**Performance**

**Report**

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| Name of service: | Country Home Advocacy Project Inc. (Trading as Country Home Services) |
| Service address: | Level 1, Chateau Building, Beckwith Park, 30-38 Barossa Valley Way NURIOOTPA SA 5355 |
| Commission ID: | 600124 |
| Home Service Provider: | Country Home Advocacy Project Inc |
| Activity type: | Quality Audit |
| Activity date: | 14 April 2023 to 18 April 2023 |
| Performance report date: | 19 May 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.

**This performance report**

This performance report for Country Home Advocacy Project Inc. (Trading as Country Home Services) (**the service**) has been prepared by A. Grant, 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.

# Services included in this assessment

**Home Care:**

* CHAP Community Care Program, 18478, Level 1, Chateau Building, Beckwith Park, 30-38 Barossa Valley Way, NURIOOTPA SA 5355

**CHSP:**

* Community and Home Support, 24176, Level 1, Chateau Building, Beckwith Park, 30-38 Barossa Valley Way, NURIOOTPA SA 5355

# Material relied on

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

* The assessment team’s report for the Quality Audit; the Quality Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* The provider’s response to the assessment team’s report received 12 May 2023.

# Assessment summary for Home Care Packages (HCP)

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

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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

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| Standard & Requirement Description | | HCP | CHSP |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | **Compliant** | **Non-compliant** |
| 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. | **Non-compliant** | **Non-compliant** |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | **Non-compliant** | **Non-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. | **Non-compliant** | **Non-compliant** |

# Standard 1

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

Findings

The service was able to demonstrate each consumer is treated with dignity and respect, with their identity, culture and diversity valued. Consumers described staff as kind, caring and respectful. Management and staff spoke respectfully about consumers with an understanding of consumers' personal circumstances and described how it influenced the delivery of their individual services. Documentation viewed demonstrated the service is inclusive and respectful of consumers' identity.

The service was able to demonstrate services are culturally safe. Consumers described what is important to them and how their services are delivered in a culturally safe way. Staff demonstrated an understanding of consumers’ cultural background and described how they ensure services reflect consumers’ cultural needs and diversity. Care planning documentation for consumers showed the service had discussed and documented consumers’ cultural background, preferred language, and interpreter requirements if required.

The service was able to demonstrate how each consumer is supported to exercise choice and independence, make decisions about their care and services including when others should be involved, and communicate their decisions. Consumers and/or representatives confirmed the service involves them in making decisions about care and services. Staff described how they support consumers and their representatives to exercise choice and make decisions about the consumers’ services. This was confirmed through documentation viewed.

The service was able to demonstrate consumers are supported to take risks to enable them to live the best life they can. Sampled consumers indicated they do not wish to take risks, however, the services they receive enables them to maintain their independence and make decisions in their day-to-day life including activities that may involve risk. Staff and management demonstrated an understanding of dignity of risk, and how the service supports consumers with informed decision making through discussions of possible risks and management strategies. Contractors could speak to dignity of risk, citing examples to support their understanding. The service’s risk management policies provide guidance to staff in relation to consumers’ dignity of risk processes.

# Standard 2

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

Findings

Compliant Evidence

The service was able to demonstrate assessment and planning identifies and addresses the consumers’ current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. Consumers and/or representatives confirmed assessment and planning processes identified consumers’ current needs, goals and preferences. Staff and management demonstrated discussions with consumers and/or representatives about consumers’ needs, goals and preferences, which were documented in the consumers’ care plan and informed care and services.

The service was able to demonstrate assessment and planning is based on ongoing partnership with the consumer and/or their representative, and others who are involved in the care and services of consumers. Consumers and/or representatives interviewed confirmed they are involved in planning and making decisions about consumers’ care and services. Coordinators described how consumers and their family are involved in assessment and planning of care and services. Care planning documents viewed for sampled consumers confirmed that consumers and/or their representatives were involved in the assessment and planning of consumers’ care and services.

Overturned Recommendation

In respect to Requirement 2(3)(a) the Decision Maker notes the service responded proactively to the Assessment Teams findings and already implemented corrective action. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response did meet and exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendation of “not met”. Documented below will be a summary of the Assessment Teams findings and a summary of the services corrective action.

Assessment and planning, including consideration of risks to the consumer’s health and well-being, does not inform the delivery of safe and effective care and services. For some consumers, while key risks had been identified, these had not been assessed and strategies to manage those risks had not been documented. Care plans reviewed did not include sufficient detail about assessed needs and risks to the consumer to guide independent contractors in managing the risks for consumers. In some cases, independent contractors relied on their own knowledge of the consumer to manage the risks.

The services response shows the following actions have been implemented and/or will be implemented shortly to remediate the deficiencies identified by the Assessment Team during the Quality Audit:

* Draft intake form has been created and to commence trial.
* Developed a detailed process to sit alongside the intake form ‘where to’ update fields in VC.
* Updated intake process to commence with roll out of CHSP care plan.
* Education and training for employees.
* A hard copy of the care plan is available for clients in their HCP folder at home and electronic version is available for contractors in Visual Care. They can view this via the vWorker app. All HCP care plans have been uploaded to VC and all workforce have been notified.
* Coordinators review app notes during business hours. CEO and MO monitored after hours. App notes reviewed, appropriately categorised and assigned accordingly for further follow up.
* All incidents are monitored by the Team Leader Service Delivery who will determine when a review of services is required. This has been updated in the employee guide “how to report an incident/hazard in Visual Care”. IMS & SIRS Policy documents the procedure for the management of incoming incidents.

In respect to Requirement 2(3)(e) the Decision Maker notes the service responded proactively to the Assessment Teams findings and already implemented corrective action. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response did meet and exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendation of “not met”. Documented below will be a summary of the Assessment Teams findings and a summary of the services corrective action.

The service was unable to demonstrate that care and services are reviewed regularly when circumstances change or when incidents impact on the needs, goals, or preferences of the consumer. While care and services had been reviewed on the agreed review date documented on the service’s electronic system for both HCP and CHSP consumers, the review process was not always effective, as identified risks and strategies to mitigate risks had not consistently been actioned following the identification of changes to the consumers’ circumstances and/or following incidents. Care documentation reviewed for 2 consumers showed the service did not undertake timely reviews following changes to circumstances and/or incidents to assess and mitigate risks associated with these consumers.

The services response shows the following actions have been implemented and/or will be implemented shortly to remediate the deficiencies identified by the Assessment Team during the Quality Audit:

* Develop a guide to writing app notes in Visual Care for the workforce to improve documentation of client deterioration or other change in circumstances. An email has been sent to all the workforce with a copy of the Guide to writing app notes in Visual Care and Record Keeping Guidelines. Guide has been included in the contractor induction process.
* Education/communication to staff on the process for follow up of app notes, including reminder/review dates to be added when further follow up is required. Changes made to effectively monitor and manage app, client and worker notes. Verbal and written communication sent to all staff along with work instruction. This will be incorporated in training plans for new staff.
* Refresher communication to be sent to all workforce on incident identification & reporting. Email communication sent to all workforce with attached copies of employee/contractor guides to reporting incident/hazard.
* Communication to staff that a note must be added to the client notes when an incident form has been received. Reminder email sent to employees – employee guide to reporting incidents/hazards.

Non-compliant Evidence

In respect to Requirement 2(3)(d) the Decision Maker notes the service responded proactively to the Assessment Teams findings and already implemented corrective action. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendation of “not met”. If the actions outlined in the services PCI are followed through the Decision Maker is confidant the service will return to compliance.

For CHSP consumers, the service was not able to demonstrate that assessment and planning are effectively communicated to the consumer and documented in a care plan, that is readily available to the consumer, and where care and services are provided. The Assessment Team identified through review of consumers’ care documentation that the service does not systematically develop a care plan, to ensure safe and effective delivery of care and services. Consumers and/or representatives interviewed could not recall being offered a care plan or having a copy in their home. Coordinators and independent contractors advised that consumers’ information is available in their mobile application (app), however, the information is generic, and they relied on their knowledge of the consumers.

CHSP consumers and/or representatives interviewed in relation to this requirement stated there are no care plans documented and provided in the home. While they have communication with coordinators and independent contractors, they were not aware of anything being documented and provided to them. However, they stated independent contractors providing care and services go above and beyond to meet their needs and they have a strong knowledge of how they like things done.

# Standard 3

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| Personal care and clinical care | | HCP | CHSP |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | **Compliant** | **Compliant** |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | **Compliant** | **Compliant** |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | **Compliant** | **Compliant** |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | **Compliant** | **Compliant** |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | **Compliant** | **Compliant** |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | **Compliant** | **Compliant** |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | **Compliant** | **Compliant** |

Findings

Compliant Evidence

The service was generally able to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. Consumers and/or representatives described how they receive care and services to maintain their wellbeing and maintain their independence. Coordinators and management described processes for the management of consumers’ identified risks. For consumers sampled, care planning documentation reflected key high impact high prevalent risks were identified and addressed, however, the service does not have processes in place for the monitoring and oversight of the provision of care and services for these identified consumers.

The service was generally able to demonstrate they would respond appropriately to support the needs, goals and preferences of consumers nearing the end of life to maximise their comfort and preserve their dignity. Coordinators and management described how consumers’ end of life wishes are discussed with consumers and/or their representatives when there is established rapport with their coordinators. Management advised the service is currently supporting one consumer currently palliating.

The service was generally able to demonstrate deterioration or change to consumers’ capacity or condition is recognised and responded to in a timely manner. Consumers and/or representatives sampled felt confident that staff would notice if their health changed and would respond appropriately. Staff described processes to report and respond to changes related to consumers, for example, general deterioration, change in consumer’s mobility, mental health, or level of independence.

The service was able to demonstrate information about consumers’ needs, goals, preferences and conditions is documented and communicated within the organisation, and with others where responsibility for care is shared. Consumers and/or representatives confirmed consumer care is consistent, they have continuity of care and they do not need to repeat their needs and preferences to multiple people. Coordinators and management described communication processes within and outside the service and confirmed information about consumers is effectively communicated.

The service was able to demonstrate timely and appropriate referrals to individuals, other organisations and providers are made for consumers. Consumers and/or representatives confirmed consumers had been referred to health professionals when required. Coordinators described processes to refer consumers externally for AHP services, to other health professionals or My Aged Care (MAC). This was confirmed through documents provided to the Assessment Team for sampled consumers.

The service was able to demonstrate they minimise infection related risks through the implementation of standard and transmission-based precautions to prevent and control infections. Consumers and/or representatives felt the service and staff keep them safe through the use of personal protective equipment (PPE), and pre-visit COVID-19 screening. Management described the service’s policies, procedures, training and monitoring processes that are in place to prevent and control the risk of infections.

Overturned Recommendation

In respect to Requirement 3(3)(a) the Decision Maker notes the service responded proactively to the Assessment Teams findings and already implemented corrective action. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response did meet and exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendation of “not met”. Documented below will be a summary of the Assessment Teams findings and a summary of the services corrective action.

The service could not demonstrate that each consumers gets safe and effective personal and clinical care that is best practice, tailored to their needs and optimises their health and well-being. Most consumers and/or their representatives considered that consumers receive personal and clinical care that is safe and right for them. While coordinators described how the personal and clinical care provided to consumers is tailored to their needs and optimises the consumers’ health and well-being, care planning documentation showed that consumers are not consistently receiving care and services due to a workforce shortage in the rural areas they service. Care plans for consumers sampled did not consistently document information and strategies to guide staff practice to ensure it is tailored to their needs.

The service’s response shows the following actions have been implemented and/or will be implemented shortly to remediate the deficiencies identified by the Assessment Team during the Quality Audit:

* Service delivery policy to be reviewed and provide detail to guide staff practices in the provision of safe and effective practices. Service Delivery Policy has been reviewed and updated in the Document Management System (DMS). Staff have been advised that policy has been updated. Copies of the policy provided in the services response to the Assessment Team report show the amendments to the policy are sufficient.
* The statement made by the Assessment Team relating to workforce shortage will be addressed within Standard 7 of this Performance Report.

# Standard 4

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| Services and supports for daily living | | HCP | CHSP |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | **Compliant** | **Compliant** |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | **Compliant** | **Compliant** |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | **Compliant** | **Compliant** |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | **Compliant** | **Compliant** |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | **Compliant** | **Compliant** |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | **Compliant** | **Not applicable** |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | **Compliant** | **Not applicable** |

Findings

The service was able to demonstrate consumers get safe and effective services and support for daily living that meet the consumer’s needs, goals and preferences, and optimise their independence, health, well-being and quality of life. Consumers and/or their representatives advised consumers are supported to live independently through the varied services they receive. Independent contractors, coordinators and management demonstrated services provided to consumers were tailored to their needs, goals and preferences, and optimised their independence, wellbeing and quality of life.

The service was able to demonstrate services and supports for daily living promote consumers; emotional, spiritual and psychological wellbeing. Consumers stated the services provided promote their psychological wellbeing and support them emotionally. Independent contractors, coordinators and management demonstrated how they support consumers emotionally and promote their psychological wellbeing.

The service was able to demonstrate services and supports for daily living assist consumers to participate in their community, have social and personal relationships, and do things of interest to them. Consumers and/or representatives advised the services provided enable them to take part in their community and do things of interest to them. Independent contractors, coordinators and management described how the service assists consumers to participate in their community, have social relationships and do the things of interest to them.

The service was able to demonstrate that information about consumers’ needs, conditions, goals and preferences is documented and communicated within the organisation, and with other organisations where responsibility for care is shared. Coordinators and management described ongoing communication with consumers and/or their representatives, independent contractors, subcontracted clinical and allied health service providers and other mainstream services.

The service was able to demonstrate timely and appropriate referrals to individuals, other organisations and providers are made for consumers. Consumers interviewed in relation to this requirement confirmed they were referred to services as required. Coordinators and management described processes to refer consumers to other organisations and this was confirmed through care planning documents viewed for sampled consumers.

The service was able to demonstrate that, where meals are provided, they are varied and of suitable quality and quantity. One consumer sampled who has meal preparation confirmed satisfaction with the service provided. Management described and care documentation supported, provision of meal delivery services for sampled consumers.

The service was able to demonstrate, when equipment is provided, it is safe, suitable, clean and well maintained. While consumers were not interviewed in relation to this requirement, care documentation for sampled HCP consumers showed the equipment prescribed and purchased for them was suitable for their needs and was well maintained. Staff and management described the assessment and review processes related to goods and equipment, when it is provided.

# Standard 5

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| Organisation’s service environment | | HCP | CHSP |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | **Not applicable** | **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** | **Not applicable** |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | **Not applicable** | **Not applicable** |

Findings

All individual requirements are not applicable, therefore Standard 5 is not applicable and as a result was not assessed during the Quality Audit.

# Standard 6

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

Findings

The service was able to demonstrate consumers and their representatives are encouraged and supported to provide feedback and make complaints. All consumers interviewed stated they would feel comfortable to provide feedback to the service. Staff and management described their policies and procedures for obtaining feedback from consumers regarding the services delivered. Consumers advised they were provided with feedback information when they first commenced with the service, as well as ongoing information regarding provision of feedback. The service provides information to consumers in their welcome pack regarding the feedback process, and this is reflected in their policies in addition to ongoing contact with consumers to actively seek feedback and engagement. All mailed correspondence provided by the service also actively requests feedback to the service.

The service was able to demonstrate consumers are made aware of, and have access to advocates, language services and other methods for raising and resolving complaints. Management discussed processes to ensure consumers have access to advocates and language services if required, and consumers are made aware of other methods for raising and resolving complaints. The service’s Feedback and Complaints Policy contains additional information regarding advocacy services and processes for referral including to the Aged Care Quality and Safety Commission.

The service was able to demonstrate appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. Consumers sampled who had made a complaint discussed actions taken and use of open disclosure when they contacted the service with feedback. Management discussed the service’s processes for managing complaints. Complaint documentation demonstrated open disclosure principles are used as part of the complaint management process.

The service was able to demonstrate feedback and complaints are reviewed and used to improve the quality of care and services. Management was able to demonstrate the service has a process for tracking and responding to feedback and complaints and using this information to make service improvements. The Assessment Team observed Board Meeting agendas and minutes, in which consumer feedback and complaints are a standing agenda item for review and action.

# Standard 7

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| Human resources | | HCP | CHSP |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | **Non-compliant** | **Non-compliant** |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | **Compliant** | **Compliant** |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | **Compliant** | **Compliant** |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | **Compliant** | **Compliant** |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | **Non-compliant** | **Non-compliant** |

Findings

Compliant Evidence

The service was able to demonstrate the workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture, and diversity. Of the consumers sampled, they advised staff and volunteers were kind, caring, supportive and respectful. When issues were identified, consumers were confident they were addressed, and in a timely fashion. All consumers interviewed confirmed staff treat consumers with respect and are responsive to their needs. Staff, contractors and management spoke about consumers in a kind and respectful way when speaking with the Assessment Team about their services provided.

The service was able to demonstrate the workforce is competent and have the knowledge to effectively perform their roles. Consumers sampled, described in various ways that staff are competent in their job. Management described recruitment processes to ensure staff and contractors have adequate skills and qualifications, and how management monitor their competency ongoing through regular learning updates, with identified training gaps actioned. Management described how the independent contractors who undertake personal care must have a minimum qualification of Certificate III in Individualised support, or equivalent.

The service was able to demonstrate that the workforce is recruited, trained, equipped, and supported in various ways to deliver the outcomes required by these standards. Staff and management described processes and ongoing oversight to ensure maintenance of trained staff. The Assessment Team observed the current training report which provided training, accreditation and expiry dates for all staff and contractors. Where training gaps were identified, the Brokerage Support Officer could upload training requirements to staff.

Non-compliant Evidence

In respect to Requirement 7(3)(a) and 7(3)(e) the Decision Maker notes the service responded proactively to the Assessment Teams findings and already implemented corrective action. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendation of “not met”. The Decision Maker is confident if the actions listed on the PCI are followed through with the service will return to compliance.

The service was not able to demonstrate the workforce is planned to enable, and the number and mix of workforce deployed enables, the delivery and management of safe and quality services. Some consumers and/or their representatives sampled, and care documentation showed the service cannot consistently meet the assessed needs of consumers due to a workforce shortage.

Coordinators acknowledged that they are limited in their ability to deliver care and services for consumers due to limitations of contracted and external staff. Management described and organisational documentation confirmed the service is aware of the workforce shortage and are actively monitoring this. Interviews with consumers and/or their representatives and a review of care documentation showed that the service is unable to provide care and services due to a workforce shortage of independent contractors and/or ability to engage external service providers to deliver services on their behalf.

Independent contractors, coordinators and management described the process for allocating and contracting care and services, for example coordinators advised they discuss the limitations of being able to provide the full range of care and services to consumers, due to lack of contractors qualified and willing to accept and undertake the shifts.

The service was not able to demonstrate regular monitoring and review of the performance of workforce members. Management advised that there is a current backlog regarding performance reviews of staff and contractors. For contractors, management acknowledged that current performance discussions only occur based on negative feedback from consumers, with no other metrics used to monitor performance. Management acknowledged that there is ‘worker’ field tab that is utilised in the care management platform used, however it does not record performance issues, only basic information about the contractor. The Quality Coordinator, Operations Manager or Brokerage Support Officer were unable to provide an indication of current contractors being performance reviewed.

The Assessment Team viewed care management platform notes which identified one contractor who had, since July 2022 (to current) been inadequately documenting notes about the condition of consumers at end of shift by simply populating numerals or letters. When the Assessment Team identified this discrepancy to the Operations Manager, they acknowledged they were aware of the contractor, advising Numerous emails had been provided to the contractor in question, however upon request, were only able to provide one, dated 4 January 2023.

# Standard 8

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

Findings

Compliant Evidence

The organisation was able to demonstrate consumers are engaged in the development, delivery and evaluation of care and services. Consumers sampled said they have input about the services provided. Management and staff described how consumers have input about their experience and services through formal/informal feedback processes. Consumers advised of management and staff engaging them through the feedback mechanisms to ensure that they were satisfied with the services provided, evidencing the services desire to ensure positive engagement. Management actively engaged consumers in social events, and as part of the Home Services Advisory Group.

The service was able to demonstrate the organisation promotes a culture of safe, inclusive, and quality care and services and is accountable for their delivery. The service has a range of reporting mechanisms to ensure the service’s governing body is aware and accountable for the delivery of care and services. Management discussed the governance structure and reporting process to drive continuous improvement and accountability. The Assessment Team viewed meeting minutes and standing agendas for both internal management meetings and board dissemination which demonstrated appropriate monitoring and oversight of the delivery of care and services.

Non-compliant Evidence

In respect to Requirement 8(3)(c) the Decision Maker notes the service responded proactively to the Assessment Teams findings and already implemented corrective action. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendation of “not met”. The Decision Maker is confident if the actions listed on the PCI are followed through with the service will return to compliance.

*(i) Information Management*

The organisation was not able to demonstrate effective information management systems and processes to support staff and contractors in their roles or to meet the outcomes required by the Quality Standards. The Assessment Team identified that the service does not have a documented care plan for CHSP consumers and identified inconsistencies regarding the lack of accurate and detailed contractor notes recorded by contractors in the care management platform app.

Assessment and care planning information was not always documented, including where risk to consumers were identified. Information was incomplete and care plans did not consistently document strategies to guide contractor practice in the delivery of services. While coordinators and management advised they utilise the electronic system to ensure all information and communication regarding the consumers’ care and services is documented, the Assessment Team noted correspondence and email communication with representatives and other external service providers is not consistently documented.

Of the CHSP consumers sampled, none could recall receiving a documented care plan. For HCP consumers, management advised they are currently uploading care plans into the electronic database to ensure visibility of the most updated care plan for independent contractors. The service does not have a dedicated contractor file system for each contractor, instead relying on their Care Management Platform to record basic details about contractors.

*(iv) Workforce Governance, including the assignment of clear responsibilities and accountabilities:*

The organisation was not able to demonstrate the workforce is supported and developed to deliver safe and quality care and services to consumers. As documented in Standard 7, requirement (3)(a) of this Performance Report the service was unable to source suitable and sufficient workforce numbers, with identified impacts to consumers’ care and services. The Assessment Team viewed the Service Delivery policy which outlines the brokerage model, however, provides limited guidance to staff when onboarding staff and contractors to the organisation. The Assessment Team interviewed the Quality Coordinator and Brokerage Support Officer regarding contractor and staffing performance and training, however neither could provide data regarding current training needs assessments or quality reporting against the services own monthly performance measures, referring to the Operations Manager for response.Management acknowledged that due to attrition rates, the service is not building up staff numbers they had previously lost.

Overturned Recommendation

In respect to Requirement 8(3)(d) the Decision Maker notes the service responded proactively to the Assessment Teams findings and already implemented corrective action. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response did meet and exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendation of “not met”. Documented below will be a summary of the Assessment Teams findings and a summary of the services corrective action.

Evidence analysed by the Assessment Team showed the organisation was not able to demonstrate effective risk management systems and practices relating to managing high impact or high prevalence risks associated with the care of consumers, or managing and prevent incidents, including the use of an incident management system. The organisation was able to demonstrate that the service is identifying and responding to abuse and neglect of consumers and supporting consumers to live the best life they can.

The services response shows the following actions have been implemented and/or will be implemented shortly to remediate the deficiencies identified by the Assessment Team during the Quality Audit:

* Regular coordinator meetings to discuss clients at risk Coordinator’s meetings commenced 16 May 2023 and will be conducted on a monthly basis. Additional ad hoc meetings will be held as required.
* The service does have a dedicated incident management system (IMS) that has been built into Visual Care. The reference to the CEO and Manager Operations monitoring contractor notes refers to those notes that are completed at the end of each client shift. During office hours these are monitored by a Coordinator and afterhours the on-call Manager. If an incident occurs an incident/hazard form must be completed which flows into the IMS. This can be completed via the vWorker app in the client roster by a contractor or in the client profile by an employee. This is flagged in the dashboard in Visual Care and an email notification is sent to CEO, Manager Operations, Team Leaders and Quality Coordinator that a new incident has been submitted. Team Leaders manage all incoming incidents during office hours and afterhours this is managed by the on-call Manager. Incidents are reported at all Management and Board meetings.
* Lessons learnt document to be created to capture this information. Management Review Meetings are held 6 monthly and trend data reports are provided.

In respect to Requirement 8(3)(e) the Decision Maker notes the service responded proactively to the Assessment Teams findings and already implemented corrective action. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response did meet and exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendation of “not met”. Documented below will be a summary of the Assessment Teams findings and a summary of the services corrective action.

The service was unable to demonstrate established, documented, and effective organisation-wide clinical governance systems relating to minimising use of restraints and antimicrobial stewardship.

The services response shows the following actions have been implemented and/or will be implemented shortly to remediate the deficiencies identified by the Assessment Team during the Quality Audit:

* Expanded clinical governance framework to incorporate restraints and antimicrobial stewardship. Policy reviewed and updated in document management system, communication to staff of changes.
* Adapted current Open Disclosure Policy to Clinical Care Policy and include provisions for ‘minimising use of restraints’ and ‘antimicrobial stewardship’. Policy reviewed and updated in document management system, communication to staff of changes.
* Expanded clinical governance framework to provide greater clarity on all roles, functions, and overarching corporate governance implemented on 11 May 2023.
* Restrictive practices training has been included in the workforce training plan for 2023/24.

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)