**Performance**

**Report**

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| Name: | Dementia Caring Australia Pty Ltd |
| Commission ID: | 201282 |
| Address: | 4/327 Woodpark Rd, SMITHFIELD, New South Wales, 2164 |
| Activity type: | Quality Audit |
| Activity date: | 4 November 2024 to 8 November 2024 |
| Performance report date: | 11 December 2024 |

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

# Services included in this assessment

Home Care Packages (**HCP**) included:  
Provider: 8920 Dementia Caring Australia Pty Ltd  
Service: 26499 Dementia Caring

**This performance report**

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

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

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

# Material relied on

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

* the assessment team’s report for the Quality Audit report was informed by a site assessment, observations at service outlets, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 9 December 2024.

# Assessment summary for Home Care Packages (HCP)

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

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

# Areas for improvement

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

Requirement 1(3)(d) - Each consumer is supported to take risks to enable them to live the best life they can.

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.

Requirement 2(3)(a) - Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.

Requirement 2(3)(d) - The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.

Requirement 3(3)(b) - Effective management of high impact or high prevalence risks associated with the care of each consumer.

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.

Requirement 6(3)(d) - Feedback and complaints are reviewed and used to improve the quality of care and services.

Requirement 8(3)(a) - Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

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.

Requirement 8(3)(c) - Effective organisation wide governance systems relating to information management, continuous improvement, financial governance, and feedback and complaints.

Requirement 8(3)(d) - Effective risk management systems and practices relating to managing high-impact or high-prevalence risks associated with the care of consumers and managing and preventing incidents, including the use of an incident management system.

Requirement 8(3)(e) - Where clinical care is provided—a clinical governance framework

# 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. | Not 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. | Not Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Requirement 1(3)(d) - was found non-compliant for service ID 26499 following a Quality Audit undertaken from 4 November 2024 to 8 November 2024. The service did not demonstrate:

* Each consumer is supported to take risks to enable them to live the best life they can.

The Assessment Team was not satisfied the provider had an efficient and effective process implemented to monitor dignity of risk. The Assessment Team provided the following evidence to support their assessment:

* Management demonstrated an understanding of the dignity of risk principles, however provided only 2 examples of where dignity of risk principles were implemented, despite indicating there were more examples of this in practice.
* Staff interviewed were unfamiliar with the terminology ‘dignity of risk or risk acknowledgement’. Six out of 7 support workers required an explanation or example of enabling and respecting consumer’s right to take risks.
* Documentation reviewed did not demonstrate an effective process was embedded to ensure consumers were enabled to make informed choices regarding risks and supported by appropriate mitigation measures.
  + One consumers file review contained a risk acknowledgement form, with the consumer opting to self-manage wound care for a toe ulcer. The form indemnifies the provider from any issues that may arise as a result of this decision. However, the provider was unable to evidence appropriate consultation with the consumer regarding the potential risks or outcomes associated with performing their own wound management (including risk mitigation strategies).
    - Care plan or progress notes did not indicate a review of how the wound had occurred.
  + Another consumers risk acknowledgement form was sighted, regarding the purchase of a stick vacuum. The form indemnifies the provider from any issues that may arise as a result of this decision.
    - Documentation reviewed indicated that the consumer would use the stick vacuum in a seated position. The risks associated with this form of usage was the potential of aggravating gout symptoms and risk of falling (as documented within their care plan).
    - Additional risk mitigation strategies were not documented, nor a timeframe for a review of circumstances.

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

Information extracted from Plan for Continuous improvement (PCI) included.

* New dignity of Risk Policy is currently being reviewed and will be completed (GM Quality and Compliance – planned completion date 31 December 2024)
* Risk acknowledgement form to be reviewed and renamed client dignity of risk form. This will be enhanced to ensure it captures standardised questions to ensure risks are considered with mitigation plans. This will include prompts to consider engagement of multidisciplinary healthcare professionals can be engaged in risk assessments if needed. (GM Quality and Compliance – planned completion date 31 December 2024)
* The existing process of the Internal Quality Team performing daily phone calls will include a question to incorporate capturing feedback on dignity of risk for applicable consumers. (Quality Audit Team – planned completion date 31 December 2024)
* Our existing process requires case managers to contact consumers monthly. To enhance compliant execution a check list will be created to guide case managers to ensure dignity of risk factors are reviewed. (Quality Audit Team – planned completion date end February 2025)
* Create more specific training on Dignity of Risk and Duty of Care, focusing on key concepts such as:
  + Understanding clients’ rights to take risks.
  + Legal and ethical considerations of risk-taking.
  + Techniques for supporting clients in making informed decisions.

(Quality Audit Team – GM Quality and Compliance – planned completion date end March 2025)

* Enhance existing internal audit process to more specifically capture dignity of risk assurance. (Quality & Compliance Manager – planned completion date 31 January 2025)

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with the information provided.

The intent of this requirement is about consumers having the right to make decisions about things that affect their lives and to continue to make those decisions as they get older. Making decisions in everyday life involves risks. This requirement is about how the organisation respects a consumer’s wishes and preferences relating to the risks they choose to take.

I appreciate the provider’s acknowledgement regarding identified deficiencies and proposed timeframes in responding to them, however at the time of my finding, the full suite of proposed Plan for Continuous improvement (PCI) actions have not been implemented or embedded. Once established and embedded, results should identify themselves expediently.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 1(3)(d) in Standard 1 Consumer dignity and choice.

Requirement 1(3)(e) - was found non-compliant for service ID 26499 following a Quality Audit undertaken from 4 November 2024 to 8 November 2024. The service did not demonstrate:

* 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.

The Assessment Team was not satisfied all consumers received monthly statements. The Assessment Team provided the following evidence to support their assessment:

* One consumer advised and reported an error in their July 2024 statement relating to a services. At the time of the assessment, the consumer stated that to their knowledge their complaint had not been resolved.
  + Corporate management was not aware of this complaint as this was raised with the franchise management.
  + Franchise management indicated that this would be investigated.
* One consumer representative made a complaint with the provider in August 2024 regarding the July statement being inaccurate. The representative described a calendar where services and appointments were documented. The representative then compared this with the July 2024 statement which reflected inconsistency with the services received.
  + Corporate management showed evidence that this error would be rectified and reflected in the October 2024 statement.
  + Franchise management explained that an error was made by a previous employee in entering booked shifts with correct descriptions prior to approval.

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

Information extracted from Plan for Continuous improvement (PCI) included.

* The organisation is in the process of implementing new business software that will assist with more streamlined statement preparation and centralised electronic distribution of statements.
* Upgraded system is undergoing testing and refinement currently.
* The Department’s better practice guide template has been referenced in developing the revised statement format (currently undergoing internal testing) to improve clarity and useability. (Finance Team – planned completion June 2025).
* Expectation regarding timeframes for statement delivery will be reiterated to case managers. (Finance Team – planned completion June 2025).
* Case managers will also receive education and ongoing support on how to present and explain the statement content to clients and assist clients with questions or concerns about their package budget, funding status or specific transactions. (Finance Team – planned completion June 2025).

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with the information provided.

The intent of this requirement is about expected that organisations communicate clearly and supply helpful resources about their care and services, including the care and services they offer, commitments and obligations.

I appreciate the provider’s acknowledgement regarding identified deficiencies and proposed timeframes in responding to them, however at the time of my finding, the full suite of proposed Plan for Continuous improvement (PCI) actions have not been implemented or embedded. Once established and embedded, results should identify themselves expediently.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 1(3)(e) in Standard 1 Consumer dignity and choice.

Requirements 1(3)(a), 1(3)(b),1(3)(c), and 1(3)(f)

Consumers and representatives stated consumers are treated with respect by staff. Staff described how they treat consumers with dignity and respect. Documentation showed detailed recognition of consumers’ identity, culture and diversity, with each consumer’s background, social, cultural, language and family composition recorded.

Consumers confirmed care and services are culturally safe, with staff confirmed they consider the consumer’s cultural background when providing care and services.

Consumers and representatives confirmed the service supports consumers to exercise choice and independence, with staff ensuring the consumer is provided opportunities to decide on services and care provided. Staff described how they support consumers to make day-to-day choices. Management discussed how the service has ongoing discussion with consumers to support consumer choice and independence. Documentation showed the service captures details about whom the consumers wish to be involved in decisions.

Consumers and representatives confirmed consumers receive information about the care and services provided. Consumers and representatives confirmed staff respect and protect the consumer’s privacy. Staff described how they maintain consumer privacy and confidentiality by not sharing information with others who are not authorised to receive it. Management described the process for sharing personal and sensitive information only with those who require the information. Documentation confirmed the service uses a privacy consent process prior to sharing information with others.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirements 1(3)(a), 1(3)(b),1(3)(c), and 1(3)(f) in Standard 1, Consumer dignity and choice.

# 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. | Not Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Not Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

Requirement 2(3)(a) - was found non-compliant for service ID 26499 following a Quality Audit undertaken from 4 November 2024 to 8 November 2024. The service did not demonstrate:

* Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.

The Assessment Team was not satisfied all care plans were sufficiently detailed to guide the delivery of safe and effective care, with some containing contradictory information. The Assessment Team provided the following evidence to support their assessment:

* One consumer care plan referred to them as being non ambulant, bedbound, and needing regular pressure injury checks. The care plan also described them as spending their days resting in bed or a chair and required 2 persons to assist with personal care. However, the care plan states, ‘staff to assist when ambulates.’ The contradictory nature of details within the care plan does not provide sufficient guidance to inform care and services.
* One consumer care plan failed to document supervising exercises, despite balance and proprioception exercises as they have multiple amputations.

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

Information extracted from Plan for Continuous improvement (PCI) included.

* Review and update the assessment documents and process to ensure advanced care planning and end-of-life preferences are clearly identified for each client. (Quality and Compliance – planned completion date end of January 2025)
* Enhance existing internal audit processes to enhance clarity and specificity of advanced care, end-of-life preferences and substitute decision makers are consistently documented and addressed. (Quality Team – planned completion end of March 2025)
* Conduct a review of identified contradictory care plan information by the commission and provide additional training to the respective case managers. (GM Quality and Compliance – planned completion date end of January 2025)
* Enhance existing documentation training to re-enforce that care staff must only deliver care as per the care plan and ensure the care plan captures the care being provided. (GM Quality and Compliance – planned completion date end of March 2025)
* Multilingual resources will be procured to assist with the advanced care planning and end of life discussion. Documents will be made available for locations to access and use with consumers. (Quality and Compliance – planned completion date end of January 2025)

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with the information provided.

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

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

I appreciate the provider’s acknowledgement regarding identified deficiencies and proposed timeframes in responding to them, however at the time of my finding, the full suite of proposed Plan for Continuous improvement (PCI) actions have not been implemented or embedded. Once established and embedded, results should identify themselves expediently.

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

Requirement 2(3)(d) - was found non-compliant for service ID 26499 following a Quality Audit undertaken from 4 November 2024 to 8 November 2024. The service did not demonstrate:

* The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.

The Assessment Team was not satisfied all care plans were provided to consumers. 20% of consumers and representatives did not recall receiving a care plan, with the rest saying they received one at commencement of service. The Assessment Team provided the following evidence to support their assessment:

* One manager interviewed, and client management systems examined evidenced inconsistent imputing care plans on the system. Management explained that they were in limbo about moving forward with the new electronic database and hadn’t been updating the old one.
* Requested care plans and consumer documentation was difficult to locate due to multiple storage platforms. Inconsistent naming conventions made it difficult to track individual documents for consumers.
  + In many instances management would contact the sites directly and discover that the document had not been uploaded.
* A review of the shift instructions in the electronic system showed that, whilst some were quite detailed, others would refer to care plans. These care plans would often not be on the system, have insufficient direction, or be out of date.

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

Information extracted from Plan for Continuous improvement (PCI) included.

* Re-enforce the current process to ensure all consumers and their representatives receive a copy of the care plan at the commencement of service, and at any change of care and service needs. Ensure that this is clearly documented in the consumers progress notes. (Quality and Compliance Manager – planned completion date end of March 2025).
* Deliver refresher training to elevate the requirement to follow current procedures of ensuring the client or substitute decision maker is to sign that the care plan has been provided or offered and is documented in the progress notes. (Quality and Compliance Manager – planned completion date end of March 2025).
* Provide additional education to case managers to ensure care plans are explained during the intake process and key information is presented clearly and that consumers understand their contents and importance. (Quality and Compliance Manager – planned completion date end 31 December 2025).
* In order to improve consistency in following operational manuals to achieve more consistency in file storage structure and file naming conventions, a policy will be written and assurance included within internal audit processes. (Quality and Compliance Manager – planned completion date end of March 2025).

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with the information provided.

The intent of this requirement is ensuring a care and services plan is expected to be documented and reflect the outcomes of assessment and planning for each consumer. Accurate and up-to-date care and services plans are important for delivering safe and effective care and services, as well as positive outcomes for consumers.

A care and services plan, which includes a person’s needs, goals and preferences, should be available to the consumer in a way they can understand. This may involve support to have information in an accessible language and format, or to help consumers understand the content. It may include involving consumers in discussions, inviting them to meet and encouraging them to ask questions about their care and services plan. This will help consumers understand and have ownership of the care and services plan as they are entitled to have.

I appreciate the provider’s acknowledgement regarding identified deficiencies and proposed timeframes in responding to them, however at the time of my finding, the full suite of proposed Plan for Continuous improvement (PCI) actions have not been implemented or embedded. Once established and embedded, results should identify themselves expediently.

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

Requirements 2(3)(b), 2(3)(c), and 2(3)(e)

Consumers and representatives confirmed assessment and care planning occurs. Care planning documentation showed assessment and planning considers risks to consumer health and well-being. The service uses validated tools to assess risks to guide the delivery of safe and effective care and services. Risks assessed include falls, pain, wounds and cognition. Staff confirmed they have access to care planning documentation to guide them on the care and services provided.

Consumers and representatives confirmed assessment and planning outcomes are reflective of what is important to the consumer to meet their needs and goals. Staff demonstrated awareness of what is important to each consumer, including the consumer’s needs and preferences for care. Staff and management described how assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and (palliative) end of life planning if the consumer wishes. Management explained care planning documentation is updated regularly based on ongoing assessment and planning processes. Documentation showed clear directives for staff to support the consumer based on the consumer’s assessed needs and goals.

Consumers and representatives confirmed the service involves them, and others they wish involved, in the care planning and assessment process. Staff and management demonstrated how assessment and planning occurs in partnership with consumers, the service and other health care professionals where necessary. Documentation showed assessment and planning involves the consumer and others the consumer agrees to be involved, including other organisations, individuals and other providers.

Staff confirmed they receive access to updated care plans when services change with clear directives included. Management described how care is formally reviewed at regular intervals and when circumstances change or when incidents occur. Documentation showed regular reviews are conducted. Management advised they will ensure it is clearly documented new and updated care plans are provided to consumers.

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

# 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. | Not 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. | Not 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

Requirement 3(3)(b) - was found non-compliant for service ID 26499 following a Quality Audit undertaken from 4 November 2024 to 8 November 2024. The service did not demonstrate:

* Effective management of high impact or high prevalence risks associated with the care of each consumer.

The Assessment Team was not satisfied there were regular reporting mechanisms in place for self-managed staff to report incidents for, or changes to, consumers. It is expected that the self-managed consumers will contact the case manager to discuss changes. The Assessment Team provided the following evidence to support their assessment:

* Evidence regarding the clinical governance group, where clinical issues may be raised, however this is not mandatory, and attendance lists indicate this group is not well attended. Issues raised in this group are documented in an hoc manner.
* Incident registers evidenced that incidents for provider-managed consumers were recorded in incident registers; however, these are managed by the individual sites.
  + As the provider has no uniform register to compile this information it was unclear and disjointed. This made it difficult to identify incidents across the client cohort or be able to target areas experiencing concerns.
* The evidenced vulnerable client and clinical care list were not up to date.
* Management advised that it does not have a restrictive practice register and any restrictive practice would only be noted in the consumer’s individual care plan.
* One consumer file identified a consumer as having advanced dementia, resulting in limited insight into their condition. The consumer has a restrictive practice in place from their previous provider, regarding a locked medication box. This was reported to be put in place at the consumers request, after several medication mismanagement incidents, but no handover was noted from the previous provider. Whilst this strategy was noted in the care plan this was not noted as a restrictive practice. The provider is working with his general practitioner (GP) to pursue state guardianship as they are socially isolated, and no one else to represent their interests.

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

Information extracted from Plan for Continuous improvement (PCI) included.

* Currently establishing specific High Impact High Prevalence Risk Indicators (HIHP) These HIHP will be measurable, specific, and directly tied to the organization’s priorities. (Quality and Compliance Manager – planned completion date end of December 2024).
  + Choking and swallowing issues
  + Skin problems like incontinence-associated dermatitis
  + Falls and injuries from falls
  + Underweight and poor nutrition
  + Dehydration
  + Mental health distress or changes Declining oral health
  + Pain management
  + Pressure injuries prevention and management and wounds
  + Medication mistakes or side effects
  + Aggressive or violent behaviour
  + Delirium
  + Restrictive practices
  + Hearing loss
  + Diabetes
  + Dementia
  + Recurrent UTI’s
* With an understanding for all our staff and the organisation that older adults with frailty and multiple health conditions, these risks may also lead to: (Quality and Compliance Manager – planned completion date July 2025).
  + Preventable harm, pain, and suffering
  + Distress for the older person, their family, and caregivers
  + Lower quality of life
  + The need for new medications, increasing the risk of side effects and drug interactions
  + Preventable hospital stays
  + Unnecessary changes in care
  + Avoidable trips to the emergency department
* A register will be expected from each franchisee, with accessibility to the Quality team for review and auditing.
* Create a process to regularly track and review the trends in high-impact or high-prevalence risks.
* Add a trigger or section in the assessment documents to identify potential high prevalence or high impact risks. This would help ensure that when a HIHP risk is suspected, it is flagged early and addressed with appropriate documentation and management.
* Use risk trend data to inform ongoing staff training, development, and quality improvement initiatives. Regularly update staff on best practices and new strategies to mitigate high-impact/high-prevalence risks.
* Existing protocols for managing consumers are to be applied for self-managed packages. The business will remove any ambiguity identified around this and re-enforce existing protocols to meet the requirements.
* Existing protocols for managing consumers are to be applied for self-managed packages. The business will remove any ambiguity identified around this and re-enforce existing protocols to meet the requirements.
* Existing protocols for managing consumers are to be applied for self-managed packages. The business will remove any ambiguity identified around this and re-enforce existing protocols to meet the requirements. (Quality and Compliance Manager – planned completion date end of December 2024).
* The current Clinical Governance Committee Terms of Reference is currently under review. The structured plan will reflect robust requirements with standing agenda, quorum, minutes, consumer representation, and board reports. (Quality and Compliance Manager – planned completion date end of February 2025).
* The IT team is reviewing a new risk, incident and consumer feedback management system to centralise and enhance the tracking and transparency of incidents across the organisation. This system will ensure all incidents are captured and analysed, providing clear visibility in a robust manner. (IT – planned completion date end of July 2025).
* As an interim improvement initiative and as part of redesigning the clinical governance committee, a section to discuss trends observed in incidents will be tabled with inputs consolidated and reported to the board. (GM Quality and Compliance – planned completion date end of February 2025).
* Current protocols will be highlighted and re-enforced. Additionally, assurance of this being completed will be incorporated into internal audit processes. (Quality and Compliance – planned completion date end of January 2025).
* A restrictive practices register will be implemented. (Quality and Compliance – established and communicated end of December 2024).

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with the information provided.

The intent of this requirement is ensuring organisations need to do all they can to manage risks related to the personal and clinical care of each consumer. This means following best practice guidance and applying measures to make sure the risk is as low as possible whilst supporting a consumer’s independence and self-determination to make their own choices, including to take some risks in life.

I appreciate the provider’s acknowledgement regarding identified deficiencies and proposed timeframes in responding to them, however at the time of my finding, the full suite of proposed Plan for Continuous improvement (PCI) actions have not been implemented or embedded.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 3(3)(b) in Standard 3 personal care and clinical care.

Requirement 3(3)(e) - was found non-compliant for service ID 26499 following a Quality Audit undertaken from 4 November 2024 to 8 November 2024. The service did not demonstrate:

* 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.

The Assessment Team was not satisfied where care is engaged with a self-managed consumer, there is limited contact with the staff providing care. The provider has four different platforms where they store documents, making navigation difficult and determining which care plans were the most relevant. There was no uniform approach to documentation across the different sites, resulting in inconsistent information capture within care plans and shift notes. The Assessment Team provided the following evidence to support their assessment:

* Management advised, and reviewed care plans confirmed difficulty in searching and locating the most recent assessments, reviews, or care plans.
* Management reported the following.
* The provider has been transitioning to new client management platform for the last two years. At the same time, they were also transitioning to a different document storage system.
* Some sites may have only uploaded the first care plan and not uploaded more recent ones as there is no clear timeline to transfer to the electronic system.
* Some sites did not wish to transition to the new platforms, advising they wished to remain with the previous platform or exploring different options.
* When the Assessment Team asked how that was being managed it was reported that they would have to “figure it out” and had not amended or developed any processes to manage this.
* Reviewed documentation of self-managed consumers showed that there was limited communication with staff engaged in this manner. When questioned case mangers reported that they often went through the consumer of the representative for information. These updates were irregular and had no details of the care being delivered.

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

Information extracted from Plan for Continuous improvement (PCI) included.

* The business will reinforce and train case managers on existing protocols and ensure information is available for staff to access on the platform and via their mobile phone apps. (Quality Team –end of January 2025).

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with the information provided.

The intent of this requirement is ensuring organisations need to do all they can to manage risks related to the personal and clinical care of each consumer. This means following best practice guidance and applying measures to make sure the risk is as low as possible whilst supporting a consumer’s independence and self-determination to make their own choices, including to take some risks in life.

Whilst I appreciate the provider’s acknowledgement regarding identified deficiencies and proposed timeframes in responding to them, I note that at the time of my finding, the full suite of proposed Plan for Continuous improvement (PCI) actions have not been implemented or embedded.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 3(3)(e) in Standard 3 personal care and clinical care.

Requirements 3(3)(a), 3(3)(c), 3(3)(d), 3(3)(f), and 3(3)(g)

Consumers and representatives confirmed consumers receive quality personal care. Staff were knowledgeable of each consumer’s unique needs and preferences. Management described how personal care is tailored to the needs of the consumer to optimise the consumer’s health and well-being. Documentation showed care directives clearly guide staff in how to provide personal care.

Consumers and representatives confirmed discussions about end-of-life planning are held. Staff and management described strategies for maximising consumer comfort when a consumer is nearing end of life. Documentation showed the service has procedures to prioritise services and onward referrals for consumers nearing end of life.

Consumers and representatives expressed confidence in staff being able to recognise and respond to a change in the consumer’s condition. Staff described how they would identify deterioration and how the service would adjust service delivery to meet the changed needs of the consumer. Management and staff have received training in recognising and responding to deterioration. The service uses a deterioration assessment tool which enables staff and management to identify, record and report signs and symptoms of deterioration.

Consumers and representatives expressed satisfaction that the consumer’s condition, needs and preferences are communicated within the service and with others where care is shared. Staff confirmed they have access to the consumer’s care directives through an application on their mobile device. Management discussed how information and recommendations to other health practitioners are received, reviewed and implemented and documented. Documentation showed the service communicates with others to ensure the provision of personal and clinical care for consumers.

Consumers and representatives confirmed staff use personal protective equipment when providing care and services. Staff stated they have completed infection control training to minimise infection. Management advised all staff have completed infection control training and staff have access to personal protective equipment. Documentation showed the service has an emergency management plan inclusive of infection control and outbreak plans.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirements 3(3)(a), 3(3)(c), 3(3)(d), 3(3)(f), and 3(3)(g) in Standard 3, Personal care and clinical care.

# 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. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Consumers and representatives confirmed the services and supports for daily living the consumers receive support the consumers to optimise their independence and well-being. Staff described how individualised and effective services and supports for daily living meet each consumer’s needs, goals and preferences. Management stated feedback from consumers on activities would be part of the service’s activities calendar. Documentation showed assessments and care plans identify services and supports for daily living which promote individual consumer’s independence and enhanced quality of life.

Consumers and representatives expressed satisfaction with the supports for daily living received by consumers. Staff described how they recognise and support consumers’ emotional, spiritual and psychological well-being and how services provided meet those needs. Management demonstrated an understanding of supporting consumers in their emotional, spiritual and psychological well-being. Documentation showed evidence of support strategies to meet individual consumer’s emotional, spiritual and psychological well-being.

Consumers and representatives confirmed consumers participate in activities of interest to them in their homes and in the community. Staff stated they access information about consumers on the mobile application to guide them on how to support the consumer in their personal relationships. Management described processes used by the service to meet the social and personal needs of consumers. Documentation showed services and supports for daily living support consumers to participate in the community, do things of interest to them and have social and personal relationships.

Consumers and representatives confirmed the consumer’s needs and preferences are communicated during the assessment process. Staff confirmed they have access to each consumer’s needs and preferences through a mobile application. Management advised consumer care plans are available to staff through a mobile application and to subcontracted services through a service request process. Documentation showed care plans include clear directives about the consumer’s condition, needs and preferences.

Consumers and representatives confirmed the service supports consumers to access other services, including other lifestyle services where appropriate. Staff stated they will document concerns about consumers for management to review and make referrals where necessary. Management discussed processes used to refer consumers for additional care and higher-level packages. Documentation demonstrated the service refers consumers to organisations and providers for additional services and supports when necessary.

Consumers confirmed the food provided is satisfying and nutritious. Staff described how the service ensures appropriate meals are provided based on consumer needs and preferences, including allergies and likes and dislikes. Documentation showed the service has a documented emergency plan which identifies allergies, likes and dislikes of consumers and there are special directives for consumers with diabetes.

Consumers and representatives confirmed consumers have received equipment, which is safe, and suitable. Management described the assessment and ongoing processes to ensure equipment provided is suitable and safe for the consumer. Management stated equipment is checked at reassessment and will be serviced or replaced as necessary. Documentation showed equipment is selected for safety and suitability on the recommendations of allied health professionals.

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

# Standard 5

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| Organisation’s service environment | | 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

The organisation is not funded to provide HCP services in a centre-based environment, therefore this standard was not applicable, and has not been assessed.

# 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. | Not Compliant |

Findings

Requirement 6(3)(d) - was found non-compliant for service ID 26499 following a Quality Audit undertaken from 4 November 2024 to 8 November 2024. The service did not demonstrate:

* Feedback and complaints are reviewed and used to improve the quality of care and services.

The Assessment Team was not satisfied feedback data analysis and trending occurred. The documentation reviewed did not demonstrate timely actions to the increased monthly statements complaint trend, nor did it present feedback trends to the governing body to enable oversight. The Assessment Team provided the following evidence to support their assessment:

* Evidence viewed confirmed three out of 5 complaints received from the Commission in October 2024 related to delayed reimbursements or timeliness of statements. Additionally, several internal complaints related to invoices and statements.
* Franchise management and corporate management advised most complaints received related to the accuracy and timeliness of invoices and statements.
* Complaints information viewed identified gaps in timely payments to third-party providers significantly impacted some consumers.
* Corporate management advised they were aware of complaints trends relating to statements and invoices and was making improvements. However, it was unclear when the improvement to statements would be completed. As the provider has not established a consumer advisory body, consultation with consumers and representatives on the improvements has not occurred.

The Assessment Team considered the intent of this requirement, which states that organisations must have a best practice management system for feedback and complaints, as well as use complaints information to improve care and services.

* The provider did not demonstrate efficient and effective management of complaints data received from individual franchisees. This impacted the ability of corporate management to analyse and inform from data, for tracking and trending purposes.
  + As of November 2024, corporate management commenced compiling the data received into a centralised system. However, at the time of the quality audit only 27 out of 70 franchises had submitted their data.

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

Information extracted from Plan for Continuous improvement (PCI) included.

* Advisement that the IT team is reviewing a new risk, incident and consumer feedback management system to centralise and enhance the tracking and transparency of incidents across the organisation. This system will ensure all incidents are captured and analysed, providing clear visibility in a robust manner. (IT - July 2025).
* The organisation is in the process of implementing new business software that will assist with more streamlined statement preparation and centralised electronic distribution of statements. (Finance – planned completion date of June 2025).
* Upgraded system is undergoing testing and refinement and will be implemented in the first half of 2025. (Finance – planned completion date end of March 2025).
* The Department’s better practice guide template has been referenced in developing the revised statement format (currently undergoing internal testing) to improve clarity and useability. (Finance – planned completion date end of March 2025).
* Expectation regarding timeframes for statement delivery will be reiterated to case managers. (Finance – planned completion date end of March 2025).
* Case managers will also receive education and ongoing support on how to present and explain the statement content to clients and assist clients with questions or concerns about their package budget, funding status or specific transactions. (Finance – planned completion date end of March 2025).

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with the information provided.

The intent of this requirement is ensuring an organisation is expected to have a best practice system to manage feedback and complaints. Organisations should use this system to improve how they deliver care and services.

Whilst I appreciate the provider’s acknowledgement regarding identified deficiencies and proposed timeframes in responding to them, I note that at the time of my finding, the full suite of proposed Plan for Continuous improvement (PCI) actions have not been implemented or embedded.

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

Requirements 6(3)(a), 6(3)(b), and 6(3)(c)

Consumers and representatives confirmed they are aware of how to provide feedback and raise complaints and feel safe to do so. Staff stated they seek feedback from consumers during service delivery and emphasise to consumers the importance of making feedback. Management stated the complaint procedure is explained to consumers. Documentation showed complaint mechanisms and procedures are included in consumer agreements and consumer information manuals.

Consumers and representatives confirmed they are aware other methods for raising and resolving complaints, including knowing how to contact the Commission. Management described how the service supports consumers to access advocates and other services and methods for raising and resolving complaints. Documentation showed the service’s complaints procedure and consumer manuals offer consumers diverse internal and external feedback, complaints and advocacy options, in the consumer’s language of choice.

Consumers and representatives confirmed the service resolved issues or informal complaints they had made. Staff described processes for escalating complaints from consumers. Management described how the service responds to complaints and how it uses open disclosure when issues are identified. Documentation showed the service uses an open disclosure approach to resolve issues.

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

# 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

Consumers and representatives confirmed consumers feel respected. Staff described how they relate to consumers respectfully. Evidence showed 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

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

Staff confirmed they receive induction training and ongoing mandatory training. Management explained and documentation review confirmed staff receive ongoing training and support through staff meetings and via an online learning portal, where training is delivered when necessary.

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

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 7, Human resources.

# 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. | Not 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. | Not Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Not Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Not Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Not Compliant |

Findings

Requirement 8(3)(a) - was found non-compliant for service ID 26499 following a Quality Audit undertaken from 4 November 2024 to 8 November 2024. The service did not demonstrate:

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

The Assessment Team was not satisfied feedback captured from individual consumer surveys is captured consistently, noting that the provider does not follow up with various locations regarding whether surveys were sent or seeking the results or analysis of feedback received or if any trends were identified. Furthermore, the organisation has not yet set up a consumer advisory body, which has been a requirement for home care service providers since December 2023. The Assessment Team provided the following evidence to support their assessment:

* No survey results or analysis reports from any of the locations were sighted by the Assessment Team.
* Management advised they prepare surveys for consumers and representatives, and these are sent out to the franchises/locations for dispersal to their consumer and representative cohort. However, when asked about whether a timeline is given for returns or how they seek information from the various locations on the analysis of their results and identification of any trends, management advised this does not occur.

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

Information extracted from Plan for Continuous improvement (PCI) included.

* Advisement to engage stakeholders (clients, family members), to provide feedback on policy, process and documentation via the below mechanisms.
* Leverage existing group meetings that are currently conducted to obtain feedback.
* Expand the use of existing satisfaction survey’s to improve the quality of care and services.
* Invitations will be sent out to all clients and their representatives to participate in a Consumer Advisory Body. The invitations will be sent out yearly to all clients and their representative. Assistance with Minutes and Terms of reference will be offered to the Consumer Advisory Board.
* The Consumer Advisory Body will be encouraged to write to the board with any suggestions that can improve the delivery of care and services on a periodic basis. Every three months when the board meets.
* Representative consumers will be invited to attend the Clinical Governance Committee twice yearly to have input in to care delivery.
* Client feedback will be tabled and considered in the Quality and Safety Committee.

The Quality and Compliance Manager, with a planned completion date February 2025, is expected to have oversight and responsibility for implementation of the full suite (above) of proposed actions.

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with the information provided.

The intent of this requirement is to ensure that organisations are expected to have an organisation wide approach to involve consumers in developing, delivering and evaluating their care and services. This is an essential part of an organisation’s governance for a consumer-centred aged care service.

I appreciate the provider’s acknowledgement regarding identified deficiencies and proposed timeframes in responding to them, however at the time of my finding, the full suite of proposed Plan for Continuous improvement (PCI) actions have not been implemented or embedded.

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

Requirement 8(3)(b) - was found non-compliant for service ID 26499 following a Quality Audit undertaken from 4 November 2024 to 8 November 2024. The service did not demonstrate:

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

The Assessment Team was not satisfied monitoring processes are in place to ensure offices and franchises are regularly feeding back consistent information on risks, ultimately resulting in the organisation not having accountability for the delivery of safe quality services across all offices and franchises. The Assessment Team provided the following evidence to support their assessment:

* Although initial vulnerabilities were captured for consumers within the vulnerable consumer list, several examples of consumers with incidents or receiving clinical services were not included in the list. For further information please refer to Requirement 3(3)(b).
* Documentation viewed regarding Dignity of Risk consumers did not include triggers to ensure risks were adequately explained to consumers and representatives and checking of their understanding. Discussions with various staff also indicated a lack of understanding regarding dignity of risk. Please refer to Requirement 1(3)(d) for further information.
* Despite clinical governance processes, and meetings held on an ongoing basis, it was noted that representation at high level or all locations was inconsistent.

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

Information extracted from Plan for Continuous improvement (PCI) included.

* Advisement of a focus on strengthening our governance and in totality this continuous improvement plan will revise committee structures and implement new systems to centralise key information and trend analysis. Sections 1.3.d and 3.3.b speak specifically to the items raised in this area of the report. (GM Quality and Compliance Manager – planned completion date end of October 2025).

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with the information provided.

The intent of this requirement states the governing body of the organisation is responsible for promoting a culture of safe, inclusive and quality, care and services in the organisation. The governing body of the organisation is also responsible for overseeing the organisation’s strategic direction and policies for delivering care to meet the Quality Standards.

Whilst I appreciate the provider’s acknowledgement regarding identified deficiencies and proposed timeframes in responding to them, I note however at the time of my finding, the full suite of proposed Plan for Continuous improvement (PCI) actions have not been implemented or embedded.

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

Requirement 8(3)(c) - was found non-compliant for service ID 26499 following a Quality Audit undertaken from 4 November 2024 to 8 November 2024. The service did not demonstrate:

Effective organisation wide governance systems relating to information management, continuous improvement, financial governance, and feedback and complaints.

The Assessment Team was not satisfied information management, continuous improvement, financial governance, and feedback and complaints was sufficiently established with robust systems and oversight to ensure effective oversight. Please refer to Requirement 6(3)(d) for further information regarding feedback and complaints. The Assessment Team provided the following evidence to support their assessment:

* Although the organisation promotes a continuous improvement philosophy, there is a lack of monitoring of various locations regarding their individual continuous improvement activities, resulting in a lack of clarity as to whether processes at various locations were reflective of the organisation’s philosophy and processes. There was also a lack of any trending of information received from various offices and franchises to drive continuous improvement as a whole in the organisation.
* Regarding information management, the organisation has a range of various databases where consumer information is held. The Assessment Team needed to log into 4 different electronic systems in order to check whether consumers had relevant documentation in place. Management advised they are moving to a centralised system for this, however this had not yet occurred at the time of the quality audit and it was unclear whether all locations would be using the centralised system, with one location advising the Assessment Team they would not be moving to that system.
* Despite financial governance processes established within the organisation overall, ongoing issues were identified regarding consumer statements and budgets, resulting in issues with the management of individual consumer package funds. Negative feedback was received from several consumers and representatives regarding this, with some saying they had not received the services they needed, based on limited funds due to overcharging or slow reimbursements of funds. For further information please refer to Standard 1(3)(e).
* A gap was identified in feedback and complaints regarding the link between complaints and feedback and continuous improvement activity. Please refer to Requirement 6(3)(d) for further information.

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

Information extracted from Plan for Continuous improvement (PCI) included.

Regarding Information management

* The business is currently in transition from one online cloud platform to another. This transition was occurring during the audit. Once this transition is complete, this will remove one from the system architecture and reduce the number of systems the auditors would have observed.
* There is no plan to consolidate the business onto a determined client management system and some franchisees will continue to use an alternative system. This is part of our plan for the business operation and each franchisee will operate only one of these, meaning there is no confusion where documents are stored. (IT – planned completion date March 2025).

Regarding Continuous improvement

* Feedback is currently received via the franchisee monthly reports and is a standing agenda item in the monthly franchisee meeting.
* In addition, the business is actively recruiting for 2 new management roles – called Regional Operations Managers – this role is designed to be a business partner and relationship manager with the locations and will play an important part in identifying and providing feedback back the support functions as part of adopting and prioritising improvement opportunities. (COO – planned completion date March 2025).

Regarding Financial Governance

* Please refer to section 1.3.e

Regarding Feedback and Complaints

* Please refer to 6.3.d

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with the information provided.

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

Whilst I appreciate the provider’s acknowledgement regarding identified deficiencies and proposed timeframes in responding to them, I note however at the time of my finding, the full suite of proposed Plan for Continuous improvement (PCI) actions have not been implemented or embedded.

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

Requirement 8(3)(d) - was found non-compliant for service ID 26499 following a Quality Audit undertaken from 4 November 2024 to 8 November 2024. The service did not demonstrate:

* Effective risk management systems and practices relating to managing high-impact or high-prevalence risks associated with the care of consumers and managing and preventing incidents, including the use of an incident management system.

The Assessment Team was not satisfied management of high-impact or high-prevalence risks of consumers and managing and preventing incidents, including the use of a consistent incident management system are used. There was also a lack of tracking and trending this information at corporate level from information provided by various locations. The Assessment Team provided the following evidence to support their assessment:

* The provider has a clinical governance group, where clinical issues may be raised, but this group is often not well attended. Issues raised in this group are done in an ad hoc manner.
  + Incidents for provider-managed consumers were recorded in incident registers however these are managed by the individual sites.
* Support workers engaged through self-managed packages were not usually provided with the consumer’s care plan and did not necessarily communicate regularly with case managers.
* There is no regular mechanism currently for self-managed support workers to report incidents or changes regarding consumers they are providing services to. It is expected the self-managed consumers will contact the case manager to discuss any changes.
* Although there is a vulnerable consumer list and clinical care list, these were noted to not be up to date. For further information on examples evidenced, please refer to Requirement 3(3)(b).
* The provider has a risk acknowledgement form. Whilst this form is sent to the corporate office for approval this is responded to on an individual consumer level.
  + The provider does not track these forms for trends and they are not matched against the vulnerable client list.
* The provider does not have a restrictive practice register and any restrictive practices would only be noted in the consumer’s individual care plan. This makes the monitoring of restrictive practices potentially inconsistent and dependent upon the skills of the various case managers, who are not necessarily clinical staff. Please refer to Requirement 3(3)(b).
* Management currently does not track high impact or high prevalence risk at a provider level. This may be done at a site level but is not required. This resulted in an inability for management to advise the assessment team of incident specific information such as dates, times, and trends without going through each site’s incident register.
* Each site has different template for their incident register, meaning they could not be combined without substantial individual adjustments. The provider has recently created a monthly report system where each site reports their issues, however it does not have to be very detailed. Management discussed adding education for the sites on the expectations around their monthly report to their continuous improvement plan.

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

Information extracted from Plan for Continuous improvement (PCI) included.

Regarding High-Impact or High-Prevalence risk

* We are currently establishing specific High Impact High Prevalence Risk Indicators (HIHP) These HIHP will be measurable, specific, and directly tied to the organization’s priorities Please refer to section 3.3.b

Regarding Managing and preventing incidents, including the use of an incident management system

* The IT team is reviewing a new risk, incident and consumer feedback management system to centralise and enhance the tracking and transparency of incidents across the organisation. This system will ensure all incidents are captured and analysed, providing clear visibility in a robust manner. Please refer to section 3.3.b

(GM Quality and Compliance Manager – planned completion date end of June 2025).

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with the information provided.

The intent of this requirement is to ensure organisations have systems and processes that help them identify and assess risks to the health, safety and well-being of consumers. If risks are found, organisations are expected to find ways to reduce or remove the risks in a timeframe that matches the level of risk and how it’s affecting consumers.

I appreciate the provider’s acknowledgement regarding identified deficiencies and proposed timeframes in responding to them, however at the time of my finding, the full suite of proposed Plan for Continuous improvement (PCI) actions have not been implemented or embedded.

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

Requirement 8(3)(e) - was found non-compliant for service ID 26499 following a Quality Audit undertaken from 4 November 2024 to 8 November 2024. The service did not demonstrate:

* Where clinical care is provided - a clinical governance framework.

The Assessment Team was not satisfied regarding the lack of clinical oversight regarding clinical services provided from the various offices and franchises. The Assessment Team provided the following evidence to support their assessment:

* Although policies are in place, there were some inconsistent practices and documentation noted regarding documenting the use of restraints. For example regarding a locked box in place for a consumer’s medications. For further information please refer to Requirement 3(3)(b).
  + One consumer file identified a consumer as having advanced dementia, resulting in limited insight into their condition. The consumer has a restrictive practice in place from their previous provider, regarding a locked medication box. This was reported to be put in place at the consumers request, after several medication mismanagement incidents, but no handover was noted from the previous provider. Whilst this strategy was noted in the care plan this was not noted as a restrictive practice. The provider is working with his general practitioner (GP) to pursue state guardianship as they are socially isolated, and no one else to represent their interests.

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

Information extracted from Plan for Continuous improvement (PCI) included.

* The current Clinical Governance Committee Terms of Reference is currently under review. The structure plan will reflect robust requirements with standing agenda, quorum, minutes, consumer representation and board reports. (Please refer to 3.3.b)
* The business will re-enforce the existing protocols on the use and documentation of restraints. Our existing assurance processes will continue to monitor quality of execution. (GM Quality and Compliance Manager – planned completion date end of March 2025).
* Create a process to regularly track and review the trends in high-impact or high-prevalence risks. (GM Quality and Compliance Manager – planned completion date end of July 2025).

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with the information provided.

The intent of this requirement establishes the clinical governance set of relationships and responsibilities between the organisation’s governing body, executive, clinicians, consumers and others to achieve good clinical results. It puts systems in place for delivering safe, quality clinical care and for continuously improving services. Clinical governance usually includes involving consumers, clinicians, clinical review, training, risk management, use of information and workforce management.

This requirement describes the clinical governance and safety and quality systems that are required to maintain and improve the reliability, safety and quality of clinical care, and to improve outcomes for consumers where organisations provide clinical care.

I appreciate the provider’s acknowledgement regarding identified deficiencies and proposed timeframes in responding to them. In light of this requirement, I’m further encouraged by the response as outline within the providers overall response to the audit including.

*Providing Clinical oversight of various locations*

‘Each location has an internal audit completed of 10% of total files every 6 months. The internal audits include a range of clinical assessments and checks to ensure the files are up to date. We currently do have a Restrictive Practice register for NDIS clients but have not implemented same for Home Care Package clients. This is an oversight which will be attended to as per improvement plan. For Franchisees that are not led by a clinician, they are encouraged, and often do utilise the Clinical Governance Committee group email for any queries or follow up. If the Franchisee is not clinically trained, they will recruit an appropriately trained clinician to oversee their care plan development and relevant assessments. Our Executive Manager also attends the Clinical Governance Committee Meetings for those who do not have clinical experience (note, the assessor said he attends for Corporate locations, this is incorrect). He will meet with them prior to the Committee Meeting and ensure that any concerns or current issues are noted in the Committee.’

I acknowledge however at the time of my finding, the full suite of proposed Plan for Continuous improvement (PCI) actions have not been implemented or embedded.

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

1. The preparation of the performance report is in accordance with section 57 of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)