**Performance**

**Report**

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Bega Valley Community Options |
| Commission ID: | 200605 |
| Address: | 1 Zingel Place, BEGA, New South Wales, 2550 |
| Activity type: | Assessment contact (performance assessment) – non-site |
| Activity date: | on 13 October 2023 |
| Performance report date: | 15 December 2023 |

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

# Service included in this assessment

Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 8181 Bega Valley Shire Council  
Service: 24168 Bega Valley Shire Council - Community and Home Support

**This performance report**

This performance report for Bega Valley Community Options (**the service**) has been prepared by J Renna, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the Assessment Team’s report for the Assessment contact (performance assessment) – non-site report which was informed by review of documents and interviews with staff, consumers/representatives and others
* the performance report dated 3 March 2023 in relation to the Quality Audit undertaken from 1 February 2023 to 3 February 2023.

The provider did not submit a response to the Assessment contact (performance assessment) – non-site report.

# Assessment summary for Commonwealth Home Support Programme (CHSP)

|  |  |
| --- | --- |
| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

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 2

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

Findings

Requirements (3)(a), (3)(b) and (3)(c) and (3)(e) were found non-compliant following a Quality Audit undertaken from 28 March 2023 to 30 March 2023, as the service did not demonstrate:

* current risks to consumers health and well-being informed the delivery of services, as consumer care planning documentation had not been reviewed and sub-contracted service providers were not communicating changes or risks that may have been identified by staff in progress notes
* assessment and planning identified and addressed the consumer’s current needs, goals and preferences including advance care planning and end of life planning, as the care plan did not consolidate this information from various documents and the service did not seek information about advance care planning
* assessment and planning was based on ongoing partnership with the consumer and others the consumer wished to be involved in their care, with consumer care planning documentation unclear if consumers were provided with choice of providers allocated for supports
* Consumer care plans were reviewed regularly or when circumstances change, with sampled care plans not reviewed since 2018.

The Assessment Team’s report for the Assessment Contact undertaken on 13 October 2023 includes evidence of actions taken by the service in response to the non-compliance. These actions include, but are not limited to, reviewing and updating care planning documentation to ensure consumers are receiving the care and services they require, including advance care planning in care plans and implementing a memorandum of understanding with sub-contracted providers to guide communication expectations about changes to individual consumer’s condition, goals and preferences. The Assessment Team was satisfied these improvements were effective and recommended Requirements (3)(a), (3)(b) and (3)(c) met. Although Requirement (3)(e) was not specifically assessed during the Assessment contact undertaken on 13 October 2023, corroborating evidence was gathered which addressed this Requirement. I have therefore considered this information to determine whether it’s sufficient to support a finding of compliance.

Management advised that all consumers had received a home visit for review in April/May 2023. Risk assessments for each consumer have been completed and are in consumer files. Increased communication with providers, inclusive of face-to-face meetings every 3 months ensures consumers risk, health and well-being understanding is consistent will all parties. Documentation reviewed confirmed assessment and planning is completed with the consumer and/or their representatives to inform the delivery of safe and effective services.

Consumers confirmed their needs, goals and preferences are assessed by the service regularly and confirmed advance care planning has been discussed and information has been provided. Staff demonstrated they are aware of individual consumer needs and preferences and the service’s processes for reassessing consumer needs, goals and preferences on a regular basis and in response to a change in care needs. Management said that, as part of initial care planning with consumers, advance care planning and end of life planning is discussed and recorded in care planning documentation. Information about advance care planning is provided as part of the consumer’s information package.

Staff described how they work collaboratively with others in assessment and planning of consumer services. This information aligned with feedback from consumers. Management advised that care planning documentation was updated to ensure consumer choice of providers is evident. Documentation reviewed showed care planning and assessment occurs in consultation with the consumer and others, including other providers with evidence of referrals to allied health clinicians as needed. Brochures about providers are readily available to consumers at all home visits for all services, providing choice of providers for consumers.

Consumers confirmed they receive either a phone call review or visit in person at 3 and 6 month intervals to discuss their needs, goals and preferences as well as having an annual review. Consumers advised that if anything were to change, they could raise this with staff and the care plan would be adjusted. Management said after meeting with the consumer, a visiting schedule is developed and agreed upon and becomes part of the care plan provided to the consumer. Documentation reviewed showed care plans have recent reviews and scheduled reviews recorded.

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

# Standard 4

|  |  |  |
| --- | --- | --- |
| Services and supports for daily living | | CHSP |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |

Findings

Requirements (3)(a), (3)(d) and (3)(e) were found non-compliant following a Quality Audit undertaken from 28 March 2023 to 30 March 2023, as the service did not demonstrate:

* each consumer received safe and effective services and supports for daily living that met the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life, as care plan reviews had not been undertaken
* information about the consumer’s condition, needs and preferences were communicated within the organisation and with others where responsibility for care is shared, as information was not documented which could result in changes to consumer’s health or cognition not being recognised and information not being readily available should a change be required, or information needed to be shared with others responsible for care
* timely and appropriate referrals to individuals, other organisations and providers of other care and services, specifically when changes or deterioration or additional risks are identified through care plan reviews.

The Assessment Team’s report for the Assessment contact undertaken on 13 October 2023 includes evidence of actions taken by the service in response to the non-compliance. These actions include, but are not limited to, reviewing and updating care planning documentation to ensure consumers are receiving the care and services they require and implementing a memorandum of understanding with sub-contracted providers to guide communication expectations about changes to individual consumer’s condition, goals and preferences. The Assessment Team was satisfied these improvements were effective and recommended Requirements (3)(a), (3)(d) and (3)(e) met.

Consumers described how they are regularly asked if there is anything they want to do differently or achieve in the next few months and agreed they receive the services they need, with discussion about the services improving consumers’ quality of life. Management advised that care planning documents have been updated to ensure consumer needs and preferences are recorded. This was confirmed through review of sampled care documentation. Management said to ensure staff are informed of consumer goals, needs and preferences, providers are contacted through phone and email to update consumer requirements, and this is further updated at 3 monthly meetings with providers.

Consumers confirmed staff know them well and they do not need to repeat information about their needs and preferences. Staff advised that relevant information about consumer services are documented and communicated through care planning documents. Management said the memorandum of understanding was updated to include risk assessment requirements and formal notification requirements from providers to the service. Meetings are conducted with providers every 3 months to ensure the individual needs and requirements of each consumer are being attended to according to the consumer’s choice. Documentation reviewed showed evidence of consumer goals and preferences.

Consumers said they are satisfied there are timely and appropriate referrals to individuals and other providers of care and services. Staff described processes to refer consumers internally and externally to other providers or to My Aged Care. This was confirmed through care planning documents viewed for sampled consumers.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirements (3)(a), (3)(d) and (3)(e) in Standard 4 Services and supports for daily living.

# Standard 6

|  |  |  |
| --- | --- | --- |
| Feedback and complaints | | CHSP |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Requirements (3)(a), (3)(c) and (3)(d) were found non-compliant following a Quality Audit undertaken from 28 March 2023 to 30 March 2023, as the service did not demonstrate:

* consumers were supported to provide feedback and make complaints, as feedback and complaints are not routinely reported to the service when sub-contracted providers receive feedback or complaints from consumers, with no clear pathway for this to occur
* appropriate action was taken in response to complaints and an open disclosure process was used when things go wrong because the service did not have a method for recording or documenting how complaints were resolved, did not have a feedback or complaints register and the service relied on consumers to raise complaints directly with the service but, consumers reported they contact the sub-contracted provider when they have issues and there is no process for these issues to reported back to the service
* feedback and complaints were reviewed and used to improve the quality of care and services because complaints were received by sub-contracted service providers and information was not being transferred to the service and the service was not collating feedback or complaints through other mechanisms, including surveys.

The Assessment Team’s report for the Assessment contact undertaken on 13 October 2023 includes evidence of actions taken by the service in response to the non-compliance. These actions include but, are not limited to: the memorandum of understanding has been updated to include formal notification to the service about feedback, risks and incidents; regular consumer surveys have been implemented; the feedback process is outlined on the service’s website and feedback brochures are provided in consumer information packs; and the service has developed a complaints register to include information, resolution and outcomes details. The Assessment Team was satisfied these improvements were effective and recommended Requirements (3)(a), (3)(c) and (3)(d) met.

Consumers stated they have no concerns but, they described how to raise a complaint. Staff described the feedback management process and how they would assist consumers to raise complaints. Management advised the complaints procedure is available on the service’s website and information is included in the consumer information pack. The service has commenced 6 and 12 monthly surveys to obtain consumer feedback.

Consumers said they would be comfortable to raise complaints and were confident the service would respond in a respectful and timely manner, and it would be followed up and registered appropriately. However, no consumers interviewed said they have needed to make a complaint. Although no complaints have been received from consumers, the service has implemented a complaints register to record complaint information, resolution and outcomes. Management and staff outlined appropriate action to respond to complaints with a process of open disclosure. Documentation reviewed evidenced a survey conducted in May/June 2023 resulted in actions and outcomes from the feedback received, including action taken to address a request for more consistency with staff scheduled. Another survey is scheduled for November 2023.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirements (3)(a), (3)(c) and (3)(d) in Standard 6 Feedback and complaints.

# Standard 8

|  |  |  |
| --- | --- | --- |
| Organisational governance | | CHSP |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | 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 |
| 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 |

Findings

Requirements (3)(a), (3)(b), (3)(c) and (3)(d) were found non-compliant following a Quality Audit undertaken from 28 March 2023 to 30 March 2023, as the service did not demonstrate:

* consumers were engaged in the development, delivery and evaluation of care and services and are supported in that engagement because the service was not actively seeking feedback from consumers and was not receiving feedback and complaints from consumers who were reporting directly to sub-contracted service providers
* the organisation’s governing body promoted a culture of safe, inclusive and quality care and services and was accountable for their delivery because the service did not have management plans for diabetes management and advance care planning, risk analysis processes were in development and consumer surveys had not been implemented to gather consumer feedback for consideration by the governing body
* effective organisation wide governance systems in relation to information management, specifically not all consumer information was recorded on consumer electronic files and, progress notes that identified trends in consumer health and well-being were kept on the sub-contracted provider’s servers and were not accessible to the service
* a process for managing high-impact or high-prevalence risks, specifically not having a process in place for the sub-contracted service providers to report incidents to the service, leading to not collating and analysing incidents or reporting information about incidents to the governing body.

The Assessment Team’s report for the Assessment contact undertaken on 13 October 2023 includes evidence of actions taken by the service in response to the non-compliance. These actions include but are not limited to: regular consumer surveys conducted to gather feedback; an updated memorandum of understanding with sub-contracted to ensure appropriate information sharing and complaint/feedback, risk management and incident reporting occurs. The Assessment Team was satisfied these improvements were effective and recommended Requirements (3)(a), (3)(b), (3)(c) and (3)(d) met.

The Assessment Team provided the following evidence in relation to my finding:

* Consumers engaged in the development, delivery and evaluation of care and services
  + The service implemented a regular consumer survey to gather and address feedback, with feedback from the May/June 2023 survey used to improve services.
  + The service updated its memorandum of understanding with sub-contracted service providers to ensure appropriate complaint/feedback information sharing to assist the service to collate and evaluate this information.
  + Feedback forms with envelopes are provided to consumers and they can provide feedback anonymously.
* Governing body promotes a culture of safe, inclusive and quality care and is accountable for their delivery
  + The service has a management team which meets on a regular basis to review and discuss the service and the quality of care.
  + Management said the service is documenting these meetings and have developed management reports which are tabled at these meetings.
* Information management
  + The service has established information management systems, including policies and procedures to manage information and electronic documentation.
  + The service updated its memorandum of understanding with sub-contracted service providers to strengthen communication expectations about changes to individual consumer’s condition, goals and preferences, along with complaint/feedback and incident management processes.
  + Information is maintained securely, and privacy and confidentiality policies apply.
* Continuous improvement
  + The service identifies opportunities for improvement through feedback and complaints systems including analysis of consumer and representative survey feedback, incident management and changes to legislation.
* Financial governance
  + The service’s financial governance is monitored by the finance team and reported to the executive leadership board.
  + Consumers are sent a statement for billing, and this is followed by an invoice 6 weeks later. Consumers interviewed had not issues with billing or statements.
* Workforce governance
  + Direct staff for the CHSP funded programs have position descriptions, access to online and face-to-face training, supervision and annual individual staff performance appraisals.
* Regulatory compliance
  + Management monitors changes to aged care law through subscriptions to government departments.
* Feedback and complaints
  + The service updated its memorandum of understanding with sub-contracted service providers to strengthen complaint/feedback processes.
  + The service has feedback and complaints systems, processes and procedures to support improved outcomes for consumers.
* Effective risk management systems and practices
  + The service has processes for monitoring and reviewing its risk management systems and processes.
  + The service has a risk framework for managing high-impact and high-prevalence risks, for identifying and responding to abuse and neglect of consumers, to support consumers to live their best life and for managing and preventing incidents.
  + High-impact and high-prevalence risks associated with the care of consumers are identified through initial assessment and through the incident reporting system.
  + Staff demonstrated consumer well-being and safety is monitored through ongoing face-to-face and telephone contact.
  + The service has policies and procedures in place to promote a balanced approach to enable consumer enjoyment and choice.
  + The service updated its memorandum of understanding with sub-contracted service providers to strengthen incident reporting processes.

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

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