**Performance**

**Report**

**1800 951 822**

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| --- | --- |
| Name of service: | Dale Community Care |
| Service address: | 1 The Grove ARMADALE WA 6112 |
| Commission ID: | 500005 |
| Home Service Provider: | Dale Cottages (Inc.) |
| Activity type: | Quality Audit |
| Activity date: | 10 May 2023 to 12 May 2023 |
| Performance report date: | 15 June 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 Dale Community Care (**the service**) has been prepared by F.Nguyen, 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:**

* Dale Community Care, 19138, 1 The Grove, ARMADALE WA 6112

# 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 1 June 2023 and 14 June 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 as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Compliant** |

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

# Areas for improvement

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

# Standard 1

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| Consumer dignity and choice | | HCP |
| 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

Compliant Evidence:

Evidence analysed by the Assessment Team showed the service was able to demonstrate that consumers are treated with dignity and respect, with their identity, culture and diversity valued. Consumers and their representatives said that staff were respectful to them during service delivery, staff spoke respectfully of consumers and could provide information on consumers interests and lives. Consumers and representatives interviewed advised staff were warm and respectful of them and their homes.

The service was able to demonstrate that care and services provided are culturally safe. Consumers/representatives confirm staff consider and support their cultural needs and preferences when providing care. Staff understand what it means to deliver culturally safe care and they were able to describe what this means in practice. Consumers and representatives advised that the staff know them and their background and respect their cultural needs.

The service was able to demonstrate that each consumer is supported to exercise choice and are actively involved in planning their care, including when others should be involved. Choice and decision making are discussed as part of the initial assessment with the details recorded. Staff interviewed discussed promoting choice and independence to consumers and were able to provide examples. Consumers and representatives reported that they actively participated in the development of their care plan and are encouraged to participate in services which foster the development of relationships with others.

The service was able to demonstrate that information is provided to each consumer that is current, accurate and timely. Staff and management were able to describe how they provide information to consumers at the commencement of services and ongoing. Consumers and representatives interviewed advised that they were given information regarding their care plan and service costs which enabled them to make informed decisions.

The service was able to demonstrate that each consumer’s privacy is respected and personal information is kept confidential. Staff and management were able to describe how consumer privacy and confidentiality are respected. Consumers and representatives interviewed advised they were informed of their right to confidentiality in the consumer handbook and this was reiterated in the section referencing consumers rights and responsibilities as a service user. Consumers did not express any concerns with the service or staff respecting their privacy and confidentiality.

Requirement 1(3)(d)

In respect to Requirement 1(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 deem this requirement as 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 service was able to demonstrate that it supports each consumer to take risks to enable them to live the best life that they can. The service demonstrated that consumers are supported to make decisions about their care and services, including when their choice involves an element of risk. However, the service was not able to demonstrate that consumers had been informed of risks and possible consequences of their decisions, to enable them to make informed decisions; and that the service had discussed with consumers strategies to manage the risk whilst supporting them to live their best life.

The services response shows a significant number of actions have been implemented post Quality Audit to remediate the deficiencies identified by the Assessment Team during the Quality Audit. Evidence has been provided by the service to substantiate these claims. A few key examples are documented below.

* The service has reviewed its Consumer Risk Taking Policy and Informed Risk Form.
* The Clinical Governance Committee are to endorse use the use of the Consumer Risk Taking Policy and Informed Risk Form.
* Staff training of the Dignity and Respect in Aged Care training module to be undertaken and added to training matrix.

The Decision Maker deems Requirement 1(3)(d) to be compliant.

# Standard 2

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

Findings

Compliant Evidence

Evidence analysed by the Assessment Team demonstrated that the service involves the consumer and carer or representative, in the planning of the care and services to be provided to the consumer. The service has processes in place to support consumers to access external service providers in accordance with their obligations relating to privacy of information. All consumers and representatives interviewed reported they have had an opportunity to meet with their home care coordinator to discuss their specific preferences including how services are delivered to them, a time and day suitable to them and care/services/equipment that will fit with their budget constraints.

The service was able to demonstrate that outcomes of assessment and planning are effectively communicated. Home care assistants said the care plan is available to them. Staff said information is also provided through email or by phone as relevant. All consumers interviewed advised care planning documents are discussed and agreed to prior to the commencement of the services with a copy of the current care plan placed in their home.

Requirement 2(3)(a) and 2(3)(b)

In respect to Requirement 2(3)(a) and 2(3)(b) 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 deem this requirement as 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 demonstrated that the assessment and planning process does not provide an opportunity for the home care coordinator to ensure care plans are sufficiently detailed to provide staff with information that guides the delivery of care while ensuring staff are aware of the risks associated with each consumers care.

The service was not able to demonstrate that has processes are in place to support the identification of consumer centred specific goals and preferences. Consumers and representatives said advance care planning has been discussed and if relevant, they have been provided with written information for them to consider.

The services response shows a significant number of actions have been implemented post Quality Audit to remediate the deficiencies identified by the Assessment Team during the Quality Audit. Evidence has been provided by the service to substantiate these claims. A few key examples are documented below.

* The service has recruited into the newly created role of Community Care Manager, a registered nurse with extensive senior leadership and management experience in the home care sector. This role will commence 14 June 2023.
* The service to review:
  + Assessment and Care Planning Policy and Procedure.
  + Accessing Our Services and Consumer Inquiries Policy and Procedure.
  + Assessment for Care and Services Admission and Delivery Policy and Procedure.
  + Assessment and Planning Consumer Delivery Policy and Procedure.
  + Advance Care Planning Policy and Procedure.
  + Palliative and End-of-Life Care Policy and Procedure.
* The Clinical Governance Committee are to endorse the use of policies and procedures.
* Training added to the training matrix:
  + Partnering to Plan and Deliver Care Training Module.
  + Documentation, Collaboration and Communication Training Module.

The Decision Maker deems Requirement 2(3)(a) and Requirement 2(3)(b) to be compliant.

Requirement 2(3)(e)

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 deem this requirement as 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 service was not able to demonstrate that care and services are reviewed for effectiveness when circumstances change. The organisation’s policy indicates care plans are reviewed annually or as required, reassessments conducted as required for example on discharge or hospital stay or changes in a consumer’s condition reported by the home care assistants. However, a review of documentation noted while care plans are reviewed annually, care plans are not always reviewed when a consumer’s condition or situation changes, or an incident occurs. In addition, unless clinically indicted, reassessments of the consumers’ needs, goals and preferences are not conducted.

The services response shows a number of actions have been implemented post Quality Audit to remediate the deficiencies identified by the Assessment Team during the Quality Audit. Evidence has been provided by the service to substantiate these claims. A few key examples are documented below.

* Meet with registered nurse and team leaders to review content of current care plan template and identify opportunities for improvement.
* Reach out to colleagues at other providers to obtain sample copies of care plans.
* Draft care plan template.
* Seek consumer feedback on draft template.
* High impact or high prevalence risk reporting to the Clinical Governance Committee developed.

The Decision Maker deems Requirement 2(3)(e) to be compliant.

# Standard 3

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| Personal care and clinical care | | HCP |
| 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 |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | 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 |
| 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 |
| 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 |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | 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 |

Findings

Compliant Evidence:

Evidence analysed by the Assessment Team showed the service was able to demonstrate that consumers are provided an opportunity to share their needs, goals and preferences nearing the end of their life, maintaining each consumers’ dignity and comfort and with respect to their cultural preferences. Consumers confirmed that, as part of the initial care planning discussion, advance care planning and end of life planning are discussed.

The service was able to demonstrate that deterioration or change to a consumer’s cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. Staff are clear about their roles and responsibilities including identifying and reporting signs of deterioration. Representatives interviewed reported satisfaction with the management of clinical incidents and the way staff keep them informed of adverse events consumers are involved in or impacted by.

The service was able to demonstrate that communication systems available to the workforce to assist them to provide and coordinate care that respects the consumer’s choices ensuring safe, effective and consistent care is provided. All staff have access to information pertinent to their role. Consumers said they feel that their needs, and preferences are effectively communicated between staff.

The service was able to demonstrate timely and appropriate referrals to individuals, other organisations and providers are made for consumers. Staff described processes to refer consumers for allied health services and additional services through contact with the team leaders.

Requirement 3(3)(a) and 3(3)(b

In respect to Requirement 3(3)(a) and 3(3)(b) 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 deem this requirement as 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 service was not able to demonstrate it delivers safe and effective personal and clinical care that is best practice optimising the consumers health and well-being. Whilst all consumers interviewed reported satisfaction with the care they receive, the Assessment Team noted the lack of policies and procedures guiding the delivery of clinical care may put all consumers at risk of receiving clinical care that is not best practice, not tailored to each consumers needs and does not optimise their health and well-being.

The service was not able to demonstrate that effective management of high impact or high prevalence risks associated with the care of each consumer. The team leaders advised the identification of risk and strategies to mitigate or reduce the risk to each consumer is not discussed with the consumer and/or their representative at the time of admission or during the ongoing review process. The service does not have a process in place to guide staff in ensuring consumers understand, acknowledge and accept risks identified. The organisation has an incident reporting system in place to ensure incidents are reported and reviewed. However, the information is not collated to identify opportunities for improvement resulting in improved outcomes for consumers.

The services response shows a significant number of actions have been implemented post Quality Audit to remediate the deficiencies identified by the Assessment Team during the Quality Audit. Evidence has been provided by the service to substantiate these claims. A few key examples are documented below.

* Review and edit the Management of High Impact or High Prevalence Risks Policy and Procedure to ensure:
  + each consumer gets safe and effective personal care, clinical care, or both personal and clinical care, that:
    - is best practice; and
    - is tailored to their needs; and
    - optimises their health and well-being.
  + effective management of high impact or high prevalence risks associated with the care of each consumer by:
    - ensuring that high impact or high prevalence risks associated with consumers’ care are identified and safely managed by our workforce and in line with current evidence-based practice
    - implementing policies and procedures that contain appropriate and effective safeguards in relation to interventions for high impact or high prevalence risks to ensure that they are effectively managed as part of the consumer’s care and support
    - providing consumers who require support in decision-making with access to information and the required support that is necessary for them to make, communicate and participate in decisions that affect their lives
* The Clinical Governance Committee are to endorse use the use of policies and procedures.
* Policies and Procedures adopted and training provided.
* High impact or high prevalence risk reporting to the Clinical Governance Committee.

The Decision Maker deems Requirement 3(3)(a) and 3(3)(b) to be compliant.

Requirement 3(3)(g)

In respect to Requirement 3(3)(g) 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 deem this requirement as 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 service was able to demonstrate documented policies and procedures to support the minimisation of infection related risks, through infection prevent and control practices. A COVID-19 community management plan is available to all staff. However, the service does not have processes in place to promote appropriate antibiotic prescribing.

Staff stated they work with the consumer and their medical practitioner when they are prescribed antibiotics. However, practices to promote antibiotic prescribing and reduce the risk of increasing resistance to antibiotics are not available to staff or consumers.

The services response shows a significant number of actions have been implemented post Quality Audit to remediate the deficiencies identified by the Assessment Team during the Quality Audit. Evidence has been provided by the service to substantiate these claims. A few key examples are documented below.

* The service has distributed the Antimicrobial Use and Resistance in Australia (AURA) “Do I really need antibiotics’ leaflet by the Australian Commission on Safety and Quality in Health Care to all consumers.
* The service has included the leaflet in the Home Note file that will be distributed to new clients.

The Decision Maker deems Requirement 3(3)(g) to be compliant.

# Standard 4

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| Services and supports for daily living | | HCP |
| 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. | Not applicable |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Compliant Evidence

Evidence analysed by the Assessment Team showed the service was able to demonstrate that supports are in place to promote each consumer’s emotional, spiritual, and psychological wellbeing. Home care assistants demonstrated that they are aware of individual consumer’s needs in relation to their emotional, spiritual, and psychological wellbeing. Consumers and representatives interviewed said that the staff are very knowledgeable about them and know what their individual needs are.

The service supports consumers to participate in the community and they are supported to maintain relationships that are important to them. The service demonstrated that consumers are supported to do things that are of interest to them. All consumers spoken with said that they are happy with the access they have to social and community activities.

The service has processes in place to ensure information about the consumer’s condition, needs and preferences are communicated within the service, and ensure that information shared is kept private and confidential. Consumers interviewed said the home care assistants know their service needs and they don’t have to repeat information or direct them about what to do.

The service was able to demonstrate that there are timely referrals to other organisations and providers of care and services. Consumers and representatives said they were satisfied with the services and supports delivered by those the consumer was referred to. A review of the care documentation noted emails are used to refer to community support services including occupational therapy and physiotherapy.

The service was able to demonstrate that where equipment is provided it is safe, suitable, clean and well maintained. Equipment provided to consumers is fit for purpose for the consumer and tailored to their specific needs. Consumers and representatives interviewed provided examples of how the service has supported them to have equipment supplied through their home care funding.

Requirement 4(3)(a)

In respect to Requirement 4(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 deem this requirement as 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 service was able to demonstrate that each consumer gets safe and effective services and supports that meet the consumers’ needs and preferences and optimise their independence, health and well-being. However, the service was unable to determine if the care provided is aligned to the consumers individualised goals as the goals identified are generic or each service type and consumers are not provided with an opportunity to develop measurable individualised goals.

The services response shows a significant number of actions have been implemented post Quality Audit to remediate the deficiencies identified by the Assessment Team during the Quality Audit. Evidence has been provided by the service to substantiate these claims. A few key examples are documented below.

* The service will review, edit and adopt the Assessment and Care Planning Policy and Procedure.
* Training will be provided for:
  + Partnering to Plan and Deliver Care Training Module.
  + Documentation, Collaboration and Communication Training Module.

The Decision Maker deems Requirement 4(3)(a) to be compliant.

# Standard 5

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| Organisation’s service environment | | HCP |
| 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

All individual requirements within Standard 5 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 |
| 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

Compliant Evidence

Evidence analysed by the Assessment Team showed the service was able to demonstrate that consumers and representatives are encouraged and supported to provide feedback and make a complaint. Interviews with consumers and representatives confirmed they have been provided with information and ways to provide feedback. Consumers and their representatives advised that they were aware of how to give feedback or make a complaint and that they felt comfortable to do this should the need arise.

The service was able to demonstrate that consumers are made aware of and have access to advocates, language services and other methods for resolving complaints. Consumers and representatives confirmed they can ask for support and are aware of how they can contact others to support their concerns. Consumers and representatives advised they were aware that they can access an external aged care advocacy service or the Commission to gain assistance with raising complaints.

The service was able to demonstrate that feedback and complaints are reviewed and are used to improve the quality of care and services through feedback received in the annual survey. Consumers and representatives interviewed were able to describe how feedback provided had been used to improve their service and satisfaction.

Requirement 6(3)(c)

In respect to Requirement 6(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 did meet and exceed the threshold required for the Decision Maker to deem this requirement as 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 service was not able to demonstrate that appropriate action is taken in response to feedback and complaints and did not use an open disclosure process when things go wrong. Complaint’s data capture was not contained to a single register with some complaints being managed via email. Consumers and representatives when asked were unsure of what open disclosure was. Consumers and representatives sampled who had raised a concern recently was noted to have not been recorded on the feedback or complaints register

The services response shows a significant number of actions have been implemented post Quality Audit to remediate the deficiencies identified by the Assessment Team during the Quality Audit. Evidence has been provided by the service to substantiate these claims. A few key examples are documented below.

* The service to review and edit the following related documents
  + Open Disclosure.
  + Aged Care Standards and Open Disclosure.
  + The Importance of Practising Open Disclosure.
  + The Four Principles of Open Disclosure.
  + The Five Elements of Open Disclosure.
  + How we Enable Open Disclosure.
* Documents to be adopted and training delivered.
* Training for Customer Service in Care (including feedback and complaints) added to training matrix.
* Reporting on Open Disclosure to Clinical Governance Committee.

The Decision Maker deems Requirement 6(3)(c) to be compliant.

# Standard 7

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| Human resources | | HCP |
| 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. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Compliant Evidence

Evidence analysed by the Assessment Team showed the service was able to demonstrate that the directly employed workforce is planned which enables an appropriate number and mix of skills required to ensure the delivery and management of safe and quality care services. Consumers were satisfied with services provided, staff could speak to their role adequately and management could advise how they provide agile services to compensate for unexpected staff leave. Consumers and representatives sampled advised that they were satisfied that the staff delivering services were adequately trained and considered that the staff were competent in the roles.

The service was able to demonstrate that workforce interactions with consumers are kind, caring and respectful of consumers identity, culture and diversity. Consumers and representatives valued the support from the staff and spoke of the staffs’ kindness. Staff spoke of their commitment to treating consumers with respect and dignity. Consumers and representatives spoke of the kindness and respect with which they were treated by staff and how this gave them peace of mind.

The service is proactive in recruiting staff on an ongoing basis and that skills and knowledge are adequate to complete the service required and ensure adherence to the aged care quality standards. Consumers and representatives were satisfied that staff were adequately trained and equipped to complete their duties.

Requirement 7(3)(c)

In respect to Requirement 7(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 did meet and exceed the threshold required for the Decision Maker to deem this requirement as 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 service was able to demonstrate that the directly employed workforce are competent to undertake their respective roles and have the skills and knowledge to effectively perform their roles. However, the service does not have oversight of the skills, qualifications and abilities of brokered staff.

The services response shows a significant number of actions have been implemented post Quality Audit to remediate the deficiencies identified by the Assessment Team during the Quality Audit. Evidence has been provided by the service to substantiate these claims. A few key examples are documented below.

* Review and edit Contractor Brokerage and Management Policy.
* Clinical Governance Committee to endorse and implement.
* Policy adopted and training provided.
* Training added to training matrix.
* Brokerage agreement template developed and sent to all providers.
* Brokerage contracts management reporting developed.

The Decision Maker deems Requirement 7(3)(c) to be compliant.

Requirement 7(3)(e)

In respect to Requirement 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 did meet and exceed the threshold required for the Decision Maker to deem this requirement as 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 service was not able to demonstrate that formal annual performance reviews are conducted by the organisation’s human resources (HR) department. This was confirmed through discussion with care delivery staff and senior management. However, the service demonstrates that it completes regular review with staff members. Monitoring is done on an informal level through staff training record review.

The services response shows a significant number of actions have been implemented post Quality Audit to remediate the deficiencies identified by the Assessment Team during the Quality Audit. Evidence has been provided by the service to substantiate these claims. A few key examples are documented below.

* Creation of the new Performance Development and Review template that covers:
  + Employee Self-Evaluation.
  + Manager Evaluation.
  + Joint Meeting.
  + HR Department Sign-Off.
* The new Manager of Community Care will adopt the new appraisal template with the goal to complete the outstanding appraisals by the end of 2023. Although the team is small, the timeline will allow the new manager to understand and develop the team.

The Decision Maker deems Requirement 7(3)(e) to be compliant.

# Standard 8

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

Findings

Compliant Evidence

Evidence analysed by the Assessment Team showed the service was able to demonstrate that consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. Consumers and representatives reported that they have not been invited to contribute to the service development of the organisation at the board level but advised that they are actively encouraged to provide feedback on services through surveys.

The service was able to demonstrate it has effective organisation wide governance systems in place in relation to information management, continuous improvement and regulatory compliance.

Information management:

The service demonstrated adequate information management with respect to consumers who had access to accurately and timely information regarding their care. They were encouraged to provide feedback on a regular basis and were aware of the complaint’s mechanism.

Continuous improvement:

The service has sought feedback from consumers, representative and staff through an online survey tool. The service has a number of memberships to organisations such as the chamber of commerce, aged care groups and aged care law specialists which they use to inform their service provision.

Regulatory compliance:

Staff reported that they completed training on the SIRS process a month prior to it being introduced and staff meeting minutes sighted confirm that quality and regulatory compliance are standing items of the agenda on an ongoing basis. The service has effective processes to track changes to regulatory requirements and implement relevant changes. Management advised that they remain updated regarding regulatory compliance through alerts from the Commission and membership of relevant aged care organisations as well as specialists in aged care law.

The service was able to demonstrate it has effective processes for risk management systems and practices in relation to identifying and responding to abuse and neglect.

Identifying and responding to abuse and neglect:

Staff were able to describe what elder abuse and neglect can look like and said demonstrated awareness of elder abused and their responsibility to report any observed or suspected abuse. Documentation reviewed noted elder abuse training is incorporated into orientation for all staff. The training outlines the identification and responding to abuse/alleged abuse of a consumer

Requirement 8(3)(b)

In respect to Requirement 8(3)(b) 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 deem this requirement as 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 service was not able to demonstrate that where it subcontracts delivery of services, that the executive management team maintain oversight of the quality of subcontracted services. There was no dedicated community services clinical governance committee in situ at the time of the site visit therefore the service could not be accountable for the safe, inclusive and quality care and services provided by the service.

The service was able to demonstrate there is a clinical governance committee currently, management advised that the committee historically has focussed on the residential services provided by the organisation. However, management advised the service does not currently have strong clinical indicators for the home care service.

The services response shows a significant number of actions have been implemented post Quality Audit to remediate the deficiencies identified by the Assessment Team during the Quality Audit. Evidence has been provided by the service to substantiate these claims. A few key examples are documented below.

* In reference to subcontracted services, please also refer to Requirement 7(3)(c).
* The service has recruited into the newly created role of Community Care Manager, a registered nurse with extensive senior leadership and management experience in the home care sector. This role will commence 14 June 2023.
* The service has established a Clinical Governance Committee and evidenced that meetings have commenced as of 18 May 2023.
* The service is in the process of procuring an enterprise Quality Management System to support the delivery of high-quality care and services to consumers.
* The organisation to invest into policies and procedures to ensure they are contemporary and reflective of best practice.
* Provide training and development for staff with modules that aligned with policies and procedures.
* Consumer Reporting and Statements Policy and Procedure.
* Review and edit Contractor Brokerage and Management Policy.

The Decision Maker deems Requirement 8(3)(b) to be compliant.

Requirement 8(3)(c)(iii), Requirement 8(3)(c)(iv) and Requirement 8(3)(c)(vi)

In respect to Requirement 8(3)(c)(iii), Requirement 8(3)(c)(iv) and Requirement 8(3)(c)(vi) 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 deem this requirement as 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 service was not able to demonstrate that it has effective organisation wide governance systems in place in relation to financial governance, workforce governance, and feedback and complaints.

Financial governance:

Management advised that financial matters are managed directly by the finance department for the entire organisation which also provides residential services. The department forward monthly statements to the home care services monthly for consumers.

The organisation could not demonstrate it has an effective system to monitor consumers unspent funds and use this to offer additional services to consumers. Management advised that whilst they have an awareness of consumers who had high levels of unspent funds, they do not have a way of actively tracking this information. The service relies on team leaders having an awareness of the consumers and the explanation for unspent funds. This was confirmed through discussion with a team leader who could provide rationale for each consumer. Reasons provided where the consumer was satisfied that they were availing of all the services they required at the present time or if they were unwell, they did not give access to their homes to staff members.

Workforce governance:

The service demonstrated effective recruitment and training of directly employed staff through detailed position description and duty statements as well as the maintenance of training registers. The service did not demonstrate adequate workforce governance with respect to subcontracted staff. Refer to Standard 7 requirement (3)(c).

Feedback and complaints:

The organisation has a feedback and complaints processes, to encourage and support consumers to provide feedback and make complaints. The service sought feedback from consumers, representatives, and staff. However, the service could not demonstrate it has a dedicated complaint register where data is stored and trended. The service could trend feedback provided through the online audit tool however this information was not captured on the compliments and complaints spreadsheet. Management advised that the previous home care coordinator managed complaints via email.

The services response shows a significant number of actions have been implemented post Quality Audit to remediate the deficiencies identified by the Assessment Team during the Quality Audit. Evidence has been provided by the service to substantiate these claims. A few key examples are documented below.

Financial governance:

* Review and edit Consumer reporting and Statements Policy and Procedure
* Clinical Governance Committee to endorse
* Policy and procedure adopted and training provided
* Training added to training matrix
* Reporting to Clinical Governance Committee on unspent funds developed.

Workforce governance:

* In reference to subcontracted services, please refer to Requirement 7(3)(c).

Feedback and complaints:

* The service has recruited into the newly created role of Community Care Manager, a registered nurse with extensive senior leadership and management experience in the home care sector. This role will commence 14 June 2023.
* In reference to feedback and complaints, please refer to Standard 6.

The Decision Maker deems Requirement 8(3)(c)(iii), Requirement 8(3)(c)(iv) and Requirement 8(3)(c)(vi) to be compliant.

Requirement 8(3)(d)

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 deem this requirement as 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 service was not able to demonstrate that effective risk management systems and practices to managing high impact or high prevalence risks associated with the care of consumers. The service is not using its assessment processes effectively to identify and record where there may be risks for the consumer. The service does not effectively use the incident management system to review and identify opportunities for improvement.

Managing high-impact or high-prevalence risks:

The service could demonstrate that documentation of consumer risk assessments had been undertaken and risks managed. The organisation was not able to demonstrate that governance processes are in place to monitor high-impact or high-prevalence risks to consumers at service and organisational level to effectively mitigate and manage risks to consumers. Staff interviewed could identify high prevalence risks associated with the care of consumers including falls risk. Staff stated they get to know the consumers well and share information through progress notes and messages. However, this information is not consistently recorded on the care plan.

The organisation does not have a dignity of risk policy and could not demonstrate processes are in place to guide staff on informing consumers about risks and possible consequences, and support consumers to take risks if they wish to enable them to live their best life.

Supporting consumers to live the best life they can:

The service supports consumers to live their best life through consultation with how they want their care to be provided. Examples included supporting consumers with mobility equipment to maintain their independence, following exercise programs to increase physical strength and support consumers to maintain relationships and connections to their community. The organisation does not have a dignity of risk policy and could not demonstrate processes are in place to guide staff on informing consumers about risks and possible consequences, and support consumers to take risks if they wish to enable them to live their best life.

Incidents managed and prevented:

The service has an incident management system (IMS) which records incidents and staff are able to demonstrate how to use the electronic system. Once reported the team leaders are allocated the incident to investigate and action any strategies or referrals to others for support. However, the Assessment Team found while the service is collating clinical data against individual consumers and using this information to discuss strategies at a registered nurse/team leader level, it is not collating and trending data to understand how it can further support consumers or provide opportunities for education for staff

The services response shows a significant number of actions have been implemented post Quality Audit to remediate the deficiencies identified by the Assessment Team during the Quality Audit. Evidence has been provided by the service to substantiate these claims. A few key examples are documented below.

* Review and edit the edit the following related documents;
  + Management of High Impact or High Prevalence Risks Policy and Procedure.
  + Wound Management Policy and Procedure, Pain Management Policy and Procedure.
* Clinical Governance Committee to endorse.
* The service to implement a software program to maintain oversight of the organisations policies, staff training, compliance actions and reporting. The program will support the organisation with industry specific policies and procedures, online learning courses and associated forms and checklists to support good governance and comprehensive reporting.
* High impact or high prevalence risk reporting to Clinical Governance Committee developed.
* Policies and procedures adopted and training provided.
* Provide training and development for staff with modules that aligned with policies and procedures:
  + Quality Pain Management Training Module.
  + Skin Care and Wound Management (including Pressure injuries) Training Module.
  + High Impact/High Prevalence Risk Toolkit Training Module.

The Decision Maker deems Requirement 8(3)(d) to be compliant.

Requirement 8(3)(e)

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.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that there are policies to guide staff in relation to antimicrobial stewardship, minimising the use of restraint and open disclosure specifically in a community. The clinical governance framework sets out the roles and responsibilities of the governing body, management and staff and includes how risks will be managed. However, the Assessment Team noted this information is more in line with the requirements of the organisation’s residential care setting with limited reference to the community setting.

Antimicrobial stewardship:

The organisation has a policy on antimicrobial stewardship. Review of the policy showed this information is centred around practice of staff within the organisations residential care facility. The service was unable to evidence it has policy or processes to guide antimicrobial stewardship including how the service could support consumers living in the community to make informed choices in their medications including when taking antibiotics.

Minimising the use of restraint

The organisation has a policy in relation to minimising the use of restraint. However, the policy does not reference strategies to minimise the use of restraint in a community setting and staff have not been provided education on what minimising the use of restraint means in practice in the community. The service did not evidence a policy on open disclosure specifically related to the community service in place, staff demonstrated they use an open disclosure approach to resolve complaints and incidents.

Open disclosure:

The service did not evidence a policy on open disclosure specifically related to the community service in place, staff demonstrated they use an open disclosure approach to resolve complaints and incidents.

The services response shows a significant number of actions have been implemented post Quality Audit to remediate the deficiencies identified by the Assessment Team during the Quality Audit. Evidence has been provided by the service to substantiate these claims. A few key examples are documented below.

* In reference to antimicrobial stewardship, please also refer to Requirement 3(3)(g).
* Review and edit the following related documents;
  + Restrictive Practices Prevention and Management Policy and Procedure.
  + Open Disclosure, Aged Care Standards and Open Disclosure.
  + The Importance of Practising Open Disclosure.
  + The Four Principles of Open Disclosure.
  + The Five Elements of Open Disclosure.
  + How We Enable Open Disclosure.
* Clinical Governance Committee to endorse.
* Policies and Procedures adopted and training provided.
* Provide information, training and development for staff with modules that aligned with policies and procedures for:
  + Antimicrobial Stewardship
  + Minimising Restrictive Practices Training Module
  + Organisational/Clinical Governance (including open disclosure)

The Decision Maker deems Requirement 8(3)(e) to be compliant.

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)