**Performance**

**Report**

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| Name: | Cooma Challenge Limited |
| Commission ID: | 200909 |
| Address: | 2 Walgarra Street, COOMA, New South Wales, 2630 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 7 August 2024 to 8 August 2024 |
| Performance report date: | 5 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: 7818 Cooma Challenge Limited  
Service: 25026 Cooma Challenge Limited - Care Relationships and Carer Support  
Service: 25027 Cooma Challenge Limited - Community and Home Support

**This performance report**

This performance report has been prepared by J Durston, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the 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 Assessment contact (performance assessment) – site 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 4 November 2024.

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 6** Feedback and complaints | **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) - the provider is to ensure that it completes the implementation of its new, more comprehensive assessment system and process to include all consumers, such as those who joined the organisation before the change commenced.
* Requirement 2(3)(b) - the provider is to ensure there are systems and processes in place to ensure care plans are person-centred with individualised consumer needs, goals and preferences, that consumers are offered the opportunity to have a discussion about advance care planning and if they choose that their advance care plan is included in care planning documentation.
* Requirement 2(3)(d) - the provider is to ensure consumers receive a copy of their care plan that clearly identifies the outcomes of assessment and planning and is available at the point of care and services.
* Requirement 2(3)(e) - the provider is to ensure there are systems and processes in place that ensure care and services are reviewed and care plans are updated when consumer circumstances change or when incidents impact on their needs, goals and preferences.
* Requirement 3(3)(e) - the provider is to ensure there are systems and processes in place to ensure consumer data on the electronic care management system and staff mobile phone applications is consistent, and that progress notes record information about consumers’ wellbeing as well as tasks/services performed to enable effective monitoring of consumers’ health, safety and wellbeing.
* Requirement 6(3)(c) - the provider is to ensure there are systems and processes in place to ensure complaints are recorded, responded to, progress towards resolution is tracked and that staff are educated about the use of open disclosure.
* Requirement 6(3)(d) - the provider is to ensure the organisation follows its Client Complaints and Feedback policy that stipulates both positive and negative feedback data should be used and considered in organisational reviews and in planning for service improvements.
* Requirement 8(3)(c) - the provider is to ensure there are effective organisation wide governance systems in place for information management, continuous improvement, workforce governance, regulatory compliance and complaints and feedback.
* Requirement 8(3)(d) - the provider is to ensure there are systems, and processes in place to ensure all consumers receive comprehensive risk assessments, consumers are offered dignity of risk support to live their best life, staff receive education on the Serious Incident Response Scheme; and there is an effective incident management system that staff and management are educated to use to ensure consistent and accurate recording, rating, monitoring, trending and analysis of incidents to inform risk mitigation at the individual and strategic organisational level.

# 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. | 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

**Findings of non-compliance**

Requirement 2(3)(a)

The service was previously found non-compliant in Requirement 2(3)(a) following an Assessment Contact from 21 August 2023 to 22 August 2023. The service did not demonstrate consumer risks were considered in the assessment and planning process.

During the Assessment Contact conducted on 7 August 2024 to 8 August 2024 the Assessment Team found the service’s plan for continuous improvement (PCI) noted the risk management system does not meet regulatory standards which may impact compliance with the standards and the safety level of care provided to consumers and staff.

The Assessment Team found the service has an electronic consumer management system (ECMS). Staff described several paper-based assessments completed when consumers commence with the service, including a home risk assessment checklist, risk assessment and a limited assessment and intake form that inform the consumer’s care and service plan. However, the Assessment Team found there was inconsistent information regarding consumers’ medical history and diagnosis across sampled consumer documentation and the ECMS. The service advised it is currently conducting a care plan audit to identify discrepancies and ensure documentation and the ECMS contain consistent information.

In their response to the Assessment Team report the provider acknowledged they previously did not have an intake and assessment process that met the standards. The provider acknowledged that currently information on the ECMS is incomplete and inconsistent across consumer documents. However, the provider advised the service commenced the implemented a new documentation process for all new consumers in November 2023. The provider is currently working towards completing the project for all consumers as part of their continuous improvement plan, and they continue to monitor completions which currently stand at 33%. The provider stated its commitment to address all the discrepancies in consumer documentation and to support staff to improve the quality of information recorded.

I commend the provider for the work it has done to consolidate and improve the quality of its consumer assessment process, and its commitment to full implementation for new and existing consumers. However, I consider it will take time for the improvements to be embedded and sustained in practice.

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

Requirement 2(3)(b)

The service was previously found non-compliant in Requirement 2(3)(b) following an Assessment Contact from 21 August 2023 to 22 August 2023. The service did not demonstrate consumer care plans, were individualised, clearly setting out their needs, goals and preferences.

During the Assessment Contact conducted on 7 August 2024 to 8 August 2024 the Assessment Team found the service’s PCI provided a description of the proposed area for improvement, but did not contain actions to return to compliance in this Requirement.

The Assessment Team found the care plans for 2 of 6 consumes contained clear individualised needs, goals and preferences. The 4 remaining consumer care plans contained generalised goals, such as a consumer was to remain living independently and to receive domestic assistance. The care plan did not indicate the medical reason as to why the consumer required the assistance. Care planning documentation for 4 consumers did not include advance care plans. The registered nurse advised there was an action item in the PCI to conduct an audit to identify consumers who do not have advance care plans, but due to competing priorities it had not yet been actioned.

The Assessment Team found the service’s advance care directive policy (last updated in 2019) appears to place the onus on the consumer to provide these details if they have an existing advance care directive, rather than on staff to offer consumers the choice to complete an advance care directive during the initial assessment discussion.

In their response to the Assessment Team report the provider acknowledged that the use of the care plans is still being introduced to clients, but not all clients have yet. The provider noted this is part of the compliance Continuous Quality Improvement Project mentioned in Requirement 2(3)(a).

I commend the provider for working to further individualise care plans for consumers towards person centred care, and its commitment to full implementation for new and existing consumers. However, I consider it will take time for the improvements to be embedded and sustained in practice.

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

Requirement 2(3)(d)

The service was previously found non-compliant in Requirement 2(3)(d) following an Assessment Contact from 21 August 2023 to 22 August 2023. The service did not demonstrate consumers were provided with a copy of their care plan and staff were relying on their own knowledge of consumers when providing their services.

During the Assessment Contact conducted on 7 August 2024 to 8 August 2024 the Assessment Team found the service’s PCI provided a description of the proposed area for improvement, but did not contain actions to return to compliance in this Requirement, that all consumers received updated consents and agreed care plans.

The Assessment Team found the outcomes of assessment and planning were not effectively communicated and documented in a care plan that was readily accessible to consumers. All sampled consumers advised they had initial discussion when they commenced with the service, but 5 out of 6 did not know what a care plan was, how to access one, or if they had received a copy. One staff member advised all consumers are given a copy of their care plan but could not provide an example. All staff advised they can access consumer information and care plans via an application on their electronic device, but were unsure as to how consumer information is updated on the electronic consumer management system.

In their response to the Assessment Team report, the provider stated care plans are uploaded to the ECMS. They are available to staff who are providing a service to the client and clients are offered a copy of the care plan. However, the provider also acknowledged that that the clients are not provided with a copy of their care plan as a rule. The provider committed to providing a copy of the care plan to all clients in an identifiable service folder, or by email if preferred, to document the client has received a copy of their care plan and to ensure staff are made aware of the process.

I commend the provider for its commitment to provide consumers with a copy of their care plan that clearly identifies the outcomes of assessment and planning and is available at the point of care and services. However, I consider it will take time for the improvements to be embedded and sustained in practice.

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

Requirement 2(3)(e)

The service was previously found non-compliant in Requirement 2(3)(e) following an Assessment Contact from 21 August 2023 to 22 August 2023. The service did not demonstrate consumer care plans are reviewed when their condition changes or there are incidents or accidents.

During the Assessment Contact conducted on 7 August 2024 to 8 August 2024 the Assessment Team found this was not addressed in the service’s PCI.

The Assessment Team found the service did not demonstrate care and services are reviewed when consumer circumstances change or when incidents impact on their needs, goals and preferences. One consumer living with diabetes, did not have a diabetes management plan in place despite a recent incident where the service called an ambulance for the consumer who had contacted them, concerned about their blood glucose levels. The report notes there was no evidence indicating the consumer was reassessed and a diabetes management plan was put in place. However, I note the report states that 6 days after the incident the consumer’s medical officer increased their insulin dosage.

The Assessment Team found a progress note that indicated a consumer did not need to collect their webster medications pack, as they had a backlog at home. This included medication for blood pressure, heart failure and depression. When raised with management they advised they were unaware of the situation, and committed to completing an incident report, contacting the consumer’s medical officer and sending an email to the team leader to follow-up. However, no immediate strategies were actioned to mitigate the risk of the consumer storing their medication, or to analyse the cause of the behaviour.

The Assessment Team found 60% of consumer care plans had not been reviewed in line with the service’s 12 monthly care plan review policy and were not current. Management advised this is an area for continuous improvement that the registered nurses and team leaders are working on.

In their response to the Assessment Team report the service acknowledged recognises that care plan reviews are not occurring on a regular basis and this is part of the Compliance Continuous Improvement Project. The provided outlined a detailed plan of how this would be achieved.

I commend the provider’s demonstrated commitment to and detailed plan to achieve effective and regular care plan reviews to ensure the health safety and wellbeing of consumers. However, I consider it will take time for the improvements to be embedded and sustained in practice.

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

# Standard 3

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| Personal care and clinical care | | CHSP |
| Requirement 3(3)(e) | 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 Compliant |

Findings

**Findings of non-compliance**

Requirement 3(3)(e)

The service was previously found non-compliant in Requirement 3(3)(e) following an Assessment Contact from 21 August 2023 to 22 August 2023. The service did not demonstrate that information including incidents was being recorded on the incident risk register, information was not forwarded to others within the service responsible for care, and care planning reviews were not scheduled.

During the Assessment Contact conducted on 7 August 2024 to 8 August 2024 the Assessment Team found the service’s PCI contained action items to return to compliance in this Requirement, which were noted to be in progress. These included the implementation of an alert system with consistent organisational tools and documentation to identify consumer risks, and the capture and trending of incidents and accidents in an incident register.

The Assessment Team found the actions taken in response to the non-compliance have not been effective. Management identified a mobile application has been implemented for staff to enter progress notes and incident reports, and to access care plans and consumer risk alerts at point of care. However, data contained on the electronic care management system is inconsistent and is currently being addressed by the service.

The Assessment Team found the service only enters incidents that occur when staff are present. Hence incidents such as unwitnessed falls are not recorded. This means the incident register may not accurately assist in the identification of deterioration in a consumer’s condition.

Progress notes for several consumers contained inconsistencies in information and often focused on the completion of tasks rather than consumers’ wellbeing, thereby limiting capacity of team leaders and staff to recognise and/or review services and supports to address consumer deterioration. Management acknowledged the significant variation in the level of detail recorded in progress notes, and identified this needs to be included in the cultural change being undertaken by the service.

In their response to the Assessment Team report, the provider did not dispute the team’s findings. The provider outlined a detailed improvement plans to be implemented to address the identified areas of non-compliance in this Requirement.

I commend the provider’s demonstrated understanding of and commitment to mitigate and minimise the risks to safe and effective care of consumers. However, I consider it will take time for the improvements to be embedded and sustained in practice.

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

# Standard 6

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

Findings

**Findings of non-compliance**

Requirement 6(3)(c)

The service was previously found non-compliant in Requirement 6(3)(c) following an Assessment Contact from 21 August 2023 to 22 August 2023. The organisation did not demonstrate complaints were being recorded, or that open disclosure processes were being used.

During the Assessment Contact conducted on 7 August 2024 to 8 August 2024 the Assessment Team found the service’s PCI contained actions to return to compliance in this Requirement, including development of a policy and delivery of training on open disclosure. However, the plan notes this action has not commenced. The Assessment Team found the actions taken in response to the non-compliance have not been effective.

The Assessment Team found an incident record regarding a complaint made by family regarding a transport incident involving their consumer dated 14 May 2024, was recorded in an incident report. The family’s complaint was not recorded in the complaints register and there was no further information recorded in either document. The Representative said the service visited the consumer and said they would follow-up the incident, an apology was given, but there has been no further follow-up by the service. The Assessment Team found the complaint was still open, no further actions or use of open disclosure recorded.

The Assessment Team found staff interviewed were unable to explain the concept of open disclosure but could provide examples of how they have used it. The service’s Client Complaints and Feedback policy reviewed by the service in August 2024, does not provide information on open disclosure.

In their response to the Assessment Team report the provider did not dispute the findings of the Assessment Team. The provider confirmed the ECMS now has a dedicated section for recording complaints. The provider acknowledged improvements are needed in relation to open disclosure, and outlined detailed improvement plans to be implemented to address the identified areas of non-compliance in this Requirement.

I commend the provider’s demonstrated understanding of and commitment to improving its response to complaints and its open disclosure process. However, I consider it will take time for the improvements to be embedded and sustained in practice.

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

Requirement 6(3)(d)

The service was previously found non-compliant in Requirement 6(3)(d) following an Assessment Contact from 21 August 2023 to 22 August 2023. The service did not demonstrate feedback and complaints are reviewed or used to improve services.

During the Assessment Contact conducted on 7 August 2024 to 8 August 2024 the Assessment Team found the service’s PCI contained actions to return to compliance in this Requirement, including revising the client survey to be sent out in 2024, and supporting a culture of reporting and trending of complaints and how they impact systems and processes. The last item was recorded as still in progress.

The Assessment Team found the actions taken in response to the non-compliance have not been effective. The service did not demonstrate it followed its Client Complaints and Feedback policy that stipulates both positive and negative feedback data should be used and considered in organisational reviews and in planning for service improvements. The PCI actions for this Requirement had not commenced or were not completed. Consumers and representatives interviewed said the service has not asked them for feedback or provided them with a survey or questionnaire. Management confirmed the last survey undertaken was 2 years ago, but advised the service was developing one. The complaints register showed 2 complaints recorded as incidents; one regarding a worker being late for work and the other that no support staff had attended them in over a week. There was no outcome of how the issues were investigated, resolved, or considered to improve the consumers’ services.

In their response to the Assessment Team report the provider acknowledged improvements are required in the quality of incident reporting and the process of reviewing and responding to incidents and making quality improvements from incidents. However, the provider noted that since August 2023, the organisation had changed the culture of minimal incident reporting to a culture of incident reporting being a standard and that staff have embraced this and are now competent in using the ECMS to report incidents moving away from paper-based incident reporting. The provider outlined a detailed improvement plan be implemented to address the identified issues in complaints and compliments.

I encourage the provider to continue its work to improve its systems and processes to ensure feedback and complaints inform improvements in the quality of care and services, and I commend the provider’s commitment to building a culture to documenting and capturing the learnings from incidents to do the same. However, I consider it will take time for the improvements to be embedded and sustained in practice.

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

# Standard 8

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| Organisational governance | | CHSP |
| 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 |

Findings

**Findings of non-compliance**

Requirement 8(3)(c)

The service was previously found non-compliant in Requirement 8(3)(c) following an Assessment Contact from 21 August 2023 to 22 August 2023. The organisation did not demonstrate effective organisation wide governance systems in the areas of information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints.

During the Assessment Contact conducted on 7 August 2024 to 8 August 2024 the Assessment Team found the service’s PCI contained actions to return to compliance in this Requirement, including review and simplification of the current document control system. The Assessment Team found this action had not commenced.

The Assessment Team found that except for financial governance (that was previously found compliant), the organisation did not demonstrate improvements in the other areas of governance that were found non-compliant.

The Assessment Team found the organisation has an ECMS for care planning, and progress notes and incidents can be accessed and completed by staff using a mobile application. The system also facilitates rostering and invoicing. Management advised the organisation has purchased a new system to provide online training, create and update policies and track service compliance with the Quality Standards, with an estimated launch date of late August 2024.

The Assessment Team acknowledged the organisation is improving its systems, but noted the service was unable to meet a request to extract CHSP consumer information including services and supports being provided.

Management advised that continuous improvement is identified through the incident and accident register. Meeting minutes reflected the Board reviews the PCI at Board meetings. However, the Assessment Team found areas for improvement identified from the last Assessment contact conducted on the 7 August 2024 to 8 August 2024 were noted, but no actions were commenced and there were few timelines for improvement.

The organisation demonstrated they have effective financial management and reporting systems in place to manage finances and resourcing needed to deliver safe and quality care to consumers.

The Assessment Team found the organisational chart included pathways for communication and reporting. However, the Team also found the job descriptions for CHSP support workers and team leaders were almost the same.

Management advised that policies and procedures are amended when there are changes to the legislation, and any modifications are incorporated into the documents. However, the Assessment Team found several policies and procedures had not been updated regularly or contained incorrect information regarding compliance. The Deteriorating Client policy refers to Quality Standard 5 which focuses on the service environment. Management advised the service recently purchased an electronic system will enable the service to track policies and required updates.

The organisation could not demonstrate that feedback and complaints are collected, trended, or used to improve care and supports. The CHSP complaints and incident register did not accurately identify and record complaints. As such, this information is not trended or passed to the Board for consideration.

In their response to the Assessment Team report the provider stated that they continue to be committed to improve their information management, but have faced challenges extracting data from the new ECMS and recently rolled out system mobile application. The provider advised that if the service had been given prior notice of the required CHSP consumer data (prior to the Assessment Contact) this would have reduced the delays in providing the requested information to the Assessment Team. I note the provider’s suggestion regarding forewarning. However, it is the provider’s responsibility to ensure that it has effective information management systems and processes in place to provide the right information when and where it is needed to enable better, more informed decision making by consumers, care staff, the management team and the governing body, ultimately to maximise the health safety and wellbeing of consumers. Further, the provider acknowledged a CHSP client list was provided to the team but was limited to the information the ECMS provided. Further the provider advised the organisation has purchased a platform to manage and update policies and record training.

Regarding continuous improvement, the provider advised a policy is currently in draft for the management consumer deterioration, and the organisation will develop a policy on open disclosure. In relation to regulatory compliance, the provider advised several policies were updated and implemented at the time of the Site Audit, with policy updates prioritised based on policy age and legislative changes. The provider also noted the Deteriorating client policy was in draft, referred to both Standards 3 and 5, and corrections would be made to the draft. As previously acknowledged in the provider’s response, the provider did not dispute that feedback and complaints processes require attention.

I acknowledge the provider’s commitment to, planned and current actions taken to address identified non-compliance in key areas of organisational governance. However, I consider it will take time for the improvements to be embedded and sustained in practice.

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

Requirement 8(3)(d)

The service was previously found non-compliant in Requirement 8(3)(d) following an Assessment Contact from 21 August 2023 to 22 August 2023. The service did not demonstrate it was using effective risk management systems and practices including managing high impact risks, identifying and responding to abuse and neglect of consumers, supporting consumers to live their best life and managing and preventing incidents.

During the Assessment Contact conducted on 7 August 2024 to 8 August 2024 the Assessment Team found the service’s PCI contained actions to return to compliance in this Requirement, including staff training on documentation of risk assessment for high-risk clients and develop a vulnerability list in consultation with the council emergency management committee. The Assessment Team found both actions had not commenced. The Assessment Team found the organisation could not demonstrate that improvements had been made in relation to those areas previously identified as non-compliant in this requirement.

The Assessment Team found the organisation was unable to demonstrate that high impact or high prevalence risks are identified, monitored or discussed. Management advised the organisation is currently undertaking risk assessments for consumers, and currently around one third have been completed, and new consumers have a personal risk assessment completed during the initial assessment. Unwitnessed incidents are not recorded, which provides incomplete information for accurate monitoring, identification and response to consumer deterioration, and to identify and mitigate organisational trends in relation to high impact high prevalence risk.

Staff said they had received training on identifying and responding to abuse and neglect of consumers. However, a review of training records did not include training on the Serious Incident Response Scheme (SIRS), but the service advised there is a proposal to include SIRS training in the new electronic learning system. Staff receive SIRS information in the staff handbook. The organisation has a Protection Against Violence, Abuse, Neglect, Exploitation, Discrimination Policy.

The service could not demonstrate that consumers are supported to live their best life. The work plan for the consumer who was the subject of a complaint by their family considered in Requirement 6(3)(c), who was left unaided to catch a taxi home from the shops, stated the consumer wants to be unaccompanied while shopping. However, the service did not demonstrate a dignity of risk discussion occurred with the consumer nor that a dignity of risk record/form was completed. Further, there was no evidence provided by the service that showed the Board was made aware of the incident.

The service could not demonstrate that it is able to identify, manage and prevent incidents using the incident management system. Actions undertaken following an incident are not recorded, and terminology such as accident or incident is used interchangeably. Incident information was not presented to the Board for consideration, and there was no differentiation between CHSP and National Disability Insurance Scheme (NDIS) consumers in reports tabled.

The organisation has an incident and injury reporting policy. However, definitions of high, medium and low risk do not correspond with entries in the incident report. The policy states that low incidents are those which do not result in injury. However, the Assessment Team found some incidents where consumers required medical attention in hospital were inappropriately recorded as low risk, including one consumer with a potentially perforated eardrum and another consumer who was unable to urinate.

Overall, the Assessment Team found that the gaps, inaccuracies and inconsistencies identified in the organisation’s incident and risk management systems and processes, means that the Board is not receiving accurate information on incident and risk trends to provide effective input to and oversight of targeted, strategic prevention actions for high impact high prevalence risks in the organisation’s PCI.

In their response to the Assessment Team report the provider advised the organisation has reviewed and updated the Violence, Neglect, Abuse, Exploitation and Discrimination policy and training has been completed by all staff on Incident Management and Abuse and Neglect. The organisation has implemented 2 risk assessment tools for all new consumers since November 2023 and commits to extend completion to consumers who joined the service prior to the new risk assessment process being implemented, to review all risk assessments annually and when circumstances change. The provider advised completion of risk assessments is progressing slowly, but the service engaged a roster clerk, in early August 2024, that will allow the team leaders to concentrate on completing the risk assessments. Further, the provider advised the Board had requested that they increase review of the risk register through its sub committees from 6 monthly to quarterly.

The provider advised staff attended training on identifying and responding to abuse and neglect of consumers in the last 12 months and they would complete SIRS training on the new electronic learning portal. In relation to supporting consumers to live their best life, the provider advised they will improve the quality of consumer documentation to ensure goals are met and align with the care plan and work instructions. The provider acknowledged the incident management process requires improvement and outlined a detailed improvement plan to address the issues identified by the Assessment Team.

I acknowledge the provider’s commitment to, the work it has done and its planned improvements to the service’s risk management systems and processes. Further, I encourage the provider to ensure that it uses consistent risk ratings across its risk and incident management systems to ensure an accurate picture of high impact high prevalence risks can be obtained, managed and mitigated. Further, I consider it will take time for the improvements to be embedded and sustained in practice.

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

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