**Performance**

**Report**

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| Name: | First Call Nursing |
| Commission ID: | 201410 |
| Address: | Suite 8, 72-74 Bathurst Street, LIVERPOOL, New South Wales, 2170 |
| Activity type: | Quality Audit |
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| Performance report date: | 6 March 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: 7122 SCC Health Pty Limited  
Service: 26116 First Call Nursing

**This performance report**

This performance report for First Call Nursing (**the service**) has been prepared by P. Sherin, 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 23 February 2024 providing additional information.

# Assessment summary for Home Care Packages (HCP)

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| Standard 1 Consumer dignity and choice | Non-compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

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

# Areas for improvement

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

* Requirement 1(3)(d) – Ensure policies, processes, and training in place to guide staff in documenting and managing dignity of risk.
* Requirement 1(3)(e) – Provide financial statements to consumers in a current, accurate, and timely manner.
* Requirement 2(3)(a) – Ensure ongoing assessment and planning, including consideration of risks for consumers, occurs consistently.
* Requirement 2(3)(e) – Conduct regular review of care and services, including when circumstances change, or incidents occur.
* Requirement 3(3)(b) – Effectively manage high impact and high prevalence risks associated with the care of each consumer.
* Requirement 6(3)(d) – Implement effective processes to document all feedback and complaints and demonstrate these are used to improve the quality of care and services.
* Requirement 7(3)(c) – Implement effective processes to ensure compliance with mandatory worker screening requirements.
* Requirement 7(3)(d) – Implement effective processes to monitor staff mandatory training compliance.
* Requirement 7(3)(e) – Conduct regular assessment and review of the performance of each member of the workforce.
* Requirement 8(3)(c) – Demonstrate effective organisation-wide governance systems in relation to information management, continuous improvement, financial governance, workforce governance, regulatory compliance, and feedback and complaints.
* Requirement 8(3)(d) – Implement effective risk management systems and practices.
* Requirement 8(3)(e) – Establish an effective clinical governance framework.

# Standard 1

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

Findings

Having considered the Quality audit report and the Provider's response, I find the service non-compliant with this Standard. The non-compliance is related to the following:

* The service is not demonstrating policies, processes, and training in place to guide staff in documenting and managing dignity of risk.
* The service is not ensuring financial statements are provided to consumers in a current, accurate, and timely manner.

Requirement 1(3)(d)

The Quality audit report identified whilst consumers are supported to take risks of their choosing, there are inconsistent processes for documenting, monitoring, and reviewing dignity of risk. Staff and management did not demonstrate a shared understanding of dignity of risk. There are no policies, procedures, or training in place to guide staff in documenting and managing dignity of risk.

The Provider’s response advised a dignity of risk policy and form template has been implemented to guide staff practice. However, a copy of the policy and template were not provided for review. Staff training on dignity of risk has been scheduled in February 2024. Consumers are to be reviewed to identify any current or potential risks and strategies to manage and mitigate these risks.

Having considered the Quality audit report and the Provider’s response, I find deficits remain. Improvement actions have not been fully implemented, will require time to be embedded within the service’s processes, and to demonstrate effectiveness and sustainability.

I, therefore, find this Requirement is non-compliant.

Requirement 1(3)(e)

The Quality audit report identified information provided to consumers is not current, accurate or timely specifically in relation to monthly financial statements. Majority of consumers/representatives sampled expressed dissatisfaction with information provided via monthly statements, stating these were either not received regularly or were not accurate. Review of documentation identified annual budgets have only been completed for a small number of consumers for the 2023-2024 period, and only 6 of 33 consumers have received a monthly statement in December 2023 and January 2024.

The Provider in its response advised consumer budgets have been reviewed and a copy of the budget and monthly statements has been issued to all consumers and/or their representatives. Consumers have been contacted to ensure they understand the information received.

Having considered the Quality audit report and the Provider’s response, I am not satisfied the Provider has demonstrated financial information is provided to consumers in a timely manner. Nil documentary information has been submitted to evidence the actions implemented. New processes to ensure consumers receive financial information in a current, accurate and timely manner will require time to be embedded within the service’s operations and to demonstrate their sustainability.

I, therefore, find this Requirement is non-compliant.

I find the remaining Requirements under this Standard compliant as:

Consumers and representatives said consumers are treated with dignity and respect. Care documentation includes information regarding consumers’ background, culture, and spiritual preferences. Staff demonstrated knowledge of consumers’ individual needs and described how they ensure care is delivered respectfully.

Consumers and representatives confirmed care provided is culturally safe and consumers’ cultural background is considered in care and service delivery. Staff could describe how the care and services they deliver are adapted for individual consumers to ensure the consumer feels valued and safe. Management and staff described how translation services are utilised to assist communication with consumers from a diverse cultural background.

Consumers and representatives said the service supports consumers to exercise choice and maintain their desired level of independence, and to involve family members in liaising with the service and decision-making about their care. Care documentation includes information about representatives involved in the consumer’s care.

Consumers and representatives expressed satisfaction with how staff respect consumers’ privacy when providing services within their homes and keep their information confidential. The service advises consumers how their personal information will be stored and used. Staff described various ways used to maintain consumer privacy and confidentiality of information. Management advised staff receive training on privacy and confidentiality and are required to sign a confidentiality agreement on commencement.

# 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. | Non-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. | Non-compliant |

Findings

Having considered the Quality audit report and the Provider's response, I find the service non-compliant with this Standard. The non-compliance is related to the following:

* The service is not demonstrating ongoing assessment and planning, including consideration of risks for consumers, occurs consistently.
* The service is not conducting regular review of care and services, including when circumstances change, or incidents occur.

Requirement 2(3)(a)

The Quality audit report identified most consumers’ care documentation did not include current assessment and planning, and consideration of risks. Care documentation for 3 consumers identified no assessments or information to guide staff in managing risks to the individual consumer such as in relation to refusal of personal care, management of wounds and pressure injuries, changing behaviours, or risk of falls. Whilst staff were aware of these risks and described strategies implemented, these had not been documented using assessment and care planning documentation. Whilst assessments and care planning occur for consumers on commencement with the service, these are not ongoing. Six consumers’ risk assessments were completed over 5 years ago and had not been updated since.

The Provider’s response identifies a registered nurse has been allocated to complete re-assessments and care planning with an expected completion date of 30 April 2024. For consumers identified in the Quality audit report, reassessments have been completed. A consumer risk register has been established. However, nil documentary evidence was provided to evidence completion of these actions.

Having considered the Quality audit report and the Provider’s response, I find deficits remain. Improvement actions have not been fully implemented and will require time to be embedded within the service’s processes and to demonstrate effectiveness and sustainability.

I, therefore, find this Requirement is non-compliant.

Requirement 2(3)(e)

The Quality audit report identified regular care plan reviews are not occurring. Whilst consumers and representatives said they are contacted to discuss care plan reviews; this information is not documented. Care plans had not been reviewed and updated for sampled consumers who had experienced a change in circumstances, changed behaviours, or incidents such as a fall or admission to hospital. Management confirmed care plans had not been reviewed annually in accordance with the service’s processes.

The Provider’s response included information on implementing a business activity and internal audit schedule and monthly meetings to track progress for care plan reviews. A copy of the audit schedule and meeting minutes were not provided for review. The Provider advised staff education on identifying and reporting consumer changes and ensuring consultation during care plan reviews is planned in March 2024.

Having reviewed the Quality audit report and the Provider’s response, I find deficits remain. Supporting documents have not been submitted to evidence improvement actions implemented. Planned improvements such as staff education, ongoing monitoring via meetings and an internal audit schedule will require time to be embedded within the service’s processes and to demonstrate effectiveness and sustainability.

I, therefore, find this Requirement is non-compliant.

I find the remaining Requirements under this Standard compliant as:

Consumers and representatives said they are involved in discussions to identify the consumer’s needs and preferences, including discussions around end-of-life wishes and advance care planning. Care planning documentation includes information on the consumer’s needs, goals and preferences and details of services to be provided. Registered staff said they discuss consumers’ end-of-life preferences when consumers are new to service and as part of care plan reviews.

Consumers and representatives said they are kept involved in assessment, planning and review. Care documentation demonstrated other organisations and health professionals are included such as physiotherapists, occupational therapists, and podiatrists. Registered staff described how they include consumers and those they wish to be involved in the assessment and planning process.

Consumers and representatives said outcomes of assessment and planning are discussed with them, they have access to care planning documentation, and staff communicate with them regularly. Registered staff described how they communicate with consumers/representatives and document discussions using progress notes. Staff described how they access care planning documentation through a digital application to guide service delivery when in consumers’ homes.

# 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. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

Having considered the Quality audit report and the Provider's response, I find the service non-compliant with this Standard. The non-compliance is related to the following:

The service is not demonstrating effective management of high impact and high prevalence risks associated with the care of each consumer.

Requirement 3(3)(b)

The Quality audit report identified the service is not effectively managing high impact and high prevalence risks to consumers. Incidents such as falls and changed behaviours whilst reported by staff, are not consistently recorded within an incident management system. Clinical indicator data trending and analysis does not occur and there are no processes in place to ensure effective oversight and management of risks and response to incident trends. Risks to consumers are not identified as part of assessment and care planning.

The Provider’s response includes various improvement actions that have either been planned or implemented. These include, but are not limited to, establishing a new electronic reporting process, internal audit schedule, and incident register; staff education; and monthly meetings to identify and manage risk. Improvement action dates specified range from February to April 2024. Additionally, the Provider stated consumers named in the Quality audit report have been re-assessed and strategies implemented to manage individual risks to those consumers.

Having considered the Quality audit report and the Provider’s response, I am not satisfied the Provider has demonstrated effective management of high impact and high prevalence risks to consumers. Nil documentary information has been provided to evidence improvement actions taken. Improvement actions have not been fully actioned and will require time to be embedded within the service’s processes, and to demonstrate their effectiveness and sustainability.

I, therefore, find this Requirement is non-compliant.

I find the remaining Requirements under this Standard are compliant as:

Consumers and representatives said consumers receive personal and clinical care which is tailored to consumers’ needs and delivered in a safe and effective manner. The service works with the consumer and their representatives supporting consumers to make informed decisions about their options and the degree to which they wish to manage their care themselves and/or in collaboration with others, including health professionals. Whilst gaps were identified in information being documented via assessments and care plans as outlined under Requirement 2(3)(a), staff demonstrated knowledge of consumers’ personal and clinical care needs and strategies to support their care.

At the time of the Quality audit, the service did not currently have or recently provided care and services for a consumer nearing end of life. Registered staff described the processes for engaging with consumers and their families and ensuring consumers’ end of life needs and preferences are met. Care documentation includes consumers’ end of life preferences, such as whether they wish to be resuscitated, transferred to hospital, and to receive medical intervention.

Most consumers and representatives said staff identify and respond to deterioration or any changes in the consumer’s health or condition. Care staff were aware of the escalation processes when changes in a consumer are identified, and registered staff described steps taken following escalation. Whilst information is not consistently documenting, this has been considered under Requirement 2(3)(e) above.

Consumers and representatives said staff know the consumers well and have the information required for care and service delivery. Staff said they have access to care plans via a digital application on their mobile devices and are kept informed of any urgent changes via telephone. Whilst assessments and care plans have not been consistently updated, feedback from consumers and representatives was positive and staff demonstrated knowledge of consumers’ care needs. This information has therefore been considered under Requirements 2(3)(a) and 2(3)(e) above.

Consumers and representatives said consumers have access to medical and allied health professionals when needed, and this is supported and/or facilitated by the service. Registered staff described how referrals to allied health professionals are completed for consumers as required and how they communicate with consumers/representatives when a review by their general practitioner or referral to a specialist is needed. A review of care documentation demonstrated referrals are initiated by the service when requested by the consumer/representative or in response to escalation of information by care staff. Assessments are completed by allied health practitioners to determine if equipment is needed to assist consumers.

Consumers/representatives said staff wash hands and use personal protective as required. Staff have completed training in infection prevention and control, hand hygiene, and use of personal protective equipment. Staff demonstrated knowledge of processes used to minimise infection related risks.

# Standard 4

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

Findings

Consumers and representatives said the services and supports for consumers help optimise their independence and well-being. Staff described how they support consumers to maintain their independence and quality of life and engage with consumers to ensure their preferences are met. Care planning documentation includes information relating to the service and supports for individual consumers to guide staff practice.

Consumers and representatives described how staff support consumers’ emotional and spiritual well-being. Staff demonstrated an understanding of consumers’ individual spiritual needs and gave examples of how they have supported consumers’ emotional wellbeing. Review of progress notes evidenced how staff have identified changes in consumers’ psychological wellbeing and actions taken in response.

Consumers and representatives said the service supports consumers to participate in the community and maintain relationships. Staff described how they assist consumers to engage in the community and undertake activities of interest to them. Care documentation includes information on consumers’ activities of interest and relationships important to them to guide staff practice.

Consumers and representatives said staff know the consumers well and understand their needs and preferences. Care documentation is stored via an electronic care management system. Staff described how they can access consumer information via a digital application on their mobile devices. Management said staff are alerted to any changes for consumers through the digital application or by phone when required.

Staff and management described the processes implemented by the service to ensure timely and appropriate referrals to other organisations and providers of care, based on consumer needs. Review of care documentation identified referrals are made as required.

Management described how the service supports consumers to access prepackaged meals by providing meal options. Review of documentation evidenced communication between the service and consumers in relation to meal services, and provision of information on other meal service options where the consumer was not satisfied.

Consumers and representatives said the service supports consumers to access equipment and ensure the equipment is maintained. Staff described how they ensure equipment provided is kept safe, clean, and well maintained and the processes to raise any maintenance requests. Management described how the service supports consumers by identifying when equipment is still under warranty, providing a choice with repairers, and providing the level of support in line with consumers’ preferences.

I find this Standard compliant, as all Requirements under this Standard are compliant.

# 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. | Non-compliant |

Findings

Having considered the Quality audit report and the Provider's response, I find the service non-compliant with this Standard. The non-compliance is related to the following:

* The service is not implementing effective processes to document all feedback and complaints and demonstrate these are used to improve the quality of care and services.

Requirement 6(3)(d)

The Quality audit report brought forward information demonstrating the service is not consistently documenting all feedback and complaints and using this to identify trends and implement improvements in line with the service’s policy. The service’s complaints register captured 3 complaints for the period of July to December 2023. Whilst the service has self-identified the need to improve processes to document and monitor continuous improvement in response to feedback and complaints, no action has been taken to progress this.

The Provider’s response includes planned improvement actions including education to staff; implementing new complaints management processes clearly identifying roles and responsibilities; commencing surveys to gather feedback; and using a monthly office meeting to track and monitor continuous improvement actions.

Improvement actions have yet to be fully implemented and will require time to be embedded within the service’s processes and to demonstrate their effectiveness and sustainability.

I, therefore, find this Requirement is non-compliant.

I find the remaining Requirements under this Standard are compliant as:

Consumers and representatives said they are encouraged to provide feedback or make a complaint and felt comfortable to do so. Information on how to submit feedback and complaints is provided to consumers via agreements and information folders kept within the consumer’s home. Management described how they encourage feedback informally through reviews, home visits, or phone conversations.

Consumers and representatives said they receive information on accessing external complaints processes. Management described how information relating to language services, advocacy, and external complaints mechanisms is provided to consumers with entry information and as part of the service agreement. The Provider advised following the Quality audit home folders had been recently updated to reflect current contact information for internal staff and external complaints agencies.

Consumers and representatives said they were satisfied with the service’s response to feedback and complaints, confirming prompt action is taken and an apology provided. A feedback and complaints policy is available to guide staff practice. Staff said they always apologise to consumers if something goes wrong. Management said the service provides training on complaints and feedback as part of mandatory induction training.

# 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. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant |

Findings

Having considered the Quality audit report and the Provider's response, I find the service non-compliant with this Standard. The non-compliance is related to the following:

* The service is not demonstrating effective processes to ensure compliance with mandatory worker screening requirements.
* The service is not demonstrating effective processes to monitor staff mandatory training compliance.
* The service is not conducting regular assessment and review of the performance of each member of the workforce.

Requirement 7(3)(c)

The Quality audit report identified the service did not demonstrate an understanding of mandatory aged care worker screening requirements and there was no process in place to monitor compliance. The service’s recruitment policy and position descriptions for various roles identified inconsistent information regarding the screening checks required. The service was unable to provide current police checks for 14 staff and majority of external contractors delivering care and services.

The Provider’s response stated position descriptions have been updated to reflect screening requirements. The plan for continuous improvement captures an improvement action for the service to implement clear responsibility for monitoring and managing compliance of probity checks for staff and contractors. Estimated completion date is end of March 2024.

Having considered the Quality audit report and the Provider’s response, I find the service has not demonstrated compliance with mandatory worker screening requirements. Improvement actions have yet to be fully implemented. Nil documentary evidence has been provided to evidence 14 staff and majority of external contractors as identified in the Quality audit report have current police checks in place.

I, therefore, find this Requirement is non-compliant.

Requirement 7(3)(d)

The Quality audit report identified the service is not consistently monitoring staff mandatory training compliance and currency of training. Review of training records identified whilst mandatory training is provided on a range of topics, only 30 of 42 staff have completed mandatory induction training between 2007 to 2023. All staff have not completed training on topics such as the Aged care code of conduct, Quality standards, or the Serious incident response scheme. Management acknowledged there has not been a consistent process or clear responsibilities for monitoring training compliance.

The Provider’s response captured improvement actions planned and implemented. This includes, but is not limited to, use of attendance records for staff education sessions; discussion on training compliance with the service’s management and governing body; implementing an education calendar; and conducting a training needs analysis. Mandatory training on topics related to legislative compliance requirements have been included in the staff induction kit, with training scheduled in February 2024.

Having considered the Quality audit report and the Provider’s response, I find deficits remain. Improvement actions have not been fully implemented and will require time to demonstrate their effectiveness and sustainability. Nil documentary evidence has been provided to demonstrate the service has established a staff mandatory training register and training compliance is now up to date.

I, therefore, find this Requirement is non-compliant.

Requirement 7(3)(e)

The Quality audit report identified the service did not demonstrate regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. The service’s induction kit includes a policy for staff reviews approved May 2022 outlining the requirement for staff to be reviewed within 14 days of commencement, a 6-monthly review, and annually thereafter. Management advised the service has recently recommenced performance assessments and have completed informal one-to-one conversations with staff, however this has not been documented. The Assessment Team identified only 11 of 42 staff have completed a performance assessment in the last 12 months.

The Provider in its response advised all staff appraisals are to be completed by mid-March 2024. A copy of the staff appraisal register or documentary evidence of completed staff appraisals was not provided for review.

I, therefore, find this Requirement is non-compliant.

I find the remaining Requirements under this Standard are compliant as:

Consumers and representatives said they were satisfied with the availability of staff and responsiveness of management. Care and services are delivered by the service’s staff with support from contracted staff. Staff said they have sufficient time to complete their allocated duties in line with consumers’ needs and preferences. Management described the service’s processes to ensure the number and mix of staff enables the delivery of safe and quality care and services.

Consumers and representatives confirmed staff are kind, caring, and respectful. The service has policies and procedures on workforce interactions and providing care and services that are culturally safe. Staff demonstrated knowledge of individual consumers’ background, diversity, and preferences and described how they ensure respectful and caring interactions. Management advised informal spot checks are conducted to monitor staff interactions with consumers.

# 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. | Non-compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Non-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. | Non-compliant |

Findings

Having considered the Quality audit report and the Provider's response, I find the service non-compliant with this Standard. The non-compliance is related to the following:

* The service is not demonstrating effective organisation-wide governance systems in relation to information management, continuous improvement, financial governance, workforce governance, regulatory compliance, and feedback and complaints.
* The service is not implementing effective risk management systems and practices.
* The service is not demonstrating an effective clinical governance framework.

Requirement 8(3)(c)

The Quality audit report identified deficiencies with the service’s organisation-wide governance systems as specified below:

* Information management: Majority of consumers/representatives sampled expressed dissatisfaction with information provided via monthly financial statements, stating these were either not received regularly or were not accurate. Most consumers’ care planning documentation does not include current assessment and planning. Minutes of staff, management, and advisory group are not always recorded.
* Continuous improvement: the service is not demonstrating consistent documentation and analysis of feedback, complaints, and incidents to inform continuous improvement. Improvement actions are not consistently documented under the service’s plan for continuous improvement. Actions do not consistently include timeframes for completion or steps to monitor effectiveness.
* Financial governance: the service is not demonstrating effective financial governance with the failure to provide monthly financial statements to consumers in a timely manner. Management confirmed financial statements for December 2023 had only been provided to 6 consumers on 30 January 2024. Refer to Requirement 1(3)(e) for information more broadly.
* Workforce governance: the service did not demonstrate effective workforce governance as there were no systems and processes in place to monitor workforce screening requirements, track staff mandatory training compliance, and to ensure regular performance review.
* Regulatory requirements:review of documentation and discussions with management and staff identified a lack of shared understanding in relation to regulatory compliance requirements. The service is not offering home care package agreements to consumers and amending these as changes occur; not providing consumers with regular monthly statements; not monitoring staff and contractor compliance with mandatory screening requirements; not demonstrating an understanding of strengthened governance requirements in relation to implementing a quality of care advisory body; and not demonstrating staff are trained in response to regulatory changes such as the Serious incident response scheme.
* Feedback and complaints: the service does not have a consistent process in place to document all feedback and complaints received and use these to inform improvements.

The Provider submitted information on improvement actions planned to address the above-mentioned deficits. These include, but are not limited to, implementing meeting schedules and documentation suites; revising processes for issuance of monthly statements; reviewing and updating regulatory compliance and complaints management processes; and providing staff education. Most actions are due for completion by the end of April 2024.

Having considered the Quality audit report and the Provider’s response, I find deficits remain. Improvement actions have not been implemented and will require time to be embedded within the service’s processes and to demonstrate their effectiveness and sustainability.

I, therefore, find this Requirement is non-compliant.

Requirement 8(3)(d)

The Quality audit report identified the service does not have effective risk management systems and practices in place. Staff and management did not demonstrate a shared understanding of dignity of risk, and there were no policies and procedures to guide staff practice in relation to this. Risk assessments had not been completed consistently for all consumers. Care planning review is not consistently occurring for all consumers, including when an incident occurs. The service is not conducting incident analysis and trending. Refer to Requirements 1(3)(d), 2(3)(a), 2(3)(e) and 3(3)(b) for information more broadly.

The Provider’s response included information on planned and completed improvement actions including, but not limited to, the development of a risk framework; review and update of incident management policies and procedures; and establishing a risk register and internal audit schedule. The Provider plans to have these actions completed by May 2024.

I, therefore, find this Requirement is non-compliant.

Requirement 8(3)(e)

The Quality audit report brought forward information identifying the service does not have a documented clinical governance framework or procedures to guide staff and management. The service informally monitors consumer clinical needs through progress notes and meeting minutes, however no clinical data is collected to monitor trends. Staff training compliance on topics such as restrictive practices, the Serious incident response scheme and open disclosure is low. There is no antimicrobial stewardship policy or procedure in place.

The Provider’s response states policies have been developed in relation to clinical governance, open disclosure, and minimising the use of restraint. New processes have been established to document and monitor clinical incidents and trends. Staff education on these topics via quarterly staff meetings have commenced. However, nil documentary evidence was provided for review and to evidence the actions implemented.

I, therefore, find this Requirement is non-compliant.

I find the remaining Requirements under this Standard are compliant as:

Consumers and representatives said they can provide feedback and suggestions which is considered by the service. Management engages with consumers and representatives in the development, delivery and evaluation of care and services via various methods. A consumer advisory committee has been established with the first meeting scheduled for February 2024. Informal consumer feedback is actively sought by management during review meetings and is used to implement improvements.

Consumers and representatives said they felt the service is well run. Management described the service’s governance structure and advised of actions implemented to improve overall governance and accountability. The service has engaged an external consultant to assist with preparing for compliance auditing and improving accountability processes.

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)