**Performance**

**Report**

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| Name: | HCA Home Care No hidden costs |
| Commission ID: | 600594 |
| Address: | 201 Elizabeth Street, SYDNEY, New South Wales, 2001 |
| Activity type: | Assessment contact (performance assessment) – site |
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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.

# Services included in this assessment

Home Care Packages (**HCP**) included:  
Provider: 9272 HCA Corporate Health Pty Ltd  
Service: 27037 HCA Home

Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 9801 HCA Corporate Health Pty Ltd  
Service: 27726 HCA Corporate Health Pty Ltd - Care Relationships and Carer Support  
Service: 27725 HCA Corporate Health Pty Ltd - Community and Home Support

**This performance report**

This performance report has been prepared by A Cachia, 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 services it operates, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

# Material relied on

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

* the Assessment Team’s report for the Assessment Contact 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 15 November 2024.

# Assessment summary for Home Care Packages (HCP)

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 4** Services and supports for daily living | Not applicable as not all requirements have been assessed |
| **Standard 6** Feedback and complaints | Not applicable as not all requirements have been assessed |
| **Standard 7** Human resources | Not applicable as not all requirements have been assessed |
| **Standard 8** Organisational governance | Compliant |

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| Standard 1 Consumer dignity and choice | Not applicable as not all requirements have been assessed |
| **Standard 2** Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 4** Services and supports for daily living | Not applicable as not all requirements have been assessed |
| **Standard 6** Feedback and complaints | Not applicable as not all requirements have been assessed |
| **Standard 7** Human resources | Not applicable as not all requirements have been assessed |
| **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)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant | Compliant |

Findings

Requirement 1(3)(a) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate each consumer is treated with dignity and respect, with their identity, culture and diversity valued.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* Consumers and representatives said staff make them feel respected and valued as individuals and advised that they have never felt unimportant or disrespected by the provider or staff.
* Staff and management interviewed explained and provided evidence of how they respect and promote cultural awareness in their everyday practice by engaging and supporting consumers to make informed choices in the care and services they receive.
* Reviewed policies and procedures on providing an inclusive, consumer-centred service delivery, including the implementation of a diversity action plan, to inform and direct staff.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report, which does not demonstrate a failure in consumers being treated with dignity and respect, with their integrity, culture and diversity valued.

I am satisfied with the corrective action the provider has demonstrated in line with the evidence outlined in the Assessment Team’s report that the provider is demonstrating working with consumers in an inclusive and respectful manner.

Requirement 1(3)(b) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate care and services were culturally safe.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* Explanation, with evidence provided, the organisation considers consumers family, community connections, cultural customs, beliefs, needs and practices when planning care and services.
* Reviewed consumer files, policies and procedures demonstrated cultural safety practices and diversity outlined in detailed progress notes and training material.

The providers response included comprehensive information in support of my finding of compliance including:

* Explanation of the providers response, implementing changes to orientation training and staff education to ensure workforce understands cultural diversity, advising all staff completed culturally specific training on the ALIS platform.
* Explanation demonstrated the provider’s posture and response to addressing policies and training available at the time of the Assessment Contact.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report, in conjunction with information provided in response, which shows the provider is delivering care and services that are culturally safe. This Requirement expects the organisation to recognise, respect and support the unique cultural identities of consumers by meeting their needs and expectations and recognising their rights. It is expected that organisations know what to do to make each consumer feel respected, valued and safe.

I have placed weight on the evidence in the Assessment Team’s report which demonstrated corrective steps were made to address the previous non-compliance and consumers expressed satisfaction with care and services received. The provider demonstrated the diversity action plan was updated to reflect a consumer-centred approach and staff are trained in understanding policies and procedures to guide them.

Requirement 1(3)(c) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate each consumer is supported to exercise choice and independence, including improved lines of communication about consumer choice and decision-making and documentation from consumers to staff and management.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved lines of communication and documentation from consumers to staff members across the organisation.
* improved documentation and access to documentation for staff regarding consumer’s choices and decisions.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 1(3)(c) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and representatives said they are informed about their care and service options available and are encouraged to actively make decisions about their care and delivery of services.
* Staff were knowledgeable and explained how they support consumer decisions and provide options when undertaking services.
* Sampled consumer documentation showed staff are actively working with and involving consumers in the planning of their care and services, including examples of involving representatives which include advocates and representatives in decisions around consumer’s ongoing care.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring each consumer is supported to exercise choice and independence, particularly in relation to communication around their decisions.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, and consumers expressed satisfaction with requesting changes in their choice of care and needs. The provider demonstrated each service is supporting consumers to exercise their rights and make decisions for themselves, and sampled consumer documentation evidenced reflects the involvements of consumers and their chosen representative.

Requirement 1(3)(f) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate each consumer’s privacy is respected and personal information is kept confidential.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved policies and training for staff in relation to mobile phone and application security.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 1(3)(c) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and their representatives said consumers felt their privacy was respected, and personal information remained confidential, advising they had no concerns.
* Staff were knowledgeable and provided examples of how they ensure a consumer’s privacy is maintained, by ensuring consent and privacy documentation are up to date.
* Staff and management said they only share consumer information directly with consumers or their nominated representatives and are aware of the need to maintain confidentiality.
* Reviewed policies outlined protocol for protecting personal information, including how information is used, collecting necessary information only and how information is protected.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring each consumer’s privacy is respected, and personal information is kept confidential.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, and consumers expressed satisfaction with the organisation respecting their privacy when delivering services. The provider demonstrated communicating, behaving and interacting in ways that promote consumer privacy and dignity.

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

# Standard 2

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| Ongoing assessment and planning with consumers | | HCP | CHSP |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant | Compliant |
| Requirement 2(3)(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

Requirement 2(3)(a) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate assessment processes identified and addressed risk for consumers.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved oversight and input from clinically trained staff on complex care needs.
* improved initial assessment processes to ensure risks are identified and documented for consumers.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 2(3)(a) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and representatives are satisfied with how services support consumer needs, which was captured through the services assessment and planning process by the provider’s registered nurse or allied health professionals.
* Staff discussed the high level of information available on the client management system mobile application including access to risk assessments.
* Each service demonstrated current assessment and care planning, including consideration of risks to consumer’s health and well-being.
* Sampled care plans showed comprehensive detail to guide the delivery of services, including the use of validated assessments, risks are identified and non-response instructions are documented.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider conducts 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.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, including oversight and input from clinically trained staff and improved initial assessment processes to ensure risks are identified. The provider demonstrated consumer satisfaction with the initial assessment processes, with consideration to consumer risk, health and well-being.

Requirement 2(3)(b) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate assessment and planning was identifying and addressing the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wished.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved clinical nursing assessments and review processes to identify and address consumers current needs, goals and preferences.
* improved documentation processes within care plans.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 2(3)(b) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Sampled care plans captured sufficient detail of consumers' needs, goals and preferences to enable staff to provide effective services.
* Consumers and representatives said care and services meet consumers’ needs and goals, and said advanced care and end of life planning were discussed across.

Staff said they undertake assessments which consider consumer’s needs, goals and preferences and plan services accordingly. In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring assessment and planning identifies and addresses the consumer’s needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, and consumers expressed satisfaction with the organisation capturing what is important to them and discussing advanced care planning arrangements. The provider demonstrated clinical nursing assessments and review processes to identify and address consumers current needs, goals and preferences, and improved documentation processes within care plans.

Requirement 2(3)(d) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate the outcomes of assessment and planning were 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.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved documentation of assessment and planning outcomes for consumers.
* improved care plans that capture all aspects of consumers health and wellbeing.
* improved guidance and/or instructions for staff to deliver safe and effective care and services.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 2(3)(d) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and representatives described the care and services they receive, with most consumers recall being provided with a copy of the consumer care plan.
* Staff and management described how they provide services and support in alignment with the consumers care plans available on a mobile application, where all information is available to staff.
* Management said the use of the electronic management system allows staff to immediately review and revise care documentation at the point of delivery of care and services.
* Sampled consumer files evidenced demonstrated care planning and assessment documentation available for all consumers.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring the outcomes of assessment and planning are being effectively communicated to consumers and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, including improving the documentation of assessment and planning outcomes for consumers. The provider demonstrated further improvements in care plans capturing all aspects of consumer health and well-being, improving guidance material and instructions which guide staff to delivering safe and effective care and services.

Requirement 2(3)(e) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate 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.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved effectiveness of reviews, including the frequency of reviews when circumstances changes.
* improved effectiveness of identification of risks for consumers after incidents or hospital discharges.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 2(3)(e) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and representatives said they are satisfied with the regular reviews of care and services, confirming that staff make changes to meet consumers current needs.
* Staff and management said consumers’ care and services are reassessed regularly, with the involvement of consumers and their representatives or when a change in circumstances occurs.
* Management described the organisation’s review intervals at 6-weeks following onboarding, followed by every 3-months for home care packages, while Commonwealth Home Support Programmes are reviewed on an annual basis.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring reviews are conducted regularly effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, and consumers expressed satisfaction with the organisation regularly reviewing their needs and when change occurs. The provider demonstrated improvements to the effectiveness of reviews, including the frequency when circumstances change and when incidents impact consumers need’s, goals and preferences.

Based on the evidence summarised above, I find the provider, compliant with Requirements (3)(a), (3)(b), (3)(d), (3)(e), in Standard 2 Ongoing assessment and planning with consumers.

# Standard 3

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| Personal care and clinical care | | HCP | CHSP |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant | Compliant |
| Requirement 3(3)(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 |

Findings

Requirement 3(3)(a) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate each consumer is receiving safe and effective personal care and/or clinical care that is best practice, tailored to their needs, and/or optimises their health and well-being.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved policies, procedures and training to guide staff in providing safe and effective personal and clinical care.
* improved clinical care that is best practice and tailored to the consumer’s needs.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 3(3)(a) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and their representatives said they are satisfied with the services received for personal and/or clinical care.
* Staff demonstrated familiarity with consumer needs, and described how consumers are assessed as individuals.
* Management and clinical staff described how clinical care is tailored to meet consumer needs to optimise health and well-being, including where services are brokered.
* Sampled consumer documentation demonstrated sufficient detail outlining instructions for the delivery of care and services, including verified assessment tools, ensuring consumers receive the support they require to maintain their health and well-being.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring each is receiving safe and effective personal care and/or clinical care that is best practice, tailored to their needs, and/or optimises their health and well-being.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, and consumers expressed satisfaction with the organisation providing safe and effective personal and clinical care when delivering services. While consumer’s expressed satisfaction, information in the Assessment Team report suggests improvements were made to the training, policies and procedures to guide staff. I have considered this information to be more appropriately aligned with Requirement (3)(d) in Standard 7 Human resources, however, I acknowledge the information addresses the Requirement’s previous non-compliance.

Requirement 3(3)(b) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate effective management of high-impact or high-prevalence risks associated with the care of each consumer.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved policies and procedures to guide staff in identifying high-impact and high-prevalence risks for consumers.
* improved assessment and planning that better identifies risk to consumers.
* improved validated risk assessment tools to identify and monitor risks to consumers.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 3(3)(b) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and their representatives said they are satisfied with how risks associated with consumer care are managed.
* Staff were knowledgeable of consumers’ risks and interventions used to manage or minimise risk of harm, and discussed how any high impact or high prevalence risks are recorded on the incident register and vulnerable consumer risk register for monitoring.
* Processes and policies are in place to manage high impact or high prevalence risks associated with the care of consumers.
* Sampled consumer files and vulnerable consumer register documentation demonstrates effective management of high impact or high prevalence risks, including falls risk, pain and other risks associated.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring each consumer is receiving care that is associated with effective management of high-impact or high-prevalence risks.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, and consumers expressed satisfaction with the organisation’s manner in which risks are managed. Furthermore, the provider demonstrated improvements across assessment and planning to better identify risks associated with consumers along with validated risk assessment tools and monitoring strategies.

Requirement 3(3)(d) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate 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.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved training and education to all staff to recognise and respond to deterioration or changes to consumer’s mental health and/or cognitive or physical function.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 3(3)(d) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and representatives said they are confident that staff would recognise and respond to consumer deterioration and change.
* Staff were knowledgeable and understood documentation processes, along with their responsibilities when responding to consumer deterioration and change.
* Documentation showed, and management said deterioration in consumers’ health, cognition or physical function is recognised and responded to, in line with the organisation’s policies and procedures

In response to the Assessment Team’s report, the provider submitted a response outlining additional information and actions undertaken to address missing information. The response includes the following evidence relevant to my finding:

* Explanation outlined how during orientation, staff receive training on reviewing care plans and progress notes before attending to services, to ensure baseline knowledge of the consumer’s health, physical function is known, enabling early identification of any health changes.
* Explanation outlining training which occurs on-site during induction and orientation periods, offering ongoing support, guidance, and mentoring from the service delivery leader (SDL). The SDL monitors the requirement to review the care plans, read previous notes, and capture new notes during the review periods and offer additional coaching and home visits with support workers.
* The provider advised support workers are trained to immediately contact the office team if they arrive at a customer’s home and find that the customer is not well, behaving atypically, or has other concerns. This is immediately escalated and documented through our incident management system.
* The provider described the various processes followed to ensure the organisation is capturing subtle deterioration or changes, including, but not limited to:
  + staff writing compulsory end-of-service notes, which are reviewed by care teams to identify changes in consumer health status’ and respond appropriately.
  + staff are trained to contact management if they have any concerns about changes and to document them accordingly. All staff are trained on and must adhere to HCA’s policy of Recognising and responding to customer deterioration.
* The provider outlined training delivered to reflect various policies and procedures, including induction checklists, recognising and responding to deterioration in customers, assessment and planning, comprehensive care policy and home care clinical assessment responsibilities.
* The provider advised that in response to the Quality Audit in June 2023,the organisation commenced weekly clinical oversight meetings led by the clinical manager and various executive and operational staff. Furthermore, the provider explained how these meetings are designed to discuss consumers on the vulnerable consumer register, clinical escalations, and staff updates on consumer concerns, including actions undertaken. The meeting provides coaching opportunities for new staff on identifying and managing changes in customers' health conditions.
* The provider advised clinical staff are knowledgeable about vulnerable consumers across services by dedicating time to review these consumer files for increased clinical oversight.
* The provider advised the organisation’s quality team conducts an annual audit timetable and sample size of consumers in each region. In 2024, internal audits were completed on care plans, falls risks, and restrictive practices. Internal audit outcomes are shared with management and the team. Identified gaps are added to the continuous improvement plan, and re-education occurs.

In coming to my finding, I have considered the information in the Assessment Team’s report and provider response, which demonstrates that deterioration or changes of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.

I have placed weight on the evidence in the Assessment Team’s report along with explanations provided by the organisation, which showed improvements were made to address the previous non-compliance, and consumers expressed satisfaction with the organisation’s ability to recognise and respond to deterioration or change. The provider demonstrated a range of improvements to staff training, implementation of clinical meetings, conducting internal quality audits and vulnerable consumer case conferencing.

Requirement 3(3)(e) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate information about consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved documentation and communication within the organisation and across all services in relation to consumer’s needs, preferences, conditions and changes.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 3(3)(e) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Information regarding consumers’ condition, needs and preferences is documented on a care plan and readily available to staff and others where responsibility for care is shared.
* Consumers, representatives and staff considered consumers’ needs and preferences are effectively communicated between staff.
* Staff said, and management confirmed, they communicate information about consumer’s conditions by submitting progress notes after each shift, with notifications for specific progress notes directed to case managers or management for review.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring information about consumers’ conditions, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, and consumers expressed satisfaction with the information they receive which are documented in consumer care plans. The provider demonstrated transference of information across the organisation and others who also care and support consumes.

Based on this evidence, I find the provider, compliant with Requirements (3)(a), (3)(b), (3)(d), (3)(e) in Standard 3, Personal care and clinical care.

# Standard 4

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| Services and supports for daily living | | HCP | CHSP |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant | Compliant |
| Requirement 4(3)(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)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant | Compliant |

Findings

Requirement 4(3)(a) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate 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.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved policies, procedures and training to guide staff in consumer care planning.
* improved consumer documentation focusing on consumer’s needs, goals and preferences.
* improved processes, monitoring and response time, including timely and appropriate referrals and purchase of equipment in line with consumer’s needs.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 4(3)(a) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and representatives said, and documentation reflected how consumers are supported to live healthy and social lives, which optimises their quality of life and their well-being through the social services received.
* Staff said they support consumers independence, health and well-being through providing support to access the community, including individual social support services to increase independence.
* Sampled care plans identified examples of consumers supported to maintain their independence and quality of life in line with their goals.

In response to the Assessment Team’s report, the provider submitted a response outlining additional information and actions undertaken to address the deficiencies. The response includes the following evidence relevant to my finding:

* Explanation on how care managers have been encouraged to document consumer needs, goals, and preferences through the rollout of a new case management system in 2023. This enables staff to update consumer information promptly, which is live to field staff via the mobile application, ensuring appropriate delivery of care and services.
* The provider advised all staff have received training on the case management system, including refresher training, with specific focus on documenting goal achievements and how to save and commence an annual assessment.
* Explanation outlined how care planning training was conducted to address information at the point of care and shared care, information required for a care plan, how to review a care plan and provide feedback on the new care plan, including a new template developed following the Quality Audit in June 2023.
* Explanation on the ongoing coaching available, including random care planning reviews completed by management, ensuring all care plan reviews are complete within general processes to provide appropriate care and services, ensuring consumer needs, goals, and preferences are documented.
* Explanation of how the organisation has reviewed numerous policies and procedures following the Quality Audit in 2023, including various templates, orientation checklists and training material.

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

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, and consumers expressed satisfaction with the organisation’s delivery of care and services, which helps them remain independent in their homes. The provider demonstrated improvements to care planning and documentation, ensuring consumers were at the centre of their needs, goals and preferences.

Requirement 4(3)(b) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved identification, recording, documentation and communication of consumer’s emotional, spiritual and psychological well-being and tailored services to meet their needs.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 4(3)(b) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and their representatives confirmed their general well-being is supported and provided examples of how staff would recognise if they were feeling low.
* Staff described how they provide support to address consumer needs, enhancing consumers mood by listening and showing compassion.
* Sampled documentation outlined consumer information specific to individuals’ emotional, spiritual and psychological well-being, including religious preferences and social activities.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, and consumers expressed satisfaction with the organisation’s response to supporting consumers when they feel low. The provider demonstrated embedding approaches to promote consumer’s emotional, spiritual and psychological well-being to minimise the risk of stress and depressive symptoms and further support consumers experience meaning and purpose.

Requirement 4(3)(d) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate information about consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved documentation and communication of consumers conditions, needs and preference within the service and where the responsibility for services and supports for daily living is shared.
* improved documentation and communication in relation to ongoing reviews to consumers incidents, deterioration and changes.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 4(3)(d) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and representatives said they are satisfied with how the provider communicates needs and preferences where care is shared across all services.
* Staff were knowledgeable when describing consumers conditions, needs and preferences and expressed satisfaction with the information they received.
* Management said staff have access to appropriate systems to add and maintain progress notes and records and access care plans while delivering services.
* The service has policies and procedures to guide staff to facilitate and remain informed about processes for consumers changing needs.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring each consumer’s information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, and consumers expressed satisfaction with the organisation, including staff understanding their needs and preferences during service delivery. The provider demonstrated and Assessment Team evidenced, information about consumer’s support and services is documented and effectively communicated.

Requirement 4(3)(g) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate where equipment is provided, it is safe, suitable, clean and well maintained. While the provider engaged with allied health professionals such as occupational therapists to assess and recommend required equipment, the organisation did not consistently purchase and implement the equipment in a suitable or timely manner.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved consistency in purchasing and implementing equipment in a suitable and timely manner.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 4(3)(g) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers said they are satisfied with equipment provided, describing equipment as safe, suitable, and maintained to assist consumers in their daily lives.
* Staff said they have access to equipment to support consumers, such as wheelchairs, shower chairs and mobility devices for use in the home as required.
* Staff said they monitor consumers mobility, encourage them to use their equipment and explained the referral process for consumers who need to be assessed, by involving appropriate staff to ensure consumer needs are met.
* Sampled consumer files showed assessments and purchased equipment, including the ownership of purchase, which is incorporated into the care plan for staff awareness.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring equipment is purchased in a suitable and timely manner following assessments.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, and consumers expressed satisfaction with the organisation providing equipment that is safe, suitable, clean and well-maintained in a timely manner.

Based on the information summarised above, I find the provider, compliant with Requirements (3)(a), (3)(b), (3)(d) and (3)(g), in Standard 4 Services and supports for daily living.

# 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)(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) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate they encourage and support consumers and their representatives to provide feedback or make a complaint about the care and services that consumers receive.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved complaints processes and communications with consumers in relation to the complaints process.
* improved systems and processes to encourage and document feedback from consumers.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 6(3)(a) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and representatives said they feel supported and know how to provide feedback and make complaints.
* Staff and management were knowledgeable of the feedback and complaints process, and said they support consumers and representatives by providing information to assist with providing feedback or to make a complaint.
* Management described organisational processes in place to support consumers and representatives to provide feedback, including policies and procedures
* Improvements implemented since the last Quality Audit outlined the introduction of a consumer newsletter and noted to include organisational contacts.
* Documentation showed information about the organisation’s internal and external complaints and feedback processes available.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring each consumer and representative is encouraged and supported to provide feedback or make a complaint about the care and services that consumers receive.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, and consumers expressed satisfaction with the organisation involvement in encouraging consumers and their representatives for feedback and to raise complaints, which they feel safe to do so.

Requirement 6(3)(c) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate how complaints are consistently addressed and documented, and that an open disclosure process is used when things go wrong. Although management interviewed had an understanding of feedback, complaints and open disclosure processes, they could not demonstrate that consumer feedback had consistently been identified and addressed, and documented, to a satisfactory outcome for consumers, and could not provide examples when the service used an open disclosure approach. Policy and procedures viewed did not reflect best practice for managing and resolving complaints from consumers, specifically in relation to open disclosure

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved processes, training and documentation of complaints, and utilisation of open disclosure throughout the complaints and feedback process.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 6(3)(c) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and representatives said they are satisfied that concerns raised are actioned to their satisfaction in a timely manner, explaining how each service keeps consumers informed throughout the process.
* Staff described how they escalate and record complaints regarding care and services. Although staff were not able to consistently demonstrate an understanding of open disclosure, evidence including the complaints register and associated documentation demonstrated each service is consistently applying an open disclosure process.
* Management described the organisation’s complaints process, outlining how they ensure complaints are promptly addressed by maintaining a minimum 3-day response time.
* Furthermore, the organisation has appointed a dedicated complaints management staff member to liaise with consumers and relevant management to ensure consumers are satisfied.

In response to the Assessment Team’s report, the provider submitted a response outlining additional information and actions undertaken to address the deficiencies. The response includes the following evidence relevant to my finding:

* Explanation outlined the complaints handling policy and procedure has been updated, underpinning the organisation’s practices on a day-to-day basis.
* Explanation from the provider advising how organisational staff receive annual complaints training to support their knowledge and confidence in complaint management.
* The provider advised that improvements have demonstrated to be effective as the organisation is correctly and promptly responding complaints information into the complaint management system. This has allowed the provider to improve tracking and management of complaints to ensure timely and effective handling and resolution of complaints being actioned.
* Explanation, that all complaints received from external authorities are centrally managed and reviewed by the organisation’s quality team.
* Explanation from the provider addressed consumer examples outlined in the previous Performance Report, outlining actions taken by the organisation to address three HCP consumers.

In coming to my finding, I have considered the information in the Assessment Team’s report and provider’s response, which shows the provider is ensuring complaints are consistently addressed and documented, and that an open disclosure process is used when things go wrong.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, and how consumers and representatives said the organisation does their best to resolve any issues raised. The provider outlined an explanation to address the previous deficiencies, and while at the time of my decision there is no further evidence in addition to the explanation provided by the organisation, the evidence outlined in the Assessment Team report indicate improvements that have been made and embedded into organisational practices.

Requirement 6(3)(d) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate feedback and complaints are reviewed and used to improve the quality of care and services. Staff and management were not able to describe how the provider used consumers’ feedback and complaints to improve the quality of services. The provider was not able to demonstrate feedback and complaints are documented and reviewed to improve the quality of care and services delivered to consumers.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved policies, processes and training in relation to the utilisation of consumers feedback and complaints to improve the quality of services.
* improved systems and processes to document, track and trend complaints and feedback from consumers.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 6(3)(d) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and representatives said they are satisfied the service listens to their feedback and makes necessary changes to ensure feedback is actioned promptly.
* Staff described actions they have taken to address consumer feedback about their care and services, demonstrating awareness of the organisation’s continuous improvement functions.
* Management described examples on how informal feedback, formal complaints and survey results have been used for continuous improvement across services.
* Management described improvements that they have actioned as a result of feedback and complaints and provided examples of service improvements made through the improvement of systems and processes to document, track and trend complaints and feedback from consumers.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring feedback and complaints are reviewed and used to improve the quality of care and services.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, and how staff and management able to describe how the provider used consumers’ feedback and complaints to improve the quality of services. The provider demonstrated feedback and complaints are documented and reviewed to improve the quality of care and services delivered to consumers.

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

# Standard 7

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| Human resources | | HCP | CHSP |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant | Compliant |
| Requirement 7(3)(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) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate the workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved risk management strategies and processes when insufficient staff are available to undertake all services for the allocated time period.
* implementing strategies to increase staffing levels to better match and service the number of consumers.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 7(3)(a) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and representatives were satisfied with the number of staff available, advising that staff arrive on time and have enough time to complete their duties.
* Staff said in different ways that each service allocates sufficient time to complete their work effectively.
* Management discussed workforce planning and analysis of workforce needs, by using internal staff to ensure scheduling sufficient resources and a mix of members are deployed to deliver safe and quality care and services.
* The Assessment Team sighted team meeting minutes which addresses staffing across various locations and services.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services..

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, and consumers expressed satisfaction with the organisation and how services are often delivered at preferred times. The provider demonstrated sufficient staffing numbers to address previous deficiencies.

Requirement 7(3)(c) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved policies, procedures and training for staff delivering care and services to consumers.
* improved documentation and accuracy of information within the training register and calendar.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 7(3)(c) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and representatives provided positive feedback that staff understood consumers’ needs and effectively performed their roles.
* Management explained how they determine staff competency and capability by ensuring staff have a minimum essential qualification requirement in line with relevant job descriptions, which are reviewed during recruitment processes and initial onboarding.
* Documentation evidenced including policies, procedures and training records evidenced induction and ongoing training for staff occurs.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring the workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, and staff expressed satisfaction and confidence with the organisation that they have completed induction training and participated in buddy training in line with their job descriptions.

Requirement 7(3)(d) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate the workforce is recruited, trained, equipped, and supported to deliver services, specifically in relation to workforce education, training, and policy support to deliver outcomes for consumers in line with the Aged Care Quality Standards.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved awareness and training specifically relating to inductions and mandatory training.
* improved processes and policies for communications between management and staff specifically relating to changes to requirements within the aged care sector.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 7(3)(d) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and representatives provided positive feedback about staff across all services, including their care and service delivery skills.
* Staff said the organisation provides a comprehensive induction on commencement along with ongoing training opportunities and support. Furthermore, staff described how the organisation organises buddy shifts to prepare staff for independent service delivery.
* Management described training needs are generally identified by reviewing incident and complaints reports, while working with a registered training provider, as well as online annual and refresher training.
* The Assessment Team evidenced a training matrix and training schedule outlining mandatory training and status of completion, which management maintain oversight.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring the workforce is recruited, trained, equipped, and supported to deliver services, specifically in relation to workforce education, training, and policy support to deliver outcomes for consumers in line with the Aged Care Quality Standards.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, and consumers expressed satisfaction with organisational staff when receiving services. The provider demonstrated improvements in consistently providing induction, training and support to workforce.

Requirement 7(3)(e) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved systems and processes for gathering feedback on staff performance in relation to delivering care and services.
* improved processes in relation to management of staff performance and the undertaking of performance appraisals.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 7(3)(e) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Staff and management said staff are required to undertake performance appraisals annually, and identify goals, concerns and what support each service can provide to address any concerns raised.
* Management described the process for monitoring and reviewing staff performance through probationary periods and ongoing annual performance reviews, explaining each service uses feedback from consumers and staff appraisals to inform training needs.
* The Assessment Team sighted probationary and annual performance appraisals are regularly completed with staff.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, including improving systems and processes for gathering feedback on staff and improving staff performance management. The provider demonstrated that services are effectively managing performance appraisals for staff, including probationary and annual performance reviews.

Based on the information summarised above, I find the provider, compliant with Requirements (3)(a), (3)(c), (3)(d), (3)(e) in Standard 7 Human resources.

# 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) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate that consumers are engaged in the development, delivery and evaluation of care and services, and are supported in that engagement. Staff and management could not describe how consumers are actively engaged in the development, delivery and evaluation of care and services beyond that associated with the informal feedback processes. The organisation did not demonstrate they apply effective governance systems to meet the requirements of the Quality Standards to enable consumers to feel they are partners in improving the delivery of care and services.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved processes and systems to ensure an organisation wide approach to involve consumers in developing, delivering and evaluation their care and services.
* improved consumer engagement through the collection of feedback.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 8(3)(a) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and representatives said they are encouraged to participate in the development, delivery and evaluation of care and services, including having the opportunity to provide feedback through the consumer advisory committee.
* Management explained how they engage consumers through various mechanisms, including consumer satisfaction surveys and involving consumers on the services consumer advisory body by regularly seeking input and feedback through feedback forms and informal consumer groups to improve care and services.
* Documentation showed the consumer information packs have feedback information and options, including relevant contact details.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, and consumers expressed satisfaction with the organisation for the opportunity to provide feedback, and confirmed relevant changes had been made to address previously raised concerns. The provider demonstrated consumers are engaged in the development, delivery and evaluation of care and services, and are supported in that engagement. Management could describe how consumers are actively engaged in the development, delivery and evaluation of care and services and demonstrated how they apply effective governance systems to meet the requirements of the Quality Standards to enable consumers to feel they are partners in improving the delivery of care and services.

Requirement 8(3)(b) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate that the organisation’s governing body effectively promotes a culture of safe, inclusive, and quality care and services, and is accountable for their delivery. While the organisation had an established governance framework, the organisation did not have effective data gathering, reporting, and monitoring systems and processes to enable effective governance oversight and accountability.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved data gathering, reporting, and monitoring of systems, and processes to enable effective governance oversight and accountability at all levels from the board to staff.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 8(3)(b) as Met. The Assessment Team provided the following evidence relevant to my finding:

* The Board meets regularly to ensure oversight of quality care and services is maintained with all positions currently filled. The Board meets to review reporting on incidents, complaint data, clinical care, along with any areas of concern.
* Consumers and staff said they are satisfied the service promotes a culture of safe, inclusive and quality care, with consumers complimenting staff responsiveness.
* The provider has an electronic database for recording and monitoring incidents and management regularly reports statistics and issues to the board.
* Documentation and information showed various registers in place to document and monitor the individual risks of consumers.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring the organisation’s governing body effectively promotes a culture of safe, inclusive, and quality care and services, and is accountable for their delivery.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, and the Assessment Team identified that the governing body implemented effective systems and processes to enable relevant data and information to be provided to, and discussed at regular meetings to enable the governing body to effectively monitor care and services delivered to consumers. The provider demonstrated discussions about organisational structure, roles and expectations including, human resources, staff education and training.

Requirement 8(3)(c) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate effective organisation governance systems relating to (i) assessment and care planning information regarding the consumers’ risks, needs and preferences is consistently documented and communicated within the service; (iii) an established, documented, and effective organisation-wide financial governance systems; (iv) effective workforce governance to ensure staff receive the ongoing support, training, professional development, and feedback they need to ensure staff are competent in order to meet the needs of aged care consumers and deliver the outcomes of the Quality Standards; (v) effective systems and processes in place to support the service to meet regulatory requirements in respect of the HCP, CHSP funding arrangements and Aged Care Quality Standards; (vi) effective systems and processes to capture, monitor, analyse and use feedback and complaint data to improve the quality of care and services. The provider was able to demonstrate effective continuous improvement processes, at the service level, to improve the quality-of-service delivery for consumers accessing CHSP and HCP services.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved established, documented, and effective organisation-wide governance systems in relation to information management, workforce governance, financial governance, regulatory compliance, feedback and complaints.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 8(3)(c) as Met. The Assessment Team provided the following evidence relevant to my finding:

* Interviews with consumers and staff, and documentation showed there are effective organisation wide governance systems in place to support information management, continuous improvement, workforce governance, financial governance and feedback and complaints.
* There are systems and practices in place to ensure effective regulatory compliance including information reviewed by the organisation’s quality assurance and risk division to inform the board and director of the responsible area.
* Management explained information regarding legislative and regulatory changes are communicated to staff and consumers through written correspondence.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring effective organisation wide governance systems relating to information management, financial governance, workforce governance, regulatory compliance and feedback and complaints.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance. The provider demonstrated improvements to address the deficits identified in information management, financial governance, workforce governance, regulatory compliance and feedback and complaints.

Requirement 8(3)(d) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate effective rick management systems and practices relating to (i) effective systems and processes to identify, assess, manage and monitor risks to consumers; and (iv) effective incident management systems, including the effective use of an incident management system, and the governing body does not have effective processes to monitor and have oversight of consumer incidents. The provider was able to demonstrate compliance in relation to (ii) procedure to recognise and report elder abuse policy and procedure in place to guide staff.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved risk management systems and practices including to identify, assess, manage, and monitor risks to consumer’s safety and well-being and prevent further risks or incidents.
* improved consumer risk assessments and care planning to inform safe and quality delivery of care and services.
* improved systems and processes to ensure the governing body can monitor and have oversight of consumers’ high-impact or high-prevalence risks.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 8(3)(d) as Met. The Assessment Team provided the following evidence relevant to my finding:

* There are systems and practices in place to ensure effective management of high impact or high prevalence risks.
* Staff said they have been trained in high-impact and high-prevalence risks of consumers and noted this information is included in consumer care plans that guide service delivery. Furthermore, staff confirmed receiving training in incident management and SIRS and could describe processes including how to escalate risks.

Management was knowledgeable, demonstrating responsibility for undertaking evaluation and review of individual risks of vulnerable and high-risk consumers. In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring effective risk management systems and practices relating to high-impact high-prevalence risks and managing and preventing incidents, including the use of an incident management system.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance. The provider demonstrated improvements to high-impact high prevalence risks and incident management, including the use of systems, processes, procedures and further staff training to address deficits.

Requirement 8(3)(e) was found non-compliant following a Quality Audit undertaken in June 2023, as the provider did not demonstrate effective clinical governance framework including systems and processes to enable delivery of safe and quality clinical care to consumers.

The Assessment Team’s report for the Assessment Contact undertaken on 23 to 25 October 2024 included evidence of actions taken by the provider in response to the non-compliance. These actions include, but are not limited to:

* improved clinical governance framework including systems and processes to enable delivery of safe and quality clinical care to consumers.
* improved consumer clinical assessment and care planning to inform safe and quality clinical care.
* improved policies, procedures and training for staff to guide them in the assessment and delivery of clinical care, including identifying, responding and managing risks associated with consumer clinical care, antimicrobial stewardship, and minimising the use of restraint.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 8(3)(e) as Met. The Assessment Team provided the following evidence relevant to my finding:

* The organisation has a clinical governance framework in place that identifies the methods for the service to use consumer information such as incidents, risks, feedback, and complaints to measure clinical quality and safety performance.
* The framework ensures the workforce is supported with qualified clinical staff, ensuring adequate supervision and advice is provided to operational staff when clinical care is being provided.
* Management was knowledgeable, demonstrating responsibility for undertaking evaluation and review of clinical assessment submissions and determining risk ratings if consumers are to be added to the clinical risk register.
* Management explained any high-risk record in the register is reviewed by the clinical governance group, triggering a case conference among involved staff and management.

In coming to my finding, I have considered the information in the Assessment Team’s report which shows the provider is ensuring a clinical governance framework addresses antimicrobial stewardship, minimising the use of restraint and open disclosure as clinical care is provided.

I have placed weight on the evidence in the Assessment Team’s report which showed improvements were made to address the previous non-compliance, including an improved clinical governance framework, systems and processes to enable quality clinical care service delivery to consumers. The provider demonstrated policies and practices to address antimicrobial stewardship, minimising the use of restraint and open disclosure.

Based on the information summarised above, I find the provider, compliant with all Requirements in Standard 8 Organisational governance.

1. The preparation of the performance report is in accordance with section 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)