**Performance**

**Report**

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| Name of service: | ECH WEST |
| Service address: | Henley Beach Day Program, 174 Greenhill road PARKSIDE SA 5063 |
| Commission ID: | 600362 |
| Home Service Provider: | ECH Inc |
| Activity type: | Quality Audit |
| Activity date: | 21 July 2023 to 26 July 2023 |
| Performance report date: | 4 October 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 ECH WEST (**the service**) has been prepared by M Abjorensen, 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:**

* ECH Western Home Services, 18479, Henley Beach Day Program, 174 Greenhill road, PARKSIDE SA 5063
* ECH - Victor Harbor, Hills, Goolwa, Port Elliot, 18497, Henley Beach Day Program, 174 Greenhill road, PARKSIDE SA 5063

**CHSP:**

* Community and Home Support, 24156, Henley Beach Day Program, 174 Greenhill road, PARKSIDE SA 5063
* Care Relationships and Carer Support, 24155, Henley Beach Day Program, 174 Greenhill road, PARKSIDE SA 5063

# 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; and
* the provider’s response to the Assessment Team’s report received on 16 August 2023.

# Assessment summary for Home Care Packages (HCP) and Short-term Restorative Care Programme (STRC)

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| --- | --- |
| Standard 1 Consumer dignity and choice | Non-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 | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Compliant** |

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| Standard 1 Consumer dignity and choice | Non-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 | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **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.

Standard 1 Requirement (3)(e)

* Provide consumers with information that is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.

Standard 7 Requirement (3)(d)

* Ensure the workforce is recruited, trained, equipped and supported to deliver the outcomes required by the Quality Standards

# Standard 1

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

Findings

Requirement (3)(e)

The Assessment Team recommended Requirement (3)(e) not met, as they were not satisfied 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 provided the following evidence relevant to my finding:

* Nine of 17 consumers and representatives said communication is not timely when they request information about consumers’ care and services. Four consumers said it is difficult to get through when they contact the service and provided examples of the resultant impact.
* Staff said there are ongoing issues with providing timely communication to consumers, including that they get frustrated with delayed wait times. Staff said this issue is common and said they attempt to assist consumers by emailing the service on their behalf.
* The complaints register shows 27 complaints related to quality and accessibility of the service since 1 January 2023.
* Management acknowledged consumer dissatisfaction with extensive wait times and lack of communication and said attempts have been made to resolve the issue by upgrading phone systems and recruiting additional staff.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Acknowledgement that there can be extended phone wait times, however, the Assessment Team did not interview staff who manage call centre volume, wait times, enquiries and apologies for service issues.
* Explanation that a new phone system was implemented in December 2022, which resulted in increased call volumes. Call back functionality has been added to the phone system, which has resulted in improvements to voicemail volume and timeliness of reply.
* Explanation that the Board and Executive have placed a high priority on resolving phone wait time issues and monitor performance to ensure continuous improvement and resolution of feedback and complaints.
* Client experience survey action plan for the survey round undertaken in 2022, demonstrating actions taken and/or planned to improve communication, including implementation of a Duty of Care Coordinator role to provide immediate solution to consumer requests, and establishment of a contact centre.
* Client experience survey results for the survey round undertaken in 2023, demonstrating 89% of participants said they understand information given about their services. Overall, most consumers were satisfied with the services they receive.

I acknowledge actions taken by the provider to address deficits identified by the Assessment Team.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates information provided to each consumer is not current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.

I have placed weight on feedback from consumers and staff, which shows systems in place for communication result in delayed wait times. I find this places consumers at risk of not getting the information they need, when they need it, in order to exercise choice and make decisions about the care and services they receive. While the provider’s response includes information and evidence to demonstrate actions have been taken to improve current systems, there was no evidence to show these actions have effectively resolved the issue. I acknowledge that the 2023 client experience survey shows positive results in respect of consumers understanding information about their services, however, there is no evidence when this survey occurred (e.g., pre or post the Quality Audit) or that consumers were asked specifically about communication systems.

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

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

Consumers and representatives described staff as kind, caring and respectful. Staff and management demonstrated how services are tailored to each consumer through an understanding consumers’ identity and culture. The workforce receives training on treating consumers with dignity and respect.

Consumers and representatives reported services are delivered in accordance with what is important to them. Care documentation contains reference to consumers’ cultural preferences to inform care and service delivery. The service has participated in an accreditation to convey the safe and inclusive space for the for the LGBTIQ community, with an established consumer group for this community.

Consumers and representatives reported the service involves them in making decisions about the care and services consumers receive. Staff and management described how they support consumers and their representatives to exercise choice and make decisions about services through the assessment and planning process. The service made improvements for consumers to make gender preferences for staff involved in their care.

The service has dignity of risk policies and procedure, accessible to staff, reflective of the process management demonstrated through examples of supporting consumers to take risks.

Consumers and representatives reported consumers’ privacy and personal information is respected when they receive services. Management described, and the Assessment Team observed that systems are protected by passwords and staff can only access information specific to their roles. Information management and privacy policies describe how consumer personal information is stored, accessed, and protected.

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

# Standard 2

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

Findings

All consumers are assessed and triaged by clinical staff using validated tools for risks, including falls, skin integrity, cognition and nutrition. Consumers and representatives advised consumers’ needs, care and services were assessed. Care planning documents evidenced assessment and planning includes risks to inform care and service delivery.

Care planning documents viewed showed that consumers’ needs, goals and preferences had been discussed with them and documented, including in relation to advanced care directives. Consumers reported that assessment and planning processes identified their current care and service needs, goals and preferences.

Consumers and representatives reported they are involved in assessment and planning processes. Document showed consumers participate in assessment and planning including the involvement of others.

Care planning documents viewed confirmed that outcomes of consumers’ assessment and planning were documented in the service’s electronic system and care plans, which are provided to consumers. Consumers reported their care plan had been discussed and provided to them.

Consumers’ care and service review dates are monitored monthly by management. Management explained, and documentation showed, reviews are conducted in response to incidents or when risks are identified. Care planning documents showed that consumers’ reviews had been undertaken as per the service’s process.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements Standard 2 Ongoing assessment and planning with consumers.

# Standard 3

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

Findings

Consumers and representatives were satisfied with the quality, personalised, care delivery. Clinical care is overseen by a registered nurse. Policies and procedures provide guidance to clinical staff for best practice guidelines for all procedures.

Clinical staff monitor the high risk register which monitors high impact and high prevalent risks associated with the care of consumers, including cognitive decline, falls, changed behaviours and other medical conditions. Management and staff described strategies to manage the consumers’ risks for example, in relation to wound care, mobility and falls, medications, behaviour of concern and weight loss.

The service collaborates with palliative care organisations and medical practitioners to support end of life care. Care planning documents showed that advance care directives are discussed with consumers and outcomes documented within their care plans.

Consumers reported staff would recognise a change in their condition, health, or abilities to make required care adjustments. Staff described indicators to recognise consumer deterioration and care documentation showed actions were taken when consumers’ health changed or deteriorated, such as referrals to health professionals and adjusted care and services.

Management reported, and documentation showed, timely and appropriate referrals occur in relation to consumers’ needs to internal and external services. Consumers and representatives reported referrals have occurred when required.

Staff and management described, and documentation showed, the service has processes for minimising risks of infection including policies, procedures, education, and an infection, prevention and control manual. Consumers and representatives advised staff implement infection control practices such as the use of personal protective equipment (PPE).

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements Standard 3 Personal care and clinical care.

# Standard 4

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

Findings

Consumers reported services support their independence, wellbeing, and quality of life. Management described, and documentation showed, the service identifies consumers’ capability, needs, goals and preferences to inform services and supports.

Consumers and representatives described in various ways how staff and the services provided promote consumers’ psychological wellbeing and support them emotionally. Staff and management demonstrated how they support consumers emotionally and promote their psychological wellbeing through understanding personal circumstances and emotional support needs.

Consumers and representatives described in various ways their satisfaction with how the service enables consumers to maintain relationships, meet new people and do things of interest to them. Management described and documentation confirmed the process of completing a social assessment to capture consumers’ social preferences. Information received informs the continuous improvement of the social services to include activities of interest and promote consumer participation.

Consumers and representatives reported staff understand consumers’ needs and were satisfied that information about their services is shared within the organisation and with others who are involved in their care. Staff advised and documentation confirmed that they received detailed, up to date information in the electronic care system.

Management, staff and documentation demonstrate the services internal and external referrals process facilitates consumers access to additional services to supplement supports and services for daily living.

Consumers reported they are satisfied with the quality and quantity of food provided by external meal providers or at the service’s social day program. Management and staff demonstrated how they monitor consumers’ dietary needs and preferences, and identified risks relating to consumers’ nutritional status. Care planning documents identified consumers’ dietary needs and preferences.

Consumers and representatives reported equipment provided is safe to use, well-maintained and meets consumers’ needs. Documentation showed the involvement of allied health clinicians to assess consumers’ needs and regular monitoring of equipment to ensure it is clean and well maintained.

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

# Standard 5

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| Organisation’s service environment | | HCP | CHSP |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant | Compliant |
| 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. | Compliant | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant | Compliant |

Findings

Consumers and representatives described in various ways how consumers feel welcome. Management demonstrated through documentation provided that an audit was conducted of the service environment to ensure the design was safe, and suitable for consumers living with dementia. Observations confirmed that the service environment is welcoming, easy to understand and functional.

Consumers and representatives described how consumers feel safe. Management advised, and documentation confirmed the service environments undergo regular cleaning. Maintenance records demonstrated how unplanned maintenance is documented and resolved within a timely manner to ensure the service environment remains safe and well maintained. Observations showed the service environment was clean, well maintained and consumers have access to move freely.

In relation to the service environment, staff and management described processes to ensure the service equipment is safe, clean, and well maintained. Consumers and representatives were satisfied with the safety and maintenance of equipment. Staff were observed cleaning equipment between exercise sessions. Hazard tape was present on raised equipment to alert consumers for potential tripping hazards.

In relation to the vehicles used to transport consumers, information and evidence under (3)(c) in Standard 7 shows relevant vehicle certificates were not produced by the service. The provider’s response shows corrective actions have commenced to obtain, and monitor, required documents for vehicle safety and maintenance.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements Standard 5 Organisation’s service environment.

# Standard 6

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

Findings

Requirement (3)(c)

The Assessment Team recommended Requirement (3)(c) not met, as they were not satisfied appropriate action is taken in response to complaints and that an open disclosure process is used when things go wrong. The Assessment Team provided the following evidence relevant to my finding:

* Eight of 10 consumers and representatives said they were not consistently provided an apology for delayed services or not being able to get through when trying to make contact. Only one consumer explicitly said they had lodged a complaint and it was not resolved in a timely manner.
* The organisation’s process for complaints handling is not provided to subcontractors to guide practice.
* Staff are not required to complete training in relation to complaints handling or open disclosure.
* Staff and volunteers demonstrated an understanding of the need to apologise when things go wrong, however, were inconsistent in their response of what to do in the event of a complaint.
* Management acknowledged anomalies in complaints management processes and said they are working to update the system to include actions taken, follow up and open disclosure. Management provided further examples of improvements implemented to address deficits identified as a result of complaints, including analysis of staffing data, commencement of a scheduling project, recruitment of new staff, and implementing mandatory complaints management and open disclosure training for all staff.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Updated contractor onboarding and induction handbook to show contractors are now informed of the organisation’s complaints handling processes.
* Extracts of progress notes and case note discussions demonstrating that prior to the Quality Audit, the service had attempted to contact and/or had been working with named consumers to address their concerns.

I acknowledge actions taken by the provider to address deficits identified by the Assessment Team.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does not demonstrate deficiencies in relation to this Requirement.

I have considered that while a number of consumers and representatives expressed dissatisfaction with the care and services consumers’ receive, with the exception of one consumer, there was no evidence indicating they had lodged a complaint with the service, either formally or informally. On the contrary, management’s response and evidence in the Assessment Team’s report under Requirement (3)(e) in Standard 1 shows the service is aware of ongoing trends in complaints and has taken and/or planned actions to address them. Furthermore, information and evidence in the provider’s response shows the service was aware of concerns by named consumers and prior to the Quality Audit, had attempted to make contact and/or were working with them to address the issues.

I have considered that following the Quality Audit, the organisation’s contractor onboarding and induction handbook has been updated to include actions to be taken in the event of a complaint.

I have considered the lack of staff training in complaints handling and open disclosure under Requirement (3)(d) in Standard 7 Human resources, as the core deficit relates to systems in place for training and support.

Based on the above evidence, I find the provider, in relation to the service, compliant with Requirement (3)(c) in Standard 6 Feedback and complaints.

Requirements (3)(a), (3)(b) and (3)(d)

Consumers and representatives were able to describe how the service seeks their feedback regarding care and services they receive. Consumers and representatives said they were aware of internal feedback and complaints processes during the initial entry to the service and on an on-going basis. The service provides a hard copy complaint and feedback form in the consumer information pack. In addition, the service has an on-line feedback and complaint function located in their web site.

Consumers and representatives said they were aware of external agencies to support them in raising feedback or complaints. The consumer information pack contains information on advocacy and language services and alternative methods to raise and resolve complaints.

Consumers and representatives said changes have been made in response to their individual feedback and complaints, although they were unaware if their feedback results in improvements to the overall quality of care and services. Documentation confirmed the complaints and feedback register is routinely populated and regularly reviewed to ensure the service has oversight of improvement matters.

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

# Standard 7

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

Findings

Requirement (3)(a)

The Assessment Team recommended Requirement (3)(a) not met, as they were not satisfied 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. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and representatives said staff do not always turn up when expected, they experience changes in staff and have difficulties contacting the service when needed.
* The consumer experience survey undertaken in August 2022 showed responses to ‘how often do staff come on time?’ that include 0.5% for never, 5.1% for some of the time, 37.6% for most of the time and 56.6% for always.
* There were 61 unfilled shifts for June 2023.
* Management said there are generally enough staff to fill shifts and an additional pool of casual staff and contractors is available where required.
* Management also said resourcing and scheduling teams are employed to monitor and fill shifts and where there is a change in staff, consumers are notified via telephone.
* Under Requirement (3)(c) in Standard 8 Organisational governance, the Assessment Team’s report states ‘the governing body undertakes reviews of internal staff workforce and examines the growth of the client base to identify workforce planning going into the future’.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Explanation that as evidenced under Requirement (3)(e) in Standard 1 Consumer dignity and choice, numerous initiatives have been implemented to address concerns regarding the phone systems.
* Evidence that average number of staff per consumer and percentages of services delivered on time are tracked quarterly. This shows that in 2022-23, only 77.6% and 92.1% of fixed and window visits were delivered on time.

I acknowledge actions taken by the provider to address deficits identified by the Assessment Team.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates 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.

I have considered that while consumers and representatives said staff do not always turn up when expected, they experience changes in staff and have difficulties contacting the service when needed, there is limited evidence linking these experiences to insufficient staffing numbers. The Assessment Team’s report states that there were 61 unfilled shifts in June 2023, however, there is no evidence demonstrating how this has impacted consumers’ care and service delivery or whether it is proportionate to the volume of consumers (total of 1,980 HCP/STRC and CHSP consumers at the time of the Quality Audit).

I have placed weight on evidence in the provider’s response, which shows the average number of staff per consumer and percentages of services delivered on time are regularly tracked. I have also considered a statement by the Assessment Team under Requirement (3)(c) in Standard 8, which indicates reviews of growth in consumer numbers are undertaken to plan the workforce. Furthermore, I have considered information and evidence throughout the Assessment Team’s report shows consumers are generally satisfied their care and service needs are met, indicating the number of staff are sufficient.

Based on the above evidence, I find the provider, in relation to the service, compliant with Requirement (3)(a) in Standard 7 Human resources.

Requirement (3)(c)

The Assessment Team recommended Requirement (3)(c) not met, as they were not satisfied the workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles. The Assessment Team provided the following evidence relevant to my finding:

* Qualifications, licences and/or registrations of staff, including dietitians, physiologists, podiatrists, drivers and domestic assistance, were not consistently recorded.
* The service could not produce evidence demonstrating cars owned by volunteers that are used to transport consumers, were insured, registered and/or roadworthy. Management said processes have commenced to determine staff car roadworthiness for those over five years old.
* There are no processes to identify if volunteers have been a resident or citizen of a country, other than Australia, over the age of 16 years. Management said this does occur.
* Clinical credentialling and scope of practice processes exist and are due for completion in November 2023.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Explanation that a compliance audit for allied health professionals was undertaken on 7 August 2023 and showed all staff had appropriate professional registrations.
* Explanation that volunteers do not provide transport services to consumers. At the time of the Quality Audit, vehicle registration and/or roadworthiness information was captured for 69% of employees who provide transport services.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does not demonstrate deficits in relation to this Requirement.

I have considered that while information and evidence in the Assessment Team’s report shows areas for improvement in relation to documenting staff qualifications, licences and/or registrations, there was no evidence demonstrating staff were not competent or unregistered/unqualified. I find this evidence better relates to workforce governance processes and have therefore considered it under Requirement (3)(c) in Standard 8 Organisational governance.

I have also considered that the evidence relating to assessment of roadworthiness for vehicles owned by staff used to transport consumers, is better related to the safety and maintenance of equipment and have therefore considered it under Requirement (3)(c) in Standard 5 Organisation’s service environment.

I have considered that there are clinical credentialling and scope of practice processes in place to ensure staff are competent. Furthermore, I have placed weight on information and evidence throughout the Assessment Team’s report which shows consumers are generally satisfied their care and service needs are met, indicating staff are competent and have the knowledge to effectively perform their roles.

Based on the above evidence, I find the provider, in relation to the service, compliant with Requirement (3)(c) in Standard 7 Human resources.

Requirement (3)(d)

The Assessment Team recommended Requirement (3)(d) not met, as they were not satisfied processes are in place to ensure workers are trained and equipped to deliver the outcomes required by the Quality Standards. The Assessment Team provided the following evidence relevant to my finding:

* The service does not routinely provide training to staff in relation to complaints handling, open disclosure and the Quality Standards.
* The service was not able to produce evidence demonstrating volunteers or contractors have participated in training on the Code of Conduct, Quality Standards, the Serious Incident Response Scheme (SIRS), incident management, and feedback and complaints. Volunteers were unable to provide examples of training they have attended.
* Management said the service is currently identifying volunteer training needs and attendance requirements.
* Management said they do not monitor the education, training and competencies of their subcontracted workforce.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Explanation that an open disclosure module of training will be provided to all staff by September 2023 and the Quality Standards are discussed with all staff as part of induction processes. Furthermore, scheduled system improvements include mandatory induction training in relation to complaints handling.
* Explanation that the seven volunteers who engage with consumers have been scheduled to complete further training in October 2023.
* Explanation that all contracted businesses are required to acknowledge the Code of Conduct and the SIRS as part of their pre-qualification and onboarding. This requirement is also pushed down to their employees and subcontractors.
* Explanation that all subcontractors are required to conduct an annual induction in the contractor management system, which includes information on the Quality Standards, incident management and feedback and complaints. This induction requires an upload of relevant licencing/registration/certification for roles being performed and mandatory acknowledgement and understanding of the contractor orientation and onboarding handbook. Qualification as a registered subcontractor will not be completed until all compliance documents are received. A copy of the March 2023 subcontractor newsletter, the orientation and onboarding handbook, and the provider agreement was supplied in support of this assertion.
* Subcontractors are also provided a six-monthly newsletter, which details various reform measures. A copy of the March 2023 newsletter was provided to support this assertion.
* Compliance and reporting obligations procedure manual showing external contractors are responsible for ensuring their staff meet legislative requirements and

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which demonstrates the workforce is not recruited, trained, equipped and supported to deliver the outcomes required by the Quality Standards.

This Requirement expects an organisation to review the training, learning and development needs of the workforce regularly and when practices change. I find this did not occur, as the service did not routinely provide or monitor staff and volunteer training to ensure risk is minimised and care is improved for consumers. I acknowledge actions taken by the service to address deficits identified by the Assessment Team, however, these actions have not been completed at the time of my finding. Furthermore, the provider’s response did not address how training will be monitored going forward to prevent the deficit from reoccurring.

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

Requirement (3)(e)

The Assessment Team recommended Requirement (3)(e) not met, as they were not satisfied regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. The Assessment Team provided the following evidence relevant to my finding:

* The volunteer handbook shows their supervisor is responsible for arranging meetings to discuss performance, development and issues of concern, however, this is not occurring.
* The service does not have oversight of its subcontracted workforce to ensure they are effectively performing their roles to an expected level, and no feedback from consumers is sought regarding their satisfaction with subcontracted services.
* Information and evidence in the Assessment Team’s report under Requirement (3)(b) in Standard 7 Human resources shows staff are engaged via a behaviour conversation, which provides both parties the opportunity to discuss behaviours that are to continue and others which are to stop.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes the following additional information and evidence to clarify aspects of the Assessment Team’s report:

* Explanation that a training needs analysis of all staff is conducted with the induction training program to ensure skills are maintained.
* Explanation that the annual performance development planning process includes six-monthly check-ins with staff and regular contact with consumers to identify areas for improvement.
* Explanation that each contracted service provider is assigned a risk rating (reviewed annually) to determine the frequency of contractor performance meetings, application of contractor system audits, and the person responsible for managing a contractor’s performance. A copy of the risk matrix was provided to support this assertion.
* Explanation that the seven volunteers are always supervised by a team leader and manager, and do not provide HCP/CHSP funded services or replace the use of employees. Any identified performance issues are escalated for ongoing management.
* Explanation that all consumers, including those who receive subcontracted services, receive information about how to provide feedback or make a complaint as part of onboarding processes.
* Explanation that annual client surveys allow for feedback, compliments or complaints relating to subcontracted services.

I acknowledge actions taken by the provider to address deficits identified by the Assessment Team.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does not demonstrate deficits in relation to this Requirement.

I have considered that while no feedback is sought from consumers specifically in relation to contracted services, I have placed weight on evidence in the provider’s response, which shows general feedback is sought about the quality of care and services consumers’ receive. This general feedback would capture feedback about core staff, contractors and volunteers. The provider’s response also includes evidence demonstrating a framework is in place to have performance meetings with contracted service providers.

I have considered that while the Assessment Team asserts that performance and development discussions are not undertaken with volunteers, there is no supporting or corroborating evidence that this has impacted on the quality of consumers’ care and services. I have placed weight on information included in the provider’s response which shows that these volunteers are always supervised by a team leader and do not provide HCP or CHSP funded services. Furthermore, I do not consider it to be proportionate to determine the organisation’s whole performance management system to be ineffective based on seven volunteers.

The Assessment Team’s report focused on performance management and monitoring of volunteers and subcontractors, and did not include any evidence to demonstrate systems in place for core staff. I have therefore placed weight on information in the provider’s response showing that annual performance reviews are in place, and include six-monthly check-ins.

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

Requirement (3)(b)

Consumers and representatives said staff and volunteers are kind, caring and respectful of consumers. Induction processes and the organisation’s policies guide staff in expectations on the treatment of consumers and organisational culture. Staff were observed interacting with consumers in a caring and respectful manner.

Based on the above evidence, I find the provider, in relation to the service, compliant with Requirement (3)(b) in Standard 7 Human resources.

# Standard 8

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

Findings

Requirement (3)(c)

The Assessment Team recommended Requirement (3)(c) not met, as they were not satisfied organisation wide governance systems are in place in relation to workforce governance, regulatory compliance and feedback and complaints. The Assessment Team provided the following evidence relevant to my finding:

* In relation to workforce governance, oversight of contractors and volunteers is not maintained as evidenced by the not met recommendations in Standard 7 Human resources.
* In relation to regulatory compliance, oversight of staff, volunteer and contractor qualifications, skills and knowledge is not monitored as evidenced by the not met recommendations in Standard 7 Human resources.
* In relation to feedback and complaints, three sampled Board meeting minutes did not include discussion of feedback and complaints.
* In relation to information management, staff have access to consumer information via an application and can communicate information to team leaders through a chat box function. Information management and security guidelines are in place and electronic information was observed to be secure.
* In relation to continuous improvement, the organisation maintains a continuous improvement plan that includes inputs from audits and clinical lead best practice, however, does not consider feedback and complaints. Where audits identified actions required, it was noted these were not always completed in a timely manner.
* In relation to financial governance, monthly finance and risk committees are in place to discuss budget forecasting, reports and actuals. Processes are in place to review unspent funds and manage financial hardship.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes the following additional information and evidence to clarify aspects of the Assessment Team’s report:

* The policy governance and flowchart for 2021 to 2024 showing multiple committees in place, which include, but are not limited to, continuous improvement, training, legislative updates, information governance and quality.
* Corporate governance policy which outlines corporate and clinical governance principles that underpin and govern the organisation’s systems and processes.
* Reports to the governing body and various committees that includes, but is not limited to, information relating to finance, staffing, property, people and culture, customer experience, quality, SIRS and incident management, consumer case studies, workplan calendar, workforce strategies and clinical risk.
* Explanation that oversight of contractors is maintained, as each contracted service provider is assigned a risk rating (reviewed annually) to determine the frequency of contractor performance meetings, application of contractor system audits, and the person responsible for managing a contractor’s performance. A copy of the risk matrix was provided to support this assertion.
* Explanation that all contractors are required to conduct an annual induction in the contractor management system, which includes information on the Quality Standards, incident management and feedback and complaints. This induction requires an upload of relevant licencing/registration/certification for roles being performed and mandatory acknowledgement and understanding of the contractor orientation and onboarding handbook. Qualification as a registered subcontractor will not be completed until all compliance documents are received. A copy of the March 2023 subcontractor newsletter, the orientation and onboarding handbook, and the provider agreement was supplied in support of this assertion.
* Explanation that the seven volunteers are always supervised by a team leader and manager, and do not provide HCP/CHSP funded services or replace the use of employees. Any identified performance issues are escalated for ongoing management.
* Explanation that a compliance audit for allied health professionals was undertaken on 7 August 2023 and showed all staff had appropriate professional registrations.
* Explanation that there are several levels of governing bodies with terms of reference that ensure ongoing oversight of feedback and complaints, including audit and risk, client experience and service quality, consumer reference group, executive committee and the board.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does not demonstrate deficiencies in relation to this Requirement.

I have placed weight on evidence in the provider’s response which demonstrates a governance framework is in place to oversee information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints.

In relation to the Assessment Team’s assertion that oversight of contractors and volunteers is not maintained, there is no supporting or corroborating evidence that this has impacted on the quality of consumers’ care and services. I have placed weight on information included in the provider’s response which shows that volunteers are always supervised by a team leader and do not provide HCP or CHSP funded services, and oversight of contractors occurs through consumer feedback mechanisms and performance meetings.

In relation to the Assessment Team’s assertion that oversight of staff, volunteer and contractor qualifications, skills and knowledge is not maintained, there was no evidence demonstrating how this relates to a failure in the organisation’s regulatory compliance governance system. I have considered that while information and evidence in the Assessment Team’s report shows areas for improvement in relation to documenting staff qualifications, licences and/or registrations, there was no evidence demonstrating staff were not competent or unregistered/unqualified. I encourage the provider to ensure processes are in place to document and monitor this information going forward.

I have also considered the service failed to implement processes to monitor staff completion of training, however, it is not proportionate to consider the organisation’s whole governance system to be ineffective based on this one deficit alone.

In relation to feedback and complaints, all Requirements in Standard 6 Feedback and complaints have been found compliant, which is indicative of a robust governance system.

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

Requirements (3)(a), (3)(b), (3)(d), (3)(e)

Consumers and representatives are encouraged to provide feedback regarding their care and services. The service seeks consumer and representative feedback via an annual survey and other planned feedback approaches including the consumer reference group committee and the LGBTI reference group, which was specifically established to support and address cohort matters including outings and peer support to consumers.

The governing body, including the quality improvement committee, reviews the ‘reports dashboard’ which is prepared on a daily basis and reflects changes to consumer conditions, as well as consumer and representative feedback, complaints and incidents and evidence based clinical best practice. The service has a suite of clinical audit tools and an accompanying schedule. Audits include allied health, diet, infection control, nursing, and wounds. The service audit and risk, and quality improvement committees review information gathered on a 4 monthly basis and reviewed at a senior level.

The service has effective risk and incident management systems and processes that assist in the identification and response to risks to the health, safety, and well-being of consumers. Staff log consumer incidents into the service risk management system and matters are triaged to relevant personnel for review and action The service has policies and guidelines, including a client protection framework to support instances of consumer absconding as well as abuse and neglect.

The service has a strategic risk profile, risk assessment procedure and risk management frameworks. Frameworks include clinical governance and detailed risk matrix/profiles which are reviewed by the governing body. The service has appointed a dedicated infection control lead. The service has outbreak management guidelines and procedures

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

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