**Performance**

**Report**

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| Name: | Kal'ang Community Care |
| Commission ID: | 700173 |
| Address: | 133 Denmans Camp Road, Kawungan, Queensland, 4655 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 22 May 2024 |
| Performance report date: | 20 June 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: 340 Kal'ang Respite Care Centre Aboriginal Corporation  
Service: 18232 Kal'ang Community Care

**This performance report**

This performance report for Kal'ang Community Care (**the service**) has been prepared by P. Sherin, 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 10 June 2024 providing additional information.
* the assessment team’s report for the Quality audit conducted 30 October to 02 November 2023 and the performance report dated 15 December 2023.

# Assessment summary for Home Care Packages (HCP)

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| Standard 1 Consumer dignity and choice | Non-compliant |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

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

# Areas for improvement

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

* Requirement 1(3)(d): Implement staff training and related improvement actions to ensure consumers are supported to take risks to live the best life they can.
* Requirement 6(3)(d): Implement effective processes to ensure all feedback and complaints are recorded, analysed, and used to inform improvements.
* Requirement 8(3)(a): Ensure effective mechanisms in place to engage consumers in the development, delivery, and evaluation of care and services.
* Requirement 8(3)(c): Implement improvement actions to ensure effective governance systems in relation to information management, continuous improvement, and workforce governance.
* Requirement 8(3)(e): Ensure effective clinical governance, including the appointment of clinical staff and processes for oversight and monitoring of clinical service delivery.

# Standard 1

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| Consumer dignity and choice | | HCP |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Non-compliant |

Findings

The service was found non-compliant in the previous Quality audit conducted 30 October – 02 November 2023 due to staff not demonstrating a shared understanding of how to support consumers who choose to take risks, and lack of processes to assist staff in this regard.

The assessment team’s report identified the service has implemented improvements including introducing an indemnity form for consumers to sign, providing staff training on dignity of risk, and developing a dignity of risk policy. However, the assessment team’s report identified training has not been effective as staff did not demonstrate an understanding of dignity of risk and their responsibilities in supporting consumers who choose to engage in activities of risk. A review of the service’s risk indemnity form completed for 3 separate consumers identified the form was not fit for purpose, did not correctly capture identified risks, and listed generic strategies to mitigate risks. Interviews with management and staff showed a lack of understanding regarding consumers’ freedom to take risks of their choosing and how this can be managed and supported. Training evidence provided was limited to staff directly engaged by the service. There are no processes to test understanding and implementation for staff employed by brokered services responsible for delivering a range of care and services.

The Provider’s response included information on additional improvement actions planned, such as a review and amendment of dignity of risk forms and engaging a training provider to deliver training to staff (including staff engaged by brokered services) on dignity of risk commencing from July 2024. The service’s continuous improvement plan identifies these actions are to be completed by December 2024.

Having considered the assessment team’s report and the Provider’s response, I find the deficits remain. Improvement actions have yet to be implemented and will require time to be embedded within the service’s processes and to demonstrate effectiveness and sustainability.

I, therefore, find this Requirement is non-compliant.

# Standard 6

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| Feedback and complaints | | HCP |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Non-compliant |

Findings

Requirement 6(3)(c)

Consumers who had made a recent complaint said when issues are raised the service takes action to address their concerns.

Management and staff described the service’s complaints handling process and demonstrated a shared understanding of open disclosure.

Review of the service’s complaints system identified actions are documented and there is a process to ensure complaints are appropriately addressed and closed off.

The service was found non-compliant in the previous Quality audit conducted 30 October – 02 November 2023 due to the service not demonstrating timely action is taken in response to complaints or utilising an open disclosure process. The service has implemented the following improvement actions to remediate these deficits:

* The service has communicated with brokered services who are now required to complete a tracker and escalate complaints to the management team to ensure complaints are actioned in a timely manner. A review of the tracking sheet evidenced complaints are documented and the progress is recorded.
* The service has commenced conducting surveys and calling consumers to ensure their satisfaction with the services they are receiving.

Based on the information recorded above and the positive feedback from consumers, I find this Requirement is now compliant.

Requirement 6(3)(d)

The service was found non-compliant in this Requirement in the previous Quality audit conducted 30 October – 02 November 2023 due to the service not demonstrating feedback and complaints are reviewed and used to inform improvements to care and services.

The assessment team’s report identified the service has included an action under their plan for continuous improvement to review consumer feedback. However, management, staff, and sampled consumers/representatives were unable to provide specific examples of improvements made at the service in response to consumer feedback. Management confirmed the process of reviewing and trending feedback and survey results had not commenced. Management from brokered services were unaware of processes to escalate areas for improvement to the service. The service did not have established systems to ensure feedback and complaints from all sources are collected, trended, and analysed to inform improvements to care and service delivery.

The Provider’s response included information on actions planned and implemented including but not limited to, developing a flowchart for escalation of consumer complaints by brokered services; completing analysis of feedback and complaints to identify trends; implementing a log to capture improvement actions; and commencing monthly meetings with brokered services which includes discussion on feedback and complaints.

Having considered the assessment team’s report and the Provider’s response, I am not satisfied the Provider has demonstrated regular review of feedback and complaints currently occurs. The Provider has advised improvement actions will be completed between the period July to December 2024. Improvement actions will require time to be embedded within the service’s processes and to demonstrate their effectiveness and sustainability.

I, therefore, find this Requirement remains non-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. | Non-compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Non-compliant |

Findings

Requirement 8(3)(a)

The service was found non-compliant in this Requirement in the previous Quality audit conducted 30 October – 02 November 2023 due to not demonstrating consumers are actively engaged in the development, delivery, and evaluation of care and services.

The assessment team’s report identified whilst the service has engaged consumers by conducting surveys in December 2023 and March 2024, the results have not been analysed since. Sampled consumers advised they had completed surveys but were unaware how this feedback has been considered by the service. The service’s Board and management team were not aware of the legislative requirement that came into effect 1 December 2023 for the service to offer to establish a consumer advisory body at least once every 12 months and had therefore not offered consumers and representatives this option.

The Provider’s response included information and supporting documentation to evidence actions planned and implemented following the assessment contact. A letter requesting expressions of interest from consumers and representatives by 30 July 2024 to form a consumer advisory body has been drafted, together with a code of conduct and terms of reference. Analysis of feedback and trends to identify improvements is planned for completion by end of July 2024 with consumers and representatives to be informed of the outcome by September 2024.

I acknowledge the Provider’s efforts to strengthen its performance in this Requirement. However improvement actions have yet to be implemented and at the time of this decision, the deficits remain.

I, therefore, find this Requirement is non-compliant.

Requirement 8(3)(c)

The service was found non-compliant in the previous Quality audit conducted 30 October – 02 November 2023 due to the service not demonstrating effective governance systems relating to information management, continuous improvement, workforce governance, and feedback and complaints.

The assessment team’s report identified the service demonstrated improvements in resolution of feedback and complaints as outlined under Requirement 6(3)(c) above. However, improvements relating to information management, continuous improvement, and workforce governance have not been effectively implemented as outlined below:

* Information management: the service was unable to demonstrate effective communication with its brokered services. Staff of brokered services advised they report to the service only as requested or by exception when there is an update to care requirements. Consumers receiving services as well as staff of brokered services said when they request assistance it can take up to a week to receive a call back from the service.
* Continuous improvement: review of the service’s plan for continuous improvement identified feedback from consumers and representatives is not used to inform improvements to service delivery. Information regarding complaints provided by brokered services is not consistently recorded. Trending and analysis of feedback and complaints currently does not occur.
* Workforce governance: whilst the service has commenced obtaining information on staff qualifications, training, and performance management from brokered services there are no established processes to track and monitor this information on an ongoing basis.

The Provider’s response outlined a range of planned improvement actions. These include but are not limited to, commencement of monthly meetings with brokered services; implementing flow charts and amending procedure documents to ensure timely communication; developing a compliance dashboard; and completing trending and analysis of feedback and complaints and recording of improvements.

In relation to workforce governance, the Provider advised staff of brokered services have been given access to an online training platform and a template provided to track staff training due for completion by December 2024. Whilst the Provider advised qualifications, police checks, and vaccination records for staff of brokered services have been submitted, no documentary evidence was provided to demonstrate this. No information was provided in relation to performance appraisals for brokered staff and how this is being monitored.

In response to the previous Quality audit conducted 30 October to 02 November 2023, I note the Provider had committed to completing improvement actions between December 2023 to February 2024. However, these improvement actions have either not been fully implemented or have not resulted in remediating the deficits. This has further influenced my decision.

Having considered the assessment team’s report and the Provider’s response, I find the Provider has not demonstrated effective governance systems in relation to information management, continuous improvement, and workforce governance. Improvement actions have yet to be implemented, will require time to be embedded within the service’s processes and to demonstrate their effectiveness and sustainability.

I, therefore, find this Requirement is non-compliant.

Requirement 8(3)(e)

The service was found non-compliant in this Requirement in the previous Quality audit conducted 30 October – 02 November 2023 due to the service having no clinical personnel to ensure oversight and monitoring of clinical care; no clinical governance committee as outlined under the service’s clinical governance framework; and an absence of policies to guide staff practice on antimicrobial stewardship and minimising the use of restrictive practices.

The assessment team’s report identified the service has commenced some improvement actions to address these deficits. This includes employing a community health worker currently studying a diploma of nursing and developing policies in relation to antimicrobial stewardship and minimising the use of restrictive practices.

However, the assessment team’s report identified other than a community health worker, the service continues to have an absence of clinical staff to effectively ensure clinical oversight and monitoring. The organisation’s Board includes a retired registered nurse who is not confident in the currency of their skills to ensure this function. Risk assessments in most cases have not been completed by a registered health professional. Four out of 7 brokered services responsible for delivering clinical care do not have clinical staff for oversight of clinical care and service delivery. Current actions under the service’s plan for continuous improvement to engage a clinical advisor and establish a clinical governance committee remain outstanding.

The Provider’s response advises of extensive work on governance planning currently underway within the organisation. Planned actions to remediate deficits include continuing ongoing efforts to recruit a clinician to the Board and engaging local medical and allied health expertise in the interim; amending contracts with brokered services to include a requirement to appoint clinical personnel for clinical oversight; and establishing a clinical governance committee and a Quality Care Advisory Body. The Provider proposes to have these actions completed by December 2024. In response to the previous Quality audit, I note the Provider had committed to completing improvement actions between December 2023 to February 2024. However, these improvement actions have either not been implemented or have not resulted in remediating the deficits. This has further influenced my decision.

Having considered the assessment team’s report and the Provider’s response, I am not satisfied the Provider has demonstrated effective clinical governance. Improvement actions have yet to be implemented, will require time to be embedded within the service’s processes, and to demonstrate their effectiveness and sustainability.

I, therefore, find this Requirement is non-compliant.

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