**Performance**

**Report**

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| --- | --- |
| Name of service: | HCA Home Care No hidden costs |
| Service address: | 35 King William Road UNLEY SA 5061 |
| Commission ID: | 600594 |
| Home Service Provider: | HCA Corporate Health Pty Ltd |
| Activity type: | Quality Audit |
| Activity date: | 16 June 2023 to 22 June 2023 |
| Performance report date: | 28 August 2023 |

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

**This performance report**

This performance report for HCA Home Care No hidden costs (**the service**) has been prepared by A. Grant, 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:**

* HCA Home - SA, 27037, 35 King William Road, UNLEY SA 5061

# 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 20 July 2023.

# Assessment summary for Home Care Packages (HCP)

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

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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

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

# Areas for improvement

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

*Requirement 1(3)(a)*

Improvements could be but are not limited to improved written and verbal communication and communication response time between staff and consumers.

*Requirement 1(3)(b)*

Improvements could be but are not limited to improved cultural diversity training and awareness and a concerted effort to meet consumers cultural care requests and needs.

*Requirement 1(3)(c)*

Improvements could be but are not limited to improved lines of communication and documentation from consumers to staff members to Customer Care Manager (CCM) about consumer’s choices and decisions. Improved documentation and access to documentation for staff regarding consumer’s choices and decisions.

*Requirement 1(3)(f)*

Improvements could be but are not limited to improved policies and training for staff in relation to mobile phone security and Carer Support Application security.

*Requirement 2(3)(a)*

Improvements could be but are not limited to improved oversight and input from clinically trained staff on all complex care needs. Improved initial assessment processes to ensure risks are identified and documented for consumers.

*Requirement 2(3)(b)*

Improvements could be 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.

*Requirement 2(3)(d)*

Improvements could be 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.

*Requirement 2(3)(e)*

Improvements could be but are not limited to improved effectiveness of reviews and frequency of reviews when circumstances change or when incidents impact on consumer’s needs, goals and/or preferences. Improved effectiveness of identification of risks for consumers after incidents and/or hospital discharges.

*Requirement 3(3)(a)*

Improvements could be but are not limited to improved policies, procedures and training to guide staff in providing safe and effective personal and clinical care that is best practice and tailored to the consumer’s needs.

*Requirement 3(3)(b)*

Improvements could be but are not limited to improved training, policies and procedures relating to high impact, high prevalent 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.

*Requirement 3(3)(d)*

Improvements could be but are not limited to improved training and education to all staff to effectively recognise and respond to deterioration or changes to consumer’s mental health and/or cognitive or physical function.

*Requirement 3(3)(e)*

Improvements could be but are not limited to improved documentation and communication within the service regarding consumer’s needs, preferences, conditions and changes.

*Requirement 4(3)(a)*

Improvements could be but are not limited to improved policies, procedures and training relating to consumer care planning and documentation for consumers primarily focused on their needs, goals and preferences. Improved processes, monitoring and response time of consumers timely and appropriate referrals and purchase of equipment as per consumers assessed needs.

*Requirement 4(3)(b)*

Improvements could be but are not limited to improved identification, recording, documentation and communication of consumer’s preferences for emotional, spiritual and psychological well-being and tailored services to meet those needs.

*Requirement 4(3)(d)*

Improvements could be but are not limited to improved documentation and communication of consumers conditions, needs and preferences within the service and where the responsibility for services and supports for daily living is shared. Improved documentation communication, ongoing reviews relating to consumers incidents, deterioration and changes.

*Requirement 4(3)(f)*

Improvements could be but are not limited to improved processes and timeliness in purchasing and implementing assessed/recommended equipment as required for consumers.

*Requirement 6(3)(a)*

Improvements could be 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.

*Requirement 6(3)(c)*

Improvements could be but are not limited to improved processes, training and documentation of complaints, utilisation of open disclosure throughout the complaints and feedback process.

*Requirement 6(3)(d)*

Improvements could be but are not limited to improved policies, processes and training in relation to 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.

*Requirement 7(3)(a)*

Improvements could be but are not limited to improved risk management strategies and processes for when insufficient staff are available to undertake all services for that day. Implement strategies to increase staffing levels to better match and serve the number of consumers.

*Requirement 7(3)(c)*

Improvements could be but are not limited to improved policies, procedures and training for staff delivering care to consumers. Improved documentation and accuracy of information within the training register and calendar.

*Requirement 7(3)(d)*

Improvements could be but are not limited to improved awareness and training specifically relating to inductions and mandatory training. Better processes and policies for communications between management and staff specifically relating to changes to requirements within the Aged Care sector.

*Requirement 7(3)(e)*

Improvements could be but are not limited to improved systems and processes for gathering feedback on staff performance in relation to delivering care and services. Improved process in relation to management of staff performance and the undertaking of performance appraisals of staff.

*Requirement 8(3)(a)*

Improvements could be 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.

*Requirement 8(3)(b)*

Improvements could be 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.

*Requirement 8(3)(c)*

Improvements could be 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.

*Requirement 8(3)(d)*

Improvements could be 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.

*Requirement 8(3)(e)*

Improvements could be 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.

# Standard 1

|  |  |  |  |
| --- | --- | --- | --- |
| 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. | **Non-compliant** | **Non-compliant** |
| Requirement 1(3)(b) | Care and services are culturally safe | **Non-compliant** | **Non-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. | **Non-compliant** | **Non-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. | **Non-compliant** | **Non-compliant** |

Findings

Non-Compliant Evidence

*Requirement 1(3)(a)*

In respect to Requirement 1(3)(a) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that they treat each consumer with dignity and respect, with their identity, culture and diversity valued. Consumers and/or representatives described staff as kind, caring and respectful, however, some consumers and/or their representative felt disrespected by the service when they had not had their calls returned and or issues sorted. Two consumers and one consumer’s representative interviewed by the Assessment Team felt disrespected by the service when they had raised feedback or complaints about care and services.

* The representative of Consumer A (HCP) stated they were waiting on equipment for over twelve months and whilst in communication with the service and with various staff, they advised they did not feel listened to or respected.
* The representative of Consumer B (HCP) explained that they had been delivered insufficient incontinence pads, and after many conversations with staff in early 2023. This was still not rectified at the time of the Quality Audit, and their calls to the service were not returned, resulting in the consumer purchasing the products themselves. The representative stated that they felt disrespected and unheard by the service. This consumer has significant unspent funds.
* One consumer stated they felt disrespected because they had advised the service they get distressed at shift and staff changes and feel there is a lack of communication from the service regarding consistent staff changes.
* The lack of communication and progress notes at the level of care, demonstrated that the service is unable to understand how consumers culture, personal attitudes, values and beliefs affect the delivery of care and services.

*Requirement 1(3)(b)*

In respect to Requirement 1(3)(b) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that care is consistently provided in a culturally safe manner. Consumers and/or representatives advised in various ways that the service did not consider consumer’s needs, preferences and what is important to them to inform care and services. Staff were unable to describe an understanding of consumer’s backgrounds or how they ensure care and services reflect consumer’s individual needs. Eight of twenty-nine consumers sampled stated they would prefer and have requested access to staff members that speak their first language; however, management stated they were not always able to source bilingual staff to meet the consumer cultural needs.

* The representative for Consumer C (HCP) advised their family member does not speak English and the service has been unable to provide staff that speak the specific required language to meet their cultural preference. When required, the representative will translate for their family member and staff. The representative advised they would like culturally appropriate food options and continue to cook meals for the family member as the service cannot currently provide this.

While the service has a Cultural and Diversity Statement and provided documentation to demonstrate that Diversity and Culture are discussed at the Home Worker Induction Training Module for Community Workers, three staff interviewed stated they did not recall any training in cultural safety or awareness.

* One staff member interviewed, when asked what Cultural Safety training they had received, they replied “what's that?”
* One staff member stated they find it difficult to provide care and services to two consumers from non-Australian backgrounds as the consumers cannot speak English.
* Another staff member advised they have not received any cultural training since commencement at the service.
* One Team Leader stated they are aware some consumers will request staff who speak their preferred language, and this was not always possible to schedule with their current staff. The Team Leader advised staff are encouraged to use their mobile phone to translate and use picture books to communicate with consumers and for one consumer, the service was able to match the consumer with a staff member from the same cultural background.

*Requirement 1(3)(c)*

In respect to Requirement 1(3)(c) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate 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. Some consumers and/or representatives described how the service does not communicate with them in making decisions about the consumer’s care and services. Sampled consumers in relation to this requirement advised they are unable to make decisions about their care and how their services are delivered, and when they communicate their decisions, they do not feel heard by the service.

* The representative for Consumer D (HCP) advised they call the service to verbally provide information following General Practitioner (GP) appointments to update them on Consumer D’s medical issues. No information was provided to the Assessment Team to demonstrate the service seeks input post Consumer D’s GP appointments.
* The representative of Consumer E (HCP) explained how they had requested home modifications at the end of 2022 and after receiving quotes, they have not heard back from the service despite numerous messages being left and requesting a return phone call to discuss the required home modifications. The representative also said they are unable to get an update on their case or availability of funds as staff do not return calls.

Two of five staff interviewed advised they have been unable to communicate the consumers decisions to the Customer Care Managers (CCM), advising the CCM is often unavailable or did not return their call.

* One staff member advised their progress notes, which contained information regarding the consumer’s decisions about the way their care and services are delivered, were often closed without being read by the CCM.
* Another staff member stated that they would call their CCM three to four times a day and they would not return any calls. Adding, they were unable to reach the CCM to discuss consumer requests.

Documentation provided to the Assessment Team did not consistently demonstrate that consumers are being provided the opportunity to make decisions about their care and services and how they are to be delivered.

*Requirement 1(3)(f)*

In respect to Requirement 1(3)(f) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through with-in its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate each consumer’s privacy is respected and personal information is kept confidential. Whilst consumers and/or representatives felt that staff are respectful of the consumer’s privacy when providing care and services, staff interviewed described how each consumer’s privacy and confidentiality is not respected with the use of the service’s mobile application on their personal phones that holds each client's data; because the electronic application (app) does not require a password to access client data. Management advised it is the responsibility of staff to ensure their mobile phone is secured and staff are required to contact the service in the event they lose their mobile phone.

* Three of five staff advised they ensure their mobile phone is locked, however, advised the mobile application they require to access to view consumer information is not password protected. Staff stated that if they lost their phone, the data would not remain secure.
  + Management provided the Assessment Team with the services’ Privacy policy dated 14 June 2023 that outlined steps in the event that a mobile phone was lost or stolen, including the deactivation of the app for the staff member.
* While the Home Worker Induction Training Module for Community Workers instructs staff to ensure their phones have an activated passcode for security, two staff interviewed confirmed their phone does not have an active passcode.
* Whilst the Privacy policy mentions the app and security requirements, management was not able to demonstrate they have oversight of individual staff personal mobile phones, and the security settings staff have on their devices.

Compliant Evidence

*Requirement 1(3)(d)*

The service was able to demonstrate that each consumer is effectively supported to take risks to enable them to live the best life they can. The service demonstrated that consumers are supported to make decisions about their care and services, including when their choice involves elements of risk. However, the service was not able to demonstrate that consumers had been informed of risks and possible consequences of their decisions, to enable them to make informed decisions; and that the service had discussed with consumers strategies to manage the risk whilst supporting them to live their best life.

While the service has a Duty of Care and Dignity of Risk policy and a My Risk form, management advised staff will be reminded of the My Risk form with coaching provided on how to rate a potential risk and how to implement strategies to mitigate risk and will also raise awareness of dignity of risk within the team. In addition, consumers with identified risks should be entered on high-risk register.

The Decision Maker notes that although there were gaps originally identified in this requirement that on balance the requirement is compliant as there is minimal consumer impact and the minor consumer impact identified at the Quality Audit, was rectified by the service and evidence of the rectification was provided in the Services response.

*Requirement 1(3)(e)*

Evidence analysed by the Assessment Team showed the service was able to demonstrate that information provided to consumers is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. Sampled consumers and/or representatives confirmed information is provided to them verbally and in writing when they first access the services and ongoing. Staff and management described how they provide information to consumers at commencement of services and ongoing.

* Whilst some consumers advised they have no communication from the service, they did receive information provided by the service including a welcome pack, a budget which is explained to them, and monthly statements.
* Consumers sampled said that they knew how to read their monthly statements and that they were mostly on time.
* Management advised, and documentation viewed confirmed, the service supported consumers to understand information provided, including through advocacy and interpreting services if required.

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

Findings

Non-compliant Evidence

*Requirement 2(3)(a)*

In respect to Requirement 2(3)(a) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through with-in its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective services. For some consumers sampled, while key risks had been identified through My Aged Care (MAC) assessments and GP health summaries, these had not been assessed by the services staff or clinical team and strategies to manage those risks were not effectively considered or documented. Care planning documentation did not include sufficient detail about assessed needs and risks to the consumer to guide staff in managing the risks for consumers.

Consumer E’s (HCP) care plan, completed in mid-2023, documents significant physical medical conditions. Additional information located in various sections throughout their care plan notes the following:

* Skin to be very thin and breaks easily;
* Has a hearing impairment;
* Requires continence aids; and
* Has mobility aids to use to support them with walking.

No documentation was provided to the Assessment Team to demonstrate that the risk associated with pain, falls, skin, memory loss were assessed by a clinician using validated tools. Progress notes for Consumer E documented Consumer E had a fall in early 2023 and required hospitalisation. Further documentation stated Consumer E had no fractures but a bit of chest pain from the fall and the hospital was going to monitor Consumer E over the next few days as their potassium levels were low. There are no further progress notes regarding their condition, discharge from hospital or review until mid-2023, where a home visit had been scheduled.

Consumer E has had three hospital admissions since the end of 2022. No evidence was provided to the Assessment Team that information from the hospital was collected by the service on discharge, a referral was made to an Allied Health Professional (AHP), that Consumer E underwent a review, or that their clinical needs were overseen by a health care professional.

The Assessment Team reviewed care plans for sampled consumers and noted the service had identified some risks to a consumer’s health and wellbeing, for example, mobility issues, medical conditions and pain. However, assessment and planning documentation did not demonstrate the service is including the consideration and assessment of risks to the consumer’s health and well-being to inform the delivery of safe and effective services.

Care planning documentation identified when consumers:

* Are at risk of social isolation but does not provide further information on how to support potentially vulnerable consumers;
* Are a falls risk or have a history of falls, however, does not consistently include information on mobility assistance and types of aids that are used.
  + Falls are not assessed using the validated tools the service includes on their “My Assessment Form” which suggests a Fall Risk for Older People (FROP) screen or assessment.
* Have ongoing pain however does not provide information on strategies to reduce episodes.
  + Pain is not assessed using the validated tools the service includes on their “My Assessment Form” which suggests a My Say – Pain Assessment or Abbey Pain Scale
* Have a diagnosis of dementia or cognitive decline but does not provide information on how to support consumers or staff.
  + Dementia or cognitive decline is not assessed using the validated tools the service includes on their “My Assessment Form” which suggests a Rowland Universal Dementia Assessment scale (RUDAS), Psychogeriatric Assessment Scale (PAS), Delirium Screen or a Geriatric Depression Scale.
* Have skin conditions or wounds however do not provide clinical oversight to manage these.
  + Skin integrity is not assessed using the validated tools the service includes on their “My Assessment Form” which includes a My Skin assessment, Braden Score, Pressure injury classification, wound Assessment, Wound Management Chart, Mini Nutritional Assessment or Pain assessment.

The service did not demonstrate the workers conducting the reviews had the required skills or training to effectively consider the risk to each consumer’s health and wellbeing to inform the delivery of the consumer’s care and services.

*Requirement 2(3)(b)*

In respect to Requirement 2(3)(b) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate assessment and planning identifies and addresses the consumer’s current needs, goals and preferences including advance care planning. Consumers and representatives sampled described in various ways how the service meets their current needs, goals and preferences. However, the Assessment Team noted that this information collected was not documented within the care plan to inform the staff and volunteers when providing services.

Consumers files sampled did not effectively identify individualised needs, goals and preferences or provide instructions to staff on how to achieve these. Twenty of the twenty-nine sampled files documented generic needs, goals, and preferences and information about how these would be achieved was not documented, and documentation was not provided to the Assessment Team to demonstrate that these were discussed during reviews.

Four of four CHSP consumer files sampled did not include information regarding consumer’s needs, goals, or preferences. At the time of the Quality Audit the service did not have effective policies and procedures to guide staff to collect information regarding consumers' needs, goals, and preferences, during initial assessment and review, and were unable to demonstrate that staff at point of care had the appropriate training and skills to collect this information.

*Requirement 2(3)(d)*

In respect to Requirement 2(3)(d) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate the outcomes of assessment and planning are effectively documented, and these documents are available to consumers and the workforce at point of care. Interviews with consumers and a review of care documentation identified that, the service does not provide a comprehensive care plan that captures all aspects of a consumer’s health and wellbeing including emotional, spiritual and psychological. Most consumers interviewed in relation to this requirement confirmed a care plan is provided to them however, the care plans viewed for sampled consumers did not provide sufficient guidance or instruction for staff to deliver safe and effective care and services.

Documentation provided to the Assessment Team demonstrated that care plans are not consistently up to date with current information. For example:

* Consumer H’s (HCP) care plan identifies Consumer H has arthritis in their hands and can find gripping items difficult, and that they required help with domestic assistance.
  + A representative for Consumer H stated that the service had sent a worker for domestic assistance who could undertake the requested domestic assistance task. The representative described how they specifically requested a staff member who could complete this task.
  + This information is not documented within the care plan.
* Consumer I’s (HCP) care plan lists Consumer I allergies as Allergy A and Allergy B however a patient health summary from the GP notes their allergies to be Allergy C and Allergy D (removed actual allergies to ensure anonymity), causing severe hallucinations.
  + Management provided the Assessment Team with the updated care plan with allergies listed as Allergy C and Allergy D.
  + There is no information in the current or previous care plan as to the adverse reactions to the medications or strategies for staff to manage any symptoms.

Care plans viewed for sampled consumers did not include information on the outcomes of assessment and planning including the consideration of risk, and when risks have been identified this information is not documented within the care plan or the referral for workers.

Staff completing care planning documentation are not trained and equipped to assess consumers clinical or care planning needs, including requesting information from other health professionals or internal referrals for clinical oversight.

*Requirement 2(3)(e)*

In respect to Requirement 2(3)(e) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals, or preferences of the consumer. Care planning documentation viewed for sampled consumers showed that, when reviews were completed, these were not always effectively identifying risks to consumers, including following incidents, hospital discharges, or when circumstances change.

* The representative for Consumer J (HCP) explained how Consumer J has recently returned from hospital after a change in condition in mid-2023.
  + Consumer J’s representative advised that the service did not make contact with the family after their discharge from the hospital however advised an annual review was booked in a month or so time.
  + There was no information provided to the Assessment Team to demonstrate that information from the hospital admission/ change in condition was obtained by the service to inform a safe and effective review process.
* Consumer K’s (HCP) representative described a recent admission to hospital. The representative advised the service had not been in contact with them since being discharged and a review of care and services was not undertaken upon discharge.
  + The representative informed the Assessment Team they would have benefited from increased services had a review had been conducted.

Progress notes viewed for sampled consumers did not provide comprehensive information regarding the consumers, their condition or any changes that would inform the review process. As discussed in requirement (3)(a) of this Standard, while scheduled reviews are completed regularly, they are not capturing all aspects of consumer’s health and wellbeing including emotional, spiritual and psychological needs or being overseen by clinical staff to assess risk for the delivery of safe and effective care and services.

Compliant Evidence

*Requirement 2(3)(c)*

Evidence analysed by the Assessment Team showed the service was able to demonstrate assessment and planning is based on ongoing partnership with the consumer and/or their representative, and others who are involved in the care and services of consumers. Consumers and/or representatives confirmed they are involved in deciding the care and services provided to consumers such as personal care, transport, social support, domestic assistance and gardening. Management described how consumers and/or representatives are involved in the planning of care and services and consumers can elect to have a representative present during assessments and reviews. Care planning documents viewed for sampled consumers confirmed that consumers and/or their representatives, were involved in the planning of consumer’s care and services.

* Most consumers and/or representatives interviewed confirmed they are involved in the ongoing assessment and planning of care and services;
* Staff interviewed described how they liaise with the consumer and their families when organising a review, ‘so everyone has the opportunity to be involved’; and
* Documentation provided to the Assessment Team demonstrated the service inconsistently requests medication summaries from a consumer’s GP.

# Standard 3

|  |  |  |  |
| --- | --- | --- | --- |
| 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. | **Non-compliant** | **Non-compliant** |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | **Non-compliant** | **Non-compliant** |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | **Compliant** | **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. | **Non-compliant** | **Non-compliant** |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | **Non-compliant** | **Non-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

Non-compliant Evidence

*Requirement 3(3)(a)*

In respect to Requirement 3(3)(a) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that each consumer gets safe and effective care that is best practice, tailored to their needs, and optimises their health and well-being. While care plans for consumers sampled did not consistently document information and strategies to guide staff practice, most consumers and/or their representatives considered that consumers receive personal and clinical care that is safe and right for them. As previously demonstrated under Standard 2 Requirement (3)(a) assessment and planning was not effective in identifying risks impacting the delivery of safe and effective care.

Consumer K’s (HCP) care plan lists significant medical conditions: (removed to ensure anonymity)

* Documented in the ‘special instructions’ it states "It can be a bit scary as the symptoms Consumer K shows are like stroke. Please check her BP. I don’t call an ambulance unless Consumer K’s blood pressure is extremely high and doesn’t lower itself after second reading at 5 mins after first reading”.
* There were no further instructions within the care plan regarding the monitoring of Consumer K’s blood pressure, the parameters for when to call an ambulance, if Consumer K’s performs her own blood pressure monitoring or if staff are to assist her.
* Consumer K’s care plan identifies they wear continence aids to support Consumer K with their incontinence. There is no additional information to inform staff of what type of incontinence they have, the severity or strategies for staff to assist her with her continence.

The Assessment Team noted three documented instances where support workers were providing wound care to consumers without documented clinical oversight or appropriate training.

The service does not have effective policies or procedures, and training in place to guide staff in providing safe and effective personal or clinical care that is best practice, tailored to the consumers' needs and optimises their health and well-being.

*Requirement 3(3)(b)*

In respect to Requirement 3(3)(b) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through with-in its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. Staff did not consistently identify, report and manage consumer’s risks and incidents. When incidents occurred, they were not consistently identified as an incident, or followed up, and consumer’s care needs and risks were not effectively reviewed, and management strategies implemented, to prevent further incidents for the consumers.

Consumer L (HCP) care planning documentation detailed how Consumer L is experiencing auditory and visual hallucinations exacerbated by a high level of opiates to treat their pain. Progress notes detailed how the representative was locking an exit point as Consumer L had utilised this exit on occasions at an unsafe time of the day/night.

* This was not identified by the service as a restrictive practice. During the Quality Audit when the Assessment Team enquired around the restrictive practice, management were unaware it was taking place;
* Management informed the Assessment Team that they spoke to the representative and the exit point is now unlocked;
* There was no assessment undertaken to determine if the lock was safe to remove and no Behavioural Support Plan (BSP) provided to the Assessment Team; and
* There was no information provided to the Assessment Team that the service initiated clinical intervention to assess, monitor and assist with Consumer L’s pain, mental health, delirium or restrictive practice.

Consumer M (HCP) has a significant number of medical conditions diagnosed including insulin dependent diabetes.

* There was no documentation provided to the Assessment Team to demonstrate the service was seeking information from the GP for effective oversight of their diabetes.
* Management responded that “representative manages Consumer M’s medications including monitoring their blood sugar levels and administering insulin.”

Risks to the consumers were not consistently identified during the assessment and planning process, therefore not effectively communicated to the workforce who were delivering care and services. None of the twenty-nine consumer files sampled included completed validated risk assessment tools to identify and monitor risks to consumers. Staff interviewed could not describe the high impact, high prevalent risk for their consumers or advise how they identify or manage risks.

*Requirement 3(3)(d)*

In respect to Requirement 3(3)(d) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

The service was not able to demonstrate that deterioration or change of consumers’ mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. The service does not have robust processes in place to support staff to identify, report, escalate and/or follow up appropriately. Care planning documentation provided for sampled consumers demonstrated that consumer deterioration and/or changes had not consistently been recognised and responded to appropriately.

Consumer N (HCP) had a “my 5 questions” review in early 2023 where it was detailed how Consumer N was admitted to hospital at the end of 2022, following a serious incident. It detailed how Consumer N was in significant pain, experiencing auditory hallucinations and noted that her mental health was declining. A GP letter dated in early 2023 detailed how Consumer N’s pain had been treated with opiates and weaning them off this would require alternative pain management strategies.

It was discussed with the service that Consumer N was to receive craniosacral therapy as an alternativee pain management strategy.

* The service replied that it was an excluded item under HCP and the family had to pay for it themselves.
* There was no further documentation to demonstrate that the service monitored Consumer N’s mental health, psychosis or pain levels throughout this period.

Consumer O’s (HCP) care planning documents stated that Consumer O does not have any problems with going to the toilet. However, in an OT review in November 2022, stated that Consumer O was incontinent.

* The representative of Consumer O described how their continence continues to deteriorate.
* Invoicing information provided to the Assessment Team confirmed that continence aids are being purchased for Consumer O, however, their care plan had not been updated to reflect these changes.
  + There is no information within the documentation provided to the Assessment Team to demonstrate that the deterioration of Consumer O’s incontinence was identified or monitored by the service or that clinical oversight was sought.

Staff attending consumers’ homes do not receive effective training to be able to identify and appropriately respond to the deterioration of a consumer. The service does not have effective systems in place to escalate changes in a consumers’ condition to the clinical team for oversight.

*Requirement 3(3)(e)*

In respect to Requirement 3(3)(e) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that information about consumer’s needs, preferences, conditions and changes are consistently and effectively documented and communicated within the organisation, and with others where responsibility for care is shared.

Consumer P’s (HCP) care plan documentation does not include information regarding their catheter.

Consumer Q’s (HCP) MAC assessment completed in early 2021 identified pain that disturbed Consumer Q in their sleep and identified that at the time of the report, they had lost significant weight.

* Care planning documentation does not make reference to Consumer Q’s weight or how the service is to monitor for any weight loss.
* In reference to Consumer Q’s pain, Consumer Q stated that they cannot lift their arms and that they take an analgesic in the evening, which helps relieve their pain.
* There is no information in the care plan to guide staff on how to assist Consumer Q with their pain, severity or frequency of pain, or when to report the pain to the service to ensure appropriate referrals can be actioned.
* The care planning documentation stated that Consumer Q will report any concerns to their GP. However, there was no evidence in the documentation provided to demonstrate that the service seeks information from the GP, and that this information is then documented within the care plan and shared with others involved with the delivery of care services.

A support worker called an ambulance for Consumer R (HCP) while at Consumer R’s residence as Consumer R was in severe pain. The service followed up with a phone call to Consumer R who explained that it was a reoccurring head pain from a previous accident and medication does not help.

* Management advised this pain is managed by their doctor and ongoing hospital admissions.
* There was no evidence provided to the Assessment Team that the service sought information from Consumer R’s GP, or other health professionals, to manage Consumer R’s pain.
  + Consumer R’s care planning documentation stated Consumer R was always in pain and takes tramadol for pain relief, however there are no instructions for staff as to where or when the pain occurs, the frequency, duration, or level of pain experienced by the consumer.

Seventeen of twenty-nine consumers sampled had memory issues, a diagnosis of dementia, intellectual disability or acquired brain injury. None of the care plans sampled provided a validated assessment tool to monitor these conditions and allow staff to notify management for any changes in condition.

Staff interviewed described whilst they have access to the care plan in the form of an electronic app, they are unable to access recent progress notes and are not aware of any changes that may have occurred prior to their visit.

Care planning documentation viewed for sampled consumers showed that important information about consumer’s care, including incidents, deterioration or changes, is not consistently and effectively documented, reviewed and communicated to staff to inform safe and quality care and services.

Compliant Evidence

*Requirement 3(3)(c)*

Evidence analysed by the Assessment Team showed the service was able to demonstrate they would respond appropriately to support the needs, goals and preferences of consumers nearing the end of life to maximise their comfort and preserve their dignity. Most staff interviewed advised they have not encountered consumers who are, or were, provided care and services at end of life, however, described how they would liaise with the consumers doctor and engage external services to provide the required palliative needs. Care planning documents showed that advanced care directives are discussed with consumers and outcomes documented within their care plans if the consumer wishes to share this information. Consumers were not interviewed in relation to this requirement.

* One staff member interviewed described how they visited a consumer nearing the end of life personally to discuss the services they could provide. The staff member described how they referred this client to an external palliative care service to coordinate the lease of equipment and implemented additional services to support the consumer and their family during this time

*Requirement 3(3)(f)*

Evidence analysed by the Assessment Team showed the service was able to demonstrate timely and appropriate referrals to individuals, other organisations and providers are made for consumers. Consumers and/or representatives confirmed consumers had been referred to health professionals when required. Management described processes to refer consumers for different services externally, to other health professionals or MAC. This was confirmed through documents provided to the Assessment Team for sampled consumers.

* Staff and management interviewed provided examples to the Assessment Team of referring consumers to other health professionals including physiotherapists, podiatrists and GPs.
* While the service was able to demonstrate that timely and appropriate referrals are made to MAC and allied health professionals. They were unable to demonstrate that they consistently action the recommendations in a timely manner, this is further discussed in Standard 4, Requirement (3)(g).

*Requirement 3(3)(f)*

The service was able to demonstrate they minimise infection related risks through the implementation of standard and transmission-based precautions to prevent and control infections. Consumers and/or representatives advised that staff keep them safe through the use of personal protective equipment (PPE) and cleaning. Staff and management described, and documentation viewed confirmed that, the service has processes for minimising risks of infection, including policies, procedures and education.

* Management advised that staff are provided PPE to wear when attending consumer’s homes and they provide consumers with PPE to wear when leaving their homes, such as gloves and face masks.
* Consumers sampled confirmed that staff wear masks when attending their homes for services.

# 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. | **Non-compliant** | **Non-compliant** |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | **Non-compliant** | **Non-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. | **Non-compliant** | **Non-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** | **Not applicable** |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | **Compliant** | **Not applicable** |

Findings

Non-compliant Evidence

*Requirement 4(3)(a)*

In respect to Requirement 4(3)(a) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that each consumer gets safe and effective services and supports for daily living that meet their needs, goals, and preferences, and optimises their independence, health, well-being and quality of life. Some consumers and/or representatives interviewed expressed dissatisfaction with the services and supports for daily living they receive. The Assessment Team identified through care planning documentation, and interviews with staff and management, that identified consumers were not always effectively supported with their daily living needs, including ongoing monitoring of consumers timely and appropriate referrals, and purchase of equipment as per their assessed needs.

Eight of twenty-seven consumers and/or their representatives interviewed described their ongoing issues with the service to receive the services and supports for daily living to optimise their independence health and wellbeing. For example:

* Consumer S (HCP) advised that their Friday services have previously been cancelled, and meaning they were unable to get their groceries, and therefore have gone through the weekend without food.
* The representative for Consumer T (HCP) advised they had one incontinence pad delivered, after they requested a box of continence aids from their CCM. The representative also stated they never get return phone calls to the messages they have left with the service and have been purchasing their own continence aids.
* The representative for Consumer U (HCP) stated that Consumer U had a fall in mid-2023 and they reported the fall to the service. The service did not conduct a review after they were notified of the fall. Referrals to other allied health professionals were not made, resulting in the representative seeking alternative allied health services to aid the consumer. The representative stated it takes a long time for anything to be received from the service and whenever they have asked for something for the consumer, it takes a while for them to come out to the house, in one instance the correct photos were not taken, and another OT had to come out. The representative stated that the consumer is hesitant to get help as it has been hard to get help for them in the past. The representative stated that due to the consumer having a cognitive medical condition, Consumer U likes routine. Consumer U likes the same cleaner at the same time each week and this does not currently happen.

*Requirement 4(3)(b)*

In respect to Requirement 4(3)(b) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate services and supports for daily living promote consumers’ emotional, spiritual and psychological wellbeing. Consumers and/representatives sampled stated that staff and the services provided do not promote the consumer’s wellbeing or support their emotional and spiritual needs. Staff and management did not demonstrate how they support consumers emotionally and promote their psychological wellbeing.

* Consumer V’s (HCP) care plan stated that Consumer V likes to watch television shows and that XX (removed language to ensure anonymity) is Consumer V’s first language. No further notes or documentation was provided to the Assessment Team to evidence that these needs were being supported.
* Consumer W (HCP) stated that all of their friends are dying and that Consumer W fears they are next. There were no notes or documentation provided to the Assessment Team that this comment was followed up to support the consumers psychological wellbeing.

The majority of sampled consumers said that they do not like the inconsistency with the staff, as new staff do not understand them or the duties they are to perform. Inconsistent staff also means they are unaware of the base line of the consumer. The information provided in the consumers care plans is to guide staff as to normal base line for consumer.

* One representative explained that they were so distressed at the dealings with the service and the lack of support, that twelve months ago they felt like undertaking deeply disturbing actions (actual action and statement removed to ensure anonymity). The Decision Maker notes the Service’s response indicates this representative no longer thinks this and the representative’s thoughts on the Service are now positive.
* The Assessment Team noted a complaint on the Complaint Register provided by the service, where a worker had arrived at a consumer’s residence at 9.30am. The consumer began swearing and yelling at the support worker because the consumer was not aware, or advised they had another different care worker and they did not know why they had another care worker. There was no additional documentation provided to the Assessment Team to demonstrate how the consumer was supported, or strategies put in place to reduce the likelihood of this incident recurring.

*Requirement 4(3)(d)*

In respect to Requirement 4(3)(d) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confidant if the corrective action is followed through within its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that information about the consumer’s condition, needs and preferences is communicated within the service, and with others where the responsibility for services and supports for daily living is shared. Care planning documentation viewed for sampled consumers showed that important information about the consumers, including incidents, deterioration or changes, is not consistently or effectively documented, reviewed and communicated to staff to inform safe and quality services. The service was not able to demonstrate that information about consumer’s needs and preferences are consistently and effectively documented and communicated within the organisation.

* Care planning documentation viewed for sampled consumers showed that important information about consumer’s care, including incidents, deterioration or changes, is not consistently and effectively documented, reviewed and communicated to staff and others to inform safe and quality care and services. For example:
  + One representative interviewed described their frustration with having to be present each time a new staff member attended their parent’s home for domestic assistance, stating they had to show the staff member where everything was and what was required.
* Documentation sampled for this consumer did not provide adequate information to guide staff in the delivery of services, for example, the location of cleaning materials or services to be performed. Care plans are not consistently completed, nor are progress notes consistently available at point of care. When care plans are available, they are not always up-to-date and/or do not include sufficient information about the consumer, such as risks, conditions and management strategies to ensure safe, quality services and supports for daily living. Refer to Standard 2, Requirements (3)(a) and (3)(b) for further information around assessment and planning.
* Three staff interviewed advised that there was a lack of communication within the organisation, and this impacted their ability to deliver safe and quality care and services.

Requirement 4(3)(g)

In respect to Requirement 4(3)(g) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that where equipment is provided, it is safe, suitable, clean and well maintained. While the service does engage with allied health professionals such as OT’s to assess and recommend required equipment, the service does not consistently purchase and implement the equipment in a suitable or timely manner.

* Representative for Consumer X (HCP) stated they are currently using homemade and altered grips as the handles on Consumer X’s 4-wheel walker because Consumer X requires handles with specialised grips. The representative stated the current grips are too hard and Consumer X cannot grip the handles for stability. The representative advised they have been waiting for new handles to be ordered since the OT assessment was completed in early 2023. The Assessment team noted in the OT referral dated early 2023 stated that the walker was not safe for use in its current state.
* Consumer Y (HCP) had a sling lifter provided by a previous service, which his partner utilises every day to mobilise the consumer from their bed to the toilet and their bed to their wheelchair. The representative could not advise who the lifter was being maintained by to ensure safety, cleanliness and suitability. There was no documentation in care planning documentation or progress notes provided to the Assessment Team about the maintenance of the lifter.

Compliant Evidence

*Requirement 4(3)(c)*

Evidence analysed by the Assessment Team showed the service was able to demonstrate services and supports for daily living assist consumers to participate in their community, have social and personal relationships, and do things of interest to them. Consumers and/or representatives, and staff interviewed confirmed that the service supports consumers to participate in their community and to do things of interest to them in their home. This was confirmed through care planning documentation viewed by the Assessment Team.

* Consumer Z’s representative advised that each week Consumer Z’s care worker takes Consumer Z to visit a childhood friend, who resides in a residential care facility.
* Consumer A’s (HCP) representative advised that the service transports Consumer A to three different support groups on a weekly basis.

*Requirement 4(3)(e)*

Evidence analysed by the Assessment Team showed the service was able to demonstrate timely and appropriate referrals to individuals, other organisations and providers are made for consumers. Consumers and/or representatives confirmed that consumers were timely and appropriately referred as required, for example, to allied health professionals and/or for purchase of mobility equipment. This was confirmed through care planning documents viewed for sampled consumers. Care planning documentation for sampled consumers confirmed the service engages with meal service providers to provide prepared meals to consumers within a brokerage agreement.

*Requirement 4(3)(f)*

Evidence analysed by the Assessment Team showed the service was able to demonstrate that, where meals are provided, they are varied and of suitable quality and quantity. Consumers order their own meals. Consumers interviewed described how they are satisfied and involved in the choice of meals being provided, and they meet their nutrition and hydration needs and preferences. Feedback from consumers interviewed were generally positive.

* Consumers interviewed in relation to this requirement, that received meals, confirmed the meals provided offer a variety of choice and are of good quality.
* The meals provided are ordered by the consumers through various meal providers, therefore they are varied and provide the consumers with choice.
* The Assessment Team noted consumers likes and dislikes for food are not consistently documented on sampled consumer’s care plans, however, consumers who are receiving the prepared meals are satisfied.

# 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. | **Not applicable** | **Not applicable** |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | **Not applicable** | **Not applicable** |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | **Not applicable** | **Not applicable** |

Findings

All individual requirements within Standard 5 are not applicable, therefore standard 5 is not applicable and was not assessed as part of the Quality Audit.

# Standard 6

|  |  |  |  |
| --- | --- | --- | --- |
| 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. | **Non-compliant** | **Non-compliant** |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | **Compliant** | **Compliant** |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | **Non-compliant** | **Non-compliant** |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | **Non-compliant** | **Non-compliant** |

Findings

Non-compliant Evidence

*Requirement 6(3)(a)*

The Decision Maker notes the Assessment Team recommended Requirement 6(3)(a) – CHSP as “met”. The Decision Maker has considered the totality of the evidence collected during the Quality Audit, specifically relating to Standard 6, and has decided based on the systemic deficiencies across CHSP and HCP services within Standard 6 in addition to the insufficient evidence provided by the Assessment Team to substantiate the “met” recommendation that Requirement 6(3)(a) – CHSP is also not compliant.

In respect to Requirement 6(3)(a) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate they encourage and support consumers and their representatives to provide feedback or make a complaint about the care and services that consumers receive. Consumers and representatives generally knew how to provide feedback or make a complaint, however, stated they felt their concerns were disregarded. Staff advised they are aware consumers and representatives are reluctant to provide feedback and complaints. Management discussed several ways in which they promote feedback and complaints, however, were unaware of the consumers' concerns with the complaints process. The Assessment Team observed there are no effective systems in place to encourage and document feedback.

All sampled consumers interviewed in relation to this requirement advised they have provided feedback verbally and/or in writing and once the complaint has been submitted, they do not hear back from the provider. Ten of eleven sampled consumers and/or representatives advised they have provided feedback multiple times and were advised to put their complaint in writing or speak with their Customer Care Manager.

* Consumer B advised they contacted the service weekly to raise concerns with multiple aspects of their care and services, such as gardening, staff attendance/consistency and how the cost of Consumer B’s medical treatments impacts on their ability to purchase food. Consumer B stated they often ask to speak to a manager and is generally advised they are not available. Consumer B expressed concerns at having three CCM’s in the last six months and advised they felt disregarded by the service.
* Representative for Consumer C (HCP) advised they had made multiple verbal complaints in relation to Consumer C not being collected on multiple separate occasions from their social support group, adding they only require minimal transport assistance each week, yet Consumer C’s transport services were often cancelled or missed. Consumer C is living with dementia and in each instance, this has caused Consumer C to become distressed. Consumer C recently returned home after five weeks in respite care and the representative advised no services had been delivered that week. The representative stated they contacted the CCM to discuss and received no response.

Staff and management described their process for the collection of feedback acknowledging they do not document all forms of feedback received.

One team leader interviewed stated their team contacts consumers regularly to reschedule services and acknowledged that not all feedback provided by consumers during these contacts were documented or captured on the feedback register. They added that some concerns are placated through open and honest conversation or consumers are referred online to complete a feedback form, or to speak to their CCM to raise concerns.

* Two of five staff interviewed stated they had raised complaints with the CCM on behalf of consumers who had stated they were going to change to another provider if something did not change.
  + One staff member stated they had two consumers exit and move to a new provider because the consumers concerns were not addressed by the service in a timely manner, and they had raised several complaints in writing to advocate for their consumers.
  + One staff member stated they had raised a complaint on behalf of a consumer who had waited over five months for a piece of equipment, however, the following visit, the consumer stated they had not heard back from the service.

*Requirement 6(3)(c)*

In respect to Requirement 6(3)(c) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the service was not able to 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.

Ten of eleven consumers and representatives sampled stated complaints are not followed up, and the outcome is not communicated to them. For example:

* One HCP representative stated they have contacted their CCM to request a safety pendant on three separate occasions, adding on the last phone call, they expressed their dissatisfaction with the level of service being provided and the delays being experienced to order a safety device that was suggested by the CCM.
* Representative for two HCP consumers stated they had spoken with a support worker to raise concerns that the consumers were returning home without receipts for their expenditure and the representative had concerns about the consumers funds being handled appropriately. The representative stated they were not contacted by the service to discuss and resolve their concerns of potential theft, despite providing their contact details when lodging the complaint.

Representative for Consumer D (HCP) stated when they raised a complaint in relation to the support worker the CCM apologised over the phone, however, the representative was not contacted to discuss and resolve their concerns after the initial conversation. The representative stated they had raised multiple concerns regarding various support workers and in each instance, once the complaint was discussed, they did not hear anything further from the service.

Three of five staff interviewed were able to describe the requirement to offer an apology to the consumer, however, they did not explain the requirement to provide the consumer with the details of how the event occurred and provide details of how they have learnt from the complaint and made amendments, where appropriate, to reduce the risk of the complaint being raised again.

* One staff member advised they were not involved in the complaint handling process, and they did not know what open disclosure was and they have not heard a consumer advise their complaint was resolved, adding they were unaware if anything is fixed when it is raised;
* Another staff member stated they know to email the CCM directly, stating when they added complaints to the progress notes; the consumers would often advise they were not contacted to discuss and resolve their concerns; and
* A Team Leader interviewed described a recent complaint where the consumer requested a specific support worker with whom they had built a rapport and explained how they had practiced open disclosure. However, the result of the complaint was to call the consumers representative to determine if services should proceed on an alternative day.

*Requirement 6(3)(d)*

In respect to Requirement 6(3)(d) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the service was not able to 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 service used consumers’ feedback and complaints to improve the quality of services. The service was not able to demonstrate feedback and complaints are documented and reviewed to improve the quality of care and services delivered to consumers.

* As consumers do not always feel confident to make a complaint, and as the service does not capture all feedback and complaints, the service does not have accurate data on feedback and complaints to review and inform service improvements.
* As discussed in (3)(a) of this Standard, the service does not have implemented processes to ensure that consumers, their family, friends, carers, and others are encouraged and supported to provide feedback and make complaints. Therefore, the service does not have a documented system that would enable the service to track, review and analyse feedback and complaint trends to improve the quality of services for consumers.
* Management was not able to describe how the organisation, or the service recorded, analysed, or acted on feedback and complaints to improve the quality of their care and services. Management was not able to provide the Assessment Team with evidence of how complaints are escalated or referred within the service to drive change and improve the services available to consumers as per the provider’s Incident and Management Standard 2. Management acknowledged feedback is not routinely documented despite recent training provided to staff.
* Staff stated they were not aware, and management could not demonstrate policies and procedures that showed how the organisation asked for feedback from consumers and/or representatives about how satisfied they are with the complaints management system, or evidence of how the organisation monitored, reported, and keeps improving its performance against this requirement.

The Assessment Team viewed the results and findings from the 2022 Home Care Customer Satisfaction Survey that evidenced:

* The majority of negative responses came from anonymous respondents and noted of 181 respondents that completed the survey, 91 respondents (51%), completed the survey anonymously;
* 33% of respondents to the survey advised they never receive information about possible emergency care and how the service will escalate to support their wellbeing; and
* 27% of respondents were dissatisfied with the services they were receiving with the service.

Compliant Evidence

*Requirement 6(3)(b)*

Evidence analysed by the Assessment Team showed the service was able to demonstrate consumers are made aware of, and have access to advocates, language services and other methods for raising and resolving complaints. Management discussed processes to ensure consumers have access to advocates and language services if required, and consumers are made aware of other methods for raising and resolving complaints.

Seven of ten consumers sampled advised they were aware of how to access advocacy services, language services and other methods to raise their concerns. The representative for one consumer living with dementia stated they would advocate and raise any issues with the service on behalf of their family member. Stating they had previously raised concerns with the Aged Care Quality and Safety Commission (the Commission). Staff and management discussed processes to ensure consumers have access to advocates and language services if required. The Assessment Team viewed information regarding external complaint avenues and advocacy services are provided to consumers at entry to the service. Contact details for the Aged Rights Advocacy Service and the Commission is provided in the information pack for CHSP and HCP consumers.

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

Findings

Non-compliant Evidence

*Requirement 7(3)(a)*

In respect to Requirement 7(3)(a) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Most consumers and representatives interviewed were dissatisfied with the number of staff to deliver their services, and expressed dissatisfaction at unfilled shifts, or shifts being cancelled at the last minute without notification. Management interviewed indicated insufficient staffing numbers and advised they are recruiting additional staff to address this.

Consumers and/or representatives advised how they were dissatisfied with the number of shifts cancelled or rescheduled and that changes and/or cancellations are not always communicated effectively to consumers and representatives. For example:

* The representative for Consumer E (HCP) stated that they require minimal assistance a week, and their services are often cancelled at the last minute. Often they are not advised in advance and alternative workers are rarely provided to cover the absence. The representative stated Consumer E becomes distressed and confused when there is a new support worker and, on many occasions, the representative has had to leave work to collect their father from the social support group. The representative stated this has been an ongoing issue and liaising with the service to ensure Consumer E receives care has been more stressful than if there was no care at all.

Eight of twenty-nine consumers sampled stated they would appreciate having access to the staff members that speak their first language.

* Consumer F (HCP) and Consumer G both stated they speak XX (language removed to ensure anonymity) and would prefer a support worker who speaks their language. Consumer F stated the support worker who attended used their mobile phone to translate, and they now speak basic English to communicate with the support worker.
* One Team Leader stated they are aware some consumers will request support workers who speak their preferred language, and this is not always possible to schedule with their current staff. The Team Leader advised staff are encouraged to use their mobile phone to translate and use picture books to communicate with consumers. The Team Leader stated when they identify a need for a support worker, ‘we flag that with recruitment and try to get them to hire someone from that demographic’.
* One staff member stated they found it difficult to communicate with several consumers using their telephone and have several non-English speaking consumers they have provided care and service to.

Twenty-nine of Twenty-nine care plans viewed were completed by the CCM, who, in each state is not clinically trained, and as detailed in Standards 2 and 3, care planning documentation was generally incomplete and did not provide support workers with the guidance to deliver best practice care and support to each consumer.

* When raised with management, they stated they have access to a pool of Registered Nurses that can assist when required, however, management acknowledged CCM’s do not consistently reach out to the clinical team, which impacts the service’s ability to deliver quality care and services.

The unfilled shifts report dated 16 May to 16 June 2023 evidenced the service was unable to fill 102 shifts, and in each of these instances, the consumer had stated they required care and services to be delivered:

* SA had 34 unfilled shifts.
* QLD had 25 unfilled shifts.
* NSW had 20 unfilled shifts.
* VIC had 18 unfilled shifts.
* WA had 3 unfilled shifts.

*Requirement 7(3)(c)*

In respect to Requirement 7(3)(c) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Staff interviewed identified they do not have adequate knowledge or qualifications to deliver outcomes for consumers in-line with the Aged Care Quality Standards. Staff and management were not able to demonstrate their workforce is competent, and the members of the workforce had the qualifications and knowledge to effectively perform their roles.

Management advised they recruited staff based on their experience and use targeted ads to target staff with specific skills. However, one State Manager advised they were not aware how competency for roles was assessed within the service and stated they assessed candidates through interview questions, reference checks and consideration of the interviewees experience.

Management advised they have recently restructured and identified the need for additional Service Delivery Team Leaders, which they are in the process of recruiting to support field staff and identify training needs. Adding there had been no formal audit of staff knowledge, training had been provided to Customer Care Management staff from feedback and questions asked. Training had also been offered as per the training calendar for CCM’s, noting this training calendar was provided to the Assessment Team, however, the training outlined on the calendar did not appear on the training register provided to the Assessment Team.

One comment in the feedback/incident register advised staff ‘do not know what to do’ to assist consumers. Feedback evidenced on 20 XXX 2023 (removed month to ensure anonymity) the staff member “did not know what to do” as the consumer’s house “was a mess and there was a bad smell”.

All staff interviewed in relation to Restrictive Practices stated they were unaware of what this practice was or how to identify a consumer who has an approved Restrictive Practice. One Manager interviewed stated the service does not have clients with Restrictive Practices and that is why staff do not know, adding their National Disability Insurance Service staff do, but not home care staff.

*Requirement 7(3)(d)*

In respect to Requirement 7(3)(d) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

The service was not able to 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. Interviews with staff and volunteers demonstrated the service does not consistently provide an induction, training, or support to the workforce.

The service was not able to demonstrate staff receive an induction, or sufficient training to deliver safe and effective care and services. While the service was able to demonstrate they have policies and procedures, they were not able to demonstrate awareness, or the application of the policies and procedures to guide staff in the delivery of safe care and services.

Staff advised they do not feel like they get all the training and support required to deliver safe and effective care and services. The Assessment Team observed the service's training records and observed that relevant staff had not completed training modules including, but not limited to, identifying abuse and neglect of consumers, dementia, incontinence care, and use of restraints.

The following statements were collected from interviews with staff:

* Three of five staff members interviewed advised they received minimal induction upon commencement with the service.
* One staff member stated they did not receive any training regarding the use of the electronic systems and documentation requirements and their induction took less than an hour.
* As discussed in Standard 2, the service has not supported CCM‘s to understand the requirements of appropriate assessment, planning and documentation required to ensure the delivery of safe and quality care and services.
* Staff are not effectively guided by policies and procedures, nor were they able to demonstrate they knew where to find the policies and procedures on the service’s internal systems.
* Two staff interviewed stated they were not aware who their manager was or who to contact to discuss or request training.
* One staff member stated they have no oversight from management, and they have no communication with office staff, except receiving their roster from scheduling.

Management advised how they are subscribed to the Aged Care Quality and Safety Commission and the Department of Health emails to receive notifications about relevant changes and provide updates to staff. However, when the Assessment Team interviewed staff, they stated they were unaware of the Serious Incident Response Scheme (SIRS) and had only received updates over the last week for the Code of Conduct (COC).

*Requirement 7(3)(e)*

In respect to Requirement 7(3)(e) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the service was not able to demonstrate regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. The Assessment Team observed, and management acknowledged, that the service is not effectively managing performance appraisals for staff. Sampled consumers and representatives advised the service does not seek feedback into the performance of the staff delivering care and services. Management advised they conduct an annual survey with consumers, however, were not able to demonstrate how these surveys seek feedback on individual staff behaviour and service delivery.

Management was not able to demonstrate that all staff had received a performance review within the past twelve months, adding a high number of staff have commenced within the last twelve months. Whilst management provided an email distributed to all staff that stated ‘in order to support with this performance management process, all staff are required to hold end of year reviews with their direct reports’, management did not provide documentation or evidence to demonstrate that performance reviews are conducted consistently for all staff.

* Two of five staff interviewed advised they have never received a performance appraisal while working for the service.
* One staff member interviewed advised they had not had a performance review in over two years. The staff member advised they had sat in their car crying on the side of the road several weeks ago after an extremely bad day and were not certain of who to call for guidance.
* One staff member interviewed stated they were not aware who their manager was, and they have had no performance reviews or been provided with feedback from the service.
* One staff member advised they had a performance assessment by a manager who no longer works in their role, and that they enjoy their role.
  + Whilst the Assessment Team requested evidence of completed performance reviews, the service could only provide two completed Performance Reviews for staff located in NSW.

Compliant Evidence

*Requirement 7(3)(b)*

Evidence analysed by the Assessment Team showed the service was able to demonstrate workforce interactions with consumers are kind, caring and respectful of each consumer’s identify, culture and diversity. All consumers said staff are kind, caring and respectful and staff and management spoke about consumers in a kind and respectful manner when talking with the Assessment Team about their services.

Twenty-five of thirty consumers and representatives sampled advised staff and home care workers were kind, caring, supportive and respectful.

Staff interviewed described how they provide care and services to consumers in a kind and respectful manner including how they respect their privacy and decisions. For example, staff advised when consumers change their mind, they know to respect their decision.

The workforce and management were observed speaking to, and engaging with, consumers in a respectful manner throughout the Quality Audit.

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

Findings

Non-compliant Evidence

Requirement 8(3)(a)

In respect to Requirement 8(3)(a) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the service was not able to 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.

While consumers and representatives described their general satisfaction with the services received, they were unable to describe how the service engages them in the evaluation of their personal care and services.

* Staff interviewed could not provide examples of how the service engages with consumers and representatives in designing and improving services.
* Management acknowledged they do not have effective systems in place to engage with consumers or seek feedback from consumers in relation to their experience or the quality of the care and services they receive. They advised that consumer and/or representative complaints are currently the only way the service can evaluate their care and services. However, as discussed at Standard 6, the service does not have an effective process to encourage and capture all feedback and complaints received from consumers and representatives.

The organisation could not demonstrate that there is an organisation wide approach to involve consumers in developing, delivering and evaluating their care and services.

*Requirement 8(3)(b)*

In respect to Requirement 8(3)(b) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the organisation was not able to 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 has an established governance framework, the organisation does not have effective data gathering, reporting, and monitoring systems and processes to enable effective governance oversight and accountability.

The Assessment Team identified that the governing body has not 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.

Meeting minutes viewed for:

* Clinical Practice Advisory Committee (CPAC) dated 15 December 2022 and 3 March 2023,
* Credentialing & Compliance Sub-Committee meetings dated 21 March 2023 and 16 May 2023,
* and the Governance Safety and Quality (GSQ) reports dated April 2023 and May 2023

showed discussions about organisational structure, roles and expectations including, human resources, staff education and training. The Assessment Team noted the Committees did not receive and/or discuss information related to Home Care and CHSP consumer care and services. Furthermore, the Committees did not receive or discuss information to enable the governing body to monitor the service’s performance relating to care and services provided to consumers in line with the requirements of the Aged Care Quality Standards, such as monitoring of consumer’s risks and vulnerabilities, incidents, assessments and reviews, feedback, and complaints.

The Assessment Team viewed an incident recorded on the incident register as a SAC 2 on 6 XXX 2023 (removed month to ensure anonymity) when a consumer was found on the floor as a result of a suspected XXX (removed to ensure anonymity) by a support worker. A review of additional information provided to the Assessment Team, as outlined at Standard 2, evidenced the consumer had been on the floor for several days and was in a state of distress at the time they were found. The Assessment Team noted this incident was recorded as a major incident (SAC2), however was not reported in the SAC 1 and 2 incidents reported to the Governing Body on the GSQ minutes dated 3 XXX 2023 or the QCGB minutes dated 21 XXX 2023 (removed months to ensure anonymity). The Assessment Team noted the minutes from the GSQ meeting dated 3 XXX 2023 stated (removed months to ensure anonymity), ‘See monthly incident report’, noting no follow up to this incident is recorded on the incident register, or the minutes of meetings viewed by the Assessment Team.

The Assessment Team noted that the service was not able to demonstrate effective understanding and application of some of Quality Standards’ requirements including related to consumer dignity and choice, ongoing assessment and planning, personal and clinical care, activities of daily living, feedback and complaints, human resources, and organisational governance, however, this had not been identified by the governing body through the organisation’s performance and continuous improvement processes.

*Requirement 8(3)(c)*

In respect to Requirement 8(3)(c) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Information Management:

The organisation was not able to demonstrate assessment and care planning information regarding the consumers’ risks, needs and preferences is consistently documented and communicated within the service. Staff advised they do not have access to accurate and/or completed consumer information, including identified risks and management strategies.

As documented within Standard 2, the service did not demonstrate that assessment, planning and review resulted in safe and effective care and services for consumers. The service did not demonstrate that outcomes of assessment, planning and review activities had been effectively documented and communicated to consumers and members of the workforce to inform consumer care and services.

As demonstrated under Standards 2 and 6, the service did not demonstrate that consumers were effectively involved, consulted, and/or provided with relevant information to enable them to make informed decisions about their care and services. For example, the service could not demonstrate that consumers had been informed about feedback and complaints avenues, engaged in consistent discussions about their choices or been involved in assessment, planning and review of their care and services.

* Four of five staff interviewed advised they could not see all notes entered in the electronic system for the consumer if notes were entered within the last 48-72 hours.
* One staff member stated they felt as though they ‘were going in blind’ when they had to provide care and services to a new consumer, or if another member of staff had recently attended to the consumer, because they could not see all the notes recorded by the previous staff member.
* Management advised access to information is restricted dependent upon the staff members role, adding support workers would not have access to view clinical notes.
* Review of consumer files by the Assessment Team showed that staff do not consistently document case notes in the consumers’ files following discussions with consumers and/or representatives regarding changes in the consumers’ condition, reviews, referrals, or changes/amendments to services required. For example:
  + When a consumer's shift is amended or cancelled due to staffing restraints, information is not consistently documented on the consumers progress notes to document why a shift was amended and if the consumer was satisfied with the change.

The organisation did not demonstrate how it effectively controls privacy and confidentiality of information that is stored and shared. Management was not initially aware they did not have additional security on the electronic application staff used to access consumer information via their mobile phone when providing care and services. Following feedback from the Assessment Team, management advised they spoke with their I.T. division, who advised the electronic app cannot be installed on a mobile device that can be ‘hacked’. The Assessment Team requested additional information regarding the security on the app and management advised there is a phone number staff can call 24 hours a day, 7 days a week to have the application deactivated in the event the staff member loses their phone. However, management acknowledged the application is not password protected and they will reinforce the requirement for staff to always keep their devices locked.

Financial Governance:

The organisation was not able to demonstrate an established, documented, and effective organisation-wide financial governance systems. Management advised the report of unspent funds is generated by finance team monthly and provided to State Managers for review and discussion with the CCM team. The top ten unspent fund balances held for consumers varied between $70,000 to $123,000, with all ten consumers listed, being in receipt of a L4 HCP.

The Assessment Team requested additional evidence in relation to the management of unspent funds, and management advised:

* There is a weekly meeting with the Executive Board where service hours are discussed. Noting these meetings are not recorded in meeting minutes.
* This is then discussed at a monthly performance meeting with the Chief Financial Officer, Chief Operating Officer, Finance Heads and General Manager for Home Care and NDIS. Noting these meetings are not recorded in meeting minutes.
* There is a monthly Board meeting where these matters are discussed, however, detailed minutes at a business unit level are not noted.
  + The new Chief Financial Officer is acutely aware and is monitoring business performance closely.

The Assessment Team noted that Consumer E (HCP) who has in excess of $100,000 in unspent funds is awaiting home modifications to assist with mobility. Upon review of Consumer E’s progress notes, the support worker who attends to Consumer E’s personal care, requested an additional staff member on 31 XXX 2023, 6 XXX 2023 and 13 XXX 2023 (month removed to ensure anonymity) to assist with the sling lifter, at the time of the Quality Audit, no additional support staff had been sourced. A review of Consumer E’s expenditure between March and May 2023, evidenced Consumer E was spending a higher amount on care and package management fees, than on the care and services being delivered to them over the three-month period, noting for the month of April 2023, no care and services were delivered.

Workforce governance, including the assignment of clear responsibilities and accountabilities:

The organisation was not able to demonstrate 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. As documented in Standard 7, the organisation did not demonstrate how they consistently support staff with their induction and ongoing training and with policies and procedures to ensure safe and effective services are delivered to consumers, in line with their goals, needs and preferences, and the Quality Standards.

Staff are not effectively guided by the service’s policies and procedures, nor were they able to demonstrate they knew where to find the policies and procedures on the service’s internal systems.

* Three of five staff interviewed were not aware of what policies, processes, and procedures they should refer to.
* Two of five staff interviewed were not aware who their manager was, with one staff member advising they had been working with the service almost a year and there had been no check-ins from their management.
  + Following feedback from the Assessment Team, management advised they have recently restructured, commencing with the office staff, information will be rolled out to field staff to provide additional support and guidance over the coming months.

Regulatory Compliance:

The service did not demonstrate 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. For example:

The organisation was unable to demonstrate regulatory compliance processes are in place including providing training and ensuring all staff are made aware of legislative updates and regulatory reforms related to consumer care and services.

* Three of five staff interviewed advised they were not aware of the regulatory reforms until they received an email during the Quality Audit from the service advising the ALIS training was mandatory, the staff interviewed could not recall any training provided by the service to identify abuse and neglect of consumers and Serious Incident Response Scheme (SIRS), or the Aged Care Code of Conduct.
* One State Manager advised they were not aware of the Banning Orders Register.

Management advised staff are required to access the SIRS decision support tool to determine if a SIRS report is required and provided documentation that evidenced this information was circulated to staff. However, documentation provided to the Assessment Team evidenced reports of neglect and other incidents that had not consistently been assessed or reported as SIRS, by staff, as required, for example:

* Consumer F (HCP) was identified at risk of neglect with the potential to cause serious harm when a support worker advised the consumer’s home was unclean and uninhabitable on 20 XXX 2023 (removed month to ensure anonymity), with the consumer smoking in their room and no windows open, there was food debris and insects in the home, the washing was piled up and five bags of rubbish was removed from the home by the support worker.

Evidence analysed by the Assessment Team showed two alleged thefts appeared on the incident register, the Assessment Team noted there was no evidence that a SIRS report was considered at the time of either incident. Noting, the Assessment Team requested a register of all SIRS incidents reported, however, this information was not provided during the Quality Audit.

While management could describe how the service maintains up to date information on legislative guidelines and regulatory reforms through correspondence and media releases from funding bodies and Australian Government websites, there was no evidence provided to demonstrate regulatory compliance against all relevant legislation, regulatory requirements, professional standards and guidelines is monitored and reported on to the Board.

Feedback and Complaints:

The organisation was not able to demonstrate effective systems and processes to capture, monitor, analyse and use feedback and complaint data to improve the quality of care and services. As documented in Standard 6, requirement (3)(a) and (3)(b), and at requirement (3)(a) of this Standard, the organisation did not demonstrate effective systems regarding encouraging feedback and complaints, or consistent continuous improvements made to service delivery as a result of feedback and complaints.

Continuous Improvement:

The Decision Maker notes based on the Service’s response to the Assessment Team Report, in particular, the comprehensive and detailed PCI that improvements have been made in this sub requirement to date.

The organisation 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. Whilst the service was able to demonstrate that once issues are identified they are then actioned appropriately, the Assessment Team noted systemic deficiencies in the processes to identify opportunities for improvement.

* Consumers interviewed advised they found it difficult to reach their CCM’s Manager, adding they had the direct number to call, however, would still wait significant periods of time for a return call.
* Staff interviewed identified communication was one of the identified areas for improvement within the service, based on complaints they received from consumers, and self-identified staff also experience long wait times when contacting the service and were not able to provide feedback on behalf of consumers when they are unable to reach the service by telephone.
* The Continuous Improvement Plan procedure outlines how actions are added to the PCI, however, does not provide staff with guidance in how to raise items for consideration.

*Requirement 8(3)(d)*

In respect to Requirement 8(3)(d) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Managing High-Impact or High-prevalence Risks:

Evidence analysed by the Assessment Team showed the organisation was not able to demonstrate effective systems and processes to identify, assess, manage and monitor risks to consumers. The organisation was not able to demonstrate staff were aware of clinical policies and procedures, and complied with them, and the governing body does not have effective processes to monitor and have oversight of high impact, high prevalence incidents. Management demonstrated some knowledge and understanding of individual consumer’s risks and vulnerabilities, however, as previously identified, the organisation did not demonstrate effective assessment of risks to consumers (see Standard 2 requirement (3)(a) for further information). As previously identified in requirement (3)(b) of this Standard, the organisation does not have effective governance processes to monitor high-impact or high-prevalence risks to consumers and prevent further risks.

The Assessment Team reviewed care planning documentation for four CHSP and twenty-nine HCP consumers and identified clinical assessments had not been completed for all consumers and for some consumers where a clinical assessment had been completed in the last twelve months, all risks had not been addressed. As outlined throughout Standard 7 and 8, staff interviewed were not aware of the organisations policies and procedures to support and guide best practice when delivering care and services to consumers.

Ten of twenty-nine consumers sampled stated they lived with pain, and this was managed by medication, however, no medication statement was provided for any of the sampled consumers, and a review of their care plans did not consistently indicate who managed the consumers medication as per the organisations medication policy. Management advised they do not hold medication charts in relation to medication management for consumers as support workers assist with Medication Prompting and Medication Assistance only.

On 15 XXX2023 (month removed to ensure anonymity) an incident report for Consumer F (HCP) advised Consumer F’s medication was located on the floor by a support worker, as documented in previous Standards. The Assessment Team reviewed the consumer’s care planning documentation provided during the Quality Audit, and noted:

* There was no medication statement provided for this consumer.
* The consumer’s care plan had not been updated since 19 XXX 2022 (month removed to ensure anonymity) despite multiple falls and the missed medication incident.
* The consumer had a fall on 9 XXX 2023 (month removed to ensure anonymity), during delivery of care and services, the consumer was assessed by the support worker for an hour. The CCM referred the consumer to speak to their GP following the fall.
* A welfare check phone call was made to Consumer F on 13 XXX 2023 (month removed to ensure anonymity) and the consumer confirmed they had attended their GP. The CCM also discussed additional medication the consumer was taking.
  + The Assessment Team noted the consumer stated to the support worker and CCM they have a lot of falls; however, no referral or Falls Assessment was evidenced.

Identifying and Responding to Abuse and Neglect of Consumers:

The organisation was able to demonstrate a procedure to recognise and report Elder Abuse policy and procedure is in place to guide staff. However, as documented under Standard 7, the service was not able to demonstrate that staff had been provided education in relation to identifying and reporting suspected elder abuse.

* The Assessment Team viewed care planning documents showing the service had identified elder abuse of four of their consumers by family members. The documents provided to the Assessment Team guided staff about not contacting the family member or instructed staff to leave the home if they felt unsafe, however, did not alert staff about the risks of elder abuse.

Incident Management System:

The organisation was not able to demonstrate effective incident management systems (IMS), 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 Assessment Team viewed the service’s incident register dated November 2022 to May 2023 and noted that, consumer’s incidents had been inconsistently recorded including the description of the incident and injury sustained and the service had not documented the incident’s investigation and evaluation, and/or strategies implemented to prevent further incidents to the consumer. Management advised, and provided documentation confirming, that incidents follow up is documented on the consumer’s care documentation, however, this is not documented in the incident management system.

The Assessment Team viewed an Incident Reporting and Management Procedure to guide staff, although management advised staff were provided incident management training, they did not provide evidence of the training to the Assessment Team and two staff interviewed stated they had not received this training.

The service did not demonstrate comprehensive or effective documentation of incidents, to enable the organisation to review and analyse issues related to incidents, and identify possible systemic issues, and/or enable reporting to the governing body as required.

* One staff member stated they had not completed an incident report form, despite working for the service for over two years.
* CCM’s do not have the appropriate education, skills, training or experience to effectively identify an incident once it has occurred or know when to escalate incidents or provide support workers with correct clinical guidance.

*Requirement 8(3)(e)*

In respect to Requirement 8(3)(e) the Decision Maker notes the Service responded proactively to the Assessment Teams findings and already implemented corrective actions. Additional details, evidence and a detailed plan for continuous improvement (PCI) provided by the service in their response on this occasion did not meet and/or exceed the threshold required for the Decision Maker to overturn the Assessment Teams recommendations. The Decision Maker is confident if the corrective action is followed through within its entirety the Service should return to compliance.

Evidence analysed by the Assessment Team showed the organisation was not able to demonstrate effective clinical governance framework including systems and processes to enable delivery of safe and quality clinical care to consumers. The organisation was not able to demonstrate effective consumer clinical assessment and care planning are undertaken to inform safe and quality clinical care, and the governing body does not have effective processes to monitor and have oversight of consumer’s clinical care. The organisation was not able to demonstrate that effective policies, procedures and training for staff are in place 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.

In relation to clinical governance framework:

The organisation has a Governance Framework document in place, including clinical governance roles and responsibilities, and oversight of clinical care through organisational committees. However, as previously identified in requirement (3)(b) of this Standard, the organisation does not currently monitor and report to the governing body in relation to consumer clinical risks and/or incidents. As identified in Standard 2 requirement (3)(a), the service was not able to demonstrate effective assessment and planning including consideration of clinical risks to the consumer’s health and well-being to inform the delivery of safe and effective care and services. The organisation was not able to demonstrate that staff, including the two RN’s being trialled in NSW, are effectively supported to deliver safe and quality clinical care, including access to policies, procedures and training.

In relation to minimising the use of restraint:

The organisation was not able to demonstrate understanding and application of this requirement. Staff interviewed in relation to Restrictive Practice stated they have not been provided training to guide them in the identification, reporting and/or use of consumer restraints.

Management advised they are not aware of any consumers with current restraint in place, and one member of management advised home care staff would not know about restrictive practices and associated policies because home care consumers do not have restrictive practices, adding that National Disability Insurance Scheme (NDIS) consumers do and there are policies and procedures in place for the NDIS workers to refer to. However, the Assessment team identified 4 consumers who may be in receipt of restrictive practices.

Open Disclosure:

The organisation was not able to demonstrate complaints are documented, addressed, or that an open disclosure process is practiced. As discussed in Standard 6, requirement (3)(a) and (3)(b), and at requirement (3)(a) of this Standard, the organisation did not demonstrate effective systems regarding feedback and complaints.

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)