**Performance**

**Report**

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| Name of service: | Gunning District Community and Health Service Inc. |
| Service address: | 101 Yass Street GUNNING NSW 2581 |
| Commission ID: | 201126 |
| Home Service Provider: | Gunning District Community and Health Service Inc. |
| Activity type: | Quality Audit |
| Activity date: | 4 August 2023 to 8 August 2023 |
| Performance report date: | 8 January 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.

**This performance report**

This performance report for Gunning District Community and Health Service Inc. (**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.

# Services included in this assessment

**Home Care:**

* Gunning District Community and Health Service, 27682, 101 Yass Street, GUNNING NSW 2581

**CHSP:**

* Care Relationships and Carer Support, 26057, 101 Yass Street, GUNNING NSW 2581
* Community and Home Support, 24786, 101 Yass Street, GUNNING NSW 2581

# 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 25 August 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 | **Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Compliant** |

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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

Findings

**Requirements 1(3)(a), 1(3)(b), 1(3)(c), 1(3)(d), 1(3)(e) and 1(3)(f) – Compliant**

*Requirement 1(3)(a)*

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 representatives reported that staff treat them with dignity and respect. Staff described how they treat consumers with dignity and respect. Management and client support officer stated that there had not been any incidents or complaints relating to disrespectful staff behaviour. The Assessment Team observed staff speaking to consumers respectfully over the phone and using respectful language when talking about consumers and in the documentation.

*Requirement 1(3)(b)*

Evidence analysed by the Assessment Team showed the service demonstrated care and services are culturally safe. Consumers interviewed advised the service consults them regarding their cultural background and what is important to them during the assessment process. Staff confirmed that training was provided relating to delivering culturally safe care. They added that they respected the consumer’s background and any specific cultural requirements. Management and client support officer stated that the consumer’s background was captured during the initial assessment and cultural awareness training was part of the mandatory training.

*Requirement 1(3)(c)*

Evidence analysed by the Assessment Team showed the service demonstrated how each consumer is supported to exercise choice and independence, make decisions about their care and services including when others should be involved, and communicate their decisions. Consumers and representatives interviewed confirmed that they make decisions about their care and services including how and when this is delivered. They articulated that they felt comfortable talking to the service about changing any details of their care and services. Staff and client support officer articulated how they encouraged consumers to make their own decisions. Documentation sighted showed assessment policy and procedure that stated consumers have choice and control in the way they access supports that promote, uphold and respect their legal and human rights and are enabled to exercise informed choice and control.

*Requirement 1(3)(d)*

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 explained that staff would let them be as independent as possible. Staff and client support officer said that they did not have consumers that required a dignity of risk discussion. However, they described the process how they would manage this if they identified a need. The Assessment Team sighted the Managing Participant Risk policy. This provided clear guidance about the process that the service will take to manage the individual risks a participant may present with including the identification of risks, plans and strategies implemented to manage or mitigate the risks, and process or system in place to monitor and review the risks, tools used to balance safety with the dignity of risk.

*Requirement 1(3)(e)*

Evidence analysed by the Assessment Team showed the service demonstrated 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. Representatives reported that they received various information from the service such as monthly statements/budgets, care plans and rosters. Staff and client support officer described how they communicated with consumers. They stated that this highly depended on the consumer’s preferred method of communicating. The Assessment Team sighted the service’s welcome pack. This included the Charter of Aged Care Rights, client consent forms, care plan and agreements.

*Requirement 1(3)(f)*

Evidence analysed by the Assessment Team showed the service demonstrated each consumer’s privacy is respected, and personal information is kept confidential. Consumers and representatives interviewed did not report concerns relating to their privacy and confidentiality of information. Staff and client support officer described that they kept the consumer’s privacy and confidentiality by not sharing information with others that were not directly involved in the care or without the consumer’s consent. Management stated that applications and computers were password-protected. Consumers were asked to sign a consent form to release and gain information about them to make referrals and contact GP or other treating health professionals. The Assessment Team observed that hardcopy consumer files were kept secured and were not left unattended.

# Standard 2

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

Findings

**Requirements 2(3)(a), 2(3)(b), 2(3)(c), 2(3)(d) and 2(3)(e) – Compliant**

*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. Consumers and representatives interviewed reported that their care plan reflected their needs, goals and preferences. Staff interviewed were able to clearly articulate the services and needs of all the sampled consumers. The Assessment Team sighted 21 care plans. This demonstrated that individual risks to consumers were not reflected in the care plans, nor did it provide sufficient information to guide support workers’ care provisions as it lacked information on consumer abilities, level of assistance required, risks identified and corresponding strategies, mobility aids or equipment provided.

The Assessment Team sighted the Assessment policy and procedure which stated that a risk assessment for each consumer must be completed and documented using the risk assessment form. It indicated that this must also include appropriate strategies to treat risks and how these will be planned and implemented. It added that the service will undertake at least annual reviews of care plans, if consumers requested, or where progress differs from expected outcomes and goals.

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 undertaken a review of consumer care plans and has implemented a new care plan that now captures risks to consumers, it is individualised, sets clear goals, needs and preferences and ensures that others involved in the consumers care have visibility and are captured. In addition, the provider has established a new role within the organisation that will specifically perform care plan reviews and will ensure all consumer care plans remain up to date and capture sufficient information to inform the delivery of safe and effective care and services.

The Decision Maker notes the services responded proactively to the Assessment Team’s 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. Consumers and representatives interviewed that the service had discussed or provided information on advanced care plans during intake and at reviews. Staff stated that they had access to consumer care plans and progress notes. They explained that they were satisfied with the information provided about the consumers. Management and client support officer described the intake and review process which captured whether consumers had an advanced care plan, if they wanted to share a copy with the service and any power of attorney/guardianship in place. The service did not demonstrate that assessment and planning identified consumers’ specific needs, individualised goals, and preferences. All care plans sighted had very similar identified needs, goals, and actions to be taken by the service.

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 undertaken a review of consumer care plans and has implemented a new care plan that now captures risks to consumers, it is individualised, sets clear goals, needs and preferences and ensures that others involved in the consumers care have visibility and are captured. Consumer care plans now address the consumers current needs, goals, and preferences. In addition, the service has developed and implemented an Advanced Care Flyer that offers information to consumers regarding advanced care and end of life planning. The flyer is now included in the consumer welcome pack.

The Decision Maker notes the services responded proactively to the Assessment Team’s 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 did not demonstrate that assessment and planning is consistently occurring with ongoing consultation with the consumer, representatives and others involved in the care of the consumer. Consumers and representatives interviewed confirmed they made decisions regarding care and services. Staff explained that other care and services providers were captured in the care plans. They received reports from allied health professionals. Staff and management acknowledged that clinical care information did not feed into the care plans as the registered nurses conducted their own assessment and documentation which was not accessible to staff directly involved in managing the consumers’ care and care plans. The Assessment Team sighted care plans which demonstrated that there was insufficient information about other care and services involved in the consumer’s care. The service was unable to provide adequate evidence to satisfy the Assessment Team that care plans sufficiently reflected the care and services other providers involved in the consumer’s care were delivering. Just by reading the care plan, it was unclear whether consumers were receiving specialist care.

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 Team’s 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)(d)*

Evidence analysed by the Assessment Team showed the service demonstrated 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. Consumers and representatives interviewed recalled having care plan discussion, obtaining a copy of the care plan, and signing a copy. Staff stated that care plan instructions were available to them at point of care via a mobile application. They added that they were able to see alerts and progress notes. Management described that an initial assessment with the consumer was conducted. Consumers were then provided with a service agreement and care plan which is signed by the consumer and/or representative. The Assessment Team sighted care plans which demonstrated that consumers signed and dated the care plans.

*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. Consumers and representatives provided mixed feedback when asked about care plan reviews. A Consumer interviewed stated they have been hospitalised multiple times and have not had a review upon their discharge. Staff articulated that new care plans were communicated via the mobile application and that the service also informed them verbally. The service was unable to provide adequate evidence to satisfy the Assessment Team that care plans were reviewed regularly as per policy or when incidents impacted 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. The service has undertaken a review of consumer care plans and has implemented a new care plan that now captures risks to consumers, it is individualised, sets clear goals, needs and preferences and ensures that others involved in the consumers care have visibility and are captured. The service has established a new role within the organisation that will be responsible to the review of consumer care plans at least annually and when circumstances change. Evidence has been submitted to demonstrate the above action is already implemented.

The Decision Maker notes the services responded proactively to the Assessment Team’s 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.

# Standard 3

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

Findings

**Requirements 3(3)(a), 3(3)(b), 3(3)(c), 3(3)(d), 3(3)(e), 3(3)(f) and 3(3)(g) – Compliant**

*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. Most consumers and representatives interviewed stated that they often have different staff providing care. However, they all provided Staff demonstrated their knowledge of the sampled consumer’s care needs and preferences. They verbalised that if they had any concerns this was reported to the client support officer who was approachable and documented in the progress notes through the mobile application. positive feedback and had no concerns relating to how the care and services were delivered. The Assessment Team acknowledges that consumers’ personal care and clinical care were tailored to their needs. However, it was very apparent that management did not receive any clinical care data. Clinical care progress notes and assessments were not stored in the electronic client management system (Visual Care). As such, support workers and client support officer were unable to access documented information that was relevant to all aspects of consumers’ 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. The service has undertaken proactive steps to ensure the community nurse provides monthly clinical data report to management to ensure it is reported on and has clear oversight by the committee. A comprehensive template has been provided to be used to record and report clinical data on monthly basis. Clinical staff providing care now use the online platform Visual Care for all clinical progress notes, assessments, and care plans. This will ensure all involved in the consumers care have clear oversight to the clinical care being provided.

The Decision Maker notes the services responded proactively to the Assessment Team’s 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 Assessment Team observed that clinical assessments and documentation that identified risks to consumers were not consistently reflected in care plans or communicated to support workers. Community support workers and client support officer had no access to nursing documentation. Nursing documentations were kept separated from the electronic client system and only the clinician and general manager had access to it. The service could not provide documented evidence that clinical risks and corresponding treatment strategies were reported, documented in the care plan, or discussed with relevant 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. The service has undertaken a review of care plans. Care plans now include individualised needs, preferences and capture relevant risks associated with the consumer to inform the delivery of care. The service has undertaken proactive steps to ensure the community nurse provides monthly clinical data report to management to ensure it is reported on and has clear oversight by the committee. Clinical staff providing care now use the online platform Visual Care for all clinical progress notes, assessments, and care plans. This will ensure all involved in the consumers care have clear oversight to the clinical care being provided.

The Decision Maker notes the services responded proactively to the Assessment Team’s 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)*

Evidence analysed by the Assessment Team showed the service demonstrated the needs goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised, and their dignity preserved. Staff reported that they had not experienced caring for consumers nearing the end of their life with the service. However, they stated that care and services were aimed at providing comfort and pain management when caring for those consumers. Clinician and management articulated that comfort and pain management were important but so was the coordination of care. These included liaising with the palliative care team, the treating medical practitioner and the consumer’s family. Online training is made available and offered to staff where required regarding end-of-life care. The clinical staff interviewed provided examples of consumers that demonstrated that end of life care ensure comfort and consumer dignity is maintained.

*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 provide adequate evidence to satisfy the Assessment Team that deterioration in consumers’ cognitive and physical function was responded to in a timely manner and documented accordingly.

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 undertaken proactive steps to ensure the community nurse provides monthly clinical data report to management to ensure it is reported on and has clear oversight by the committee. Clinical staff providing care now use the online platform Visual Care for all clinical progress notes, assessments, and care plans. This will ensure all involved in the consumers care have clear oversight to the clinical care being provided. In addition, the service has undertaken a meeting with staff to ensure the use of the incident register and the online platform is mandatory and forms part of their performance reviews.

The Decision Maker notes the services responded proactively to the Assessment Team’s 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. Consumers and representatives interviewed reported staff know their care needs and preferences and felt there is never a need for them to repeat their wants and needs or direct staff to do things. The Assessment team advised clinical care information was only made accessible to the general manager and the registered nurse, it did not form part of their online platform (Visual Care). The service was unable to provide adequate evidence to satisfy the Assessment Team that the method of information sharing used by the service was the most efficient and fit the situation. It was noted by the Assessment Team that the service did not utilise a multidisciplinary team approach to improve consumer outcomes. Instead, a siloed approach was used. Nursing care had its own documentation system for progress notes, assessments and correspondence that were not shared internally except with the general manager. The Assessment Team acknowledges that the clinician had weekly discussions with the client support officer. However, there was no documented evidence that these occurred. Outcomes of clinical assessments were not consistently reflected in the electronic client system and care plans in relation to risk identification and corresponding mitigating strategies.

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 undertaken a review of consumer care plans and has implemented a new care plan that now captures risks to consumers, it is individualised, sets clear goals, needs and preferences and ensures that others involved in the consumers care have visibility and are captured. Clinical staff providing care now use the online platform Visual Care for all clinical progress notes, assessments, and care plans. This will ensure all involved in the consumers care have clear oversight to the clinical care being provided. In addition, the service has issued correspondence to employee to advise the rostering team has now implemented a Friday Wrap-up session that will capture and communicate consumers changes, deterioration and prioritisation of care.

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. Consumers and representatives stated that the service made referrals when required. Client support officers described the referrals and follow-up process. They stated that changes in care needs triggered the referral process, and this was done as soon as possible. They added that they followed up if they haven’t heard back from the service provider after a week.

*Requirement 3(3)(g)*

Evidence analysed by the Assessment Team showed the service demonstrated the service minimises infection-related risks to consumers. Consumers and representatives confirmed that they observed support workers using hand sanitisers and washing their hands and wore masks and gloves when necessary. Staff explained that training and personal protective equipment were provided. They added that the asked COVID-19 screening questions on consumers. The Assessment Team sighted training records which demonstrated that all staff completed the training ‘Meeting Infection Control Requirements for Aged and Community Care.

# Standard 4

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

Findings

Requirement 4(3)(a), 4(3)(b), 4(3)(c), 4(3)(d), 4(3)(e), 4(3)(f) and 4(3)(g) – Compliant

*Requirement 4(3)(a)*

Evidence analysed by the Assessment Team showed the service demonstrated each consumer gets safe and effective services that meet their needs, goals, and preferences. Consumers and representatives said that they are satisfied with the way that the services provided optimise their independence, wellbeing, and quality of life. They also said that they think that the services meet their needs and preferences and assist them with achieving their goals. The client services officer and staff were able to describe the ways they support consumers to remain independent, and to ensure their needs and preferences are met.

*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 expressed satisfaction with the level of support they receive and the different ways they are supported by staff in relation to their well-being. Staff interviewed said that welfare checks, and emotional and psychological support are important elements of their role. The social group coordinator said they regularly monitor and check in with consumers who attend the group to ensure they are feeling well. A review of consumer files showed regular progress notes from community support workers in relation to how they support consumer well-being and mood. The service has a ‘diversity, awareness, value and beliefs’ policy which aims to ensure that services are delivered to consumers in a manner that respects and values the beliefs of consumers and preventing discrimination of any kind.

*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. Consumers said that staff support them and the services they receive enable them to do the things that are of interest to them, participate in their community and maintain relationships. Staff described how the services and supports provided assisted consumers to remain social and connected. A review of consumer files and care plans showed that information is effectively documented regarding consumer’s interests, social and personal relationships, and community involvement.

*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. Consumers mostly said that they think staff know their condition, needs and preferences and that they wouldn’t have to repeat too much information when a new staff member attends for services. However, the service could not demonstrate that tailored information about consumers is communicated with others effectively. Care plans reviewed did not include information about other organisations involved in consumer care, such as allied health, community groups or social interests. Staff and management mainly said that all staff know consumers and their condition, needs and preferences well, however this was not reflected in care planning or communication documentation effectively.

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. The client services officer and other staff described the referral process for consumers to individuals and other organisations and/or providers, and the process they follow to ensure referrals are made in a timely manner. Staff also said that they can refer consumers back to My Aged Care if they require additional services and may need a higher-level home care package or additional CHSP services. The ‘community engagement and referral’ policy provides guidance for staff on the process for making referrals, and how they are utilised to support the needs of consumers with varying levels of services and support. It also states that staff must ensure referrals to appropriate external services are made in a timely manner to meet consumer needs.

*Requirement 4(3)(f)*

Evidence analysed by the Assessment Team showed the service demonstrated where meals are provided, they are varied and of suitable quality and quantity. Consumers interviewed were mostly satisfied with the frozen meals delivered, and the meals served in the social group. Staff and management said consumers are happy with the meals, that they are good quality and there is a lot of variety. The Assessment Team reviewed the menu and order form provided to consumers in the welcome pack. It includes multiple items categorised into meat type, vegetarian options, and then a key which includes symbols for meals that are gluten free, low sodium, lactose free and softer items. It also has ‘mini meals’, pureed meals and desserts.

*Requirement 4(3)(g)*

Evidence analysed by the Assessment Team showed the service demonstrated it is providing consumers with equipment that is safe, suitable and is regularly cleaned and maintained. Most consumers and representatives were satisfied with the equipment provided to them by the service. Consumers and staff did not describe any concerns with the quality or safety of the equipment used to provide care and services to consumers. Multiple staff and management said that they have a close organisational relationship with the local equipment provider, and they can access them for any emergencies, maintenance, or cleaning services they may require for consumer equipment.

# Standard 5

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| Organisation’s service environment | | HCP | CHSP |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant | Compliant |

Findings

**Requirement 5(3)(a), 5(3)(b) and 5(3)(c) – Compliant**

*Requirement 5(3)(a)*

Evidence analysed by the Assessment Team showed the service demonstrated that the service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction, and function. The service provides group social support in a function room a short walking distance from the head office. Consumers who attend the social support group said that they are always welcomed and feel comfortable whilst in attendance. The social group coordinator said that they always ensure consumers are feeling welcomed for activities and staff and other consumers will assist to make sure everyone feels welcomed. The Assessment Team observed the social group area whilst consumers were arriving for activities. The group coordinator met consumers at the door and assisted them to enter if they required it, such as those with walkers. Volunteers provided consumers hot drinks of their choice and were observed to be conversing with consumers in a kind and respectful manner.

*Requirement 5(3)(b)*

Evidence analysed by the Assessment Team showed the service demonstrated the service environment is safe, clean, well maintained, comfortable and allows consumers to move freely, both indoors and outdoors. Consumers interviewed who attend the social group spoke positively of the service environment, and said it seems safe, clean, and well-maintained. There was a fire extinguisher and smoke alarms present in the function room. Management said the building belongs to the council, so they are responsible for the maintenance of the building and safety equipment. Management said if there were any maintenance concerns it would be reported immediately to the council for follow up. The Assessment Team observed consumers using multiple entrances and exits to the building, with one sliding door which opened wider than others, that consumers with equipment were able to utilise.

*Requirement 5(3)(c)*

Evidence analysed by the Assessment Team demonstrated the service’ furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. Consumers interviewed said that the furniture and fittings in the function room are comfortable and fit for purpose. The Assessment Team observed the furniture to be clean and appeared well-maintained. Staff and management said that they were satisfied the equipment is cleaned and checked regularly. They said that they are confident the cleaners would report any concerns with furniture or fittings for rectification in a timely manner.

# Standard 6

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

Findings

**Requirement 6(3)(a), 6(3)(b), 6(3)(c) and 6(3)(d) – Compliant**

*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 interviewed said that they are in regular contact with community support workers and the client services officer to discuss their care and services and provide any feedback. Consumers and representatives said they would feel comfortable raising any concerns to staff verbally or by phone. The client support officer said that consumers are encouraged to provide feedback on intake and there is information in the welcome pack, such as a ‘have your say’ brochure and a feedback form, as well as contact details for the office. Management said that a consumer survey has recently been completed for Commonwealth Home Support Programme consumers, and the service is looking at commencing one for Home Care Package consumers in the future.

*Requirement 6(3)(b)*

Evidence analysed by the Assessment Team showed the service did not demonstrate consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. Consumers interviewed said that they could not recall being provided information about advocacy services, language services or alternative methods to raise and resolve complaints. The client services officer, other staff and management all said they could not recall assisting a consumer to access an advocacy service or make a complaint to an external complaints body. Although the Assessment team observed a complaints flyer available at the reception of the main office that contained information about the Commission, My Aged Care and OPAN, it was observed that it was not present in documentation provided directly to consumers, such as the welcome pack.

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 undertaken actions to ensure the Client Advocacy Pamphlet is included in the welcome pack for consumers. Consumer feedback forms have also now been made available in each consumer file, to ensure consumers have the ability and freedom to raise concerns should they wish to do so.

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 6(3)(c)*

Evidence analysed by the Assessment Team showed the service did not demonstrate appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

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 Team’s 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 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.

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 Team’s 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.

# Standard 7

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

Findings

**Requirement 7(3)(a), 7(3)(b), 7(3)(c), 7(3)(d), 7(3)(e) – Compliant**

*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. Consumers and representatives interviewed said staff always arrive when expected and have sufficient time allocated to complete the scheduled care and services. The service uses a rostering system that is connected to the client management system. The system identifies unfilled shifts and sends alerts to the rostering manager.

*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/or representatives interviewed provided positive feedback in relation to staff treating them in a kind, caring and respectful manner. The Assessment Team observed interactions between staff and consumers during the social group activity and phone calls in the office.

*Requirement 7(3)(c)*

Evidence analysed by the Assessment Team showed the service demonstrated the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. Consumers and representatives interviewed said community support workers and office staff are competent and know what they are doing. Management said they ensure community support workers are suitably qualified during the recruitment process. The Assessment Team sighted position descriptions for community support workers and client support officers. They detailed clear roles and responsibilities, accountabilities, required skills and qualifications and personal attributes required for each role. Management said all staff are provided with a copy of their position description during onboarding.

*Requirement 7(3)(d)*

Evidence analysed by the Assessment Team showed the service demonstrated the workforce is recruited, trained, equipped, and supported to deliver the outcomes required by these standards. All community support workers interviewed said they were provided with a comprehensive induction when starting at the service. All community support workers said they were provided with detailed orientation training and given buddy shifts until they were comfortable in their role. The Assessment Team sighted the mandatory training matrix for community support workers. The Assessment Team sighted minutes from staff meetings where evidence of training in privacy and confidentiality and duty of care was noted. All staff are provided with PPE and vehicles are provided to staff for each shift.

*Requirement 7(3)(e)*

Evidence analysed by the Assessment Team showed the service demonstrated regular assessment, monitoring and review of the performance of each member of the workforce. All consumers and/or representatives interviewed said if they have a concern, they are comfortable to contact the service and provide feedback. Most community support workers interviewed said they had not received formal feedback on their performance and do not have a copy of their performance plan. Management said performance plans had not been regularly completed and, up until recently, they were not aware that plans should be completed for casual staff when the discrepancy was identified through a separate audit. Management said they are progressing with implementing performance plans for all staff however at the time of the assessment, approximately 50% of plans were completed.

# Standard 8

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

Findings

**Requirement 8(3)(a), 8(3)(b), 8(3)(c), 8(3)(d), 8(3)(e) – Compliant**

*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. All consumers and/or representatives interviewed felt they had input into how their care and services are delivered and said that the service contacts them regularly for their feedback. Some consumers and/or representatives said they remember receiving a survey recently which they completed. The management committee president said the board does not engage with consumers informally or formally and there was not any consumer advisory groups or individual consumers who are engaged with the development and delivery of care. Although consumers feel they provide input into their care and services, consumers are not being engaged in the development and delivery of care and services at an organisational level.

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 Team’s 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 Assessment Team sighted minutes from the last three management committee meetings. Meetings are held every three months and the committee comprises of seven local community members with backgrounds in a broad range of occupations including a member with clinical experience. The minutes demonstrated the managing committee has oversight of finances, staffing, policies and strategic planning, however clinical data, incidents, and feedback are not shared with the management committee.

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 Team’s 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 demonstrated it has organisational wide governance systems to monitor processes such as information management, continuous improvements, financial governance, and regulatory compliance. The organisation could not demonstrate that the service has effective governance systems relating to workforce governance and feedback and complaints.

**Information management**

The service has information management systems in place that include an electronic client management system (including rostering), mobile applications for staff to use while in the field and paper files. Consumer information is maintained electronically and in hard copy files.

**Continuous improvement**

The service has a plan for continuous improvement (PCI) in place that has been captured using consumer and staff feedback, strategic planning and gap analysis.

**Financial Governance**

Financial governance is overseen by the organisation’s general manager, financial controller, treasurer, and management committee. Management said the financial controller manages the day-to-day finances, however, is overseen by the committee treasurer. Reports are provided to the general manager each month and a 6 monthly budget is developed in consultation with the general manager, financial controller, and treasurer.

**Workforce governance**

The Assessment Team sighted the services organisational chart, position descriptions, staff code of conduct and information (policies/procedures) that is supplied to new staff. The onboarding process to recruit staff is sound and copies of qualifications, vaccination status, driver’s licence, insurances, and police checks were captured and maintained. Management said staff performance plans are not up to date. Currently there are approximately 50% of plans that are yet to be completed. Most community support workers interviewed said they have not had formal feedback on their performance.

**Regulatory compliance**

Management reported there has been no adverse finding by another regulatory agency or oversight body in the last 12 months. Management said the service subscribes to several organisations to ensure they keep up to date with changes in legislation and reforms. The general manager reviews any legislative changes and recommends the relevant changes which are then endorsed by the managing committee. Evidence of discussions during committee meetings regarding the code of conduct was included in minutes of the meeting.

All staff have recently completed training in the serious incident reporting scheme.

**Feedback and complaints**

Consumers and/or representatives interviewed were able to describe how to provide feedback and complaints. They articulated that they felt comfortable talking to the service about their concerns. The organisation’s feedback and complaints system support consumers to provide feedback. The service provides options for consumers to provide feedback and/or raise a concern, including via email, in person, phone or by mail. Consumers are not provided with information regarding complaints to external organisations, advocates or translation services in their welcome pack.

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 Team’s 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 has a centralised incident management system (IMS) which captures incidents and risks. All community support workers could describe what they do in the event of an incident. This included responding to the incident by applying first aid, calling an ambulance if required, phoning the office to report and filling in an incident form on their mobile device. One community support worker said they always stay with the consumer and comfort them until family members arrive or the consumer is taken to the hospital, even if their shift is over. Incident data is not provided to the management committee for oversight and as all incidents are not being recorded in the IMS, the service is unable to trend incidents and put strategies in place to minimise reoccurrence. Staff confirmed they had received training in SIRS and in identifying abuse and neglect. The incident management system is not being utilised appropriately and incidents are not recorded when they occur. Management of high-impact and high prevalent risks are not being addressed appropriately.

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 Team’s 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 demonstrated *where clinical* care is provided—a clinical governance framework. Staff could demonstrate an understanding of what is open disclosure and could describe in various ways what they would do in the event something went wrong. This included offering a sincere apology and reporting the issue to management. The Assessment Team sighted the open disclosure policy which provided a definition of open disclosure, examples of language to use, and when to use open disclosure.

Management said there are currently no consumers who are subjected to restrictive practices. The Assessment Team sighted a restrictive practice register which did not have any entries, however management said they did not have a restrictive practices policy or procedure which would guide staff on identifying what is a restrictive practice.

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)