Activities of Daily Living Section (OARS-ADL-IADL). Other tools now added to our assessment processes are: Cognitive Screening Tools (AD8/RUDAS/PAS); Epworth Sleepiness Scale; Nutrition - MNA; Pain Assessment Tools - Abby Pain Scale/Brief Pain Inventory; Continence - Revised Urinary and Faecal Incontinence Scales; plus Further Assessment Tools identified on the revised Clinical Review Form attached.

**High-Impact and High-Prevalence risks**

HCP Care Managers have always used a meeting format to identify high impact-high prevalence clients which is conducted and minuted fortnightly. The assessment team were provided with this evidence at the time of audit. BCR is developing a register of high impact-high prevalence clients based on the Client Risk Assessment Tool previously mentioned in Standard 2 response.

Care Guides with fact sheets had been developed but not yet rolled out identifying ageing related conditions such as choking, pain management, skin integrity and preventing pressure injuries. Training will be provided in the use of the Care Guides and relevant Fact Sheets for all care workers. The relevant Fact Sheets will be provided with client support plans where these risks have been identified for particular clients.

**Responding to abuse**

Management provided an example of identifying a consumer at risk of financial abuse. One consumer was engaged in an online relationship and the service had concerns about the authenticity of the person. Staff provided her with resources and information from the Department of Health and Aged Care on elder abuse, as they had concerns for this consumers pension. This was evidenced in care notes, and through talking to the consumer. The provider has a response and prevention of abuse policy and drafted client abuse and neglect prevention and response procedure and elder abuse procedure to guide staff in supporting consumers.

**SIRS**

The service assesses SIRS based on the criteria provided by the ACQSC. Unfilled shifts are prioritised by the risk factors associated with each client. For example, an unfilled shift requiring personal support would be filled as a matter of priority over domestic assistance support taking in all relevant factors for example.

**Supporting consumer to live the best life they can**

Restrictive practices - The assessment team provided an example of an interview with a care worker where the care worker was not familiar with the term 'restrictive practices'. The assessor said that to assist the staff member understand what they were asking, the assessor asked 'leading questions' about putting restrictive practices in place (they referred to moving a walker out of the way while they were cleaning floors to keep clients safe). The staff member agreed that they would do something like that to keep the client safe. The service were not provided with the staff member name so were unable to conduct our own investigation to see whether this was true or whether the staff member was answering based on the leading question and what the individual assessor was describing as strategies to keep a client safe.

The restrictive practices described by the assessors included a client who had a bed rail to assist him to get up and out of the bed. The bed rail can be removed at any time by the client, and the client has confirmed that it is used to assist his independence, not to restrict him in any way. The client's bed is not a hospital bed as described by the assessors, and the rail is removeable. The client wishes to retain the bed rail and understands that as his mobility declines, this may be viewed as a restrictive practice if it impacts their ability to get out of bed. This has been noted on the client's care plan.

The new service Training Calendar includes restrictive practices training, and the intranet will include restrictive practices information for care workers. There has been training and mentoring on the management of high impact incidents including for the Senior Care Manager and CHSP Operations Manager. The service will provide care workers with specific information on side effects where the use of a psychotropic medication is known and will link this information to the clients Support Plan documentation.

**Incident management system**

The information in the report regarding one consumer is incorrect. Further investigation by the service Executive Manager of Aged Care Services uncovered that the assessors had been provided with incorrect information by a family member who was not present at the home at the time of the incident. The carer who resides in the home with this consumer explained that earlier in the day this consumer had eaten food which was passed the use by date and was feeling unwell. There was no relation between the cleaning being conducted and this consumer being sick while the care worker was in the home. No bleach was used during the cleaning, and a SIRS report was closed due to there being no corroboration between the client being unwell and the worker providing cleaning services.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows extensive and evidenced responses to deficiencies identified.

The intent of this requirement is to ensure organisations are expected to have systems and processes that help them identify and assess risks to the health, safety and well-being of consumers. If risks are found, organisations are expected to find ways to reduce or remove the risks in a timeframe that matches the level of risk and how it’s affecting consumers.

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

Requirement 8(3)(e) was found non-compliant following a Quality Audit undertaken from 14 to 16 May 2024. The service did not demonstrate:

* Where clinical care is provided—a clinical governance framework, including but not limited to the following: antimicrobial stewardship, minimising the use of restraint, and, open disclosure.

The Assessment Team was not satisfied the service demonstrated effective clinical governance frameworks. The Assessment Team provided the following evidence to support their assessment:

* The quality care board minutes does not include clinical indicators for tabling and discussion, although have raised it for topic of discussion to identify which clinical indicators would best suit the service.
* The provider does not use of validated assessment tools this is further discussed in standard 3(3)(a). The service does not conduct its own clinical audits, to monitor its own practice.
* The services ‘Care and clinical governance commitment statement’ does not include antimicrobial stewardship, minimising the use of restraint or open disclosure.
* Consumer files reviewed noted that minimal consumers had medication lists from their general practitioner on file suggesting a gap in Good Antimicrobial Prescribing Protocol and lack of awareness on National Safety and Quality Health services Standards for Antimicrobial Stewardship for services delivered in the community.
* the service was unable to evidence their vaccination register for staff and third-party providers, as this in the same ineffective system discussed in requirement 7(3)(c).
* The provider does not provide training in identifying and managing restrictive practices or have a policy to guide and support staff. During the Quality Assessment the Assessment Team became aware of the following potentially restrictive practices and not best practice
* The provider does not have an incident management policy and clinical governance framework which is inclusive of open disclosure. Although the complaints handling procedure refers to open disclosure, and the provider was able to demonstrate staff have an understanding of open disclosure.

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

* Clinical Indicators are to be included in the Care and Clinical Governance Sub-Committee meetings.
* Clinical staff have position descriptions which clearly outline their responsibilities and accountabilities and attend Care and Clinical Governance Sub-Committee meetings where information is shared, and any issues are raised. There is continual development of policies, procedures, forms and processes to improve clinical governance. BCR's Continuous Improvement Plan includes items under development.
* Management confirmed that the service use a tool (OARS-ADL-IADL) which is a validated tool, however as one additional question was added to the tool to meet the services needs for information gathering, this tool (called internally multidimensional functional assessment tool) was no longer considered a validated tool. The service has now changed to the OARS-ADL-IADL tool and the FROP-COM screen at initial assessment with a number of validated tools being identified and added in our Clinical Review Form to be attended by the clinical team, please find attached.
* The service have a Care and Clinical Governance Commitment Statement (Framework) which we currently operate to, however will be also developing a policy underpinned by this framework/commitment statement.
* The service has included restrictive practices training on the training calendar and will provide care workers with specific information on side effects where the use of a psychotropic medication is known and will link this information to the clients Support Plan documentation. The clinical assessment and monitoring forms and processes have been developed. The Policy and Procedure is in draft and once approved will be shared through the Intranet.
* The service will seek current medication lists from clients considered high risk of use of psychotropic medications and develop a process for clients to keep us informed of changes in medication. When clinical reviews are conducted current medications will be requested and documented with a review of polypharmacy and antimicrobial stewardship.
* The new Training Calendar includes restrictive practices training, and the intranet will include restrictive practices information for care workers. There has been training and mentoring on the management of high impact incidents including for the Senior Care Manager and CHSP Operations Manager.
* The service has included restrictive practices training on the training calendar and will provide care workers with specific information on side effects where the use of a psychotropic medication is known and will link this information to the clients Support Plan documentation.
* CHSP Client has a psychotropic medication administered by his carer Please note: this consumer has transitioned to residential care for respite. The service will arrange for a clinical review on his return home and will provide care workers with information regarding potential side effects of his medications.
* The service has included restrictive practices training on the training calendar, and will provide care workers with specific information on side effects where the use of a psychotropic medication is known and will link this information to the clients Support Plan documentation.
* The restrictive practices described by the assessors included a client who had a bed rail to assist them to get up and out of the bed. The bed rail can be removed at any time by the client, and the client has confirmed that it is used to assist independence, not to restrict them in any way. The client's bed is not a hospital bed as described by the assessors, and the rail is removeable. The client wishes to retain the bed rail and understands that as their mobility declines, this may be viewed as a restrictive practice if it impacts their ability to get out of bed. This has been noted on the client's care plan.
* Dementia Support Australia resources on restrictive practices have been accessed and will be adopted into our procedures particularly in regard to behaviour support planning.
* ACCPA slides on restrictive practices have been shared with all Care Workers and office staff whilst the procedures and policies are completed, rolled out and approved.
* The service have a Care and Clinical Governance Commitment Statement (Framework) which we currently operate to, however will be also developing a policy underpinned by this framework/commitment statement.
* The service has developed forms to be used for clients that have been identified as either using a restrictive practice or the potential for a restrictive practice. These will be rolled out with a minimising the use of restraint policy and procedure along with specific training.
* Medication management Policy and Procedure will be reviewed to include antimicrobial stewardship, but this had already been addressed in the Infection Prevention and Control Procedure and Oral Medication Skills Assessments prior to the audit.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows extensive and evidenced responses to deficiencies identified.

The intent of this requirement is to ensure organisations are expected to have systems and processes that help them identify and assess risks to the health, safety and well-being of consumers. If risks are found, organisations are expected to find ways to reduce or remove the risks in a timeframe that matches the level of risk and how it’s affecting consumers.

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

Requirements 8(3)(a) and 8(3)(b)

Consumers and their representatives are engaged in the development, delivery and evaluation of all care and services through annual surveys and the consumer advisory body. Staff stated the service is well run and that consumers are engaged in their care. Management described the different ways the organisation involves consumers in developing, delivering and managing care and services.

Management explained the governing body meets regularly and considers operational reports presented by management. Feedback, complaints, incidents and deterioration reporting are part of monitoring, incorporated into the monthly governing body reporting processes.

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)