**Performance**

**Report**

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| Name: | Home Care Assistance Gold Coast |
| Commission ID: | 700947 |
| Address: | Ground Ground Office Retail 1, 82 Marine Parade, SOUTHPORT, Queensland, 4215 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 25 June 2024 to 26 June 2024 |
| Performance report date: | 2 August 2024 |

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

# Service included in this assessment

Home Care Packages (**HCP**) included:  
Provider: 9176 Prestige Linx Pty Ltd  
Service: 26873 Home Care Assistance Gold Coast

**This performance report**

This performance report for Home Care Assistance Gold Coast (**the service**) has been prepared by E Blance, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Assessment contact (performance assessment) – site 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 19 and 23 July 2024
* other information known by the Commission

# Assessment summary for Home Care Packages (HCP)

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| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |
| **Standard 3** Personal care and clinical care | Not Compliant |
| **Standard 4** Services and supports for daily living | Not Compliant |
| **Standard 7** Human resources | Not Compliant |
| **Standard 8** Organisational governance | Not 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.

**Standard 2**

* Ensure assessments are completed for consumers where their care and service needs change to inform delivery of safe and effective care.
* Ensure that care and services are reviewed when circumstances change or incidents impact the needs of consumers.

**Standard 3**

* Ensure high impact high prevalence risks are effectively managed.
* Ensure where consumers experience clinical deterioration, clinical interventions and strategies are not implemented within a timely manner to support consumers health and wellbeing.
* Ensure that information about consumers’ condition and needs is communicated with those who share care responsibilities.

**Standard 4**

* Ensure equipment used by the consumer is safe, suitable, clean and well maintained.

**Standard 7**

* Ensure staff receive training to deliver the outcomes required by the Standards.

**Standard 8**

* Ensure the governing body receives effective information to support that the organisation promotes a culture of safe inclusive and quality of care.
* Ensure effective organisation wide governance systems in place for managing and governing all aspects of care and services particular to the training and education of staff under workforce governance.
* Ensure effective risk management framework to guide staff practice in identifying and responding to risk.
* Ensure an effective clinical governance framework where clinical care is provided.

# Other related matters:

I note the provider has engaged an external consultancy service to assist the provider to deliver the outcomes required by the Quality Standards and is committed to addressing the identified deficiencies in a timely manner.

# Standard 2

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| Ongoing assessment and planning with consumers | | HCP |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Not Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Not Compliant |

Findings

**Requirement 2(3)(a)**

The service was found to be non-compliant in this Requirement following a Quality Audit in April 2022. The service did not demonstrate assessment and planning includes consideration of risks to inform the wellbeing and delivery of safe and effective care.

An assessment of performance was conducted on 25 and 26 June 2024. The Assessment team report brought forward information the service did not demonstrate assessment and planning identified risks to consumers, and assessment and planning is not always conducted within an appropriate timeframe to inform the effective delivery of care and services. The Assessment team’s findings included:

* Appropriate assessments were not conducted for consumers following falls to determine risks.
* Appropriate assessments were not conducted for consumers requiring oxygen therapy.

The Assessment team report advises management committed to the following actions to mitigate risk to consumers:

* Staff meeting to inform and remind staff of their roles and job requirements in relation to care and services provided.
* Initiate daily progress note reviews to identify clinical incidents, and to monitor risks associated with the care provided to each consumer.
* Update clinical assessments within a reasonable timeframe as changes in a consumer’s condition occurs to ensure assessment and planning informs a safe delivery of care.
* Care plan reviews to be conducted for named consumers.
* Review oxygen management policy and train staff.

The provider’s response acknowledged the deficiencies identified within the Assessment team report and the provider has committed to undertaking the following continuous improvement actions:

* Review and update all mobility and falls risk assessments.
* Implement daily progress note reviews to identify clinical incidents, and to monitor risks associated with the care provided to each consumer. I note this has been implemented with the High Impact High Prevalence register.
* Implemented an oxygen therapy policy and procedure.
* Staff training in relation to oxygen monitoring, risk identification, assessment, and care planning, and falls management.

I have considered the information within the Assessment team report and the provider’s response. The plan for continuous improvement (PCI) and other documents within the provider’s response demonstrated the service has proactively commenced rectification processes. I have reviewed care plans and other information related to the named consumers within the report under this Requirement and note that actions to mitigate risk including the review of care plans and implementation of dignity of risk assessments have been completed. I accept that a named consumer within the report was informed of risks in relation to decline of transfer to hospital. I note the service has established policies related to the information brought forward under this Requirement. I note the assessment and planning policy includes that the service commits to conducting assessment of risks to consumers’ safety and health and wellbeing and undertaking additional reviews of consumers’ care plans where consumers’ condition changes or an incident occurs. Other policies have been updated and/or implemented to guide staff practice in relation to the information brought forward under this Requirement.

I have placed weight on information brought forward in the Assessment team report where a consumer was not reassessed in a timely manner following an incident who continued to be impacted by falls and assessments had not been conducted for the maintenance and cleaning and management requirements for consumers requiring oxygen management. I am not satisfied the service has effectively managed noncompliance within this Requirement to ensure that assessment and planning informs the delivery of safe and effective care. While the provider has committed to undertaking continuous improvement activities to mitigate risks to consumers, I am of the view these actions have not had sufficient time to become embedded to ensure their effectiveness and sustainability. I find Requirement 2(3)(a) not compliant.

**Requirement 2(3)(b)**

The service was found to be non-compliant in this Requirement following a Quality Audit in April 2022. The service did not demonstrate consumers’ current needs, goals and preferences including for advance care and end of life planning were addressed.

An assessment of performance was conducted on 25 and 26 June 2024. The Assessment team report brought forward information the service did not demonstrate assessment and planning includes, identifies and addresses advance care planning and end of life planning for consumers. The Assessment team’s findings included:

* Care documentation demonstrated consumers have not been involved in advance care planning discussions.
* Management advised consumers had not been involved in advance care planning.
* Management was unable to determine how many consumers within the service had outstanding advance care plans and could not demonstrate a process to ensure advance care planning is updated and reviewed as consumers needs change.
* The service was unable to provide policies or procedure which guided staff practice for advance care planning.

The Assessment team report advises management committed to the following actions to mitigate risk to consumers:

* Consumers will receive discussions in relation to their advance care plan goals and preferences, and care plans will be updated to guide staff in relation to consumers end-of-life preferences.
* The service will ensure all consumers entering the service will have their advance care planning goals and preferences recorded upon commencement with the service if the consumer chooses to share this information.

The provider’s response challenged the deficiencies identified within the Assessment team report however committed to the following:

* Advance care planning is discussed upon commencement with the service where the consumer wishes and information is provided to consumers to complete.
* Some consumers have declined to discuss advance care planning. Where consumers have declined to discuss their wishes, their goals will be recorded in their care plans to guide staff.
* Information regarding advance care planning will be recorded by case managers on a register.
* The service will continue to encourage conversation about advance care/end of life planning upon reviews and where circumstances change for consumers.

I have considered the information within the Assessment team report and the provider’s response. The provider has included within the response information of access to the service’s system to access policies and procedures. The provider did not include evidence of an advance care/end of life policy; however, I accept the providers advice that the service has one. Review of the service’s assessment and planning policy (updated on 12 July 2024) includes that the organisation commits to partnering with consumers and others in their care for planning services related to advance care/end of life planning. Care plans contained in the provider’s response identified 4 of the 5 care plans contained goals and preferences related to advance care/end of life planning, demonstrating a discussion about advance care/end of life planning has occurred. I accept that not all consumers wish to discuss their advance care/end of life wishes and I am satisfied the service has information/resources about advance care/end of life planning to encourage a conversation with consumers.

I consider no impact has been identified for consumers. I am satisfied the service has captured the goals and preferences for end of life planning for consumers. The provider has committed to undertaking continuous improvement activities, I am of the view these actions are sufficient to ensure their effectiveness and sustainability. I find Requirement 2(3)(b) compliant.

**Requirement 2(3)(c)**

The service was found to be non-compliant in this Requirement following a Quality Audit in April 2022. The service did not demonstrate assessment and planning is in partnership with the consumer and other organisations involved in the care of the consumer.

An assessment of performance was conducted on 25 and 26 June 2024. The Assessment team report brought forward information the service did not demonstrate assessment and planning is in partnership with the consumer and other organisations involved in the care of the consumer. The Assessment team’s findings included:

* The service has not engaged with other organisations who supply oxygen therapy to ensure the consumer’s needs are met in the operation of the equipment to guide staff in monitoring and servicing the equipment.
* The service did not have a process to monitor consumers who use oxygen therapy equipment provided by others involved in the care of consumers.
* The service had not engaged with a consumer following the consumer experiencing a fracture. The consumer said while the service occasionally phone, the consumer was required to engage other organisations to assist them as the service could not meet their needs.

The Assessment team report advises management committed to the following actions to mitigate risk to consumers identified in previous identified non-compliance in 2022:

* The service’s PCI outlined a planned action due for September 2024 to identify each consumer’s preferred level of involvement in their care, and preferences will be recorded.

The provider’s response challenged the deficiencies identified within the Assessment team report however committed to the following:

* Review all third party equipment provider contracts to ensure compliance with preventative maintenance for oxygen therapy equipment.
* Ensure management of oxygen therapy is included in audits and care plan reviews.
* Provide education to staff about equipment and falls management, risk identification and high impact high prevalence care plan evaluations.

Review of the provider’s response demonstrated the service has engaged with others involved in the care of named consumers. In addition, the provider has implemented measures to identify and review the care plans for all consumers who receive care from others to ensure assessment and planning includes ither organisations. Review of documents within the provider’s response identifies consumers who self-manage their package and I am satisfied the service has assisted with My Aged Care assessment for an increase in package funds to assist the consumer.

I have placed weight on the information received from the provider, and I consider that impact to consumers has been mitigated through the actions of the service provider. I am satisfied the service has effectively managed non-compliance within this Requirement to ensure that assessment and planning is in partnership with consumers and other organisations. The provider has committed to ongoing continuous improvement activities to mitigate risks to consumers including that care plans have been reviewed. I find Requirement 2(3)(c) compliant.

**Requirement 2(3)(d)**

The service demonstrated the outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan. The service uses an electronic care management system to monitor care and service plan reviews. Consumers say they have access to their care and services plan. Outcomes of assessment and planning is documented in care plans each 3 months in consultation with consumers. I find Requirement 2(3)(d) compliant.

**Requirement 2(3)(e)**

The service was found to be non-compliant in this Requirement following a Quality Audit in April 2022. The service did not demonstrate care plans were updated when a consumer’s condition changed or when incidents occurred, and not all care and services were reviewed on the agreed review date documented on the consumer’s care plan.

An assessment of performance was conducted on 25 and 26 June 2024. The Assessment team report brought forward information the service did not demonstrate care and service plans are regularly reviewed for effectiveness when circumstances change or incidents impacted on the needs of a consumer. The Assessment team’s findings included:

* Consumers care plans have not been reviewed to identify consumers’ current needs and goals for consumers who have experienced incidents.

The Assessment team report advises management committed to the following actions to mitigate risk to consumers:

* Staff to undertake training in relation to falls management processes.
* Case Managers to conduct daily progress note reviews to identify and action changes in consumer’s care needs.
* Case conferencing will occur for named consumers.
* Care plans will be reviewed.
* Quarterly meetings to debrief and discuss any consumer changes identified.

The provider’s response acknowledged the deficiencies identified within the Assessment team report and the provider has committed to undertaking the following continuous improvement actions:

* Review and update all mobility and falls risk assessments.
* Implement daily progress note reviews to identify clinical incidents, and to monitor risks associated with the care provided to each consumer. I note this has been implemented with the high impact high prevalence register.
* Provide education to staff.
* Ensure changes in consumer behaviour are assessed and evaluated for their effectiveness.
* Offer external referral as needed and appropriate

Review of documentation within the provider’s response demonstrated for one named consumer there was a risk of harm experienced with another named consumer and referrals to other services had been offered by the provider and declined by the consumer. I note the consumer is regularly reviewed by their medical officer. However, for the named consumer, care planning documentation does not include strategies to guide staff to support the consumer’s physical and emotional wellbeing following the incidents on 16 November 2023 and again on 30 June 2024.

I acknowledge the service has documented in the care plan of a named consumer strategies to guide staff and support the consumer, where they experience carers stress and is regularly reviewed by their medical officer.

I have also considered the provider’s response to Requirement 2(3)(a) in relation to re-assessment of consumers who have experienced a change or incident where their care plans were not reviewed for effectiveness. I accept the service has an assessment and planning policy.

I have considered the information within the Assessment team report and the provider’s response. I am not satisfied the service has effectively managed non-compliance within this Requirement to ensure that care and services are reviewed when circumstances change or incidents impact the needs of consumers. While the provider has committed to undertaking continuous improvement activities to mitigate risks to consumers, I am of the view these actions have not had sufficient time to become embedded to ensure their effectiveness and sustainability. I find Requirement 2(3)(e) not compliant.

# Standard 3

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| Personal care and clinical care | | HCP |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not 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. | Not 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. | Not Compliant |

Findings

**Requirement 3(3)(b)**

The service was found to be non-compliant in this Requirement following a Quality Audit in April 2022. The service did not demonstrate high impact high prevalence risks had been identified or adequately assessed to demonstrate they are effectively managed and care plans did not consistently document risk prevention strategies to manage all risks associated with the care of the consumer.

An assessment of performance was conducted on 25 and 26 June 2024. The service has taken the following actions to address previous non-compliance:

* The service has a reviewed assessments associated with consumer’s who are subject to high impact high prevalence risks.
* Staff have received training in relation to the importance of identifying clinical changes, and reporting risk to ensure consumer’s receive appropriate clinical assessments as changes occur.

The Assessment team report brought forward information the service did not demonstrate high impact high prevalence risks are effectively managed. The Assessment team’s findings included:

* The service was unable to demonstrate a process for monitoring high prevalence and high impact risks associated with the care of consumers.
* Care documentation demonstrated support staff had performed clinical assessments and handled medical equipment that does not align with their scope of practice.

The Assessment team report advises management committed to the following actions to mitigate risk to consumers:

* Staff meeting to be held to inform and remind staff of roles and responsibilities including scope of practice.
* Implement daily progress note reviews to identify clinical incidents, and to monitor risks associated with the care provided to each consumer.
* Review care plans of named consumers.

The provider’s response challenged the deficiencies identified within the Assessment team report. Documents reviewed within the provider's response did not address the process deficiencies identified in relation to the effective management of the named consumer’s identified care needs including an elevated blood pressure recording and blood glucose level, at the time they were identified by staff. I note the named consumer’s medication support and prompting care plan includes the consumer administers and manages their medications independently and the nutrition assessment instructs staff to monitor blood glucose levels. I acknowledge the named consumer has now been assessed by the medical officer and a plan for care has been established, however I have placed weight on the information within the Assessment team report regarding a deficit in the process for managing consumers where risk has been identified.

The Assessment team report brought forward information about staff operating equipment outside of their scope of practice. There is insufficient information regarding staff performing or recording blood pressure and blood glucose cares to form a view of scope of practice. However, elevated levels were recorded, and the service was unable to demonstrate this was escalated to registered staff or management at the time to ensure effective management of the consumer’s conditions. In relation to oxygen management, staff advised the assessment team they adjust oxygen equipment under the guidance of the consumer, where there was no assessment in place to guide staff practice, nor training, or policies/procedures to guide staff. I acknowledge these deficiencies are being addressed by the service.

While I acknowledge a named consumer who continued to experience shortness of breath has received treatment, other consumers received oxygen therapy without sufficient assessment for the cleaning, operation and management of the oxygen therapy equipment, as well as operation of the equipment by staff who were not trained. I have also considered other information under Requirement 2(3)(a) regarding the effective management of consumers who experience falls. Strategies in place to assist consumers who experience falls were ineffective. Staff did not follow the service’s policies and procedures for the effective management of falls including escalating incidents to management and evaluating the effectiveness of strategies in place for falls management. I acknowledge the service advises clinical incidents, indicators and actions are escalated to the board for review and monitoring.

I have placed weight on the evidence within the Assessment team report the service does not have systems and processes in place to effectively manage high impact high prevalence risks. This is further supported in the information brought forward in Requirement 8(3)(d).

I have considered the service’s PCI which does not specifically address this Requirement; however, I have considered further continuous improvement actions planned by the service. I am not satisfied the service has effectively managed non-compliance within this Requirement to ensure effective management of high impact high prevalence risks for consumers. While the provider has committed to undertaking continuous improvement activities to mitigate risks to consumers, I am of the view these actions have not had sufficient time to become embedded to ensure their effectiveness and sustainability. I find Requirement 3(3)(b) not compliant.

**Requirement 3(3)(d)**

The service was found to be non-compliant in this Requirement following a Quality Audit in April 2022. The service did not demonstrate consumers who experienced deterioration or a change in their condition received appropriate referrals, and their changed condition was not always escalated to clinical staff.

An assessment of performance was conducted on 25 and 26 June 2024. The service has taken the following actions to address previous non-compliance:

* Staff received training in March 2024 in relation to the importance of recognising and responding to clinical deterioration.
* The service reviewed their referral process in March 2024, and staff received education in relation to information sharing with those who share care responsibilities.

The Assessment team report brought forward information that clinical deterioration is not recognised, and where consumers experience clinical deterioration, clinical interventions and strategies are not implemented within a timely manner to support consumers health and wellbeing. The Assessment team’s findings included:

* Staff did not escalate falls incidents to management and consumers continued to experience falls.
* Deterioration of consumers was not recognised and responded to in a timely manner, strategies in place to assist consumers who experience falls were not evaluated for effectiveness.

The Assessment team report advises management committed to the following actions to mitigate risk to consumers:

* Staff meeting to inform and remind staff of their roles and responsibilities in relation to reporting incidents and changes in consumer’s conditions within a timely manner.
* Initiate daily progress note reviews to identify clinical incidents, and to monitor risks associated with the care provided to each consumer.

The provider’s response did not challenge the information brought forward in the Assessment team report. The provider has undertaken investigation of systems and processes and determined the following actions to mitigate risk to consumers:

* Staff education in identifying the importance of recognising and responding to clinical deterioration, escalating procedures and incident management.
* Review of systems.
* Registered staff to review incidents and evaluate outcomes.
* Staff meetings to discuss consumer’s ongoing care changes and needs.
* Document concerns and trends in the PCI and monitor through registers.
* Performance review and training of staff.

I have considered the information within the Assessment team report and the provider’s response. I am not satisfied the service has effectively managed non-compliance within this Requirement to ensure that deterioration or a change in a consumer’s condition is responded to in a timely manner. While the provider has committed to undertaking continuous improvement activities to mitigate risks to consumers, I am of the view these actions have not had sufficient time to become embedded to ensure their effectiveness and sustainability. I find Requirement 3(3)(d) not compliant.

**Requirement 3(3)(e)**

The service was found to be non-compliant in this Requirement following a Quality Audit in April 2022. The service did not demonstrate consumers’ condition, needs and preferences were communicated effectively within the organisation and with others where responsibility for care was shared.

An assessment of performance was conducted on 25 and 26 June 2024. The service has taken the following actions to address previous non-compliance:

* The service reviewed their referral process in March 2024, and staff received education in relation to information sharing with those who share care responsibilities.
* All consumers have received a review of their care and service plans within the last 3 months to identify their goals, needs, and preferences.

The Assessment team report brought forward that information about consumers’ condition and needs was not communicated with those who share care responsibilities. The Assessment team’s findings included:

* For consumers who experienced a fall with sustained injuries and declined hospital transfer, or shortness of breath and elevated blood pressure and blood glucose readings, the service did not demonstrate information about their changed condition and needs were shared with the consumer’s medical officer for consideration of medical review.
* Staff explained, and care documentation demonstrated the service did not communicate with allied health in relation to consumers who experienced falls where mobility needs were changed.

The provider’s response included additional information about the named consumers including care plans. While I acknowledge a named consumer was in regular consultation with their medical officer regarding their health, the provider’s response did not include documented information which demonstrated a change to the named consumers’ condition was effectively communicated with others who shared responsibility of care. Additionally, for the named consumer who experienced falls, the provider’s response did not demonstrate information was communicated with others who share care responsibilities to improve the safety, effectiveness and consistency of care and reduce the risk of harm.

I have considered the information within the Assessment team report and the provider’s response. I am not satisfied the service has effectively managed non-compliance within this Requirement to ensure that information is documented and shared with others who share responsibility of care. I find Requirement 3(3)(e) not compliant.

# Standard 4

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| Services and supports for daily living | | HCP |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Not Compliant |

Findings

**Requirement 4(3)(d)**

The service was found to be non-compliant in this Requirement following a Quality Audit in April 2022. The service did not demonstrate staff know the care needs of consumers, changes were not communicated effectively, and the service did not demonstrate effective processes to communicate or share information with brokerage services where conditions and needs changed.

An assessment of performance was conducted on 25 and 26 June 2024. The service has taken the following actions to address previous non-compliance:

* Conducted a review of all consumer’s care documentation to ensure information about the consumer’s condition needs and preferences are documented in a care plan.

The Assessment team report brought forward information that consumers/representatives say they mostly receive regular staff and staff know the consumer’s needs and preferences. Staff are alerted to any changes in the consumer’s condition, care or services. Care plans provide sufficient information to deliver care and services that meet the consumer’s needs and preferences. I find Requirement 4(3)(d) compliant.

**Requirement 4(3)(g)**

The service was found to be non-compliant in this Requirement following a Quality Audit in April 2022. The service did not demonstrate clear processes to ensure equipment used by the consumer is safe, suitable, clean and well maintained and clear responsibilities for the safe use, ongoing suitability and maintenance of equipment were not documented.

An assessment of performance was conducted on 25 and 26 June 2024. The service has taken the following actions to address previous non-compliance:

* Initiated a Home Risk Assessment to identify equipment and maintenance requirements for equipment purchased through the Home Care Package (HCP).

The Assessment team report brought forward information that while consumers/representatives were satisfied with the equipment purchased through the HCP, they were unable to describe how the equipment is maintained by the service. The Assessment team’s findings included:

* Home Risk Assessments have recently been initiated to assess the maintenance requirements of consumer’s equipment purchased through the HCP.
* Management and case managers were not able to describe an effective process for monitoring the maintenance requirements of equipment provided through the HCP.
* Care documentation did not describe the equipment the service provides through the HCP, how it should be used or who is responsible for maintenance and/or servicing.

The Assessment team report advises management committed to the following actions to mitigate risk to consumers:

* Review of the admission clinical assessment form, and consumers entering the service will have assessments regarding equipment conducted during their admission process.

The provider’s response did not challenge the information brought forward in the Assessment team report. The provider has undertaken continuous improvement actions to mitigate risk to consumers and has committed to the following:

* Review the admission clinical assessment form, and consumers entering the service will have assessments regarding equipment conducted during their admission process.
* Assessments will be conducted to identify the service’s responsibilities in relation to the monitoring of equipment supplied through the HCP.

I have considered the information within the Assessment team report and the provider’s response. I am not satisfied the service has effectively managed non-compliance within this Requirement to ensure that where equipment is provided it is safe suitable and clean. While the provider has committed to undertaking continuous improvement activities to mitigate risks to consumers, I am of the view these actions have not had sufficient time to become embedded to ensure their effectiveness and sustainability. I find Requirement 4(3)(g) not compliant.

# Standard 7

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| Human resources | | HCP |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

**Requirement 7(3)(c)**

The service was found to be non-compliant in this Requirement following a Quality Audit in April 2022. The service did not demonstrate service and brokered staff have the required competencies and knowledge to perform their role.

An assessment of performance was conducted on 25 and 26 June 2024. The service has taken the following actions to address previous non-compliance:

* Reviewed position descriptions including scope of practice for all staff responsible for assessment, care planning and the delivery of care and services.
* Established a supplier register that hold details of suppliers, agreements credentials, service capability, mandatory obligations; and establish responsibility for maintenance and review of the register.

The Assessment team report brought forward information that while consumers/representatives were satisfied that staff were knowledgeable, competent and they felt safe, and that systems to ensure staff and brokered services have the required qualifications and certifications were effective, some staff had conducted care outside of their scope of practice. The Assessment team’s findings included:

* The service did not have systems in place to ensure staff are providing care and services within their scope of roles and responsibilities in relation to oxygen therapy management, blood pressure and blood glucose management.

The provider’s response did not challenge the information brought forward in the Assessment team report. The provider has undertaken continuous improvement actions to mitigate risk to consumers and has committed to the following:

* Staff meeting held with all staff to explain, inform, and educate staff of their roles and responsibilities (scope of practice) in relation to care and services provided to consumers.

There is insufficient information regarding staff undertaking blood pressure and blood glucose checks to determine if staff worked outside of their scope of practice. I have considered information regarding performance management of staff undertaking oxygen management in Requirement 7(3)(e).

I have considered information brought forward in the Assessment team report regarding the service not demonstrating all staff have participated in risk management training to inform the safe delivery of care and services under Requirement 7(3)(d).

I have considered information under Requirement 8(3)(c) and I am satisfied the service has reviewed position descriptions, policies, and procedures to outline roles and responsibilities for clinical governance.

I have considered the information within the Assessment team report and the provider’s response. I consider that the service has undertaken proactive continuous improvement activities to mitigate risks to consumers in relation to ensuring the workforce have the qualifications and knowledge to effectively perform their roles. I find Requirement 7(3)(c) compliant.

**Requirement 7(3)(d)**

The service was found to be non-compliant in this Requirement following a Quality Audit in April 2022. The service did not demonstrate the workforce had received training to deliver the outcomes required by the Standards.

An assessment of performance was conducted on 25 and 26 June 2024. The service has taken the following actions to address previous non-compliance:

* Reviewed the orientation program to ensure new staff complete the mandatory training and are provided with information such as the Charter of Aged Care Rights and the Aged Care Code of Conduct before commencing work
* Implemented mandatory training for all staff including education surrounding the serious incident reporting scheme (SIRS) and the Standards.
* External providers of home maintenance and allied health services are provided with information about the SIRS and how to report an incident.

The Assessment team report brought forward information that while the service had undertaken measures to ensure staff had received training to deliver the outcomes required by these Standards, the service did not demonstrate all staff have participated in risk management training to inform the safe delivery of care and services, and staff did not demonstrate a shared understanding of the SIRS, risk management, or restrictive practices. The Assessment team’s findings included:

* Staff said they have not received training in risk management.
* Review of care documentation for 7 consumers identified that risks associated with the care of the consumer are not consistently identified or managed.
* Staff were not able to describe types of restrictive practices, the SIRS or what constitutes as a reportable incident.
* Staff said they have not received training in restrictive practices or the SIRS.
* Management and staff confirmed care staff providing care to consumers who require mobility assistance have not received manual handling training.
* Management was not able to describe an effective process to monitor staff have completed mandatory training annually as per the service’s policies and procedures.
* Staff had not received training in oxygen therapy management.
* Management and staff confirmed they had not received training in the effective management of high-impact and high-prevalence risks including how to identify, report, monitor and manage risks.

The Assessment team report advises management committed to the following actions to mitigate risk to consumers:

* Management will provide education to staff in relation to risk management in staff meetings and one on one sessions with staff.
* Scheduled education for all staff in restrictive practices, risk management and the SIRS.
* The service has purchased equipment and engaged external organisations to provide manual handling training and have scheduled training for all staff who perform manual handling.
* Develop a process to monitor staff completion of annual mandatory training.

The provider’s response did not challenge the information brought forward in the Assessment team report. The provider has undertaken continuous improvement actions to mitigate risk to consumers and has committed to the following:

* Commenced training for staff in relation to incidents, restrictive practices, the SIRS, and risk management in staff meetings and at one-on-one sessions.
* Incident management is now a standing agenda item for all staff meetings.
* Clinical incident indicators and actions are escalated to the board for review and monitoring.
* The service has purchased equipment and engaged external allied health organisation to provide manual handling training.
* Developed a process to monitor staff completion of annual mandatory training and to ensure all staff comply with yearly updated training.

I have considered the information within the Assessment team report and the provider’s response. I am not satisfied the service has effectively managed non-compliance within this Requirement to ensure that staff have been trained to deliver the outcomes required by the Standards. While the provider has committed to undertaking continuous improvement activities to mitigate risks to consumers, I am of the view these actions have not had sufficient time to become embedded to ensure their effectiveness and sustainability. I find Requirement 7(3)(d) not compliant.

**Requirement 7(3)(e)**

The service was found to be non-compliant in this Requirement following a Quality Audit in April 2022. The service did not demonstrate an effective system to regularly evaluate how staff are performing their role, including subcontracted staff through brokered arrangements.

An assessment of performance was conducted on 25 and 26 June 2024. The service has taken the following actions to address previous non-compliance:

* Reviewed brokered and subcontractor agreements and processes to include the roles and responsibilities of the supplier.

The Assessment team report brought forward information that the service did not have an effective performance review system to ensure all staff have participated in regular performance assessments, and ensuring staff are conducting work within their allocated roles and responsibilities. The Assessment team’s findings included:

* While staff said they completed the self-assessment and provided it to management, they did not participate in a performance review.
* Management said not all staff have participated in an annual performance review as per the service’s policies and procedures.

The Assessment team report advises management committed to the following actions to mitigate risk to consumers:

* Management added an action to the service’s PCI to implement an annual, or as required, employee performance review schedule to ensure all employees have received constructive performance feedback and identify professional development opportunities

The provider’s response challenged the information brought forward in the Assessment team report. The provider has undertaken continuous improvement actions to mitigate risk to consumers and has committed to the following:

* Implement an annual, or as required, employee performance review schedule to ensure all employees have received constructive performance feedback and identify professional development opportunities.
* Support staff to complete mandatory training and monitor staff’s completion of mandatory training.

I have considered the information within the Assessment team report and the provider’s response. Review of documents within the provider’s response demonstrated performance reviews have been conducted, including information in the PCI which advises for staff who undertook oxygen therapy management outside of scope of responsibilities. I have placed weight on the information provided by consumers who are satisfied with the performance of staff, and I have considered other information within the Assessment team report which demonstrates the service has systems assessing and monitoring the performance of staff including through feedback and complaints, surveys, consumer advisory committee reports and demonstration of instances of performance management. I find Requirement 7(3)(e) compliant.

# Standard 8

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| --- | --- | --- |
| Organisational governance | | HCP |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Not 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. | Not 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. | Not 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. | Not Compliant |

Findings

**Requirement 8(3)(a)**

The service was found to be non-compliant in this Requirement following a Quality Audit in April 2022. The service did not demonstrate consumers were actively engaged in designing and improving care and services.

An assessment of performance was conducted on 25 and 26 June 2024. The service has taken the following actions to address previous non-compliance:

* Reviewed the assessment and care planning policies and related procedures to ensure consumers/representatives are consulted about assessment outcomes and their care and service needs.
* Established a consumer advisory body to meet regularly to evaluate care and services and identify areas for improvement.
* Developed consumer satisfaction surveys to provide consumers/representatives with the opportunity to evaluate care and services and identify areas for improvement.

The Assessment team report brought forward information that consumers/representatives say they feel comfortable to provide feedback or make a complaint and said staff would be responsive to their concerns. Advisory meetings invite consumers to evaluate care and services and identify areas for improvement. Consumers are invited to social events to create an open and relaxed forum for consumers/representatives to provide feedback.

I have considered the information within the Assessment team report and the provider’s response. I am satisfied the service has effectively managed non-compliance within this Requirement to ensure consumers are actively engaged in designing and improving care and services. I find Requirement 8(3)(a) compliant.

**Requirement 8(3)(b)**

The service was found to be non-compliant in this Requirement following a Quality Audit in April 2022. The service did not demonstrate the governing body receives information related to continuous improvement, understands and sets priorities to improve the performance of the service against the Standards, or trends and analyses indicators of performance against the standards.

An assessment of performance was conducted on 25 and 26 June 2024. The service has taken the following actions to address previous non-compliance:

* Established a Board and a Quality Care Advisory Body to monitor the service’s performance against the quality standards and regulatory requirements. Interviews with members of the board and meeting minutes confirm this action has been completed.
* The Board and management have been provided with access an electronic system to review incidents and consumer feedback and complaints to assess the service’s performance and identify areas for improvement.
* Delivered mandatory training to provide staff with the knowledge and skills required to deliver the outcomes required by the Standards.
* The service engaged an external auditor to assess the service’s performance against the quality standards.
* Reviewed brokerage and subcontractor agreements and processes to include the roles and responsibilities of the supplier.

The Assessment team report brought forward information the service did not demonstrate effective systems to ensure the governing body receives performance indicators, such as clinical indicators incidents, consumer feedback and complaints, to identify risk, areas for improvement or training needs of staff. The Assessment team’s findings included:

* The Board did not have access to incident reports or consumer feedback and complaints to identify trends or areas for improvement.
* The service was not able to demonstrate effective processes for collecting and analysing quality indicators of care to identify areas of risk or risk mitigation strategies.

The Assessment team report’s findings include:

* The service was not able to demonstrate the governing body (including management and the Board) has access to incident reports or consumer feedback and complaints to identify trends or areas for improvement.
* The service was not able to demonstrate effective processes for collecting and analysing quality indicators of care to identify areas of risk or risk mitigation strategies.
* The Board met for the first time on 21 June 2024. Meeting minutes demonstrated the Board were informed of their roles and responsibilities and the agenda for future meetings. Agenda topics included regulatory compliance, feedback and complaints, key performance indicators and risks associated with the care of consumers.
* Quality Care Advisory Body meeting minutes dated 7 June 2024 demonstrate outcomes of an audit were discussed and actions taken to address any identified deficiencies were documented, and the service is committed to completing PCI actions by the end of July 2024.

The provider’s response challenged the information brought forward in the Assessment team report. The provider’s response included:

* Quality and clinical performance indicators such as clinical indicators, clinical and workplace incidents, consumer feedback and complaints, and financial reports to identify risk trends, areas for improvement or training needs of staff are reviewed by the Board.

I have considered the information within the Assessment team report and the provider’s response. While I acknowledge an agenda included within the provider’s response indicates the Board and leadership team discussed service information, I have taken into consideration incidents recorded within the organisation’s electronic care management system are not captured within the organisation’s incident system. Meaning the governing body do not have access to all incidents recorded to identify trends or areas for improvement which is discussed under Requirement 8(3)(d). I am not satisfied the outcomes of the process has been effective. I am influenced by the ongoing non-compliance findings across the Standards in relation to care and services at the service, and I am not satisfied recently established meetings have had sufficient time to become embedded to ensure their effectiveness and sustainability. I find Requirement 8(3)(b) not compliant.

**Requirement 8(3)(c)**

The service was found to be non-compliant in this Requirement following a Quality Audit in April 2022. The service did not demonstrate it has effective organisation wide governance systems in place for managing and governing aspects of care and services in relation to information management, continuous improvement, workforce governance, regulatory requirements and feedback and complaints.

An assessment of performance was conducted on 25 and 26 June 2024. The service has taken the following actions to address previous non-compliance:

* Reviewed position descriptions, policies, and procedures to outline roles and responsibilities for clinical governance.
* Reviewed consumer service agreements and consumer information books to include the Charter of Aged Care Rights, the consumer’s HCP Package budget and contact information for advocacy groups.
* Reviewed systems used for HCP budgeting and producing monthly financial statements to ensure consumers receive timely and accurate information to make informed decisions.

The Assessment team report brought forward information that while the service demonstrated effective organisation wide governance systems for information management, continuous improvement, financial governance, and feedback and complaints, the service did not demonstrate effective systems for monitoring workforce governance or regulatory compliance. The Assessment team’s findings included:

* The service did not demonstrate effective systems to:
  + monitor the completion of mandatory training.
  + ensure staff performance is regularly assessed.
  + ensure staff are performing work within their allocated roles and responsibilities.
  + ensure staff have the required skills and knowledge of to perform the outcomes required by the Standards.
* The service did not demonstrate staff have the knowledge to identify serious incidents or the use of restrictive practices, and the service does not have an effective system to ensure serious incidents, including the inappropriate use of restrictive practices are identified and reported. Some case managers and most care staff interviewed were not able to describe the types of restrictive practices.

The provider’s response did not challenge the information brought forward in the Assessment team report. The provider has committed to undertaking continuous improvement actions to mitigate risk to consumers.

I have considered and acknowledge the provider’s response which demonstrated the SIRS reporting in relation to identified incidents. There is insufficient information to determine ineffective regulatory systems particularly regarding restrictive practice deficiencies.

I have considered and acknowledge the provider’s response which demonstrated a system for managing complaints and where open complaints have now been actioned and an additional action is added to the PCI to ensure all feedback has been classified and actioned as per policy and the register is contemporary and each complaint is evaluated in a timely manner to the consumer’s satisfaction.

I have considered effective systems for serious incidents under Requirement 8(3)(d).

I have considered the information within the Assessment team report and the provider’s response. I am not satisfied the organisation has effective governance systems particular to the training and education of staff under workforce governance. While the provider has committed to undertaking continuous improvement activities to mitigate risks to consumers, I am of the view these actions have not had sufficient time to become embedded to ensure their effectiveness and sustainability. I find Requirement 8(3)(c) not compliant.

**Requirement 8(3)(d)**

The service was found to be non-compliant in this Requirement following a Quality Audit in April 2022. The service did not demonstrate an effective risk management framework to guide staff practice in identifying and responding to risk.

An assessment of performance was conducted on 25 and 26 June 2024. The service has taken the following actions to address previous non-compliance:

* Implemented a clinical governance framework that outlines the roles and responsibilities of staff in identifying and responding to risks associated with the care of the consumer.
* Implemented policies and procedures in relation to incident management and supporting consumers to live the best life they can.
* Implemented a process where staff alert management when they identify risks associated with the care of consumers.
* Provided the governing body with access and review of incidents to identify trends and incident prevention strategies.

The Assessment team report brought forward information the organisation did not demonstrate that the governing body analysed incidents to identify trends or areas for improvement. The service was not able to demonstrate that serious incidents are consistently identified or reported to the SIRS. The Assessment team’s findings included:

* Management was not able to demonstrate the service collects and analyses quality indicators of care to identify areas of risk and risk mitigation strategies or that the service is consistently identifying and responding to risk associated with the care of the consumer.
* Incidents recorded within the organisation’s electronic care management system are not captured within the organisation’s incident system. Meaning the governing body do not have access to all incidents recorded to identify trends or areas for improvement.
* The service was not able to demonstrate that serious incidents are consistently identified and reported to the SIRS. This is further discussed in Requirement 8(3)(c).
* There is no process to monitor quality indicators, such as the number of consumers: with pressure injuries or unplanned weight loss; subject to restrictive practices; who have had a fall or major injury; or require medication management.
* The service was not able to demonstrate risks associated with the care of the consumer are consistently identified and managed.

The provider’s response did not challenge the information brought forward in the Assessment team report. The provider has undertaken continuous improvement actions to mitigate risk to consumers and has committed to the following:

* Implemented a high impact high prevalence register to identify any trends identifying any abuse, neglect and risks. Training will be provided for preventing incidents with consumers through policies and procedures as part of the clinical governance framework.

I have considered information in other Requirements. I acknowledge the service advises:

* Clinical incidents, indicators and actions are escalated to the board for review and monitoring.
* The organisation is reviewing systems for the capture of incidents
* The service recently established a risk register to identify risks associated with the care of each consumer which will be discussed at the Quality Care Advisory meetings and weekly management meetings to identify trends and risk mitigation strategies.

I have considered the information within the Assessment team report and the provider’s response. I am not satisfied the service has effectively managed non-compliance within this Requirement to ensure effective risk management systems. While the provider has committed to undertaking continuous improvement activities to mitigate risks to consumers, I am of the view these actions have not had sufficient time to become embedded to ensure their effectiveness and sustainability. I find Requirement 8(3)(d) not compliant.

**Requirement 8(3)(e)**

**(3)(e)**

The service was found to be non-compliant in this Requirement following a Quality Audit in April 2022. The service did not demonstrate an effective clinical governance framework where clinical care is provided.

An assessment of performance was conducted on 25 and 26 June 2024. The service has taken the following actions to address previous non-compliance:

* Implemented a suite of policies and procedures to guide staff practices in clinical care including antimicrobial stewardship, incident management, the use of restrictive practices and open disclosure.

The Assessment team report brought forward information that while policies and procedures have been implemented, the service was not able to demonstrate effective clinical governance framework to ensure consumers subject to restrictive practices are managed; staff have the knowledge and procedures in place to conduct antimicrobial stewardship or practice open disclosure. The Assessment team’s findings included:

* The service did not have a procedure to guide staff in the identification and safe use of restrictive practices. Staff were unable to describe the types of restrictive practices, or the risks associated with its use.
* The service did not have a procedure to guide staff in conducting antimicrobial stewardship. Staff did not have a shared understanding of antimicrobial stewardship and were not able to describe how it applied to their roles.
* The service does not have a policy or procedure to guide staff in practicing open disclosure when things go wrong. Documentation did not evidence an apology or explanation was provided following an alarm incident which was left responded.

The provider’s response did not include evidence of implemented policies and procedures; however, I accept the Assessment team report information which advises the organisation has implemented policies as well as the provider’s response which advises the organisation has implemented policies and procedures.

I have considered that while policies and procedures are in place, they have been ineffective in guiding staff in providing clinical care as staff did not have a shared understanding of the policies and procedures as evidenced across the Requirements assessed as not compliant.

I acknowledge the service has undertaken continuous improvement actions to mitigate risk to consumers and has committed to the following:

* Schedule clinical related education for staff, including restrictive practice management and antimicrobial stewardship.

I have considered the information within the Assessment team report and the provider’s response. I am not satisfied the service has an effective clinical governance framework where clinical care is provided. While the provider has committed to undertaking continuous improvement activities to mitigate risks to consumers, I am of the view these actions have not had sufficient time to become embedded to ensure their effectiveness and sustainability. I find Requirement 8(3)(e) not compliant.

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