**Performance**

**Report**

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| Name: | Jubilee Community Care Association Inc |
| Commission ID: | 700196 |
| Address: | 87 Central Avenue, INDOOROOPILLY, Queensland, 4068 |
| Activity type: | Quality Audit |
| Activity date: | 6 October 2023 to 11 October 2023 |
| Performance report date: | 15 December 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.

# Service included in this assessment

Home Care Packages (**HCP**) included:  
Provider: 1171 Jubilee Community Care Inc.  
Service: 18228 Jubilee Community Care Association Inc  
  
Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 7505 Jubilee Community Care Inc  
Service: 25167 Jubilee Community Care Inc - Care Relationships and Carer Support  
Service: 25166 Jubilee Community Care Inc - Community and Home Support

**This performance report**

This performance report for Jubilee Community Care Association Inc (**the service**) has been prepared by M Murray 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 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 3 November 2023.

# Assessment summary for Home Care Packages (HCP)

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Compliant |
| **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 | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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

Requirement 2(3)(a) HCP

* Ensure assessments and care planning is effective and that the care plan produced identifies all known risks and all risk mitigation strategies being used by care staff. Ensure the care plan has sufficient detail to support any staff member, including new staff members to provide high quality tailored care.

Requirement 3(3)(e) HCP

* Ensure Care Coordinators are across all relevant information about the clinical needs of consumers and that timely, up to date, accurate and relevant information is shared between internal and external staff / providers to support end to end care.

Requirement 6(3)(d) HCP and CHSP

* Use feedback and complaints intelligence as an opportunity to improve care and services for all consumers.

Requirement 8(3)(d) HCP and CHSP

* Develop an effective incident management system to ensure the Board has visibility to incident data and can drive improvements in the quality of care.

Requirement 8(3)(e) HCP and CHSP

* Embed clinical governance practices across the service so all staff understand their role and contribution to the safety of consumers.

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

Findings

Consumers said they are treated with dignity and respect and staff are friendly and polite. Staff interviewed spoke respectfully about consumers and were able to outline for individual consumers how they treat them with respect. Staff demonstrated an awareness of the consumer’s individual identity. Care Coordinators provided examples of how consumers’ rights are respected in the service’s care model.

Consumers confirmed staff understand their needs and preferences and their service is delivered in a way that makes them feel safe and respected. Management and staff provided examples of how services are delivered to meet the needs and preferences of individuals and to support inclusive care and support. Documentation evidenced an understanding of individual needs and preferences.

Consumers/representatives say consumers are supported to make their own decisions about the services the consumer receives. Consumers said the service makes it easy for them to be involved, to include the people they want involved in their care decisions and to stay involved with those important to them. Documentation evidenced consumer involvement in decisions about the service they receive, including details for those whom consumers would like involved in their care and services.

Management and staff evidenced knowledge, awareness and an understanding of consumer choices and preferences and described how each consumer is supported to make informed decisions and described how tasks are undertaken in accordance with individual consumer’s identified priorities.

The service demonstrated that consumers are supported to take risks if they choose and that steps are taken to mitigate the potential impact of risks when possible. Staff stated they support consumers to take risks and live a life of their choosing. Staff support consumers by discussing the potential risks with them and then allowing the consumer the freedom to continue taking those risks if they choose. Staff advised they report any identified risks to the Care coordinator, including any hazards. Documentation evidenced consumers’ involvement in decision making.

Consumers said they receive written information in a way that they can understand and that enables them to make informed choices. This includes statements, pricing structures, complaints information and information on services available. Consumers reported they are involved in discussions with Care Coordinators and management as required.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all the relevant Requirements in Standard 1, Consumer dignity and choice.

# Standard 2

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

Findings

Requirement 2(3)(a) HCP

The Assessment Team reported that the service does not adequately consider risks when undertaking assessment and care planning.

The Assessment Team’s evidence that is relevant to this Requirement is summarised below.

* Key risks are not identified and risk mitigation strategies are not available to all care staff to ensure the delivery of safe and quality care.
* A consumer living with dementia with an aversion to personal care does not have strategies in their care plan to support staff to deliver safe care. Staff described how they provide personal care to the consumer, including managing environmental and other risks. The consumer is also at risk of pressure areas and while the care plan outlines the need to use moisturiser to support good skin integrity, risk mitigation strategies do not direct staff when to escalate their concerns around skin breakdown.
* A consumer who needs complex mental health support does not have any strategies outlined in their care plan to guide staff in supporting the consumer when they raise past traumas. Staff were unable to clearly articulate what constituted a change in the consumer’s mental health status.

The approved provider’s evidence that is relevant to this Requirement is summarised below. The approved provider, since the quality audit has:

* Conducted a review and updated care plans for consumers with greater risk of physical / psychological injures as a priority.
* Ensured the risk mitigation strategies are outlined in all consumers care plans and readily available for our support workers.
* Ensured key risks are documented on roster notes and roster alerts issued to support workers enabling support workers to have up to date information prior to visiting a consumer.
* Implemented regular team meetings with support workers which includes ongoing education and support enabling support workers to provide feedback or raise queries regarding the consumers in a timely fashion.
* Implemented a more detailed care plan for consumers requiring personal care, including detailed steps of the consumer’s needs and preferences for each service provided including personal care (example submitted as additional evidence).
* The service is sourcing risk screening tools/documentation to improve monitoring of consumers. This will include Falls Risk Assessment, Self-Medication assessment, Client Risk Acknowledgement Assessment, and Pressure Injury and Wound Assessment.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and the approved provider’s response. I have reviewed the additional evidence submitted by the approved provider. While I acknowledge the actions of the approved provider, the practices and system changes proposed will take some time to embed into the day to day practices of staff. Effective care assessment and planning is a cornerstone of care delivery and the services’ own quality monitoring system should have identified this deficit.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with the above Requirement.

Requirement 2(3)(b) HCP and CHSP

The Assessment Team reported that the service did not demonstrate assessment and planning is documented sufficiently to address each consumer’s current needs, goals, and preferences.

The Assessment Team’s evidence that is relevant to this Requirement is summarised below.

* Whilst a comprehensive service-level assessment is conducted for each consumer, considering relevant information and outlining their current needs, goals and preferences, documentation reviewed did not consistently reflect all relevant information. Information on risk and risk mitigation strategies are not consistently recorded.
* Advance care planning information was not consistently recorded in the online care management system, as per the process outlined by the service to ensure information is communicated across the service.

The approved provider’s evidence that is relevant to this Requirement is summarised below. The approved provider, since the quality audit has:

* Reviewed and updated the care plan template to ensure it reflects the information regarding Advance Health Directives for support workers (example submitted as additional evidence).

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and the approved provider’s response. I have considered the Assessment Team’s evidence regarding documentation of risk and risk mitigation strategies in Requirement 2(3)(a) and do not intend to consider it again in this Requirement.

The Assessment Team’s evidence is that the service has a comprehensive service-level assessment system that results in care plans which outlining each consumer’s current needs, goals and preferences, which satisfies the intent of this Requirement. I am also satisfied that staff can access the advance care plans when required. Whether these plans are held as paper based copies or on an electronic system is up to the approved provider.

Based on the information summarised above, I find the provider, in relation to the service, compliant with the above Requirement.

Requirements 2(3)(a) CHSP, 2(3)(c), 2(3)(d) and 2(3)(e)

The Assessment Team reported the assessment and care planning process is effective in identifying risks and developing strategies to mitigate risks for consumers in the Commonwealth Home Support Program.

Consumers said they participate in the planning and review of the services they receive and choose who they wish to be involved in making decisions about their care and services. Representatives confirmed they support consumers in making their preferences understood.

Care Coordinators described how they work in partnership with other individuals and service providers when undertaking assessment and care planning and communicate regularly regarding the changing needs of consumers.

Documentation evidenced consumer/representative involvement in the planning of services and in reviews.

A copy of the finalised care plan is provided to the consumer and kept in the consumer’s home file. An electronic copy is uploaded onto the service’s database.

Staff said they are informed of the consumer’s care and service delivery needs and preferences. Staff are also informed of any change in needs and the care plan in the consumer’s home is also updated.

A review of care planning documentation confirmed care plans are reviewed at least annually and more often when changes or incidents occur. Staff undertaking reviews could describe the process and under what circumstances a review or reassessment may be required. Examples included incidents, on return from hospital or when a consumer requires a change in the type or level of service they receive.

Care Coordinators demonstrated a clear system in place to ensure care plans are reviewed when required. Consumers/representatives confirmed staff consult with them to check their satisfaction with the care and services consumers receive, discuss any changes to needs and preferences and adapt care and services accordingly.

Based on the information summarised above, I find the provider, in relation to the service, compliant with the above Requirements.

# Standard 3

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| Personal care and clinical care | | HCP | CHSP |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant | Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Not Compliant | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant | Compliant |

Findings

Requirement 3(3)(b) HCP

The Assessment Team reported high impact or high prevalence risks are not managed effectively.

The Assessment Team’s evidence that is relevant to this Requirement is summarised below.

* Staff interviewed could identify consumer risks and provided examples of risk mitigation strategies.
* Although regular care staff may be aware of consumer risks there is no documented guidance for irregular care staff.
* While Care Coordinators could describe strategies to mitigate risks for one consumer with mental health support needs, which included at least weekly welfare telephone checks. For another consumer, Care Coordinators were not aware of all the risk mitigation strategies staff were using to manage the risk of falls, however, said a registered nurse visits the consumer twice a week.

The Assessment Team’s evidence in other Standards that is relevant to this Requirement:

* Management could describe the high impact or high prevalence risks associated with the current consumer cohort.
* Care staff interviewed were aware of the consumer’s mental health support needs and progress notes demonstrate different care staff have contacted the service on multiple occasions to raise concerns. Care Coordinators said, on several occasions, they have called emergency services for the consumer. Care Coordinators also said the risk is mitigated by ensuring consistent care staff. The consumer also has a medical officer who conducts weekly home visits.
* While care staff for the consumer at risk of poor skin integrity did not communicate with the service about a known skin issue getting worse, care staff did raise their concerns with the representative and the registered nurse. The representative said the consumer’s skin issue is being managed by their general practitioner.

The approved provider’s evidence that is relevant to this Requirement is summarised below. The approved provider, since the quality audit has:

* Ensured the risk mitigation strategies are outlined in all consumers care plans and readily available for support workers.
* Ensured key risks are documented on roster notes and roster alerts issued to support workers enabling support workers to have up to date information prior to visiting a consumer.
* Commenced a review to update our Risk Management Policy to provide guidelines for a more structured delivery of safe and effective care and services for all consumers.
* Risk mitigation strategies will be outlined in care plans for each consumer through consultation with consumer/representative.
* Care Coordinators have been instructed to notify support workers with changes in a consumer’s care plan prior to the care plan becoming available for viewing at the consumer’s residence.
* Roster run sheet alerts issued to support workers have been updated in the care management system, directing support workers to call a care coordinator when it is their first time visiting a consumer or when there is a change to a consumer’s care plan.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and the approved provider’s response. I have considered the Assessment Team’s evidence regarding deficits in care plan documentation about risk in Requirement 2(3)(a) and do not intend to consider the evidence again in this Requirement.

The Assessment Team’s evidence does not demonstrate a systemic failure in the management of care being delivered to consumers. Consumers identified as at risk by the Assessment Team have, in my view, effective clinical oversight through processes including registered nurse visits, welfare checks and the involvement of general practitioners and medical officers. No adverse impacts on consumers have been identified by the Assessment Team. I am satisfied there is effective management in place.

Based on the information summarised above, I find the provider, in relation to the service, compliant with the above Requirement.

Requirement 3(3)(e)

The Assessment Team reported information about the consumer’s condition, needs and preferences is not documented or effectively communicated within the organisation, and with others where responsibility for care is shared.

The Assessment Team’s evidence that is relevant to this Requirement is summarised below.

* Although evidence was sighted of frequent communication from representatives, subcontracted providers, care staff and care coordinators, relevant information was not always communicated to relevant people for some high-risk consumers nor were care plans updated to reflect new information.
* Care Coordinators were not aware of information care staff had shared with registered nurses, even though registered nurses and care coordination staff are in regular contact.
* Information is shared between regular care workers, representatives and subcontracted nursing staff, but not consistently shared with replacement staff.

The approved provider’s evidence that is relevant to this Requirement is summarised below. The approved provider, since the quality audit has:

* Conducted a review and update of care plans for consumers with greater risk of physical / psychological injures as a priority (example submitted as additional evidence).
* Ensured the risk mitigation strategies are outlined in all consumers care plans and readily available for support workers.
* Ensured key risks are documented on roster notes and roster alerts issued to support workers enabling support workers to have up to date information prior to visiting a consumer.
* A number of support worker meetings have been arranged in the immediate future to reinforce to the support workers to always call a care coordinator if there is a change in a consumer’s situation.
* Plans moving forward include to put the care plan online for all support workers for easier access.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and the approved provider’s response. I am satisfied that Care Coordinators have not been the key point of contact for important information relating to the wellbeing of consumers. Relevant information has not always been provided to care staff. Secondary communication channels are evident and include care staff updating representatives and subcontracted workers. Care staff are also making their own decision on what should be reported to Care Coordinators rather than being guided by the service’s procedures. Care coordination is not effective.

Based on the information summarised above, I find the provider, in relation to the service, non- compliant with the above Requirement.

Requirements 3(3)(a); 3(3)(b) CHSP; 3(3)(c); 3(3)(d); 3(3)(f) and 3(3)(g)

Consumers reported that the clinical and personal care they receive is safe and effective and optimises their health and well-being. Staff demonstrated a good knowledge of the consumer’s needs, goals and preferences and could describe how the service ensures care is tailored to the consumer’s needs. Assessments are completed by Care Coordinators on entry to the service and care and services implemented to meet the consumer’s needs.

The Assessment Team are satisfied that risk mitigation is occurring for CHSP consumers.

Management and staff discussed how care and services are adjusted for consumers nearing the end of life. Care Coordinators advised there is a pool of experienced care staff who can support consumers who are on a palliative pathway and the service links in with specialist palliative care providers as required.

All staff interviewed demonstrated an understanding of recognising, reporting and responding to consumer deterioration or changes in the consumer’s health and well-being. Care staff advised they observe the consumer for signs they may be unwell, including changes in behaviour, and report these to Care Coordinators. Policy and procedures outline how to recognise, escalate and respond in a timely manner to decline or deterioration in a consumer’s health and/or well-being

The Assessment Team are satisfied that information about CHSP consumers is effectively shared between those supporting the consumer.

Staff said the service regularly refers consumers to other support organisations, including dementia support services. Consumers said they have accessed other health professionals when they needed further support. Referrals to dietitians, speech therapists, physiotherapists and podiatrists were evident.

Staff interviewed understand the practical ways to minimise the transmission of infections and are alert for signs which may indicate infection. Staff have completed infection prevention and COVID-19 training. Management monitor for Department of Health alerts and communicate any changes on infection control protocols to staff and/or consumers as required.

Based on the information summarised above, I find the provider, in relation to the service, compliant with the above Requirements.

# Standard 4

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| Services and supports for daily living | | HCP | CHSP |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Not applicable | Not applicable |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant | Compliant |

Findings

Consumers reported the services and supports they receive help them to maintain their quality of life and independence. Staff interviewed demonstrated an understanding of what is important to individual consumers and could describe how they help the consumer to do as much as they can for themselves.

Care planning documents were individualised and outlined the services and supports to be provided. Consumer preferences in relation to how the services are to be delivered are also documented.

Consumers described how staff had supported their wellbeing when they had been feeling low or depressed.

Staff are alert to consumers at risk of social isolation and have developed individualised support plans for those consumers who, for various reasons, may not thrive in large group activities.

Care staff provided examples of being flexible in providing social support based on what the consumers preferences or interests are for the day. Consumers said they are provided with opportunities for social interaction and social connection through the supports they receive.

Information is effectively shared and consumers do not have to repeat instructions, saying staff know their preferences well.

Staff said the service regularly refers consumers to other support organisations, including social workers and community visitor schemes. Consumers said staff have coordinated access to other services for them when required.

Equipment is provided following an assessment by a suitably qualified practitioner. Consumer care plans remind care staff to check equipment on each shift and care staff confirmed they follow this directive. Staff were able to explain the process should unsafe or ineffective equipment be found in a consumer’s home

The service does not provide meals Requirement 4(3)(f) is not applicable.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all applicable Requirements in Standard 4, Services and supports for daily living.

# 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   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

This Standard does not apply to the service.

# Standard 6

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| --- | --- | --- | --- |
| Feedback and complaints | | HCP | CHSP |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant | Not Compliant |

Findings

Requirement 6(3)(d)

The Assessment Team reported that the service does not use feedback and complaints to improve the quality of care and services.

The Assessment Team’s evidence that is relevant to this Requirement is summarised below.

* Consumers who have raised concerns reported the service responded quickly and changes were made to their individual service, with many consumers stating that their issues were resolved immediately.
* The complaints register lists one complaint about accounts; however, staff and Care Coordinators discussed that complaints about the statements are received often but resolved with education or explanation. These discussions are noted on the consumer’s file but not on a central register.
* The service’s continuous improvement plan does not indicate improvements identified through the collation of feedback or complaints.

The approved provider’s evidence that is relevant to this Requirement is summarised below. The approved provider, since the quality audit has:

* Held a whole of staff meeting at which outlined the process for and importance of feedback/comments/complaints being communicated to the relevant person.
* Updated the Feedback and Complaints process and policy (example submitted as additional evidence).
* Made complaints, feedback and incidents a standing agenda item at the weekly Care Co-ordination meeting. This will allow the service to properly monitor, categorise and action items.
* Placed the responsibility with the Manager Care Services/Senior Coordinator for overseeing actions and outcomes of feedback/complaints.
* Human Resources will be responsible for ensuring the register is updated, reports generated, trends analysed and actions entered into the Continuous Improvement Plan.
* The Continuous Improvement Plan is now informed by the complaints, incidents and feedback (example submitted as additional evidence).
* Human Resources will prepare reports for the monthly staff meeting and Board report.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and the approved provider’s response. I have reviewed the additional evidence submitted by the approved provider. I acknowledge the steps taken by the approved provider, however, in my view this is a cultural change that will take some time and is reliant on the leadership of management to monitor the success of the initiatives undertaken and/or proposed.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with the above Requirement.

Requirement 6(3)(a); 6(3)(b) and 6(3)(c).

Consumers/representatives stated they are aware of how to provide feedback or make a complaint and felt supported to do so. They advised they would provide feedback by speaking with care staff or calling their Care Coordinator. Management and staff described ways they support consumers and representatives to provide feedback, including through participation in consumer engagement surveys.

While consumers prefer to communicate directly with the service when giving feedback or making a complaint, the service also provides information to consumers/representatives on internal and external complaint mechanisms and advocacy services. Care Coordinators provided an example of helping a consumer access an advocacy service.

Consumers/representatives who have made a complaint or raised concerns with the service, reported that management resolved the complaint in a timely manner, were transparent about their actions and provided an apology.

Based on the information summarised above, I find the provider, in relation to the service, compliant with the above Requirements.

# Standard 7

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

Findings

Requirement 7(3)(e)

The Assessment Team reported that the service does not regularly monitor the performance of each staff member.

The Assessment Team’s evidence that is relevant to this Requirement is summarised below.

* Ten staff had a formal performance review in the preceding 12 months.
* Management advised approximately 60 staff had an outstanding performance review.

The approved provider’s evidence that is relevant to this Requirement is summarised below.

* The importance of staff evaluation was recognised by the service with the strategic appointment of a Human Resource Manager in August 2023, two months prior to the audit. The Human Resource Manager and recently appointed Human Resource Officer have commenced reviews of newly appointed staff. Reviews occur during the probation period, on completion of induction, at three months post-employment and six months post probation.
* The plan for staff reviews has been discussed at recent management and whole of staff meetings.
* Coaching and mentoring of care coordination staff has been initiated and will be ongoing to develop their skills in the performance reviews of support workers and administration staff.
* Our approach to staff reviews is to have both informal check-ins and structured reviews during probation; a simple but structured annual review process incorporating an employee self-assessment to encourage feedback and engagement. The approach is supported by a platform of continuous communication, coaching, counselling and supervision.
* A suite of human resources policies have been developed.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and the approved provider’s response. I am satisfied that the recent recruitment of a dedicated human resource team will allow the service to undertake any outstanding performance reviews in a structured and timely way.

Based on the information summarised above, I find the provider, in relation to the service, compliant with the above Requirement.

Requirement 7(3)(a); 7(3)(b); 7(3)(c) and 7(3)(d)

Consumers are satisfied the workforce is sufficient to ensure they receive their services in accordance with their individual needs and preferences. Consumers reported staff arrive when expected and if they are going to be late, they are generally notified.

Management described strategies to ensure consumers with high or complex needs receive continuity of care in the event that staff take unplanned leave. This may include domestic assistance services being undertaken by different staff members or being rescheduled. Consumers receiving domestic assistance confirmed they occasionally get different domestic assistants and this was a point of dissatisfaction for them. I note management are seeking to engage additional brokered cleaning services to support continuity of services.

Consumers/representatives provided positive feedback in relation to their interactions with the workforce. They said management and staff are kind, caring, respectful and helpful.

Management demonstrated the qualifications and competencies of the workforce are monitored to ensure staff remain up to date with contemporary practice.

Staff described the onboarding and orientation process at the service including buddy shifts for staff when they first commence. Staff said they have received ‘on the job’ training and guidance and felt supported to undertake their duties safely and efficiently.

Access to online training is provided to all staff and volunteers including mandatory modules in infection control and hand hygiene, fire safety and recognising changes in consumer’s needs. Completion of relevant training is monitored and recorded in staff files.

Based on the information summarised above, I find the provider, in relation to the service, compliant with the above Requirements.

# Standard 8

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

Findings

Requirement 8(3)(a)

Consumers expressed satisfaction with how the service seeks their views on the running of the service and have participated in consumer surveys.

Requirement 8(3)(b)

The Assessment Team reported that the service does not promote a culture of safe, inclusive and quality care and services and accountability for delivery is not clear.

The Assessment Team’s evidence that is relevant to this Requirement is summarised below.

* Management advised the service is not currently trending clinical data such as infections, wound care, and falls to determine appropriate safety and quality measures are being identified and implemented. Clinical data is not being provided to the Board.
* Management and Care Coordinators advised that whilst all complaints, incidents and outcomes are documented within consumer file notes, they are not all collated and provided to management for centralised recording. This limits the information provided to the Board for review and inhibits the Board from understanding of the scope of risk for consumers and the service.

I have considered this evidence in my finding of Requirement 8(3)(d) where I find it more relevant.

I am satisfied, based on the evidence throughout the Assessment Team’s report that the Board is informing itself about relevant quality and safety issues and providing direction to management and staff about their accountabilities to deliver safe and quality care. Consumers are satisfied with the approach of the organisation to inclusivity and staff can raise issues without fear of adverse consequences when they have concerns about care and services.

Based on the information summarised above, I find the provider, in relation to the service, compliant with the above Requirement.

Requirement 8(3)(c)

The Assessment Team reported that the service does not have effective governance systems in relation to continuous improvement and feedback and complaints.

The Assessment Team’s evidence that is relevant to this Requirement is summarised below.

* Management has a continuous improvement plan in place and management and staff were able to provide examples of continuous improvement activities. However, improvements made over time and those in progress are not captured in a centralised plan. The current plan is lacking the source of the improvements, for example complaints, incidents, consumer feedback or surveys, the current status of each improvement item, the actual completion date and an evaluation of the outcomes following implementation.
* Consumers reported feeling comfortable to provide feedback and said that the service resolved complaints to a satisfactory level. However, the Assessment Team identified the service lacks processes to document and collate all complaints therefore limiting analysis, trending and identification of improvement opportunities.

The approved provider’s evidence that is relevant to this Requirement is summarised below. The approved provider, since the quality audit has:

* Held a staff meeting at which we outlined the process and importance of feedback/comments/complaints being communicated to the human resource personnel.
* Updated the Feedback and Complaints process and policy.
* Made Complaints, Feedback and Incidents a standing agenda item at the weekly Care Coordinators meeting. Allowing the team to monitor, categorise and action feedback and complaints.
* Placed the responsibility with the Manager Care Services/Senior Coordinator for overseeing the actioning and outcomes of feedback and complaints.
* Placed the responsibility with the Human Resources team for ensuring the register is updated, reports generated, trends analysed and actions entered into the Continuous Improvement Plan.
* The Continuous Improvement Plan has now been amended to reference a Complaint/Incident/Feedback category.
* The Human Resources team will prepare reports (including graphs) for the monthly staff meeting and Board report.

In coming to my finding, I have considered the information and evidence in the Assessment Team’s report and the approved provider’s response. The Assessment Team’s evidence does not demonstrate a systemic failure in continuous improvement as the failure noted is a failure in capturing continuous improvement information and not a lack of improvements occurring. I am satisfied based on the approved provider’s evidence that a centralised way of monitoring continuous improvements is now in place.

I have considered the Assessment Team’s evidence in relation to trending of feedback and complaints in Standard 6 and in my view the evidence presented in this Standard does not demonstrate a systemic failure at a governance level.

I am satisfied based on the Assessment Team’s evidence that governance systems are in place in relation to information management, financial governance, workforce governance and regulatory compliance.

Based on the information summarised above, I find the provider, in relation to the service, compliant with the above Requirement.

Requirement 8(3)(d)

The Assessment Team reported that the service does not have effective risk management systems and practices in relation to managing high-impact or high-prevalence risks associated with the care of consumers and managing and preventing incidents, including the use of an incident management system.

The Assessment Team’s evidence that is relevant to this Requirement is summarised below.

* Management could describe the high impact or high prevalence risks associated with the current consumer cohort and maintains a vulnerability register for all consumers who may need assistance in the event of an emergency.
* Consumer risk is considered as part of the assessment and service planning processes, and strategies are developed to manage and mitigate risks to consumer’s health and wellbeing. Risks considered include home safety risk, non-response to scheduled visit, and dignity of risk. However not all risks have been identified for sampled consumers and consumer representatives and care staff have reported to the Assessment Team risks and health conditions that are not documented on individual consumer care plans.
* Management confirmed that incidents are not reported to the Board unless deemed significant, which is a subjective process.

The approved provider’s evidence that is relevant to this Requirement is summarised below. The approved provider, since the quality audit has:

* Updated the incident management policy and process. The revision incorporates clearer definitions, accountabilities and reporting functions. A Risk Severity Matrix in included in the policy to help with the categorisation of risks (example submitted as additional evidence).
* Incidents are a standing agenda item on the Care Co-ordination meeting agenda and details of incidents are tabled at the monthly Staff Meeting and analysed and reported at monthly Board meetings.
* Adapted the Continuous Improvement Plan to reference incident numbers and incorporated actions that come out of the analysis of incidents.
* Undertaken staff training in respect to incident management at the October 2023 Staff Meeting and reinforced the process.

In coming to my finding on the service’s governance systems for managing high-impact or high-prevalence risks, I have considered information and evidence in the Assessment Team’s report and the approved provider’s response. The Assessment Team’s evidence outlines a failure to document risks in consumer care plans. I have considered this evidence in Standard 2. The Assessment Team’s evidence does not demonstrate a systemic failure in managing high-impact or high-prevalence risks at a governance level.

In coming to my finding on the service’s governance system for incident management, I have considered information and evidence in the Assessment Team’s report and the approved provider’s response. While I acknowledge the systems work that has been undertaken, in my view the Assessment Team’s evidence demonstrates that the focus of the Board has not been on using its incident management system to investigate and analyse what has happened or to implement changes to reduce the risk of recurrence and make consumers safer. The approved provider does not comply with Sub-Requirement (iv) managing and preventing incidents, including the use of an incident

I am satisfied based on the Assessment Team’s evidence risk management systems and practices are in place for identifying and responding to abuse and neglect of consumers and supporting consumers to live their best life.

Based on the information summarised above, as the provider has not complied with all sub-Requirements, I find the provider, in relation to the service, non-compliant with the Requirement 8(3)(d).

Requirement 8(3)(e)

The Assessment Team reported that the service does not have an effective clinical governance framework.

The Assessment Team’s evidence that is relevant to this Requirement is summarised below.

* The service has a clinical governance framework in place. This document is currently being reviewed; however, all appropriate staff have current access to this document.
* The service could not evidence appropriate clinical data collection to inform good clinical governance.
* Management and staff were unable to demonstrate a consistent understanding of restrictive practice and how it would be identified in the home.
* Management and staff confirmed awareness of the term restrictive practices but were unable to consistently provide examples of situations or demonstrate understanding of how it impacts current consumers, other than to say that there are no consumers currently impacted by restrictive practices.
* Staff advised that restrictive practice was discussed during orientation, but they were unsure of receiving further training on this. A review of training documentation identified training opportunities on restrictive practices are not provided to staff.

The approved provider’s evidence that is relevant to this Requirement is summarised below. The approved provider, since the quality audit has/is:

* Held a whole of staff meeting in which we addressed the importance of clinical incidents being reported back to the Care Coordinators.
* Implemented a process for Care Coordinators to record all clinical incidents into our centralised system.
* Assigned the Manager for Care Services to be responsible for overseeing clinical indicators on outcomes actioned.
* Assigned the Human Resource Manager with responsibility for ensuring the centralised system is up to date and reports on trends and clinical incident analysis are provided at the monthly Board meetings.
* Included clinical indicators within the weekly Care Coordinators meeting headed by the Manager for Care Services, attended by Care Coordinators and relevant staff. Minutes of these meetings are held.
* At the October 2023 Board meeting, the Manager for Care Services (Registered Nurse) communicated clinical indicator data to Board members including a Board member who is a General Practitioner with aged care experience (example submitted as additional evidence).
* Updated our staff induction process and added a restrictive practice fact sheet. (example submitted as additional evidence).
* The service is sourcing risk screening tools/documentation to improve monitoring of consumers. This will include Falls Risk Assessment, Self-Medication assessment, Client Risk Acknowledgement Assessment, and Pressure Injury and wound Assessment.
* Reviewing the Risk Management Policy, this will be updated and communicated to staff when we have determined our preferred risk screening tools/documentation.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and the approved provider’s response. While I acknowledge the systems work that has been undertaken, I am not confident with the volume of strategies being undertaken, that effective clinical governance is currently being applied day to day in the work of the service. The effectiveness of the clinical governance system and lifting the awareness of restrictive practices across the workforce, will, in my view, take some time and will need ongoing oversight by the clinical leadership team in the medium term.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with the above Requirement.

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