**Performance**

**Report**

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| Name of service: | Glow Healthcare Agency |
| Service address: | 20 Carlton Street Granville NSW 2142 |
| Commission ID: | 201453 |
| Home Service Provider: | OZConnections (NSW) Pty Ltd |
| Activity type: | Quality Audit |
| Activity date: | 17 January 2023 to 19 January 2023 |
| Performance report date: | 27 February 2023 |

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

**This performance report**

This performance report for Glow Healthcare Agency (**the service**) has been prepared by G. McNamara, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Services included in this assessment

**Home Care:**

* Glow Healthcare Agency, 27665, 20 Carlton Street, Granville NSW 2142

# Material relied on

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

* the assessment team’s report for the Quality Audit; the Quality Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others]
* the provider’s response to the assessment team’s report received 10 February 2023.

# Assessment summary for Home Care Packages (HCP)

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Not Applicable** |
| **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 2(3)(a)** - Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.

**Requirement 2(3)(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.

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

**Requirement 3(3)(a)** - Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:

(i) is best practice; and

(ii) is tailored to their needs; and

(iii) optimises their health and well-being.

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

**Requirement 3(3)(e)** - Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.

**Requirement 3(3)(f)** - Timely and appropriate referrals to individuals, other organisations and providers of other care and services.

**Requirement 6(3)(a)** - Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.

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

**Requirement 7(3)(c)** - The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

**Requirement 7(3)(d)** - The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

**Requirement 7(3)(e)** - Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

**Requirement 8(3)(b)** - The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

**Requirement 8(3)(c)** - Effective organisation wide governance systems relating to the following:

(i) information management;

(ii) continuous improvement;

(iii) financial governance;

(iv) workforce governance, including the assignment of clear responsibilities and accountabilities;

(v) regulatory compliance;

(vi) feedback and complaints.

**Requirement 8(3)(d) -** Effective risk management systems and practices, including but not limited to the following:

(i) managing high impact or high prevalence risks associated with the care of consumers;

(ii) identifying and responding to abuse and neglect of consumers;

(iii) supporting consumers to live the best life they can

(iv) managing and preventing incidents, including the use of an incident management system.

**Requirement 8(3)(e) -** Where clinical care is provided—a clinical governance framework, including but not limited to the following:

(i) antimicrobial stewardship;

(ii) minimising the use of restraint;

(iii) open disclosure.

# 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

The Quality Standard is Compliant as six of the six specific requirements have been assessed as Compliant.

The service was able to demonstrate that:

* consumers are treated with dignity and respect.
* it delivers services that are culturally safe and align with religious beliefs.
* provides information which enables the consumer to make decisions, including who is to be involved in their care.
* It supports consumers to act independently and make their own decisions; and
* That it respects consumers’ privacy.

Consumers/representatives said staff listen to consumers, understand what is important to them and respect the choices they make. Staff spoke of how they support consumers to take risks and live a life of their choosing, and provided examples. The Assessment Team performed an extensive document review under the guidance and assistance of the provider and was unable to find evidence of digital notes being recorded by the support worker that outlines the progress of an identified consumer. I have considered that information under other requirements, and on balance and based on the evidence available I consider that the service could demonstrate that it supports consumers to take risks so they may live their best life. In its written response the approved provider acknowledged nonetheless that improvements can be made and in its written response it identified the areas it would focus on.

Consumers said they receive information in a way that they can understand and that enables them to make informed choices. Consumers reported they are involved in verbal discussions with staff as required, however the Assessment Team found that information about the need for installation of equipment to assist mobility and prevent falls, and referral to a physiotherapist was not adequately communicated and followed up. I have considered that information under other requirements, and on balance and based on the evidence available I consider that the service could demonstrate that it ensures information provided to consumers is current, accurate and timely. In its written response the approved provider acknowledged nonetheless that improvements can be made and in its written response it identified the areas it would focus on.

# 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. | Non-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. | Non-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

The Quality Standard is assessed as Non-compliant as three of the five specific requirements have been assessed as Non-compliant. A decision of Non-compliant in one or more requirements results in a decision of Non-compliant for the Quality Standard.

The service is partnering with consumers/ and or representatives to ensure that assessment and planning are effective in assessing individual consumers’ needs, goals and preferences, and reviewing care and services regularly or as required

However, the Assessment Team found that the service was not considering and evaluating risks during assessment and planning of care for each consumer, in particular those with co-existing risk factors. In particular, when new consumers are onboarded the assigned Case Manager or Registered Nurse (RN) (for more complex cases) then conducts a home visit to complete the initial assessment to better understand the consumer’s medical history, physical and mental health status, any risks and how they cope with activities of daily living to inform the delivery of safe and effective care and services.

During the initial assessment risks were clearly identified through a ‘tick a box’ template with additional comments. However, despite many consumers being identified with multiple co-existing risk factors, such as falls, dementia and multiple Emergency Department (ED) admissions during the last 12 months no validated assessment tools were available. Care Plans did not include individual risk assessments, mitigation strategies or sufficient detail about assessed needs to guide staff in managing the risks for consumers, including, for example, a consumer on a level 4 package who lives with dementia and who was identified as a high falls risk with three ED admissions for falls over the last 12 months.

In addition, care planning documentation, which was at the time of the Quality Audit being transitioned from hard copy to an electronic central management system, contained allergy alerts but no risk alerts for falls, pressure injuries, wounds, swallowing difficulties or behavioural issues identified in the majority of care plans reviewed. Support workers do not have access to risk alerts. Non-response procedures were also insufficient in many cases.

In its written response to this information, and other areas in which required improvements were identified, the approved provider acknowledged the need for improvements and engaged positively with the issues identified. It also stated it had commenced reviews of all consumers identified by the Assessment Team, and provided details of what those reviews entailed. It identified that a review of care plans will be undertaken to ensure more specific details are added. It noted that risk alerts are available an further training will be provide to staff on the use of same. It also noted that training on the use of new clinical tools would be given to staff.

The approved provider is encouraged to continue to embed these improvements both for the individual consumers identified and in its systems and processes.

The Assessment Team found that the service was not providing sufficient detail of the consumer’s current needs, goals or preferences nor the opportunity for consumers to consider advanced care planning and end of life care, in particular those considered palliative. Consumers and/or representatives confirmed that the services they currently receive meets their needs, goals and preferences. They said that they have day to day control of the service they receive through providing instructions to the care worker upon arrival for that shift. However, support workers said that the Case Manager phones them prior to their first shift to provide information regarding the care needs of the consumer. Ongoing communication for changes is all via phone, and it was confirmed that the care plan is not being utilised as a practical tool in the field. In addition, care planning documentation did not describe in sufficient detail the services the consumer receives nor clear instructions for care workers. They were not individualised, goals were generic relating to ‘assistance/ support’ and there were no consumer needs or preferences listed. For one consumer who received complex clinical care, details were either unclear or missing altogether.

In addition, consumers and/or representatives confirmed that they do not have an advanced care plan in place, nor discussed end of life planning or received information, despite a care plan template including Advance Care Directive as an item. A Case Manager advised that despite providing end of life services to one consumer, they have not discussed their end of life wishes.

Policies and procedures viewed did not provide guidance to staff in terms of asking consumers about their end of life wishes or connecting to specialist palliative care providers.

In its written response to this information, the approved provider identified the improvements it had or would make, including updating care documentation and templates, refresher training for all care staff and distribution of information, and follow up conversations, regarding advanced care planning.

The service was also not communicating outcomes of assessment and planning, including not following through on risk assessments (including clinical) and making care plans accessible to staff at the point of care. Consumers and/or representatives reported that the services they receive, and the frequency of service are explained to them on commencement and whenever changes occur. They felt they were well informed by the Case Manager of the services they could access, funding available and had received a copy of their care plan when they signed up. They were able to explain the services they receive, including days and times, but care plans were incomplete for scheduled services.

However, while Case Managers or an RN conducted the initial assessment and risks were clearly identified, care plans did not include outcomes from individual risk assessments including consumers where clinical needs identified. The initial assessment document used during the home visit doubles up as the care plan, which was available for all consumers but lacked outcomes to guide staff how to deliver safe and quality care. Support workers advised that any updated information regarding the consumer condition, care and services is always communicated via a phone call or text from the Case Manager prior to the service. They also confirmed that they had never seen a care plan including at the point of care. Management explained that care plans are currently being transitioned from hard copy to an electronic central management system, but are not accessible to staff at the point of care.

In its written response to this information, the approved provider identified the improvements it had or would make, in addition to those in relation to care planning and assessment generally, including transitioning care plans from hard copy to an electronic central management system, with hard copies to be available at the premises of the consumer.

I acknowledge all the improvements the approved provider has identified in relation to all these matters. However I consider these improvements will take time to become embedded and for the approved provider to demonstrate their sustainability.

# 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. | Non-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. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Non-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

The Quality Standard is assessed as Non-compliant as four of the seven specific requirements have been assessed as Non-compliant. A decision of Non-compliant in one or more requirements results in a decision of Non-compliant for the Quality Standard.

The service is maximising comfort and preserving dignity for an end of life consumer, recognising and responding to deterioration or changes in the consumer’s condition in a timely manner and minimising the risk of infection to consumers.

The Assessment Team found that consumers and/or representatives provided positive feedback that the personal and clinical care they receive is tailored to their needs, and that the service is flexible in the delivery of care and services on each shift. In addition, staff providing either personal or clinical care to the consumers, had a good understanding of each consumer’s needs, goals and preferences relating to the delivery of that care and did not raise any specific issues. However, care planning documentation outlined basic information regarding the consumer’s current personal care needs, and there were no clear instructions for staff on how to deliver care and services. For consumer’s clinical needs, these had not been updated with current status by the RN. For example, for one consumer receiving wound care there was no wound care plan with clear instructions for a weekly dressing. Wound charts were not seen to be current, photos were not dated, handwritten progress notes were difficult to read, and when asked the RN confirmed that weekly dressings had likely been missed.

In addition, management advised that for brokered personal care services, the organisation relies on consumer feedback to ensure safe and quality care has been delivered. Management also recognised that the service had a rapidly growing dementia consumer cohort. There was no evidence of individualised behavioural support plans (including triggers), that utilised best practice, tailored care to needs or optimised the health and well-being of this consumer cohort.

Some policies and procedures reviewed, such as Assessment and Care Planning, Mobility and Falls Prevention and Behaviour Management were seen to provide guidance to staff but contained no reference to evidence/best practice guidelines.

In relation to high impact and high prevalence risks, consumers and/or representatives were satisfied that the care they received was safe and appropriate for them, and concerns were not raised in relation to the management of risks associated with their care. In addition, support workers were able to describe strategies used to minimise risk of falls or other risks to consumers, but these were not reflected in care plans. Further, Case Managers and or the RNs identified risks during the initial assessment process including falls, pressure injuries, cognitive decline, ED admissions last 12 months, swallowing difficulties and malnutrition. They were also able to describe risks for individual consumers, in particular those they were worried about or on the service’s vulnerable consumer list, but they made no reference to the risks associated with the 40% dementia cohort.

Care planning documentation included home safety assessments for all consumers, but the non-response to scheduled visits process was not robust. Care plans reflected identified risks, but did not show that risk assessments were undertaken for high-impact or high-prevalence risks to find ways to minimise these risks to consumers. Validated risk assessment tools were not in use, for example a Falls Risk Assessment Tool (FRAT) assessment had not been completed for any of the consumers at risk of falls. In addition, there was no information in relation to risk mitigation strategies or guidance for staff who regularly provide services to consumers. For example, one consumer had a wound that had been dressed by the district nurse three times a week for 16 weeks. Whilst the Case Manager checked its status over the phone, an RN visit last week had not been documented in progress notes nor alert instructions for the regular care workers to keep watch.

The service’s system has only allergy alerts, so whilst some of the support workers are using the mobile app, it does not highlight high-risk alerts regarding the consumer to remind staff of any potential risks during the delivery of care. In addition, the service does not have a comprehensive risk management system in place to monitor, identify and manage risks to consumers. The incident register is lacking in detail and there was no evidence of the process for staff to report incidents. In addition, the clinical governance committee minutes showed no evidence of trend analysis for risks of consumers across the service.

In relation to communication of information, consumers and/or representatives reported that staff know consumers’ condition, needs and preferences as generally they have the same staff providing their care and services. They also provided positive feedback on the support worker who provided their care, and explained that their Case Manager was always available by phone. Support workers document their service visit at the end of the shift, which is then available to be viewed on subsequent visits noting times and consumer status. Upon commencement with the service, the support worker is briefed on individual consumer’s condition, needs and preferences by the Case Manager and if deemed necessary a 1st visit buddy shift will be organised with the RN.

However, support workers explained that there is a mobile app available on their phones which records arrival/departure from the consumers home which some were not using. All agreed that the main communication channel is by phone with the Case Manager (available 24/7) who rang them regularly to keep them informed of changing consumers’ needs. Care planning documentation did not contain assessments, referrals, dated progress notes, and care plans overall did not provide adequate information or clear instructions for care workers to support effective and safe care. Care plans in hard copy are not available at the point of care, and the electronic version for sampled consumers either did not reflect the current service schedule or was incomplete for some consumers.

In its written response to this information, and other areas in which required improvements were identified, the approved provider acknowledged the need for improvements and engaged positively with the issues identified. It set out the improvements it had had or would implement, in addition to those previously identified, including:

* improvements in care planning and assessment
* improvements to risk systems
* clinical care notes to be electronically documented on every clinical service provided service
* completing dementia care plans for identified clients
* completing Risk Assessments using the validated tools for high clients and updating the care plans; and
* communicating the mandated changes to all case managers

In relation to referrals, consumers and/or representatives explained that whilst they had discussions with their Case Manager about referrals to access other health professionals such as physiotherapy, occupational therapists, podiatrists, specialists or equipment, often these were not actioned by the service in a timely manner. Case Managers were unable to demonstrate the clear processes in place to refer consumers to a full range of allied health services either in the private or public system, nor how consumer outcomes would be monitored. However, they were able to explain the process for a specialist referral where they fill in a form and phone the GP. Despite many consumers being identified with multiple co-existing risk factors (such as falls, dementia, multiple ED admissions during the last 12 months, swallowing difficulties, malnutrition) care plans did not include referrals to external services to address these risks for consumers. Care planning documentation indicated that only when a physiotherapy or OT assessment was conducted prior to joining the service, then the service accessed external services required by the consumer. A policy on referrals was reviewed, and did not outline a referral process.

In its written response to this information regarding referrals, the approved provider submitted that it believed Allied Health Services and needs were quickly addressed and that the consumers identified had recently been on-boarded, and they either did not have enough funds in their home account or could not be covered by the budget. I have considered that information but do not consider it demonstrated investigation of means to address or manage these needs. I also consider that the evidence indicates the organisations referral pathways are not well advanced.

I acknowledge all the improvements the approved provider has identified in relation to all these matters. However I consider these improvements will take time to become embedded and for the approved provider to demonstrate their sustainability.

# 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

The Quality Standard is Compliant as six of the six applicable requirements have been assessed as Compliant.

The service is:

* providing a wide range of options for consumers to support them to live as independently as possible, enjoy life and remain connected to their local community.
* promoting the emotional and psychological well-being of consumers through empathy, compassion and connection between consumers and members of the workforce.

The service has acknowledged its responsibility to maintain equipment provided by it, and identified how it would achieve this. No specific concerns were identified in relation to the standard of the equipment provided.

Although the processes for sharing of information in relation to services and supports for daily living were not fully developed, I have considered this information under Standards 2 and 3. Further, although the processes for referrals were not fully developed, I have considered this information under Standards 2 and 3. I consider that the improvements identified by the approved provider in relation to sharing information and referrals in Standards 2 and 3 will have a flow on effect to the equivalent requirements in Standard 4.

# Standard 5

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| Organisation’s service environment | HCP |

The organisation does not provide a service environment therefore this Standard is Not Applicable and was not assessed.

# Standard 6

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| Feedback and complaints | | HCP |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Non-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

The Quality Standard is assessed as Non-compliant as two of the four specific requirements have been assessed as Non-compliant. A decision of Non-compliant in one or more requirements results in a decision of Non-compliant for the Quality Standard.

The service is providing information to consumers have access to advocates, language services and other methods for raising and resolving complaints. It is also taking appropriate action to resolve complaints or respond in a timely manner.

Consumers and representatives advised they do not have any concerns as they are satisfied with the services and when they raised anything it was addressed quickly by the case managers. They said the staff checked with them if they are satisfied with the service and they would be comfortable raising issues if they arose as all staff at the service were very approachable. However, most consumers were not aware of external avenues to make a complaint such as commission. Support workers advised if they receive feedback from consumers they bring it to the attention of case managers whether it be positive or negative.

Management advised all consumers receive the Consumer Handbook which explains the complaints/compliment/feedback process and includes the charter of aged care rights, outlining a consumer’s right to complain. Management also explained how they encourage and support consumers and representatives to provide feedback and make complaints through various avenues like verbal feedback, via emails, and recently started consumer surveys. A complaints policy and process is in place but does not guides staff in complaints and feedback mechanisms at the service or include relevant timeframes.

The service has policies and procedures describing feedback and complaints contributing to continuous improvement, however the service was unable to demonstrate they always record complaints and feedback. For example, feedback regarding statement calculation by a consumer was resolved however it was not recorded and seen to contribute to continuous improvement. Management provided examples of feedback received such as staff preferences, statements and survey result of cleaning service concerns. However, these were not recorded or seen to contribute to continuous improvement. When the Assessment Team raised these matters management advised the service addresses each consumer/representative’s complaint individually, but noted its rapid expansion and acknowledged they were putting a system in place. The Assessment Team reviewed minutes of meetings, including the governing body’s minutes of meeting, and identified that continuous improvement is discussed but not relaying the feedback and complaints that are logged in the register.

In its written response to this information, and other areas in which required improvements were identified, the approved provider acknowledged the need for improvements and engaged positively with the issues identified. It set out the improvements it had or would implement, in addition to those previously identified, including tracking, reviewing and addressing feedback and complaints in an operations meeting every month.

I acknowledge all the improvements the approved provider has identified in relation to all these matters. However I consider these improvements will take time to become embedded and for the approved provider to demonstrate their sustainability.

# 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

The Quality Standard is assessed as Non-compliant as three of the five specific requirements have been assessed as Non-compliant. A decision of Non-compliant in one or more requirements results in a decision of Non-compliant for the Quality Standard.

The service was able to demonstrate that:

* its workforce is planned to enable, and the number and mix of member of the workforce to deliver safe and quality care; and
* workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture, and diversity.

However, the service could not demonstrate that it is monitoring compliance of staff qualifications and knowledge to perform their roles effectively for consumers with high clinical needs. Consumers/representatives all provided positive feedback regarding support workers. They advised they are satisfied with the knowledge and skills of staff overall, and management discussed that all roles have a detailed position description. However, practical application of management’s role in term of clinical reporting and managing high impact high prevalence consumer is lacking, and management acknowledged the need for improvements in clinical reporting and data collection. It was noted that nursing services are provided through a management team and there is a process in place regarding monitoring of nurse registrations and training.

Management advised that support workers were monitored in their system to correct expired qualifications, checks and vaccinations, and are removed from the roster until they came back into compliance, however the Assessment Team noted a support worker with an expired flu vaccination was still on the roster. Management confirmed that for the subcontractor staff and allied health professionals, a copy of their qualifications and checks are required. However, they were unable to provide evidence of credential checks, training, covid and flu vaccine certificates.

The service could also not demonstrate that it is providing a comprehensive training program or an understanding of how all staff are trained, equipped or supported. Consumers did not raise any issues regarding staff training, and staff advised they do and have completed online training induction that covers the policies and procedures that relate to their specific role. However, staff were not able to advise if they have done dementia and infection control training. In addition, management could not confirm how subcontracted staff and allied health professionals are trained, equipped or supported, and while management stated it analysed training needs it was unable to show evidence of this.

The service could also not demonstrate that it regularly assesses, monitors and reviews the performance of each member of the workforce. Consumers said that they are happy with staff performance, however staff could not recall of receiving formal feedback from management and have appraisals yearly. The Assessment team sighted performance appraisals for a support worker, however not for case managers, admin manager, clinical manager, and operational manager. Management acknowledged a lack of performance appraisals. The organisation has policy in place for performance assessment where two-yearly appraisals should completed for staff, however, management did not uniformly demonstrate a knowledge of this policy.

The approved provider did not specifically respond to these matters in its written response, however it stated it would focus on improvements in these areas, noting that a recent restructure meant that it could now focus on service wide improvements. The approved provider is encouraged to document the improvements it has made or will implement.

# 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. | Non-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

The Quality Standard is assessed as Non-compliant as four of the five specific requirements have been assessed as Non-compliant. A decision of Non-compliant in one or more requirements results in a decision of Non-compliant for the Quality Standard.

The service could demonstrate that consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

However, the service could not demonstrate that its governance systems show accountability for the delivery of safe and quality care and services. Executive management did not show a clear understanding of their roles and responsibilities as a governing body to be accountable for the delivery of safe, inclusive, and quality care and services. There was limited evidence that executive management remained informed through formal reporting and meeting, and despite clinical care being delivered by the management, there was no one on the board who is responsible for ensuring care and services are aligned with the best practice, and that the principles are being adopted across the service. Management acknowledged they are in the transition process to develop a formal staff meeting, clinical governance meeting and reporting system. Board meeting minutes indicated that two meetings had been held over the last year, in February and September 2022, lacked detail of service delivery oversight as there was no data or trend and analysis of clinical care, complaints, incidents, or continuous improvement.

The service could also not demonstrate it has systems in place so that they regularly report key information from the service to the governing body and systems to review this information, or that it has an effective risk management system.

The service did not show that an effective clinical governance framework is in place for the provision and oversight of clinical care. Overall the clinical governance framework lacked oversight of assessment, planning, delivery and review. Despite many consumers being identified with multiple co-existing risk factors (such as falls, dementia and multiple ED admissions during the last 12 months), no validated assessment tools were being used, care plans did not include individual risk assessments or mitigation strategies, nor was there any clinical data analysis to inform a broader risk profile to the service’s large dementia consumer cohort. In addition, there was no evidence to demonstrate the organisation's clinical governance during an outbreak, nor how issues are escalated, decisions are made, and responsibilities had not been assigned. No reference was made to an Infection Control Coordinator or a specific COVID-19 plan. Further, whilst a clinical governance meeting is held on a monthly basis, minutes were very limited in detail with no clinical reports, benchmarking, indicators or trends that are analysed to identify and manage the risk to consumers’ clinical care outcomes.

The approved provider did not specifically respond to these matters in its written response, however it stated it would focus on improvements in these areas, noting that a recent restructure meant that it could now focus on service wide improvements. The approved provider is encouraged to document the improvements it has made or will implement.

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