**Performance**

**Report**

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| Name: | Essential Care |
| Commission ID: | 201326 |
| Address: | Unit 2, 6-8 Marshall Street, DAPTO, New South Wales, 2530 |
| Activity type: | Quality Audit |
| Activity date: | 4 March 2024 to 6 March 2024 |
| Performance report date: | 30 May 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.

# Service included in this assessment

Home Care Packages (**HCP**) included:  
Provider: 9094 Always There - Essential Care Pty Ltd  
Service: 26845 Always There - Essential Care

**This performance report**

This performance report for Essential Care (**the service**) has been prepared by M Franco, 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.

# 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 the service, review of documents and interviews with staff, consumers/representatives, and others.
* the provider’s response to the assessment team’s report received 12th April 2024.

# Assessment summary for Home Care Packages (HCP)

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

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

# Areas for improvement

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

# Standard 1

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

Findings

Evidence analysed by the Assessment team showed the service demonstrated each consumer is treated with dignity and respect, with their identity, culture and diversity valued. Consumers and/or representatives felt the service staff treated them with dignity and respect through the delivery of care and services. All support workers interviewed could demonstrate how they treat consumers with dignity and respect. One support worker said she always treats consumers how she would like to be treated. Care plan documentation was written in a respectful manner. Care plans reviewed usually included service goals, and a brief introduction story about the consumer.

Evidence analysed by the Assessment team showed the service demonstrated each consumer is receiving services that are culturally safe. Support workers interviewed described how they provided culturally safe care and services to culturally and linguistically diverse (CALD) consumers. The service has processes to support the delivery of culturally safe services to consumers, and staff and management were able to describe these. The service has a cultural safety policy and a diversity policy that clearly identifies consumers’ diversities and provides an overview of specific needs and preferences associated with their individual care.

Evidence analysed by the Assessment Team showed the service demonstrated how each consumer is supported to make decisions in relation to the care and services they receive. Consumers and/or representatives advised of their involvement in making decisions about their care and services. Staff described practical ways they support consumers to make choices. These included giving consumers options and supporting their choice, using concise and simple sentences, acknowledging their need to process information, and allowing consumers plenty of opportunity to respond to the questions. Management said that they are in regular contact with the support workers to discuss consumer services and if changes are requested, they will ensure regular contact is kept with the consumer.

Evidence analysed by the Assessment Team showed the service demonstrated how each consumer is supported to take risks to enable them to live the best life they can. Consumers and representatives interviewed described how the service supported them to be as independent as possible through the care and services provided. Management described how the service undertakes Work Health & Safety risk assessments for each consumer during the onboarding process. Care planning documentation viewed by the Assessment Team included signed Charter of Aged Care Rights for consumers and consumer service agreements included information regarding the dignity of choice and risk for the consumer.

Evidence analysed by the Assessment Team showed the service demonstrated information provided to each consumer is current, accurate and timely, and communicated clearly, easy to understand and enables them to exercise choice. Consumers and representatives confirmed they received information in a format that was clear and easy to understand and enabled them to make informed choices. Consumers and representatives elaborated that all staff are approachable when they sought further information or clarifications. Management said as coordinators carry out reviews, they have discussions with consumers regarding the changes in home care packages and advise on what can and cannot be purchased under the package.

Evidence analysed by the Assessment Team showed the service demonstrated each consumer’s privacy is respected, and personal information is kept confidential. All consumers and representatives interviewed stated they felt that their privacy was respected especially during the delivery of care and services. Consumers also described their confidence that their personal information was kept confidential by the staff and service. Support workers interviewed described how they keep consumer information safe such as not sharing personal information with other people and other consumers and any information is kept locked on their phones that is password protected.

Based on the evidence summarised above, I find the provider in relation to the service, compliant with Standard 1.

# Standard 2

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

Findings

**Requirement 2(3)(a)**

Evidence analysed by the Assessment Team showed 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 service did not demonstrate that consumer’s health and well-being formed the delivery of care and services. Management advised that information including medical diagnosis is collected by the service from consumers and/or representatives during the initial assessment, forms the basis of the development of care and supports, identifies risks to consumers, and forms the consumer risk level provided to staff. The service does not undertake clinical assessments using validated assessment tools and was unable to provide evidence that it is able to identify risks, possible deterioration, or put in place additional supports, services or referrals when identified.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

**Requirement 2(3)(b)**

Evidence analysed by the Assessment Team showed the service did not demonstrate assessment and planning identifies and addresses the consumers current needs, goals, and preferences, including advance care planning and end of life planning if the consumer wishes. The service did not demonstrate consumers are receiving person-centred, individualised care and services that address consumer needs, goals, and personal preferences within their funding guidelines. The service does not undertake clinical assessments using validated assessment tools, identify possible consumer deterioration through an incident register, record progress notes for all consumers, receive all reports from allied health professionals and other medical specialists undertaking supports or services to consumers, or have the complete medical history and diagnosis of all consumers. While care planning documentation sighted provided some of the supports being provided, they do not sufficiently detail the supports, or provide guidance to staff on consumer preferences in the delivery of the supports.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team. The service has engaged an external provider to undertake and conduct risk and clinical assessments using validated assessment tools for all Home Care Package consumers, all outcomes will be included in consumer care planning documentation. Further work has been undertaken to review, monitor and document consumer goals to ensure they are meeting the consumers goals, needs and preferences.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

**Requirement 2(3)(c)**

Evidence analysed by the Assessment Team showed the service demonstrated that assessment and planning is consistently occurring with ongoing consultation with the consumer, representatives and others involved in the care of the consumer. The service could demonstrate that it involves those the consumer choses to be involved in care and planning, including representatives and family members. The Assessment Team sighted consumer documentation that provided details of contacts nominated by the consumer that the service can contact in emergencies. Management advised that services and supports regularly used by the service includes a range of medical, allied health, nursing, and other external support services to support consumers.

**Requirement 2(3)(d)**

Evidence analysed by the Assessment Team showed 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. Staff providing care and supports do not receive complete information on consumers including consumer goals, detailed information on the services or supports that are to be provided, or strategies that can be used by staff to mitigate identified risks to consumers. Consumers reported that when they have the same staff, the service is wonderful as they know them and know what is required, however if a new person is sent, they don’t know what to do. The Assessment Team sighted recently reviewed care planning documentation, and noted that services and supports no longer being provided, were still incorporated, and provided to consumers and others providing care and support.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team. The service has advised It has reviewed and updated the care plans, risk identification strategies and goal setting activities. Strategies have been implemented to ensure support workers have clear visibility to ensure informed delivery of care. For high need consumers and those with specific care delivery requirements, additional training has been delivered and additional supports are in place.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

**Requirement 2(3)(e)**

Evidence analysed by the Assessment Team showed the service did not demonstrate care and services are reviewed regular for effectiveness, and when circumstances change. The service could not demonstrate that care planning documentation is reviewed as circumstances change, or that services and supports are changed when consumer goals or needs change. The service does not undertake clinical assessments. The service does not have an incident register pertaining to consumers, and where an incident may be entered into progress notes, these are not read. Management reported that the service contacts consumers regularly to determine if there are any concerns or changes needed in supports and services, and this was confirmed by consumers. Management advised that care plans are reviewed annually for relevancy or as consumer needs change, and a copy of the care plan is then provided to consumers. Consumers confirmed that they have received copies of their care plans, and that the service had recently contacted them to review their plan. Consumers are provided a consumer handbook, which provides information on the assessment process and annual review of care plans. It also provides information on how the plan or services can be modified as consumer needs change. All consumers interviewed said that they would feel comfortable contacting the service if their circumstances changed or that they required additional supports.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team. Medical summaries from the consumers medical practitioner or My Aged Care (MAC) are being reviewed with accurate information added to customer care plan and inaccurate or no longer relevant information, e.g. wound care that is no longer required, removed from care plans.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

Based on the evidence summarised above, I find the provider in relation to the service, compliant with Standard 2.

# Standard 3

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| Personal care and clinical care | | HCP |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Not Applicable |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

**Requirement 3(3)(a)**

Evidence analysed by the Assessment Team showed the service did not demonstrate clinical care provided is congruent with best practice and optimises the health and well-being of the consumer. Consumers interviewed advised they believe staff are competent and doing a great job. The service provides personal care to consumers and uses an external agency to provide clinical care including wound management. In relation to wound management this is undertaken by an external agency and the agency is required to report progress to the service consistently and formally on annual basis in a report. The Assessment team made findings on a centralised concern relating to a sole consumer and the management and healing of their wound.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team. The service has engaged with the external provider and have requested documentation that clinical care staff have the relevant qualifications and registrations required to provide their services. The service has engaged an external provider to support the service in addressing a more detailed clinical assessment which has now been received and implemented for future assessments. Manual handling training has been delivered to field staff.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

**Requirement 3(3)(b)**

Evidence analysed by the Assessment Team showed the service did not demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. The service could not demonstrate that high impact or high prevalence risks were effectively managed or identified. While staff interviewed said that they receive sufficient information to enable them to manage consumers risks, a review of consumer care planning documentation noted that information for consumers was incorrect or incomplete; risks were not being identified through reviewing progress notes; incidents were not being recorded; risk levels assigned to consumers did not accurately reflect the level of risk; and staff were not provided strategies to mitigate risks. The Assessment Team reviewed consumer care plans, and noted several consumers with high impact and high prevalence risks which were not being effectively managed.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team. The service has engaged an external provider to undertake risk and clinical assessments that address the management of high-impact risk associated with each consumer.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

**Requirement 3(3)(c)**

Not Applicable, the service does not provide end of life care.

**Requirement 3(3)(d)**

Evidence analysed by the Assessment Team showed the service did not demonstrate deterioration or a change in consumers health is recognised and responded to in a timely manner. The service was unable to demonstrate that deterioration in consumers mental, physical, or cognitive condition is recognised, or responded to in a timely manner. Most consumers and/or representatives said that they thought staff could identify if they were feeling low or unwell. Staff reported that if they notice changes in a consumer's health, they will report concerns immediately to the service or contact an ambulance if it was an emergency. Management reported that once they were notified, they would give the client a call and talk about how they are feeling, then organise to do a house visit to see if their needs have changed and additional supports required. This would be documented in a reviewed care plan. Management advised that they may also contact the consumer’s representative.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team. The service has engaged an external provider to undertake risk and clinical assessments that address the management of high-impact risk associated with each consumer.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

**Requirement 3(3)(e)**

Evidence analysed by the Assessment Team showed the service did not demonstrate information about the consumers condition, needs and preferences is documented and communicated within the organisation as well as with others involved in their care. The service was unable to demonstrate that information about a consumer’s condition, needs or preferences are all recorded and documented; and that information including high impact and high prevalence risks were provided to care staff.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team. Medical summaries from the consumers medical practitioner or My Aged Care (MAC) are being reviewed with accurate information added to customer care plan along with a comprehensive list of medications.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

**Requirement 3(3)(f)**

Evidence analysed by the Assessment Team showed the service demonstrated timely and appropriate referrals are made to other organisations and providers when required. The service could demonstrate that it works closely with other individuals including consumer representatives, allied health professionals, and ACAT for service and support reviews. Consumers interviewed spoke about using occupational therapists and physiotherapists, and how these services are supporting them.

**Requirement 3(3)(g)**

Evidence analysed by the Assessment Team showed the service did not demonstrate that the service minimises infection-related risks to consumers. Consumers interviewed reported that staff often wear masks when undertaking services and will ask them how they are feeling prior to services or supports commencing and will wear gloves when applying sorbeline after showering or when they need to handle consumers. The Assessment Team noted that mandatory staff training does not include infection prevention, hand hygiene, or competencies in donning and doffing. Management acknowledged this needs to be addressed and has now incorporated into the continuous improvement plan that all team members require mandatory training.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

Based on the evidence summarised above, I find the provider in relation to the service, compliant with Standard 3.

# Standard 4

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

Findings

**Requirement 4(3)(a)**

Evidence analysed by the Assessment Team showed the service did not demonstrate that each consumer gets safe and effective services that meet their needs, goals, and preferences. Consumers reported that the service made them feel safe, and that they were able to receive supports and services that enabled them to remain at home and maintain independence. The Assessment Team sighted care planning documentation for consumers receiving services, and noted that consumer goals and tasks, did not reflect the information provided by consumers.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

**Requirement 4(3)(b)**

Evidence analysed by the Assessment Team showed the service demonstrated that that services and supports for daily living promote each consumer’s emotional, spiritual, and psychological well-being. Consumers and/representatives said that they felt the service would recognise when they or the consumer was feeling low.

**Requirement 4(3)(c)**

Evidence analysed by the Assessment Team showed the service demonstrated it is supporting consumers to participate in their community, have social and personal relationships, and do the things of interest to them. All consumers interviewed said the service enables them to participate in their communities, do things of interest to them. Staff interviewed spoke about how consumers remained connected with their community, friends, and family.

**Requirement 4(3)(d)**

Evidence analysed by the Assessment Team showed the service did not demonstrate it is communicating information about the consumer’s condition, needs and preferences within the organisation and with others where required.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

**Requirement 4(3)(e)**

Evidence analysed by the Assessment Team showed the service demonstrated it is making timely and appropriate referrals to individuals and other organisations. Management reported that when required, consumers are referred to other organisations and providers of care and services, including occupational therapists, physiotherapists, suppliers of mobility aid equipment, and this was confirmed by consumers and/or representatives.

**Requirement 4(3)(f)**

Not Applicable. The service does not provide meals.

**Requirement 4(3)(g)**

Evidence analysed by the Assessment Team showed the service did not demonstrate that where equipment is provided, it is safe, suitable, and well maintained. The service was unable to demonstrate that where equipment has been purchased for consumers, there is a maintenance schedule in place to ensure that it is regularly maintained, cleaned, or serviced. Management acknowledged this oversight and will develop a schedule to ensure that this takes place.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

Based on the evidence summarised above, I find the provider in relation to the service, compliant with Standard 4.

# 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

This standard was deemed not applicable as care and services were provided in consumers’ homes and the service does not provide social support group activities.

# Standard 6

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

Findings

**Requirement 6(3)(a)**

Evidence analysed by the Assessment Team showed the service demonstrated consumers, their family, friends, carers, and others are encouraged and supported to provide feedback and make complaints. Consumers and representatives reported knowing how to provide feedback and make complaints. They stated that the staff provided this information during the admission process and staff asked for feedback during reassessments. Consumers and representatives reported that the service had multiple avenues that they could utilise to provide feedback and make complaints. Staff demonstrated knowledge of the services' various feedback pathways available for consumers and would support the consumers in this process if required. They stated they encouraged consumers to speak to the care coordinators.

**Requirement 6(3)(b)**

Evidence analysed by the Assessment Team showed the service demonstrated consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. Consumers and representatives confirmed that information regarding other services and supports to assist with providing feedback and making complaints was provided. Staff had not had to refer any consumers to advocacy or language translating services but reported knowing external supports for consumers to use when needed.

**Requirement 6(3)(c)**

Evidence analysed by the Assessment Team showed the service demonstrated appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. Most consumers and representatives reported satisfaction with the service’s actions in response to their concerns and/or complaints. Support workers interviewed explained that when they received feedback or complaints, they called the coordinator. Management indicated that they have not always entered feedback/complaints in the register as soon as they are made aware of it, but instead have dealt with the concern at the time. The service’s complaints process was then followed which included an acknowledgment, investigation, gaining an understanding of the outcome that was satisfactory to the consumers, actions taken, and follow-up with the consumer. Moving forward management have acknowledged the importance of entering all feedback/complaints and they will be entering all data as it arises.

**Requirement 6(3)(d)**

Evidence analysed by the Assessment Team showed the service did not demonstrate feedback and complaints are reviewed and used to improve the quality of care and services. Feedback and complaints are not currently reviewed and used to improve the quality of care and services as not all complaints are currently being captured in the complaints register. As not all complaints and feedback are recorded it cannot be determined how they are reviewed and utilised for quality improvement of the service. Management said that complaints are discussed fortnightly at meetings however trends are not formally identified, they are discussed with the 2 directors and the operations manager.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team. All complaints, including those resolved at the time of complaint are now recorded which will give us a better understanding and view of trends or persistent issues. Following the identification of a trend within complaints we will reach out to the identified clients and address the issue before it escalates. The complaints register will be discussed in fortnightly meetings and again at the monthly Directors and Management meeting. Complaints will be addressed with the complainant or their family support/advocate to ensure they are satisfied with the outcome and rectification actions taken.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

Based on the evidence summarised above, I find the provider in relation to the service, compliant with Standard 6.

# 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

**Requirement 7(3)(a)**

Evidence analysed by the Assessment Team showed the service demonstrated 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. Most consumers said support workers turn up on time and when expected. They said support workers have enough time to carry out the tasks allocated to them. Consumers and representatives reported that missed services were not usual and that the service communicated and worked with them to reschedule services if needed. Management said services are prioritised and rescheduled as a last resort. One manager demonstrated to the Assessment Team how they manage unfilled shifts to reduce risks to the consumer. The service demonstrated that the workforce was generally planned through consideration of service demands from referrals and involvement of coordinators and management. This was evident in reviewing the services processes for allocating staff which were sighted by the Assessment Team.

**Requirement 7(3)(b)**

Evidence analysed by the Assessment Team showed the service demonstrated workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture, and diversity. Most consumers and representatives interviewed provided positive feedback in relation to staff treating them in a kind and respectful manner. They further reported they are happy with the support workers that currently provide services to them. Care plan documentation captured some of the consumers story and provided information on the consumers background and what is important to them. Care plan documentation was written in a respectful manner. Staff were observed speaking respectfully to consumers on the phone and showed patience and kindness when conversing with consumers.

**Requirement 7(3)(c)**

Evidence analysed by the Assessment Team showed the service did not demonstrate the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. Although most consumers said they are confident that staff know what they are doing when they interact with them and that they have their questions competently answered by staff, the service could not demonstrate that all staff, including sub-contracted organisations, have the appropriate qualifications to effectively perform their roles. Some staff interviewed said they have experience and an understanding because of past life experiences and roles. Management said they seek feedback from consumers on the services received. The service could not demonstrate that they have sighted or kept copies of qualifications or mandatory checks of sub-contracted organisations.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team. The service has now created a training calendar and has commenced to deliver relevant training to all staff. For new employees during their induction and on-boarding process they have created a buddy shift feedback form for the new employee, the data will be used to further refine processes and gauge effectiveness of training delivered. Mandatory training has formed part of the continuous improvement plan and will be a key focus moving forward. Sub-contracted partners have now undergone relevant checks for qualification and registrations.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

**Requirement 7(3)(d)**

Evidence analysed by the Assessment Team showed the service did not demonstrate the workforce is recruited, trained, equipped, and supported to deliver the outcomes required by these standards. Most consumers and representatives interviewed stated that they were confident and satisfied with the staff skills in delivering safe and quality care and services. Multiple staff interviewed across different sections of the organisation said that they did not receive a comprehensive induction or training program when they commenced in the role. The service could not demonstrate that ongoing training, support for staff or professional development has occurred. Management said the service has recently implemented a staff training calendar, however reinforced that at present the only mandatory training that staff were responsible to complete was manual handling. The Assessment Team sighted evidence of qualifications, police checks, licence checks and vaccination status, not all were all up to date, some were missing components due to leave.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

**Requirement 7(3)(e)**

Evidence analysed by the Assessment Team showed the service did not demonstrate regular assessment, monitoring, and review of the performance of each member of the workforce. The service could not demonstrate that regular assessment, monitoring, and review of staff occurs consistently. Some staff interviewed said they could not recall participating in a performance management or appraisal process, while others recalled having a 3-month probation phone meeting/review. Management acknowledged that there is no current formal performance appraisal review process however the plan is to review all staff in June/July 2024 and have them all due at the same time. Managers who oversee support workers, said that they are in contact regularly with consumers to discuss any performance issues relating to support worker conduct that may arise from consumer feedback or complaints.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

Based on the evidence summarised above, I find the provider in relation to the service, compliant with Standard 7.

# Standard 8

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

Findings

**Requirement 8(3)(a)**

Evidence analysed by the Assessment Team showed the service did not demonstrate consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. Consumers and representatives reported that they were unable to recall if they had ever completed a survey or been asked to provide their input to improve service delivery. Management stated they have previously run surveys however this appears to have lapsed over the past few years. Management has identified that this is a concern. To address this, the service will be implementing surveys, and feedback opportunities for consumers and this will enable the service to identify any issues with carers, services and supports; enabling them to be rectified and implement service-wide changes to suit consumer needs.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team. A new client feedback form has been created and will be sent to each of our clients. This feedback will be used to inform additional training requirements and add to our continual improvement register. Feedback forms may be submitted at any time and there will be encouragement to do so. A Consumer Survey will be created and sent quarterly. A monthly happiness survey is in place for all team members with a quarterly engagement survey scheduled. We will promote the importance of these in our full team meeting.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

**Requirement 8(3)(b)**

Evidence analysed by the Assessment Team showed 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 service has 2 directors and an operations manager, one of the directors advised she had stepped back from running the service, however, was available to assist with the audit. The directors and operations manager act as the governing body. They have monthly meetings however minutes have not previously been recorded up until last month. Management acknowledges this was not best practice. Management said that they regularly review accounts and meet monthly to discuss any identified concerns, which may include care worker updates, challenges around hiring staff and any shortages or concerns. Whilst the service has an indirect governing body, the service was unable to provide satisfactory evidence that it had adequate oversight in promoting safe and quality care and services.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team. Minutes of all meetings to be forwarded to both Directors and saved in one place for ease of access and review. Training will be developed to include advocacy, cultural and diversity, recording feedback and complaints, incidents to analyse and trend. A feedback form will be sent to each of our clients as will a quarterly survey form. The service has contacted all brokered services and requested documentation to demonstrate they are adhering to all mandatory requirements. A review of policies and procedures is currently in progress and forms part of the continuous improvement process.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

**Requirement 8(3)(c)**

Evidence analysed by the Assessment Team showed the service did not demonstrate effective organisation wide governance systems. Management and staff confirmed that the consumers’ information was stored in the office on local servers. The service backed up systems via the cloud. The electronic consumer management system used is Employment Hero and Day Spring Care. Management and staff confirmed that there had been no data breach or compromise in the last 12 months. All consumer information is accessible on a need-to-know basis and all support workers have access to the data to complete their role via an App that is password protected. The Assessment Team sighted the service's continuous improvement register. It demonstrated that incidents had been identified and corrective action taken to resolve the incident, however, did not always identify areas for improvement, nor include incidents for consumers. The service utilised a spreadsheet to monitor its finances. The spreadsheet demonstrated that the service monitored its overall budget and actual expenditures. The Assessment Team sighted the service’s organisation chart, and position descriptions for some staff. When a staff member commences employment, information gathered from the person. The service could not demonstrate that there was sufficient oversight of sub-contracted agencies performance and could not show evidence of oversight of required qualifications and licenses. The service was unable to demonstrate compliance with regulatory requirements such as the implementation of Serious Incidents Response Scheme (SIRS) in home care and the individual code of conduct in relation to its brokered services. The service has a suite of policies in relation to regulatory compliance, however, policies did not nominate a person/position responsible for reporting to the Commission. Management also acknowledged that staff training had not been provided in relation to SIRS and restrictive practices, and some staff were unfamiliar with their concepts. The Assessment Team directed staff to the Commission’s website for more information. The service was unable to provide evidence that complaints were escalated to the directors, and the service was unable to provide the Assessment Team with a feedback and complaints register prior to February 2024, additionally, not all feedback is captured if it is dealt with at the time. As such, the service could not demonstrate that feedback or complaints from consumers was always recorded, analysed, and trended to inform any improvement initiatives.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team. Various initiatives have been documented in the services’ continuous improvement register. Incidents are now documented, reported, and trended. SIRS training is underway for our regulatory compliance with policies being created to include the person/persons responsible reporting to the commission and training of staff in restrictive practices. The service has created a register of our brokered services and nursing agencies for APHRA registrations, and mandatory training. Annual performance reviews now include areas for performance management and identification of training and development requirements.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

**Requirement 8(3)(d)**

Evidence analysed by the Assessment Team showed the service did not demonstrate effective risk management systems and practices. The service is not maintaining incident management systems and practices or maintaining high-impact or high-prevalence risks associated with the care of consumers. The service is identifying, and responding to abuse and neglect of consumers and supporting consumers to live the best life they can. Staff were unable to advise how they manage high impact and high prevalence risks associated with consumers as they do not use validated assessment tools. Risk assessment forms are completed for consumers however the service was unable to explain how they rate the risks for consumers. Management confirmed that analysing the consumer care plan is the primary way that risks are identified and managed, however this information is not always available in the care plans. The Assessment team reviewed multiple consumer care plans which showed that information on individual risks were inconsistent. Some consumers had a falls risk identified with minimal risk mitigation strategies listed on the care plan and provision form, and others did not identify any risks even when they were present in the My Aged Care (MAC) record. The service could not demonstrate that there are sufficient processes in place for staff to identify and respond to abuse and neglect of consumers. Although staff could describe generally what they would do in a situation of abuse and neglect, the service has not offered any modules or face to face training on the subject. The training and development policy states elder abuse prevention is mandatory training. The Assessment Team observed the training calendar which lists it will be held in September. Consumers sampled said that their support workers have built rapport with them and know what is important to them. Consumers said staff allow them to guide them in developing services to their needs and preferences. The service could not demonstrate that all incidents are recorded, trended, responded to or risks mitigated to prevent future incidents.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team. Clinical assessments for all level 3 and 4 Home Care Package (HCP) clients have commenced and once completed we will progress to other levels also. Care plans are being re-designed to include identification and mitigation of risks and will also include full medication information and medical diagnosis. These will be subject to ongoing review with changes made as required for example, when a client starts and ceases to require wound care. Training in relation to SIRS, abuse and neglect has been delivered. The service has now implemented an incident register that captures all incidents and the response. The incident register will be discussed on fortnightly basis with staff and management.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

**Requirement 8(3)(e)**

Evidence analysed by the Assessment Team showed the service did not demonstrate where clinical care is provided-a clinical governance framework. The service does not directly provide clinical care with their staff, however, employ a brokered service to provide all clinical care to consumers. Consumers receiving clinical care said that they are satisfied with the level of services and the staff that provide them. However, the service could not demonstrate that a formalised or effective clinical governance framework is implemented to guide staff. Management said that the service does not have a formalised clinical governance framework document or policy but described the process used to inform clinical care. Management said that all clinical care is brokered out. Management does not collect clinical data on risks or incidents to report to the director or to inform improvements to services or risk mitigation strategies, and there are no regular meetings between the brokered service providing clinical care and management to discuss high risk consumers or common trends in care planning, risks, or incidents.

In response to the Assessment Team Report the service submitted a comprehensive response outlining the actions undertaken to address the deficiencies outlined by the Assessment Team. Training in relation to medication management, restrictive practices and open disclosure has been delivered and implemented in practice. The service has developed and implemented a clear pathway for all staff to discuss clinical care, concerns relating to care and deterioration. Meetings are now held to discuss and address clinical care, high risk to consumers, common trends in care planning, risks, and incidents.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. On this occasion the additional details and evidence provided by the service in their response was sufficient for the Decision Maker to find the requirement compliant.

Based on the evidence summarised above, I find the provider in relation to the service, compliant with Standard 8.

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)