**Performance**

**Report**

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| Name: | Charleville and District Community Support Association |
| Commission ID: | 700365 |
| Address: | 114 - 118 Alfred Street, CHARLEVILLE, Queensland, 4470 |
| Activity type: | Quality Audit |
| Activity date: | 29 October 2024 to 30 October 2024 |
| Performance report date: | 26 November 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.

# Services included in this assessment

Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 7914 Charleville and District Community Support Association Incorporated  
Service: 24194 Charleville and District Community Support Association Incorporated - Community and Home Support

**This performance report**

This performance report has been prepared by Peter 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 services it operates, 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 service outlets, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 13/11/2024

# 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 | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not applicable** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Not applicable** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

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

# Areas for improvement

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

* **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.
* **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.

* **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.
* **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.
* **Requirement 7(3)(d)** - The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.
* **Requirement 7(3)(e)** - Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.
* **Requirement 8(3)(c)** - Effective organisation wide governance systems relating to information management and feedback and complaints.
* **Requirement 8(3)(d)** - Effective risk management systems and practices, including managing high impact or high prevalence risks associated with the care of consumers and identifying and responding to abuse and neglect of consumers.

# Standard 1

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

Findings

Consumers and representatives said consumers are treated with dignity and respect, and they feel valued by those who provide care. Staff were observed to respect consumers dignity and engaged with them in a friendly manner. Processes include discussions with each consumer about their identity, culture and diversity needs.

The service supports consumer choice which includes consideration of risk so each consumer is able to live the best life they can. For sampled consumers who choose to undertake a risky activity, risk assessments were undertaken, the associated risk was explained to the consumer and/or representative, mitigation strategies were implemented, informed consent was obtained, and regular review was undertaken.

Consumers and representatives said consumers are provided information via various mechanisms, which enables them to exercise choice. All consumers and representatives interviewed stated that their monthly statements are clear, itemised, and easy to understand.

Consumers said staff make them feel safe and they are free to express their cultural identity. Staff were able to identify consumers with specific cultural preferences and described how they tailor care and services to support their needs. Care planning documentation included information to guide staff in providing culturally safe care and services.

Consumers and representatives said consumers can make decisions about how and when they would like care provided, who is involved in decision making about their care and are supported to maintain relationships of choice. Staff provided examples of how they assist consumers in making day-to-day decisions. Care planning documentation included consumer choice and preferences.

The service maintains consumers’ privacy, which was corroborated from sampled consumers’ feedback. Access to consumer’s personal information is protected including staff access the electronic care record system via password protected logins.

Based on the information summarised above, I find the service compliant with all Requirements in Standard 1 Consumer dignity and choice.

# Standard 2

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| Ongoing assessment and planning with consumers | | CHSP |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Not Compliant |
| Requirement 2(3)(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. | Not Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Not Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Not Compliant |

Findings

Requirement 2(3)(a) - was found non-compliant following a Quality Audit undertaken from 29 October 2024 to 30 October 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 for each consumer.

The Assessment Team was not satisfied of the effectiveness of care plans capturing consumer information pertinent to the delivery of safe and effective care and services. The Assessment Team provided the following evidence to support their assessment:

* One consumer Care plan viewed did not include strategies to guide staff to minimise risk when delivering services regarding visual and hearing impairments, despite the consumer identifying this to the Assessment Team.
* Another consumer care plan failed to capture considerations given to the relevant risks outlined in the My Aged Care (MAC) assessment to guide staff to safely and effectively deliver services regarding falls, depression, mood affective disorders, 60% hearing loss and difficulty with memory.
* Another MAC summary listed Hypertension and cholesterol under medical conditions, however this information was not captured on their meal assessment form, nor the meal delivery run sheet and did not provide strategies or alerts to inform and guide the cook’s or the meal delivery staff.

The Provider provided the following in response to the Assessment Team’s report.

* An updated client care plan template (2024\_11\_CHSP Client information Care Plan) implemented to capture assessed risks and other recommendations.

The intent of this requirement is about making sure that assessment and planning are effective. These processes will support organisations to deliver safe and effective care and services.

Relevant risks to a consumer’s safety, health and well-being need to be assessed, discussed with the consumer, and included in planning a consumer’s care. This supports consumers to get the best possible care and services and makes sure their safety, health and well-being aren't compromised.

I appreciate the provider’s acknowledgement regarding identified gaps in tracking and documentation, and updated template to be introduced. However, at this stage the service is yet to evidence the introduction of this template with existing consumers identified as having gaps in their assessment and planning, and subsequent service delivery.

At the time of my finding, these actions have not been fully implemented or embedded.

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

Requirement 2(3)(c) - was found non-compliant following a Quality Audit undertaken from 29 October 2024 to 30 October 2024. The service did not demonstrate:

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.

The Assessment Team was not satisfied planning activities are conducted in partnership with consumers/representatives, nor are consumers supported to understand information to make informed decisions when planning their services. The Assessment Team provided the following evidence to support their assessment:

* Documentation reviewed for one consumer did not evidence a plan developed in consultation with the consumer outlining services required, days or times or if there are any specific preferences for service delivery.
* Staff interviewed stated when they receive a referral from MAC, they contact the consumer/representative, advise them of receipt of the referral and advise them they will be mailing them some forms to complete and send back. Staff said the forms include the client information and consent form and the aged care charter of rights. Staff confirmed they do not explain the forms to the consumer, nor their rights.
* Staff advised with the new care planning process they commence the care plan during the initial phone call. Staff will visit the consumers home to explain the care plan to the consumer and have this signed. Not all care plans sighted included the consumer’s signature or demonstrated the consumer/representative’s involvement. Staff advised this is an ongoing process completed when staff have time in their schedule, further advising.
  + The priority is completing the new care planning process for meal delivery consumers first and where possible new referrals.

The Provider provided the following in response to the Assessment Team’s report.

* Advisement that initial phone calls to clients will include a more detailed conversation regarding service delivery and options available. Clients will be offered a visit by the service to assist with initial intake forms or, alternatively, clients can elect to attend the Centre for assistance. Updated information leaflet will be provided to clients outlining Consumer rights and Advocacy. Viewed attachment 2024\_11\_Client Information Advocacy and Rights.
* Providers Continuous Improvement Register (CIP) contained a progress note regarding *‘plan to implement care plans immediately. With a review of completed plans monthly’.* Planned due date for completion is June 2025, with 26% of care plans finalised and updated.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows the service is responding to deficiencies identified and provided prompt risk mitigation strategies associated with addressing these deficiencies.

However, I acknowledge these strategies are yet to be fully embedded. With implementation, further resulting improvements should present themselves.

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

Requirement 2(3)(d) - was found non-compliant following a Quality Audit undertaken from 29 October 2024 to 30 October 2024. The service did not demonstrate:

* 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.

The Assessment Team was not satisfied planning activities are conducted in partnership with consumers/representatives, nor are consumers supported to understand information to make informed decisions when planning their services. The Assessment Team provided the following evidence to support their assessment:

* Consumers/representatives interviewed could not recall being offered or receiving a care and services plan.
* Staff described, and documentation confirmed the recently implemented use of a care plan template and process, completed for approximately 26% of consumers at the time of the Quality Audit.
* Staff further advised that the new care planning process includes sending each consumer a copy of their care and services plan, via mail. However, due to a lack of progress note or tracking documentation, were unable to demonstrate this in practice.
* Sampled reviews of care planning documentation evidenced an inaccurate reflection of assessments completed including relevant needs, goals or preferences relevant and which were being provided. The following examples were extracted from the 26% of consumers who have the new care plan on file.
  + One consumer care plan indicated they were referred to the provider by MAC for meal services. Their care plan evidenced information from My Aged Care (MAC) assessment in relation to aspects of daily living including garden maintenance, however, did not include support required for meal services. Their care plan stated they did not have any further needs or goals. It was unclear as to what services the consumer was receiving. Review of the consumers meal service plan included the provision of meals 3 days per week, no medical conditions, allergies or dietary requirements.
  + Another consumer was referred to the provider by MAC for meal services. Review of this consumers care plan evidenced information from their MAC assessment in relation to assistance required with mobility, laundry, shopping, housework and showers.
    - MAC assessment noted this consumer has high cholesterol and goals to assist him to prepare nutritious meals. This was not reflected in their care plan.
* Reviewed policies including the organisations ‘Allocation Policy’ which outlined forms and assessments required to understand a consumer needs. However, was unable to identify a policy which outlined the organisations system for documenting and making available care and service plans.

The Provider provided the following in response to the Assessment Team’s report.

* Advisement that in addition to the organisation’s CIP to include monitoring of Care Plans (attached), copy of completed client care plans to be provided to client and staff member delivering services. Changes to care plan to be actioned by relevant staff and copy of updated plan to client and relevant staff members.
* Additional advisement of implementation of care plans for meals clients initially, followed by maintenance clients. An additional column added to client spreadsheet to track care plan and review dates (attached). Prompt added to Outlook calendar for each client care plan review date. Staff advised of reporting identifiable risks to be added to feedback and complaints register.
* Providers Continuous Improvement Register (CIP) contained a progress note regarding *‘plan to implement care plans immediately. With a review of completed plans monthly’.* Planned due date for completion is June 2025, with 26% of care plans finalised and updated.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows the service is responding to deficiencies identified and provided prompt risk mitigation strategies associated with addressing these deficiencies.

However, I acknowledge these strategies are yet to be fully embedded. With implementation, further resulting improvements should present themselves. Please see my response regarding Requirement 2(3)(c).

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

Requirement 2(3)(e) - was found non-compliant following a Quality Audit undertaken from 29 October 2024 to 30 October 2024. The service did not demonstrate:

* Each consumer’s care and services are regularly reviewed for effectiveness or when there are changes in the consumer’s needs, goals or preferences.

The Assessment Team was not satisfied services are regularly reviewed for effectiveness. Consumers/representatives could not recall a formal care and service review, or a review completed in response to changed needs. The Assessment Team provided the following evidence to support their assessment:

* The providers incident register contained one incident from May 2023 in relation to CHSP consumers. Evidence discussed under Requirement 7(3)(d) and Requirement 8(3)(d) identified deficiencies in the incident reporting process. Staff could not provide examples in the past 12 months of where an incident involving a consumer resulted in a review to care and services.
* Staff interviewed confirmed the recent implementation of care plans includes an agreed upon review date. Approximately 26% of consumers have undergone this process. Staff confirmed consumers who have not undergone this process have not had a formal care and services review in the past, nor will they have a review scheduled until they undergo the initial care planning activity.
* Sighted care plan templates have a section to include the scheduled review date. The care plan for Mr Smith was review which evidenced a care plan review dated 12 months after the initial review. Three other care plans reviewed did not include the date of the initial review and subsequently the review date.
* Staff described how they respond when a consumer/representative informs them of changes to their needs or preferences. However, deficiencies were identified in practice.

The Provider provided the following in response to the Assessment Team’s report.

* Advisement of the addition to organisation’s CIP to include monitoring of Care Plans (attached) copy of completed client care plans to be provided to client and staff member delivering services. Changes to care plan to be actioned by relevant staff and copy of updated plan to client and relevant staff members.
* Further advisement of the implementation of care plans for meals clients initially, followed by maintenance clients. Column added to client spreadsheet to track care plan and review dates (attached). Prompt added to Outlook calendar for each client care plan review date. Staff advised of reporting identifiable risks to be added to feedback and complaints register.

The intent of this requirement is to ensure that organisations regularly review the care and services they provide to consumers. This is important to make sure that the care and services plans are up-to-date and meet the consumer’s current needs, goals and preferences, care and services the organisation provides meet the consumer’s needs safely and effectively, and care and services the organisation provides are updated to apply better practice when available.

All care and services plans are expected to include an agreed review date. How often a review is done depends on the needs of each consumer and on the nature and type of services the organisation is providing. However, in addition to the reviews that are scheduled, a consumer’s care and services plan should be reviewed when the consumer’s condition changes (for example, physical or mental health). situations change (for example, if the organisation’s arrangements for a service changes), and incidents or accidents happen (for example, if a consumer has fallen).

This application is considered in proportionality to the type of service provided, and nature of consumer service delivery type.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows the service is responding to deficiencies identified and implementing mitigation strategies associated with addressing these deficiencies.

However, I acknowledge these strategies are yet to be fully embedded. With implementation, further resulting improvements should present themselves. Please see my response regarding Requirement 2(3)(c) and Requirement 2(3)(d).

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

# Standard 3

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

Findings

The Assessment Team did not assess Standard 3 as personal and clinical care is not provided under CHSP.

# Standard 4

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

Findings

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 on the mobile application 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. Staff confirmed they have access to each consumer’s needs and preferences through a mobile application. Management advised consumer care plans are available to staff through a mobile application and to subcontracted services through a service request process. 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.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 4, Services and supports for daily living.

# Standard 5

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| Organisation’s service environment | | CHSP |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Not applicable |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Not applicable |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Not applicable |

Findings

The Assessment Team did not assess Standard 5 as the provider does not deliver services within a service environment.

# Standard 6

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

Findings

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 making 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 and consumer manuals offer consumers diverse internal and external feedback, complaints and advocacy options, in the consumer’s language of choice.

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 service, compliant with all Requirements in Standard 6, Feedback and complaints.

# Standard 7

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

Findings

Requirement 7(3)(d) - was found non-compliant following a Quality Audit undertaken from 29 October 2024 to 30 October 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 that members of the workforce have received ongoing support, training, supervision or professional development. The Assessment Team provided the following evidence to support their assessment:

* All staff members interviewed confirmed they had not been provided with training or resources in relation to the organisation’s feedback and complaints management system.
  + One staff interviewed did not demonstrate an understanding of the process for escalating feedback.
* Staff interviewed stated they were unaware of the Serious Incidents Response Scheme (SIRS) and were not provided with support in identifying reportable incidents as per SIRS requirements.
  + Training records viewed demonstrated SIRS training conducted for one staff member on 2/11/2023, but similar training has not been completed by other consumer-facing staff members.
* While staff stated that they would feel comfortable raising the need for additional support, most staff members were unaware of training, resources or professional development opportunities offered by external agencies or industry bodies.

The Provider provided the following in response to the Assessment Team’s report.

* Advisement of SIRS training to be provided to relevant staff. Addition to CIP to include sourcing training (attached – planned due date June 2025)

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows the service is responding to deficiencies identified within their CIP and provided proposed training associated with addressing these deficiencies.

However, I acknowledge these strategies are yet to be fully embedded. With implementation, further resulting improvements should present themselves.

Based on the information summarised above, I find the provider, in relation to the service, non-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 29 October 2024 to 30 October 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 that members of the workforce were undergoing regular assessment, monitoring and review of their performance. The Assessment Team provided the following evidence to support their assessment:

* Staff stated they rely on consumer feedback to trigger a performance review as necessary, and that performance issues are addressed as they arise. However, review of employee documentation did not demonstrate any evidence that performance evaluations occurred.
* One interviewed staff member stated they underwent a performance review seven years ago but haven’t received a formal review since then.
  + The remaining staff members interviewed have been with the organisation for 1-5 years and stated that assessment or review of their performance has not occurred since joining the organisation.
  + All staff members interviewed were unsure about how their performance was being assessed, monitored, or reviewed. All staff members stated they do not have periodic one-on-one meetings to discuss performance or to identify professional development needs.
* The organisation’s performance monitoring and reporting policy viewed does not contain a directive to formally evaluate the performance of staff members.
* Review of all employee staff records have not shown evidence of performance assessment, monitoring or reviews.

The Provider provided the following in response to the Assessment Team’s report.

* Advisement that Staff performance appraisal conducted Sept 2024 (attached). This appraisal was in staff file for on-site assessment team visit. Assessment team may have overlooked it. All current staff have been advised on many occasions of open-door policy and have one-on-one meetings with coordinator regularly. Staff are aware that if they are seeking a formal appraisal, this can be organised with coordinator. All performance concerns are discussed with staff on an ad-hoc basis and follow up email is provided by the coordinator. Identified training requirements are emailed to coordinator for approval and met on each occasion. Please see email (attached) offering training identified by a staff member.

The intent of this requirement is to ensure all members of the workforce have an appropriate person regularly evaluate how they are performing their role, and identify, plan for and support any training, and development they need. From a workforce perspective, members of the workforce can confirm they have had a performance review or have one scheduled. Evidence the organisation uses performance assessments to work out training needs is crucial. It also uses performance assessments to review duties and responsibilities and maintain the workforce’s overall ability to provide safe and quality care and services.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows the service is responding to deficiencies identified within their CIP and provided proposed training associated with addressing these deficiencies.

Whilst I acknowledge evidence to support staff performance reviews and suitable training, I note these strategies are yet to be fully embedded. With implementation, further resulting improvements should present themselves. I also appreciate the provider uses a open-door approach, however it is also important the provider drive, oversee and upskill staff suitably, via a formal appraisal and review process.

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

Requirements 7(3)(a), 7(3)(b), and 7(3)(c)

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.

Consumers stated staff are competent. Staff described the minimum qualifications required for their roles. Management described the service’s processes for determining staff competency, including for subcontracted staff. Documentation showed evidence of minimum qualifications and knowledge required for each role.

Support staff confirmed they undergo regular informal performance appraisal processes with management. Management confirmed support staff undergo regular informal performance appraisal processes with office staff undergoing formal annual appraisal processes. Management stated a review of performance appraisal processes will be undertaken. Documentation showed evidence of performance reviews being completed for office staff.

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

# Standard 8

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| Organisational governance | | CHSP |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Not Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Not Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Not applicable |

Findings

Requirement 8(3)(c) - was found non-compliant following a Quality Audit undertaken from 29 October 2024 to 30 October 2024. The service did not demonstrate:

* Effective organisation wide governance systems relating to information management and feedback and complaints.

The Assessment Team was not satisfied information is effectively shared due to the paper-based files used to maintain and store consumer information to facilitate care. Nor were they satisfied the provider could demonstrate an effective system for identifying, escalating, and tracking all feedback from consumers. The Assessment Team provided the following evidence to support their assessment:

* Staff advised, and documentation review confirmed that the provider does not have electronic back-ups of documentation for every consumer. Consumer documentation is only consistently available to staff by entering the provider’s premises during hours when certain staff are available.
  + Staff explained that without accessible back-ups, consumer files taken out of the office during a home visit will be inaccessible by other staff members.
* The provider did not have established reporting pathways to ensure effective information sharing for staff and others involved in service delivery.
* Information regarding consumer meal preferences is not consistently communicated from the consumer to the provider and to the organisation responsible for meal preparation.
* Meal run sheets captured consumer’s meal choices but are not consistently informed by assessment and planning. Information not being consistently shared included dietary goals and changes to personal or medical conditions.
* Documentation reviewed confirmed consumers receiving home modifications are offered a paper-based exit survey to provide feedback on the quality of services, but systems were not in place to track or analyse responses.
* The provider did not demonstrate that all verbal feedback is being captured, trended, analysed and reported, despite consumers receiving meal delivery and home maintenance services being able to provide feedback verbally through the phone or face-to-face with staff, at the provider’s office or within the community.

The Provider provided the following in response to the Assessment Team’s report.

* Advisement of a process implemented by Administration Officer who has scanned completed care plans and stored electronically in shared cloud based file which others involved in service provision can access. As care plans are completed and signed by client, updated copies will be scanned to shared file.
* Further advisement of client feedback captured in register during on-site visit and approved by assessment team when on-site. Staff made aware of feedback and complaints systems in previous weekly staff meeting. All staff on commencement are made aware of all organisational policies and are encouraged to reference policies. Staff are encouraged to seek clarification from coordinator with any organisational queries.

The intent of this requirement is about how the organisation applies and controls authority below the level of the governing body. Authority flows from the governing body to the Chief Executive Officer (or similar role), then, to the executive or management team and throughout the organisation. This requirement lists the key areas that an organisation needs for effective organisation wide governance systems. These systems should take into account the size and structure of the organisation. They should also help to improve outcomes for consumers.

Effective information management systems and process give appropriate members of the workforce access to information that helps them in their roles. It also makes sure consumers can access information about their care and services. These systems cover how an organisation maintains, stores, shares, and destroys information and how it controls privacy and confidentiality. Information that supports consumers to make decisions should be relevant and accurate and provided in a timely manner.

Feedback and complaints systems and processes actively look to improve results for consumers. The system used is relevant and proportionate to the range and complexity of care and services the organisation delivers, as well as its size and scale. The system follows principles of transparency, procedural fairness, and natural justice and meets best practice guidelines.

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

However, I acknowledge these strategies are yet to be fully embedded. With implementation, further resulting improvements should present themselves.

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

Requirement 8(3)(d) - was found non-compliant following a Quality Audit undertaken from 29 October 2024 to 30 October 2024. The service did not demonstrate:

* Effective risk management systems and practices relating to identifying and responding to abuse and neglect of consumers, and managing and preventing incidents, including the use of an incident management system.

The Assessment Team was not satisfied training or support in identifying and responding abuse and neglect of consumers or SIRS obligations is provided to staff, and policies and procedures reviewed did not demonstrate that systems and practices are in place to identify and respond to abuse and neglect, or to manage and prevent incidents according to SIRS requirements. The Assessment Team provided the following evidence to support their assessment:

* Staff stated they knew how to report an incident to the office, however staff did not demonstrate an awareness of SIRS, the different categories of reportable incidents, or timeframes for reporting. Some staff stated that they do not believe elder abuse and neglect occurs in the regions they are servicing.
* Training records and employee documentation did not demonstrate that staff were equipped to identify and respond to abuse and neglect or manage and prevent incidents. Conversations around incident reporting were not recorded or evidenced.
* Subcontractor agreements include the Code of Conduct and a clause to report incidents to the provider, however it does not state what is reportable, how to report, or timeframes for reporting.

The Provider provided the following in response to the Assessment Team’s report.

* Advisement of client feedback captured in register during on-site visit and approved by assessment team when on-site. Staff made aware of feedback and complaints systems in previous weekly staff meeting. All staff on commencement are made aware of all organisational policies and are encouraged to reference policies. Staff are encouraged to seek clarification from coordinator with any organisational queries.

The intent of this requirement is to ensure Organisations 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.

It’s expected that the organisation’s risk management system identifies and evaluates incidents and ‘near misses’ (both clinical incidents and incidents in delivering care and services). A near miss is when an occurrence, event or omission happens that does not result in harm (such as injury, illness or danger to health) to a consumer or another person but had potential to do so. It’s also expected that the organisation uses this information to improve its performance and how it delivers quality care and services.

The organisation is expected to have systems to provide appropriate protections and safeguards around the delivery of care and services, to respond effectively to incidents of abuse, to report this according to the law, and to raise awareness in the organisation to lower the risk of elder abuse.

Organisations are expected to effectively prevent and manage incidents, including through the use of an incident management system that enables incidents to be identified, responded to, and notified to the Commission (as required). Incidents should be resolved in consultation with consumers and staff, and incident data should be used to identify trends, drive continuous improvement to improve the quality of the care and services, and prevent similar incidents from occurring.

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

However, I acknowledge these strategies are yet to be fully embedded. With implementation, further resulting improvements should present themselves.

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

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

Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

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

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)