**Performance**

**Report**

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| Name: | Killara Adult Day Centre & Respite |
| Commission ID: | 500032 |
| Address: | 2 Burgoyne Street, NORTHAM, Western Australia, 6401 |
| Activity type: | Quality Audit |
| Activity date: | 18 January 2024 to 19 January 2024 |
| Performance report date: | 18 April 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

Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 8405 SHIRE OF NORTHAM  
Service: 25173 SHIRE OF NORTHAM - Care Relationships and Carer Support  
Service: 27142 SHIRE OF NORTHAM - Community and Home Support

**This performance report**

This performance report for Killara Adult Day Centre & Respite (**the service**) has been prepared by K Jarvie, 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 on 18 and 19 January 2024, observations at the service, review of documents and interviews with staff, consumers/representatives
* the provider’s response to the assessment team’s report received 22 February 2024 which contained the following document titles:

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| Standard 1 Consumer dignity and choice | Not 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 | **Not Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **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 1 Requirements (3)(b), (3)(c), (3)(d), (3)(e)

* Ensure effective processes and procedures are occurring to allow the capture of cultural diversity information from consumers which then informs appropriate care and service delivery.
* Ensure the service is actively encouraging and then recording when consumers make decisions about their care, who and when others should be involved in their care, communicating decisions on their care, and to make connections with others and maintain relationships.
* Ensure that risk is adequately identified and consumers or their representatives are involved in discussions around managing those risks whilst still maintaining choices, independence and living their best life.
* Ensure consumers have appropriate access to information on language and interpreter services, and that information on communications are recorded.

Standard 2 Requirements (3)(a), (3)(b), (3)(c), (3)(d), (3)(e)

* Ensure care planning is informed via appropriate validated assessment tools and risk mitigation overseen by appropriately qualified individuals to deliver safe and effective care and services.
* Ensure that consumers are given the opportunity to discuss and plan culturally appropriate end of life care if desired.
* Ensure that consumers are being consulted and their planning updated as their circumstances change. Involve the people and service that the consumer wishes to involve.
* Establish collaborative policy and procedure around consumer assessment and planning and ensure consumers have ready access to the plans they help create.
* Regularly review care planning with consumers, ensuring changes to the care plans are being informed by their changing preferences and circumstances.

Standard 3 Requirements (3)(a), (3)(b), (3)(c), (3)(d), (3)(e), (3)(f)

* Ensuring care and services are informed by detailed consumer preferences, appropriately qualified health professionals and in line with best practice.
* Establishing effective policy and procedure around the management of high impact or high prevalence risks for to guide staff in care and service deliver for consumers.
* Ensure that consumers end of life wishes are known and if appropriate involving external services which specialise in palliative care.
* Ensure consumer presentation is accurately recorded and accessible to enable changes in presentation to be recognised and responded to in a timely manner.
* Ensure consumer care plans and progress notes are detailed and readily accessible to those delivering care and provided with consent to external service providers.
* Develop policy and procedures around assessment and referral for allied health services external to the service to maximise consumer wellbeing.

Standard 4 Requirements (3)(a), (3)(b), (3)(c), (3)(d), (3)(e), (3)(f)

* Ensure support plans are tailored and detailed in a manner that allows personalised care and services.
* Ensuring that cultural backgrounds, religion and psychological and emotional needs of the consumer are discussed and guide care and service delivery.
* Ensure consumers social and personal relationships are encouraged and respected and that the service facilitates them.
* Ensure that consumers receiving other forms of care have their condition, needs and preferences communicated with other providers to coordinate care.
* Ensure that when planning goals, consumer services that cannot be facilitated within the service are sent to external providers.

Standard 6 Requirements (3)(a), (3)(b), (3)(c), (3)(d),

* Establish policy and procedures around feedback and complaints and actively seek out this information from consumers and their representatives to inform continuous improvement in a meaningful manner.
* Ensure consumers and their representatives have access to language services and are aware of how advocacy groups can assist and facilitate lodging of feedback and complaints.
* Establish a centralised system for feedback and complaints and train staff in how to receive, action and progress. Ensure transparency and apologise when things go wrong.
* Ensure reporting to governing board around complaints where appropriate and that it informs continuous improvement.

Standard 7 Requirements (3)(c), (3)(d), (3)(e)

* Ensure the workforce is appropriately qualified in line with job descriptions and that and that appropriate systems exist to monitor training, registration and competency to be able to effectively deliver care and services
* Establish policy and procedures around compliance with the Quality Standards, recruit and train staff to develop teams experienced in its implementation.
* Establish performance review framework and regularly meet with staff to check performance and development.

Standard 8 Requirements (3)(a), (3)(b), (3)(c), (3)(d), (3)(e)

* Encourage and facilitate consumer engagement and feedback for the purpose of evaluating care and services to improve consumer outcomes.
* Establish detailed reporting lines and framework to the services governing body to enable oversight and accountability of its services.
* Ensure systems in: Information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints allow for efficient and effective data collection, analysing and action to ensure improved outcomes for consumers, and enhance quality of care and services.
* Establish policy and procedures to guide staff in service delivery, supported by robust systems that train and support staff to deliver safe and quality care in the areas of, but not limited to: high impact or high prevalence risks, abuse and neglect, dignity of risk, managing and preventing incidents via a central incident management system.
* Establish a clinical governance framework which promotes antimicrobial stewardship, assesses for restrictive practice, and finds consumer preferred options which minimise the use of restraint, and operate in a transparent and respectful manner where apologies are given if things go wrong.

# Standard 1

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| Consumer dignity and choice | | CHSP |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Not 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. | Not Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Not 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 |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Requirement 1(3)(a)

The Assessment Team found the service is treating consumers with dignity in respect in the process of service delivery and language within care plans is inclusive. However, assessed this Requirement as ‘not met’ and noted the following information:

* A lack of information that showed the service is identifying, documenting, and delivering services and care that value and cater to consumer cultural identities and diversity at assessment.
* Consumers confirmed that they felt respected by staff and that those delivering care knew their preferences and needs but were unsure how the service would support them to express their culture and diversity.
* Some consumer plans were noted to contain a brief story on the consumer but did not capture detailed cultural or information about their identity that could be used to tailor individualised care for the consumer.
* At the time of the Quality Audit this information was put to management who acknowledged that there were no policies, procedures, or structured training to assist staff asking for and recording individual stories, histories and/or cultural information of its consumers.

I also acknowledge the following information recorded by the Assessment Team which I find relevant to my finding:

* Consumers overall were satisfied with the way that the service treated them and had no adverse commentary towards the service not fulfilling their cultural requests or not valuing them as an individual.
* No consumers said they felt unsafe expressing their culture or their diversity or that they had made attempts to express this which were not supported by the service.

The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *the Killara Handbook 2022,* which is noted to contain the Aged Care Charter of Rights.
* *Killara Audit Response 1 – 8,* which identifies intent to undertake comprehensive assessment and understand consumer culture and diversity values between March and May 2024.

I have considered the intent of the Requirement which has a large emphasis upon consumers at the service being treated with dignity and feeling respected. Whilst I find the service is not appropriately seeking, recording, and utilising information around culture and diversity, on balance, consumers did not complain about the services respect towards them or their culture and diversity, or state that the service had failed to act on information they provided to them. Consumers were reportedly satisfied with the way the service treated, interacted, and engaged with them. The Assessment Team witnessed staff talk about and to consumers with inclusiveness and respect. In my findings, I acknowledge that there is the capacity within the service to further improve how service delivery can be tailored to promote cultural safety and diversity.

I also acknowledge the additional evidence submitted on 22 February 2024, which identifies that the provider intends to address the issues around culture and diversity in upcoming training and improvement strategies.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 1(3)(a).

Requirement 1(3)(b)

The Assessment Team assessed that the service is not providing care services which are culturally safe and assessed this Requirement as ‘not met’, in its assessment they noted:

* Review of consumer files showed that assessment and recording of information that would facilitate culturally safe practices is not occurring.
* Staff interviewed were unable to provide a detailed explanation of what delivering culturally safe care and services meant in practice.
* Management stated there were no policies, procedures or staff training that guided staff in the delivery of culturally safe care.
* A consumer was noted to have gone without services for a period due to the service not recording their preference in who delivers their care services.
* Another consumer stated that they were unsure how the service would support them with expressing their culture and diversity if they wanted.

The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8*, which identified intent to deliver training to staff in how to deliver culturally and diverse safe care.

I have considered the intent of the Requirement, in that consumers are confident that the service understands their needs and preferences and that they can give examples of ways the service delivers care with their cultural safety in mind. Evidence shows the organisation lacks the strategic support through training, policies, and procedures to develop and support staff knowledge and practices in this area.

I acknowledge the additional evidence submitted by the provider on 22 February 2024, which identifies their intent to develop and implement policies and procedures specific to the Killara Service, as well as training on culturally safe care. I note that at the time of the Quality Audit, or the provider response, these are yet to implemented or embedded into operational practice.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 1(3)(b).

Requirement 1(3)(c)

The Assessment Team assessed the service as not having robust or documented processes in place to encourage and support consumers to be actively making decisions in their care, who is involved, or maintaining relationships, noting that:

* Most consumers and representatives interviewed saying they are not involved in their care decisions but did state that they feel supported to get help with these decisions if required.
* There was no documentation sighted by the Assessment Team in the form of progress notes or consumer care plans that evidenced consumers were being supported to make connections with others, or that they are regularly and formally involved in making decisions about their care and services or the involvement of others in their care.
* Staff demonstrated an awareness on providing choice and independence, but this did not extend to the involvement of consumers being able to maintain their relationships of choice. A consumer noted that she would like to involve a close friend in her care delivery but was unsure how to get this to happen at the service.
* Management advised that regular verbal discussions occurred to exchange information on consumer choice and decisions and that consumers are involved in every step of the support planning process. When reviewed, the Assessment Team noted that care plans had not been updated to evidence consumer decisions or requests.

The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *the Killara Handbook 2022,* which is noted to contain information on available services, and care plan reviews timeframes.

I have considered the intent of the Requirement which identifies that the consumer should feel as though they are supported to make decisions and changes to the way their care and services are delivered at any time. Consumers should feel they have as much control over their care and planning as they want to, and the service should be able to provide examples on how they support consumers to exercise choice and that staff are training and supported to assist consumers with this.

I acknowledge for the additional evidence submitted by the provider on 22 February 2024, which identifies their intent to update existing documentation, develop and implement policies and procedures specific to the Killara service, particularly that additional training will be provided to staff on supporting consumers to make decisions on their care and services and who a consumer wants involved in their care delivery including respecting any personal and intimate relationships. I note that this is due to be actioned between March and May 2024, and that this is yet to be implemented and embedded in operational practice.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 1(3)(c).

Requirement 1(3)(d)

The Assessment Team assessed the service as not adequately supporting consumers to take risks to live the best life that they can. Whilst consumers said they were encouraged to maintain independence, processes are not in place to record, discuss, manage and mitigate risk. The Assessment Team noted that there was no dignity of risk processes in place, in particular:

* A consumer with a walking aid who chooses to ambulate independently has had no assessment or documented risk review completed, nor has the consumers preference been noted on her care planning documentation or progress notes.
* Staff noted that they encourage consumers to take risks to maintain their independence and dignity; however, the assistance offered by staff is ad hoc and not formalised on care planning documentation.
* Management and service delivery staff confirmed that dignity of risk conversations have not occurred with consumers or their representatives, and staff are not informed or trained on how to support consumers to take risks and then document consumer choice in this process accordingly.

The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8*, which identified intent to develop specific policies and procedures around dignity of risk and deliver training to staff in how to support consumers to take risks to live their best life, but within the dignity of risk processes.

I have considered the intent of the Requirement which identifies that consumers should be supported to understand the potential risks and benefits to the decisions they make, and problem solving be a part of solutions wherever possible. I note that the service had no prior awareness of the dignity of risk process, and the service has not had conversations with consumers or representatives regarding this.

I acknowledge the additional evidence submitted by the provider on 22 February 2024, which identifies their intent to update existing documentation, develop and implement policies and procedures specific to the Killara service, particularly that they intend to implement dignity of risk processes, and develop staff training around this between March and May 2024. I note that as of the date the additional evidence was submitted, this is yet to be implemented or embedded into operational practice.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 1(3)(d).

Requirement 1(3)(e)

The Assessment Team assessed this Requirement as ‘not met’ as the service is not providing timely and accurate information that allows consumers to exercise choice. The Assessment Team confirmed with management that all communication outside of the invoicing process is done by the service verbally, and that any information communicated is not formally documented on consumer progress notes or care plans. The Assessment Team noted the following:

* Invoicing communications are regular, clear and easy to understand. Consumers noted that any mistakes are quickly rectified.
* Consumers said that they do not receive information from the service other than invoicing or fee increases, however noted that this information was clear and easy to understand.
* Staff provided practical examples of how they communicated with consumers daily, using eye contact, speaking clearly and slowly, language cards, and communication cards.
* Management advised that information is shared verbally with consumers during services on Thursday at the day respite centre.
* Information that is shared is not documented or recorded on consumers care plans or progress notes.

The service response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8*
* *1.3.c – Killara Handbook 2022,* it is noted that the handbook sets out the service and fee expectations in a brief manner and does contain further points of contact if more information is sought. The handbook does not contain any information about language services or additional support for consumers who may experience language difficulties.

In considering my finding, and the intent of this Requirement, I consider that the service communicates with consumers in a satisfactory manner to relay financial information as appropriate. Information systems and their management could be improved, I consider that there is no evidence before me that consumers are unhappy or had been disadvantaged due to improper or incorrect information being provided to them. Whilst staff identified using communication techniques, there was no information available to provide consumers with English as a second language access to translating services. I note that issues relating to information within care plans is addressed in Standard 2 and is not further considered here.

I acknowledge the additional evidence submitted by the provider on 22 February 2024, which identifies their intent to update existing documentation, develop and implement policies and procedures specific to the Killara service, particularly that they intend to update that Killara Handbook and implement a consumer information correspondence register between March and May 2024. I note that this is yet to be implemented or embedded into operational practice.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 1(3)(e).

Requirement 1(3)(f)

The Assessment Team assessed this Requirement as ‘met’, as consumers’ personal information and privacy are respected and secured. It noted that data management and access was basic, and at times cumbersome to those providing care and services. Consumers and their representatives were recorded as having no concerns with the way in which their information was shared and handles. The team provided the further details and examples as follows:

* Consumers and their representatives were unaware of privacy and confidentiality policies and could not explicitly remember signing information release documentation.
* Strategies identified by staff and management in the context of information security and respecting privacy were not documented as part of the services policy and procedures but appeared to be more an information arrangement and understanding within the service. No evidence could be provided by management of consent protocols, or record of these in practice within support plans.
* Consumer progress notes were provided to and secured by the manager of the service as part of daily routine. These are then stored in locked filing cabinetry within the office, to which only the manager has access. Staff are required to contact the manager in order to access information or discuss support plans.
* The service has a generic privacy policy available online through the Shire of Northam website. This privacy policy does not detail specific actions as to how consumer information is collected or shared.
* Staff noted that they participate in privacy and consent training as part of their induction to the service.

In considering my finding, and the intent of this Requirement, I have considered that in addition to the privacy policy available online, the *Killara Handbook 2022* has detailed information in relation to privacy and confidentiality. I note that whilst consumers don’t recall signing consent, there is no evidence of a breach of consent through information being sent externally without permission. Consumers hold no concerns over the protection of their personal information, and they feel staff respect their privacy. Staff were able to describe how they adhere to confidentiality and information is stored in a manner that protects consumers, staff said that privacy is respected and given importance.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 1(3)(f).

# Standard 2

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| Ongoing assessment and planning with consumers | | 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 |
| 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. | Not 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. | Not 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. | Not 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 Assessment Team assessed this Requirement ‘not met’ with regards to ensuring that assessment and planning is inclusive of risk and ensures delivery of safe and effect care. The Assessment Team noted the following information relevant to my finding:

* They found that consumers and representatives interviewed stated that they were satisfied with processes in place however a review of documentation found that risks are not documented nor care plans sufficiently detailed to guide the delivery of care for staff.
* Care plans are created after a visit to the consumers home by the coordinator and are formulated after consultation with the consumer.
* Staff stated that as part of the initial assessment, basic information about the consumer is captured about the consumer and their medical needs, allergies, communication needs, next of kin and basic risk details such as falls or mobility issues.
* The service coordinator completes the support plan and the enrolled nurse reviews the plans after they are completed but does not appear to have input in the process.
* A review of all of the consumer support plans identified that the plans lacked: identification of risks, mitigation strategies for risk issues.
* Support plans contained only brief and basic information to guide workers with the delivery of care, such as ‘medication prompt/assistance’.
* Support plans do not contain information that would allow staff to tailor the delivery of care based on their cultural needs, social or life history.
* Validated assessment tools completed by appropriately qualified clinical staff are not evidenced in support plans, nor strategies to assist workers to deal with behavioural and medical issues such as Parkinson’s, diabetes management or ischemic heart disease.
* 80% of support plans identified consumers with falls risk, had no recorded mitigation strategies.
* Support plans do not document nonresponse to scheduled visits, other than ‘notify carer’.
* Management was unaware of the requirement to assess risks using validated assessment tools and to document the findings and risk mitigation strategies, but accepted the Assessment Teams findings and said they will review and determine changes required.

The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8*, which identifies plans to implement Killara specific Policies and procedures, comprehensive assessments and risk assessments between March and May 2024.

I acknowledge the additional evidence submitted by the provider on 22 February 2024, which identifies their intent to update existing documentation, develop and implement policies and procedures specific to the Killara service. I note that at the time of the Quality Audit, or the provider response, these are yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response and the intent of the Requirement and I find the service is not undertaking robust assessment via validated assessment tools and planning mitigative strategies comprehensively to guide staff. I find that the service is not involving appropriately qualified staff to have input into care planning to ensure safe and effective care is being delivered to consumers. I consider that management though unaware of some requirements, have undertaken to address the Assessment Teams findings.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 2(3)(a).

Requirement 2(3)(b)

The Assessment Team assessed this Requirement ‘not met’, noting that the assessment and planning process does not identify the needs, goals and preferences of the consumer including advanced support planning. Most consumers and representatives said they were satisfied with the process with only one representative saying the needs of the consumer was not always understood by the coordinator. However, the Assessment Team found that needs, goals, and preferences were not appropriately documented or in detail that would allow them to be met or care to be individualised. The following additional information and examples were identified:

* Most consumers and representatives stated that they have a say in how their day to day services are delivered and include their preferences, though one consumer was noted not to receive the care they needed.
* The new coordinator (acting) has commenced capturing goals and preferences at the initial assessment stage. The Assessment Teams review of consumer care plans found goals that were documented to be generic such as ‘to maintain current level of social interaction and maintain current level of independence’.
* Management said they were aware that consumer goals were not always captured if consumers were discharged from hospital unknowingly.
* The service had no discussions with consumers around advanced care or end of life planning, nor were they aware of an opportunity to do so. Subsequently no care plans detailed this information or consumer preferences around this topic.
* Management confirmed end of life planning was not discussed with consumers, nor were they provided with any information on the topic.
* Management said they would review the information and seek to include information on this topic.

The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* which notes that the service will seek to obtain and record comprehensive information in consumer care plans, including that relevant to advanced care planning and provide consumers information on this topic between March and May 2024.

I acknowledge the additional evidence submitted by the provider on 22 February 2024, which identifies their intent to update existing documentation, develop and implement policies and procedures specific to the Killara service. I note that as of the date the additional evidence was submitted, this is yet to be implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that the service is not discussing or recording detailed information on consumer needs, goals, and preferences to get individualised care and services that promote the health and wellbeing, including end of life planning. I have placed weight on the consumer care plans reviewed by the Assessment Team, which evidence that information captured is not comprehensive.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 2(3)(b).

Requirement 2(3)(c)

The Assessment Team assessed this Requirement ‘not met’ as they found that the service was not consulting with consumers and their representatives beyond the initial meeting. In addition to this, the Assessment Team found that the service is not referring to external services, contact with other providers or other agencies is not recorded, and care plans do not reflect consumer preference over who is involved in their care. The following additional information and examples were identified:

* Some support documentation showed partnership with consumers and their representatives; however, the process was not consistent and did not inform a systemic approach to consumer care and services.
* Care plans were not updated, and therefore no evidence could be found that consumers have an ongoing partnership in their assessment, planning and care.
* Management stated that services such as the local pharmacy were involved in the care and services delivered to consumers; however, documentation did not record or identify any services or individuals being involved.
* Some consumers and their representatives said that they had an opportunity to discuss their care and service delivery and preference what days and times it is delivered.
* Consumers receiving additional services from other providers delivering Home Care Packages (HCP) have no documented service coordination between services for assessment and planning.
* Management advised that although not well documented, then involve consumers and their representatives in their care planning, but conceded they could improve processes involving other medical professionals and service providers.

The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* which identifies intention to implement comprehensive consumer assessments, internal referral forms and seek external agency referral forms also between March and May of 2024.

I acknowledge the additional evidence submitted by the provider on 22 February 2024, which identifies their intent to update existing documentation, develop and implement policies and procedures relevant to those involved in the consumer care delivery. I note that at the time of the Quality Audit, or the provider response, these are yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that the service is not referring externally to other agencies which could mean that consumers are not receiving the care and service appropriate for their needs. Whilst I acknowledge that management have advised that consumers and representatives are involved in consumer assessment and planning, I have placed weight on the lack of evidence to show that this partnership is ongoing, and the information obtained is available to those who deliver care through appropriate documentation, as evidenced by consumer care plans not being updated to reflect current circumstances or changes.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 2(3)(c).

Requirement 2(3)(d)

The Assessment Team assessed this Requirement ‘not met’ due to the service not being able to demonstrate that validated assessments are occurring, and the outcomes documented in care plans which are available to the consumer. The following additional information and examples identified has also been considered:

* 40% of consumers were unaware of having a care plan.
* Consumer care plans displayed goals however these were noted to be generic and lacked detail, progress notes were found not to contain sufficient information that would assist the delivery of care and are not frequently updated. Management responded to the feedback on site advising that they would seek to rectify this.
* Care plans for those with clinical needs do not detail information related to delivery of services that would be specific to those needs, such as diabetic meal plans for those with diabetes.
* Assessments and their outcomes are not documented in care plans, and there is no evidence that they are communicated to consumers or are influencing the delivery of care.
* Staff said that care plans are available to them.

The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* with specific note that the service intends to implement comprehensive consumer assessments and train staff on the importance of reporting.

I acknowledge the additional evidence submitted by the provider on 22 February 2024, which identifies their intent to update existing documentation, develop and implement policies and procedures and provide further training to staff. I note that at the time of the Quality Audit, or the provider response, these are yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that the service is not providing comprehensive assessments or documenting or communicating the outcome of assessments to consumers. Whilst staff said that they have access to consumer care plans, the location of the physical documents means that only the coordinator and manager have access to them and their availability would impact when these can be reviewed to assist delivery of care and services. It is also unclear as to whether care plans are available at the respite centre for review.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 2(3)(d).

Requirement 2(3)(e)

The Assessment Team assessed this Requirement ‘not met’ as they determined that the service was unable to demonstrate care and services of consumers are regularly reviewed for effectiveness or when circumstances change. The following information and examples were identified:

* Most consumers or their representatives could not recall having consumers’ care and services reviewed. Documentation confirmed this is not occurring.
* Consumers and representatives said that they are supported by the service when their needs change or they want to change the services they receive.
* Staff described what they would do if they identified changes in consumer needs but could not provide an example and could not evidence this with consumer documentation.
* Management confirmed that consumer reviews had not all been completed in required timeframes (12 months) and noted that approximately half of the consumers were overdue for review, with some not having been reviewed for nearly 4 years. Management advised that this was due to a legacy staffing issue they had already identified and were working to rectify this situation, whilst prioritising the delivery of care and services.

The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* which notes that the service intends to implement additional Killara specific policies and procedures including feedback forms for consumers and staff, between March and May 2024.

I acknowledge the additional evidence submitted by the provider on 22 February 2024, which identifies their intent as noted above. I note that at the time of the Quality Audit, or the provider response, these are yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that the service is not regularly and routinely reviewing services and care delivery for effectiveness. I note that consumers and representatives interviewed said that the service does support consumers if they wish to alter their service delivery if their needs change. I have placed weight on managements confirmation that services have not been routinely reviewed due to legacy staffing issues, and the Assessment Teams review of documentation confirming that some care plans have not been reviewed for approximately 4 years.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 2(3)(e).

# Standard 3

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| Personal care and clinical care | | 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. | Not Compliant |
| 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)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | 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 |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Not 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 |

Findings

Requirement 3(3)(a)

The Assessment Team assessed this Requirement ‘not met’ as they found that whilst there were some examples of individualised personal care, no clinical assessments are occurring and there were instances where consumers were not receiving the personal care required. There are no policy or procedures in place for the delivery of personal or clinical care. The following information and examples were identified:

* Consumers and their representatives mostly reported satisfaction with care and services received.
* Clinical staff (Enrolled Nurse) are not meeting with consumers or their representatives to conduct clinical assessments.
* Validated assessment tools are not used in the assessment and planning for consumers with identified risks, such as Falls Risk Assessment Tool (FRAT).
* Evidence of staff competency training was not provided when requested during the audit.
* Support plans were noted to not be in line with best practice; for example, consumers with dementia did not have behavioural support plans in place, and external services in dementia care were not consulted.

The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* noting the intention to implement: Killara specific policies and procedures, comprehensive consumer assessments, update staff training records, behaviour support plans (including a review of environmental restrictive practice), and deliver further training to staff. The service noted the intention for this to occur between March and May 2024.

I acknowledge the additional evidence submitted by the provider on 22 February 2024, which identifies their intent to update existing documentation, develop and implement policies and procedures specific to the Killara service. I note that at the time of the Quality Audit, or the provider response, these are yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that the service is not delivering, individualised personal and clinical care to most of its consumers. Whilst it is noted that some consumers are receiving personal care that takes into consideration their preferences, I have placed weight of my decision on the lack of detail and involvement of staff with clinical and specialist skills in the assessment and planning of consumers’ care. This involvement would allow delivery of individualised care that is best practice. I also note a lack of policy and procedures to guide staff, which was acknowledged by management after the Assessment Team finding.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 3(3)(a).

Requirement 3(3)(b)

The Assessment Team assessed this Requirement ‘not met’ due to the service not adequately assessing or putting in place risk mitigation strategies and discussing this with consumers and their representatives. The following summary of additional information and examples was identified:

* Management advised that the management of high-impact high-prevalence risk is not discussed with consumers or their representatives at any point of service delivery.
* No policy or procedures are in place to guide staff in the management of high-impact high-prevalence risks.
* The service does not use an incident management system to track and trend these types of risks to improve consumer care.
* Staff described how they manage high-impact high-prevalence risks for consumers such as falls but acknowledged that this is not always recorded on support plans.
* Management stated they rely on family members to report incidents involving consumers.

The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* which identified the intent to implement Killara specific policies and procedures which included comprehensive consumers assessments, incident management system, risks assessments, as well as ensuring staff are trained in hazard/near miss and incident reporting form completion.
* *3.3.b – Incident-Near Miss & Hazard Report Form\_V4,* noting that this form appeared not to be a form specific for Killara staff, but more applicable to Shire of Northam staff more generally.
* *3.3.b – Medication Incident Form (Word file)*
* *3.3.b Medication Incident Register (xlt file),* noting that dates on this form indicate the service has not made entries into the document since 2010.
* *3.3.b Medication Incident Register (xlsx file)*

I acknowledge the additional evidence submitted by the provider on 22 February 2024, which identifies their intent to update existing documentation, develop and implement policies and procedures specific to the Killara service. I note that at the time of the Quality Audit, or the provider response, these are yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the requirement. I find that the service is not assessing for or managing high-impact high-prevalence risk. Consumers do not have the management of risks discussed with them, and there are no policies or procedures in place to guide the workforce in taking a systemic approach in the management, documentation, and analysis of these risks to the benefit of consumers. Management was noted to have acknowledged the deficits in risk assessment and management during the audit.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 3(3)(b).

Requirement 3(3)(c)

The Assessment Team assessed this Requirement ‘not met’ due to there being no discussions, policies or procedures and documentation on end-of-life care, and management were not aware of their obligation to assist consumers to develop and record these wishes where appropriate. The following summary of additional information and examples was identified:

* Consumers had not discussed end of life planning with the service, and documentation evidenced that no consumers had this information captured within their care plan.
* The service had no affiliation with external services such as palliative care services which would support the delivery of best practice care to consumers nearing end of life.
* Management advised that the service does not discuss or record this information about consumers and has no policies or procedures in place to support this process occurring.

The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* which notes that the service intends to implement additional Killara specific policies and procedures including comprehensive assessments and advanced care planning, including development of a referral process to external palliative care services.

I acknowledge the additional evidence submitted by the provider on 22 February 2024, which identifies their intent to implement a number of improvements to address the issues identified. I note that at the time of the Quality Audit, or the provider response, these are yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that the service was not aware of their responsibilities around end-of-life planning. Discussions are not occurring with consumers and their wishes and preferences are not being recorded. I also note that the service is not engaged with external services which would assist in the delivery of best practice palliative care to consumers nearing end of life.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 3(3)(c).

Requirement 3(3)(d)

The Assessment Team assessed this Requirement ‘not met’, as the services does not recognise and respond to consumer deterioration. Consumers and their representatives said that they relied upon their general practitioner to identify health concerns and did not appear confident or understand how the service would respond to consumers’ deterioration. The following summary of additional information and examples was identified:

* When asked how they would respond to consumer deterioration, staff indicated that they would escalate the information to management.
* There was no evidence within consumer care plans of staff reporting changes in consumer presentation or deteriorating health.
* There was no process or evidence of the service referring consumers for re-assessment, either via a general practitioner, the local hospital, or other medical services if applicable.
* Management said that they were in the process of developing staff guides to assist in recognising consumer deterioration.
* Management said that recognising consumer deterioration training would form part of mandatory staff education and that they would ensure that they would communicate with staff around recording and reporting changes in consumer presentation.

I acknowledge the additional evidence submitted by the provider on 22 February 2024. The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* noting that the service has indicated that they will implement Killara specific policy and procedures, staff training on recognising and reporting changes in consumers, and deteriorating health in aging adults.
* *3.3.d – 9 Warning Signs of Deteriorating Health in Ageing Adults Procedure,* this document also contains the signature of staff members agreeing to adhere to the ‘Deteriorating Client Procedure’ and their signatures pre-date the Quality Audit.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I note that the Assessment Team report identified that management also provided the above document (*9 Warning Signs of Deteriorating Health in Ageing Adults Procedure*) during the Quality Audit, however the Assessment Team did not find any evidence that staff were recording appropriate consumers observations within consumer progress notes relevant to consumer presentation or changes in consumer health. Consumers and their representatives did not consider the service to be an avenue to escalate health concerns. There was no evidence that the service has processes in place for referral and re-assessment when there is a change or deterioration in consumer health that may warrant an increase or change in the care and services that they receive. Management accepted the finding and advised that they were not aware of their responsibilities around referring externally.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 3(3)(d).

Requirement 3(3)(e)

The Assessment Team assessed this Requirement ‘not met’ due to the service lacking robust processes, including a lack of detail in care plans. The service is not receiving information from external providers and there is a lack of policy and procedure around the exchange and sharing of information. The following summary of additional information and examples was identified:

* Consumers and their representatives felt that effective communication of consumers’ needs and preferences occurred between staff, and that staff were consistent and knew them well.
* Management said that they do not consistently receive discharge information from hospitals or general practitioners involved in consumer care.
* There was no evidence that changes and recommendations for consumers were followed up and staff made aware.
* Medication incidents were not documented in the services main incident management system and as a result there was no record of whether consumers, and where appropriate their representatives, had been notified.
* There are no Killara specific policy and procedures around consent and the sharing of consumer information with agencies that share responsibility of care.

I acknowledge the additional evidence submitted by the provider on 22 February 2024. The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* which identified the intention to implement comprehensive consumer assessments, and ensuring all staff are reviewing and signing care plans and implementing the privacy policy.
* *1.3.c – Killara Handbook 2022,* which contains details on the Privacy Policy and some general information on the sharing of information for consumers.

I note that at the time of the Quality Audit, or the provider response, these are yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that consumers and their representatives are satisfied their needs and preferences are being effectively communicated and that care delivery staff know them well. Consumer care plans and progress notes lack sufficient detail and an absence of information obtained from external services which would enable continuity of care. I note that the service does not have processes in place for referring consumers externally, and the *Killara Handbook 2022* only addresses privacy, confidentiality, and consent to release information in general terms.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 3(3)(e).

Requirement 3(3)(f)

The Assessment Team assessed this Requirement ‘not met’ as the service is not referring consumers to external services as the service was unaware that this was required of their service. The following summary of additional information and examples was identified:

* Consumers experiencing challenges are not being referred to specialist providers to develop support plans which may assist in strategizing care and service delivery.
* There are no active consumers which have been referred to external services, staff were unaware how to undertake this or how they would refer consumers for reassessment through My Aged Care.
* The service does not have policy or procedures which addresses external referrals to allied health and/or clinical services and providers to guide staff.

I acknowledge the additional evidence submitted by the provider on 22 February 2024. The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* which notes intention to implement Killara specific policy and procedures, complete comprehensive consumer assessments, implement internal and external referral forms as well as feedback forms.

I note that at the time of the Quality Audit, or the provider response, these are yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that the service is not referring consumers externally and I note that management confirmed that they were unaware of the services requirement to do so. I find that the service had no policy and procedures in place to guide staff in the process of external referral and that staff could not describe how they would do this for consumers. At present the service is noted to have no consumers which have been referred externally by itself to allied health or other care and service delivery providers.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 3(3)(f).

Requirement 3(3)(g)

The Assessment Team assessed this Requirement ‘not met’ as they found it was unable to evidence outbreak management plans, policy and procedure to minimise infection related risks or antimicrobial stewardship available to staff and consumers. The following summary of additional information and examples was identified:

* Consumers said that staff take precautions including wearing masks and washing, sanitising hands.
* Management said that Personal Protective Equipment (PPE) is available to all staff who have also completed training in COVID-19 and donning and doffing PPE.
* Whilst staff were said to undergo infection and control training, training in anti-microbial stewardship training is not provided and information is not distributed to staff or consumers.
* The service relies on a Shire of Northam COVID-19 management plan and infection control policy/procedure, which is not specific to Killara. The Assessment Team requested a Killara specific COVID-19 management plan but was not provided with one.
* Management said that the Killara Day Respite Centre has never had a COVID-19 outbreak and that they ensure staff are COVID-19 vaccinated.
* Management confirmed that currently they do not provide staff or consumers with anti-microbial stewardship information but had identified the need to do this and would include this in the continuous improvement plan.

I acknowledge the additional evidence submitted by the provider on 22 February 2024. The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* which identifies intention to implement a Killara specific outbreak management plan and staff training on infection control and antimicrobial stewardship.

I note that at the time of the Quality Audit, or the provider response, these are yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. The Assessment Team witnessed appropriate standard outbreak prevention strategies. Evidence was reported and I find that the service is using and reliant upon an outbreak management plan that is not specific to the Killara service, whilst I acknowledge that this plan is unlikely to have the same stringent requirements of a service plan that has a cohort of vulnerable consumers, there is no evidence before me which suggests that it is ineffective. Management identified that they have not had a COVID-19 outbreak, and staff are trained in infection control. The service identified that they do not prescribe antibiotics but acknowledged the importance of educating their staff and consumers in antimicrobial stewardship within a community setting and this was reportedly added to the continuous improvement plan.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 3(3)(g).

# Standard 4

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| Services and supports for daily living | | 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 |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Not 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. | Not 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. | Not Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Not Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Requirement 4(3)(a)

The Assessment Team assessed this Requirement ‘not met’ as they identified that consumer support plans were generic in nature, which mean that it was difficult to measure progress against individual consumer goals as they are not recorded. The following summary of additional information and examples was identified:

* Consumers and their representatives indicated that they felt supported to maintain independence and preferences.
* Staff were able to describe individualised consumer knowledge of their interests and how they would work with that consumer as part of service delivery.
* A review of all consumer support plans identified that the same social support goal had been entered at the point of the initial assessment for all consumers. A statement which identified how this would occur ‘increase mental stimulation and physical activity and reduce social isolation’ was repeated verbatim through all current consumer support plans.
* Support plans did not identify individualised goals or discuss progress towards achieving these goals or if consumers wished to maintain these goals.
* Management advised that the service has identified the need to review and update support plan templates.

I acknowledge the additional evidence submitted by the provider on 22 February 2024. The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* which notes the intention to implement consumer comprehensive assessments and feedback forms.

I note that at the time of the Quality Audit, or the provider response, these are yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I acknowledge that there are consumers who have said that they are satisfied that the service supports them to maintain independence, and staff were able to describe individual consumer interests and how they engage with them. I note that whilst consumer care plans are not sufficiently detailed, there was no evidence before me that the needs of consumers are not being met. Consumers have said that staff are open to changing their care and services which provides an indication of staff flexibility to meet the changing needs of consumers. I consider that the lack of detail in care plans that assist staff has been reflected in the finding under Standard 2 (3) (b) and I don’t intend to consider it further here.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 4(3)(a)

Requirement 4(3)(b)

The Assessment Team assessed this Requirement ‘not met’ as they were unable to identify the service as meeting the consumer’s emotional, spiritual and psychological well-being. Consumers identified social engagement as an important part of their well-being. Whilst staff were aware of consumer preferences, the service is not recording information on religion, psychological or emotional needs of consumers. The following summary of additional information and examples was identified:

* Consumers value the social interaction that the service provides them, and one consumer identified that without it they feel depressed and isolated.
* Consumers and representatives said that staff know them and provide them with appropriate support where required.
* A review of all care plans identified only one consumer with spiritual well-being information, however guidance for staff did not appear to promote connectedness or identify activities that would promote consumer wellbeing.

I acknowledge the additional evidence submitted by the provider on 22 February 2024. The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* noting that the service intends to implement staff training on how to promote consumer's emotional, spiritual, and psychological wellbeing.

I note that at the time of the Quality Audit, or the provider response, these are yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the requirement. I find that the service is not assessing or documenting consumers emotional, spiritual and psychological wellbeing. In considering whether the service has failed to support the wellbeing of consumers, I note that there is no evidence before me of instances where the service is identified as having failed to support consumers. Consumers have identified that Staff are supportive and engaging and activities being delivered at the Killara centre are successful in promoting socialisation. Further detail within care plans which identifies a consumers spiritual or cultural wellbeing preferences to improve the quality of care. I note that lack of detail in care planning has been reflected in the finding under Standard 2 (3) (b) and I don’t intend to consider it further here.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 4(3)(b).

Requirement 4(3)(c)

The Assessment Team assessed this Requirement ‘not met’ as the service is not gathering or recording information from consumers about their social and personal relationships. Whilst staff appear to have some knowledge of consumer interests, this is not documented in care plans. The following summary of additional information and examples was identified:

* Consumers said that social interaction at the day respite centre provided them with a chance to meet with others of a similar background and gave them something to look forward to.
* Staff were unable to describe how consumers participate in community or what places they attend as they said there is insufficient workforce to have consumers attend community activities or go on bus trips.
* Staff advised that a service open day and other activities at the centre had been considered however there was no evidence of these in the plan for continuous improvement during the Quality Audit.
* Consumer support plans reviewed by the Assessment Team did not document consumer interests or how they would like to maintain social relationships.

I acknowledge the additional evidence submitted by the provider on 22 February 2024. The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* noting intention to implement comprehensive consumer assessments and feedback forms.

I note that at the time of the Quality Audit, or the provider response, these are yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that the service is not promoting community engagement for consumers as the service is not documenting their personal interests through assessments and planning or working to assist them to maintain the social relationships. Staff identified staffing issues as a barrier to community participation which does not appear to be resolved. As a result, consumers social interaction appears to be limited to attendance at the Killara day respite centre, which they say is a valuable social interaction.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 4(3)(c).

Requirement 4(3)(d)

The Assessment Team assessed this Requirement ‘not met’ due to the service not having appropriate policy and procedures that guide staff in communicating with others who share responsibility of care. Consumers said that staff know their needs and they do not have to repeat instructions or direct them. Staff described communicating at the beginning of a service to organise what services will be provided to consumers. The following summary of additional information and examples was identified:

* Management said that they do not currently collect information from consumers about what other services they receive.
* Support planning documentation is generic/not comprehensive or consistently reviewed and would therefore impact the amount of information available for care and services that staff could provide.
* Some consumers were noted to be in receipt of Home Care Packages from other providers, but no processes were in place and the service could not describe or provide an example of how relevant information is shared to coordinate safe and effective care to achieve the best outcome for the consumers.
* There are no policy or procedures for communicating with internal or relevant external providers, to guide staff.

I acknowledge the additional evidence submitted by the provider on 22 February 2024. The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* noting intention to implement comprehensive consumer assessments and feedback forms and a privacy policy.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that the service possesses privacy and confidentiality guidelines contained within the *Killara Handbook 2022,* it is not beneficial in guiding staff in seeking to coordinate with external providers in safe and effective care for consumers. Consumers described staff as knowing consumers and not needing to repeat instruction or direction. Staff said that they discuss service delivery prior to the opening of the centre and report any changes. I have placed weight on this requirement being focused on lifestyle services and supports as opposed to clinical care. I also acknowledge that the lack of comprehensive assessments and support plans fundamentally undermines the care and service delivery staffs’ ability to successfully communicate any changes.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 4(3)(d).

Requirement 4(3)(e)

The Assessment Team assessed this Requirement ‘not met’ in completing timely and appropriate referrals to individuals and external providers and services. Consumers and their representatives reported being confident that the service would complete timely referrals to meet consumers’ needs. There was no evidence that the service had access to or relationships with external providers with whom they could collaborate or engage consumers with for the purpose of meeting the daily living needs. The following summary of additional information and examples was identified:

* Management advised that the current consumer cohort had not required external referrals for other care and services, but these would be completed in a timely manner if required.
* The Assessment Team identified where a consumer would benefit from referral to external provider however, this has not occurred.
* The service does not have policy and procedures to guide staff in making referrals to external organisations to improve outcomes for consumers.

I acknowledge the additional evidence submitted by the provider on 22 February 2024. The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* noting intention to implement comprehensive consumer assessments and internal and external referral forms.

I note that at the time of the Quality Audit, or the provider response, these are yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that there is no evidence that the service is completing referrals to external providers for care and services. Consumer goals were also not constructed in a manner that would require or encourage consumers to engage in a setting that would engage them with lifestyle services. There is no policy or procedure to guide staff in completing referrals to external providers.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 4(3)(e).

Requirement 4(3)(f)

The Assessment Team assessed this Requirement ‘not met’ as the service is not individualising meal delivery for individual dietary requirements of consumers. The menu is posted daily with a single alternative of sandwiches provided. Food preparation staff stated that they were aware of individual consumer requirements, but these were not displayed in the kitchen where food was being prepared, including food allergies for some consumers. The following additional information and examples identified:

* Management said that the menu is based off a diabetic menu.
* Consumers were satisfied overall with meal variety, quality, and quantity.
* Meal requirements and preferences documented in consumer support plans were not available in the kitchen.
* Staff advised that there is no formal process of feedback for meals, but staff will enquire if meals go uneaten or if consumers can be heard complaining.
* The Assessment Teams review of support plans found that information was not being recorded in the appropriate section meals or allergies tab. Most information recorded in relation to meals within the support plans was not available to kitchen staff, with only one support plan matching information available to kitchen staff.
* Management said that consumers are not consulted to allow input into menu items.
* The service has been successfully audited by the environmental health department of the local council.
* The dining area was clean, bright, and welcoming. Food delivery was observed, and food looked inviting, nutritious and was served hot.

I acknowledge the additional evidence submitted by the provider on 22 February 2024. The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* noting intention to implement comprehensive consumer assessments, feedback forms, consumer dietary requirements file for the main kitchen and cottage, ensure progress noes are updated, ensure staff food handling training is maintained.

I note that at the time of the Quality Audit, or the provider response, most of the above items are yet to implemented or embedded into operational practice, excluding the staff food handling training which was up to date at the time of the audit.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that the service is maintaining appropriate food handling qualifications for staff; however, display of dietary and allergy information for consumers was not occurring and in the event of staff absence, introduces the potential of consequence if inappropriate or harmful food is served by accident. I consider that this is relevant to care planning and addressed in Standard 2, and therefore will not be further considered here. Consumers are satisfied with meals although should be given more opportunity to influence the menu and alternatives. Consumer care plans were identified as needing review to ensure relevant information is available to kitchen staff. Overall, the Assessment Team found food to be inviting, and looked nutritious and was served in a timely manner. Whilst I acknowledge the service has opportunity to involve consumers and improve the meal service, consumers were satisfied, and I therefore find that there is a lack of evidence to find service non-compliant.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 4(3)(f).

Requirement 4 (3) (g)

The service demonstrated that vehicles are suitable and safe and appropriate for the delivery of care and services provided. Staff described how maintenance is completed and how regular cleaning is documented. Documentation was witnessed for maintenance, cleaning, and accident protocols. Consumers described utilising transport services to attend the day respite service and that care equipment is used to assist with safe transfers. Consumer care notes were reviewed and document their preferences for transport services and all safety equipment including a first aid kit was witnessed by the Assessment Team and confirmed to be in good working order and well maintained.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 4(3)(g).

# Standard 5

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| Organisation’s service environment | | 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. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

Consumers and their representatives described the service environment as safe and welcoming and described a feeling of belonging in the environment. The Assessment Team witnessed interactions and the way staff greeted consumers and their representatives and noted that they were warm and genuine in their engagement, and that everyone present was participating in activities. The service environment was brightly decorated, with a flower theme to celebrate ‘flower day’ with activities to match the theme of the day.

The Assessment Team witnessed the Killara Adult Day Centre to be an environment that is safe, well maintained, and clean. Areas were well structured, and the layout enabled free movement to all areas. The environment was free of trip hazards and had ample room for mobility aids. Signage was clear and illuminated where appropriate. Fire safety was adequate and evacuation procedures were in high visibility areas and easy to read. Local procedures and available documentation recorded regular maintenance and cleaning occurrences. Exits from the building were noted to be restricted, when asked about this the service identified that they were unaware that this was a form of environmental restrictive practice. Consumers and their representatives were able to request the door open to come and go as they pleased, but there was no formal process or documentation in place identify and record this arrangement. Management advised that they would seek to rectify the matter as part of their Plan for Continuous Improvement. This topic is covered further in Standard 8 (3)(e), minimising the use of restraint, and not covered further here.

The Assessment Team observed the service environment to be safe, well maintained, and appropriate for consumers. Procedures were evidence to ensure faulty or broken equipment was quickly removed or rectified. Basic infection control such as hand sanitiser was freely available throughout the facility.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements within Standard 5.

# Standard 6

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| Feedback and complaints | | CHSP |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Not 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. | Not Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Not Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant |

Findings

Requirement 6(3)(a)

The Assessment Team assessed this Requirement ‘not met’ as it was found not to be encouraging and supporting feedback and complaints made against the service. Management stated that the service does not have policies or procedures in place to facilitate the receipt of feedback and complaints. It was also noted that there is no system to manage the information received. The following information was identified:

* Consumers and their representatives said that they were not provided with feedback or complaints forms or informed how to complete either of these. Consumers and their representatives stated this would be done verbally when it did occur.
* Staff advised they would verbally receive complaints or feedback information and then escalate this to their manager.
* Management stated that a handwritten register is used to capture complaints, of which there has been none in the last 6 months.
* At the time of the Quality Audit the Assessment Team reviewed the Killara Handbook 2022 in relation to feedback and complaints and found no information within this.

I acknowledge the additional evidence submitted by the provider on 22 February 2024. The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* noting the intention to update the Killara Handbook, implement a feedback form and implement comprehensive consumer assessments.
* *1.3.c – Killara Handbook 2022,* The document sent as part of the response is noted to contain information that addresses feedback and complaints.

I note that at the time of the Quality Audit, or the provider response, the above items are yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that the service has no feedback and complaints policy or procedure, nor does it have a system to capture, collect and process this information. Staff described a basic understanding and willingness to receive and escalate feedback and complaints however it is likely to be ineffective without a robust system to manage the information, communications, and outcomes.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 6(3)(a).

Requirement 6(3)(b)

The Assessment Team assessed this Requirement ‘not met’ due to a lack of information available relating to language services. The Assessment Team noted that advocacy service information was made available to consumers at commencement, but consumers and their representatives interviewed were unaware advocacy services could assist with resolving complaints. The following additional information and examples were identified:

* Staff said that they did not discuss advocacy or language services with consumers or their representatives.
* Consumers and their representatives were not aware of how to use external mechanisms for making a complaint.
* Staff said they would instruct anyone making a complaint to speak to management.
* Management confirmed that there is no policy or procedure, nor any training delivered to staff on external mechanisms to raise feedback and complaints.

I acknowledge the additional evidence submitted by the provider on 22 February 2024. The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* noting intention to implement staff training on how to raise consumer feedback and complaints.
* I note that at the time of the Quality Audit, or the provider response, the above items are yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that the service is providing advocacy information as part of its commencement *Killara Handbook 2022*, however no information on language services is provided and staff are unaware of how to assist consumers to use these services to the benefit of the consumer by supporting them to access it. There are no policies or procedures in place to guide staff and no training delivered in its use. The service is not actively encouraging or supporting its consumers and their representatives to make feedback and complaints.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 6(3)(b).

Requirement 6(3)(c)

The Assessment Team assessed this Requirement ‘not met’ due to management confirming that no policy or procedure exist for feedback and complaints, no processes or systems are in place to support the management, progression, and resolution of complaints. Staff interviewed could not demonstrate understanding open disclosure in practice. The following additional information and examples were identified:

* There were no consumers or representatives who had made a complaint or given feedback to the service.
* The service does not have an open disclosure policy, and training is not provided to staff on the topic.
* Management said they have no evidence of how they receive and act upon a complaint.

I acknowledge the additional evidence submitted by the provider on 22 February 2024. The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* noting the intention to implement Killara specific policies and procedures, and a consumer and representative form and register.

I note that at the time of the Quality Audit, or the provider response, the above items are yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that the service has not provided an adequate platform for consumers and their representatives to give feedback and make complaints about the service, and therefore there has not been opportunity to evidence the service taking appropriate action and using an open disclosure policy. In the event a complaint was received at the time of the Quality Audit there was no system in place to track action taken, communications and outcomes.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 6(3)(c).

Requirement 6(3)(d)

The Assessment Team assessed this Requirement ‘not met’ as the service has not provided the means or a forum for consumers and their representatives to give feedback or make complaints. The following additional information and examples were identified:

* Management stated that no feedback or complaints had been received in the last six months, or if there were, had been verbal and immediately resolved and not documented.
* The service has no system in use, was not tracking or trending feedback and complaints data and therefore had no improvements had been derived from it.
* The service does not have policy and procedure or training available for staff on feedback and complaints.
* Management said that based on feedback provided they would start to record all feedback and complaints on a register.

I acknowledge the additional evidence submitted by the provider on 22 February 2024. The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* noting intention to implement feedback form, ensure feedback register is maintained, implement consumer and representative complaints register, staff training on feedback and complaints, update continuous improvement plan.
* *6.3.d – Continuous Improvement Plan,* noting that no entries on the document are easily attributable or linked to feedback or complaints.
* *6.3.d Feedback Register,* is noted to commence on 20 October 2023, and contain seven entries through to 15 December 2023.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that the service is not tracking, reviewing, or actioning feedback and complaints for the purpose of improving the delivery of care and services. At the time of the Quality Audit no policy or procedures were in place and staff do not receive training in feedback or complaints handling. The service had not reportedly received any documented complaints in the prior 6 months. The subsequent documentation received from the service in its written response identifies a number of feedback and complaints, with some identifying that they have been entered as continuous improvement items, though no correlation is able to be made between the documents.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 6(3)(d).

# Standard 7

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| Human resources | | 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 |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | 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. | Not 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. | Not Compliant |

Findings

Requirements 7(3)(a) and 7(3)(b)

The service and its mix and number of staff is planned to enable the delivery and management of safe and quality care and services. Management described workforce planning being overseen by the Shire of Northam. Consumers and their representatives’ confirmed staff are not rushed and are on time and are given enough time to complete their duties. Management advised that they have had no unfilled shifts in the preceding month, and staff replacement is sought within the existing workforce. In the event this is unable to be facilitated alternate services can be offered including in home respite or in person respite at another facility. Staff stated that they are not adequately resource to undertake social outings. Consumer and representative feedback in relation to staffing was positive, though governance was noted to be through overarching Shire of Northam frameworks which was dated. The absence of Killara related policy and procedure may leave the service vulnerable to not achieving an appropriately mixed and skilled workforce in the event of staff attrition.

Service delivery was noted to be kind, caring, respectful and engaging however the lack policy and procedure that define and guide expectations of care and service delivery particularly in relation to cultural awareness and diversity may impact the ability to deliver person centred care, or the quality of care. Staff were noted as being kind, caring and appeared to know consumers well. Management have acknowledged the absence of a feedback system and stated intent to implement this as part of continuous improvement.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 7(3)(a) and 7(3)(b).

Requirement 7(3)(c)

The Assessment Team assessed this Requirement ‘not met’ as the service is not effectively managing staff competency and training to ensure the service is adequately qualified to perform their roles. The following summary of additional information and examples was identified:

* Representatives said that staff delivering care were competent and they were satisfied with services that were provided.
* Staff said that they were confident in performing their roles.
* Management was not familiar with position descriptions of care and service delivery staff, was not aware if the enrolled nurse at the service was registered with the Nursing and Midwifery Board of Australia (NMBA) and could not provide evidence of this when requested during the Quality Audit.
* Staff were not being tracked against the essential criteria of their job descriptions, such as possessing first aid training, having attended training in understanding dementia care or maintaining a register of staff who administer or prompt consumers with medication requirements.

I acknowledge the additional evidence submitted by the provider on 22 February 2024. The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* noting intention to appoint an infection prevention and control lead, ensure that lead is fully trained and undertakes regular reviews, and deliver infection prevention and control training for all staff.

I note that at the time of the Quality Audit, or the provider response, the above items are yet to implemented or embedded into operational practice. In its response, the provider supplied a blank performance review document, this therefore is unable to be considered evidence that the service is completing this activity with staff.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that although staff feel comfortable performing their roles and consumers and their representatives were satisfied with their competency, frameworks are not in place to ensure staff competencies are being monitored and training delivered and registered to ensure the workforce is adequately skilled and roles performing specialist tasks are managed through performance reviews. Management did not have access to position descriptions for service delivery staff and were not sufficiently aware of, tracking or across competencies.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 7(3)(c).

Requirement 7(3)(d)

The Assessment Team assessed this Requirement ‘not met’ due to a lack of targeted and monitored training that would support the service to deliver the outcomes required by the Quality Standards. The following summary of additional information and examples was identified:

* The service relies upon broader recruitment processes facilitated and run by the Shire of Northam, and whilst this wasn’t identified as an issue for initial employment and orientation, that does not reflect the specific requirements of the Killara service.
* It was also noted that Killara management did not have direct access to the training matrix and this needed to be requested from the executive team. When reviewed by the Assessment Team it was noted that it does not contain available training in areas specific to the Quality Standards such as open disclosure, advance care planning, medication competencies, dementia, falls, serious incident response scheme (SIRS) and risk management. Dementia training was provided to the service’s enrolled nurse and the other training provided to staff was first aid Cardiopulmonary Resuscitation (CPR), as well as infection control and staff food handling training.
* Staff training needs are only identified through observation, consumer care needs or staff request.

I acknowledge the additional evidence submitted by the provider on 22 February 2024. The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* noting intention to update position descriptions, workforce profile to be developed within the training matrix, performance reviews to identify training requirements and development of a business continuity plan.

I note that at the time of the Quality Audit, or the provider response, the above items are yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that the service is successfully recruiting and inducting staff using orientation and buddy systems under the broader processes within Shire of Northam, but that training that would support staff to deliver outcomes under the Quality Standards is not available to the workforce. There are no effective training registers to identify and support staff development and staff do not have direct access to training registers, matrices or participate in performance reviews as a mean of id.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 7(3)(d).

Requirement 7(3)(e)

The Assessment Team assessed this Requirement ‘not met’ as staff are not being reviewed for performance to increase capability or improve the care or service delivery being received by consumers. The following summary of additional information and examples was identified:

* Staff said that they have not had performance review since commencing with the organisation.
* Staff advised that they are comfortable raising the training needs with the service.
* Management said that performance of staff was based off feedback and complaints, but the Assessment Team found that there is no formal feedback and complaints process and that management advised that no complaints had been received in the last 6 months.
* There is no policy and procedure which governs staff performance evaluations or reviews.

I acknowledge the additional evidence submitted by the provider on 22 February 2024. The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* noting intention to implement regular performance reviews, team meetings and open communication forums.

I note that at the time of the Quality Audit, or the provider response, the above items are yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that the service is not reviewing staff performance, and that staff currently working or acting in positions said that they have not had formal review since commencing with the service. Management said that performance is based off feedback and complaints, but also confirmed that there is no formal feedback and complaints process and that this information is not documented. The service is not operating in a manner that fosters the improvement of staff performance nor does it have systems in place for monitoring or reviewing their training needs. Without these things the service places itself in a position that compromises its ability to provide safe and effective care and services.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 7(3)(e).

# Standard 8

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| Organisational governance | | CHSP |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Not 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 Assessment Team assessed this Requirement ‘not met’ as it was found that there are no proactive mechanisms in place that encourage consumer engagement for the purpose of designing and/or improving care and services. The following summary of additional information and examples were identified:

* Consumers are happy with how services are run, but confirmed their feedback is not sought by the service.
* Management confirmed an understanding of what consumer engagement in the context of seeking and utilising feedback involved but could not supply evidence that feedback from consumers is requested by the service through activities such as consumer surveys or focus groups.

I acknowledge the additional evidence submitted by the provider on 22 February 2024.The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* noting intended implementation of surveys, and consideration of focus groups and how best these would work.
* *6.3.d – Continuous Improvement Plan*
* *6.3.d Feedback Register*

I note that at the time of the Quality Audit, or the provider response, the above items are yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that the service is not conducting activities to engage consumers for the purpose of obtaining feedback to develop and improve outcomes in care and service delivery for consumers. The service has no effective systems currently in place and being utilised to track feedback, and no meetings are occurring in which feedback could be discussed. The service’s continuous improvement plan contains broad information with only brief detail. Staff would benefit from training on capturing effective information within the continuous improvement plan and feedback register to assist with tracking and progressing items within these.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 8(3)(a).

Requirement 8(3)(b)

The Assessment Team assessed this Requirement ‘not met’ due to the governing body not being abreast its responsibilities under the Quality Standards, and not having effective monitoring and oversight of the care and services delivery in place for the organisation. The following additional information and examples were identified:

* The Assessment Team verified budget and staffing reporting by management to the shire Chief Executive Officer (CEO) but found no standing council agenda item where the service was raised and discussed, or that the governing body was actively promoting a culture of safe and inclusive care.
* Management do not prepare or discuss any reports other than the funding matrix provided the shire CEO and the Assessment Team was not provided with any evidence that management and staff meetings were occurring, that outcomes or actions were being devised based on care and service delivery meetings.
* Management confirmed that there had been no staff meetings for six months.
* The service has only minimal training opportunities available for staff, which is not comprehensively representative of topics that would assist staff to deliver best practice, safe and quality care and the service to be compliant with the Quality Standards.

I acknowledge the additional evidence submitted by the provider on 22 February 2024. The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Audit Response Letter,* noting the CEO acceptance of improvements needed.
* *Killara Audit Response 1 – 8,* intention to implement managers and staff meetings.

I note that at the time of the Quality Audit, or the provider response, the above items were yet to implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that the service’s governing body has minimal involvement in the strategic operations of the service and its service and care delivery. There was no evidence that the governing body is provided information regularly that would enable it to meet on, discuss or deliver outcomes and action items with the intention to improve and support consumer outcomes. The governing body of the service, at the time of the Quality Audit, is not across the services responsibilities to consumers under the Aged Care Charter of Rights or the Quality Standards.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 8(3)(b).

Requirement 8(3)(c)

The Assessment Team assessed this Requirement ‘not met’ as the organisation does not have effective organisation wide governance systems in place that are enabling the service to coordinate, communicate, deliver, and improve care and services that are dynamic and that comply with regulatory requirements. The following is a summary of additional information and examples were identified:

**Information Management**

* The service lacks a central information system which would assist coordination of care and services across the organisation. Physical paper records are still in use and impedes timely access and review of information.
* Consumer information and records are not sufficiently detailed or individualised in a manner that allow comprehensive and efficient care and service delivery.
* Staff require training to further develop information recording to improve the effectiveness of consumer records.
* Management confirmed that there are current enquiries with the shire about the potential for the service to implement an electronic information management system.
* Policies and procedures governing the service is applicable to all services within the Shire of Northam, including information management. The service may benefit from specifically developed guidelines that could accommodate the nuances of the service.

*Response from provider received 22 February 2024*

* *Audit Response Letter,* advises there is now increased awareness and acknowledges the significant improvements required by the service and the Shires Executive.
* *Killara Audit Response 1 – 8,* noting intention to introduce electronic records management systems.

**Continuous Improvement**

* The service is not efficiently or effectively engaging with opportunities to improve care and service as systems and processes either do not exist or are not being recorded or consistently actioned.
* Information which is captured is not sufficiently detailed and actions/outcomes are not identified tracked or measured.
* Timeframes identified in the continuous improvement plan are generic and do not provide accountability or the ability to measure success.

*Response from provider received 22 February 2024*

* *Killara Audit Response 1 – 8,* noting intention to implement new methodology too process and track improvement.
* *Continuous Improvement Plan*

**Financial Governance**

* The service has minimal financial reporting being completed to the governing body.
* The service is providing timely and accurate information to consumers on invoicing and care costs, however there is no evidence that consumer unspent funds are being tracked or discussed and the service was unable to be evidenced this is occurring.
* No financial policy or procedures are currently in place guiding staff practice.

*Response from provider received 22 February 2024*

* *Killara Audit Response 1 – 8,* noting intention to review processes and improve the reporting structure, and for Killara to be a regular item on the monthly meeting.

**Workforce Governance**

* The service utilises workforce governance framework and recruitment processes coordinated by the Shire of Northam. Whilst there do not appear to be any issues securing staff resources, position descriptions are not detailed or specific to the service.
* Effective systems which guide and monitor staff performance and provide training support and education to staff are not targeted to the service and therefore not benefiting care and service delivery.
* There is minimal evidence of organisation wide governance including workforce planning occurring within the service.
* Human Resources policies and procedures being utilised by the service through the Shire of Northam does not appear to have been updated since 2011.

*Response from provider received 22 February 2024*

- *Killara Audit Response 1 – 8,* noting intention to improve current position descriptions and reporting structures, review current processes to improve staff access to information and data for staff.

**Regulatory Compliance**

* Governance systems are not in place to ensure the service is receiving updates to relevant legislation, regulatory requirements, professional standards, and regulations. There was no evidence that the service is reviewing and changing processes to ensure that care and service delivery remains contemporary best practice and keeping up to date with regulatory changes and reform.
* Management is not subscribed to regulatory newsletters or bulletins, and as a result staff are not training on how to identify and restrictive practice and report serious incidents as is required under the Serious Incident Response Scheme (SIRS) which came into effect from 1 December 2022.

*Response from provider received 22 February 2024*

* *Killara Audit Response 1 – 8,* noting that because of the Quality Audit the workforce now has access to several mailing lists that will assist staff through review of legislation and training and benefit consumers.

**Feedback and Complaints**

* The service is not effectively utilising feedback and complaints systems to improve services and care delivery. There was no evidence provided to the Assessment Team that would indicate feedback and complaints are documented, tracked, and trended to analyse data and inform continuous improvement.
* The feedback and complaints framework provided to the Assessment Team was applicable to the Shire of Northam, and not effectively implemented to the service.

*Response from provider received 22 February 2024*

* *Killara Audit Response 1 – 8,* noting the intention to implement regular consumer and staff surveys, analyse and discuss all matters individually and during monthly staff meetings.

I acknowledge the additional evidence submitted by the provider on 22 February 2024, which identifies their intent to update existing documentation, develop and implement policies and procedures specific to the Killara service. I note that this is yet to be implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that the service is not effectively documenting or managing information by making it available at care delivery and capturing the correct level of detail and coordinating it organisation wide. Whilst the service has a continuous improvement plan, the information noted within it does not sufficiently detail items or the actions needed, nor do the timeframes provide accountability or assist with tracking progress. At the time of the Quality Audit, financial reporting to the governing board was minimal and there was no evidence that unspent funds for consumers were being reviewed and no evidence was available to the Assessment Team that board meetings reviewed or had oversight of the Killara service and its compliance or responsibilities to the Quality Standards. Staff do not have access to appropriate training relevant to the Quality Standards and are not reviewed or developed to improve their capabilities or outcomes for consumers. At the time of the Quality Audit, management and the board were not aware of their responsibilities under the Quality Standards, or the need to keep abreast regulatory reform and updates. Feedback and complaints do not have effective systems with sufficient detail recorded to enable service and care improvements and accountability.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 8(3)(c).

Requirement 8(3)(d)

The Assessment Team assessed this Requirement ‘not met’ as it was not able to demonstrate or evidence that effective risk management systems and practices are in place to manage and mitigate high-impact or high prevalent risks, abuse and neglect and help consumers to live their best life. It was also ascertained from management that there was no incident management system in place to assist with these processes. The following is a summary of additional information and examples were identified:

**Managing high-impact or high-prevalence risks**

* Management did not demonstrate an understanding to of risk management frameworks or identify these in the context of care and service delivery to the Assessment Team.
* Staff are not trained on identifying or reporting risks.
* The service uses a risk management framework devised for the Shire of Northam related work health and safety incident reporting and does not account the nuances associated with consumer and care delivery incidents.
* There is no policy or procedure for the assessment and review of high impact high prevalence risks to consumers, including clinical risks, to assist in mitigation or management strategies or providing organisation oversight of incidents.
* When requested, management could not provide evidence that the governance board has oversight of consumer risks via documented meeting minutes.
* Management was unable to demonstrate that the service documents, analyses, and trends high impact high prevalence risks.

*Response from provider received 22 February 2024*

* *Killara Audit Response 1 – 8,* noting the intention to train Killara staff in risk management.

**Identifying and responding to abuse and neglect**

* Staff have not received training in how to identify and response to elder abuse and no local policy or procedures that address the subject exist within the service.

*Response from provider received 22 February 2024*

* *Killara Audit Response 1 – 8,* noting the intention to train staff in investigation techniques.

**Supporting consumers to live their best life**

* The service does not have dignity of risk policy and procedure in place which allows consumers to make choices and maintain independence through taking risks.
* Staff do not receive training to enable them to assist consumers mitigating risk and making informed choices around risk, whilst documenting and supporting those choices.

*Response from provider received 22 February 2024*

*Killara Audit Response 1 – 8,* noting the intention to implement a Killara wellbeing framework.

**Managing and preventing incidents**

* The service has no systems in place to manage and prevent incidents for consumers.
* There are no policy or procedures in place to manage occurrences of incidents, and staff have not received training on the subject.
* As incidents are not being captured, management are not reviewing or mitigating potential risks.
* Management said that they do not capture or record incidents that occur outside of the provision of care and services.
* The service has an establish work health and safety framework established through the Shire which the Assessment Team noted to only recorded workplace safety inspections.
* The service does not record and report on incident information that would be subject to the Serious Incident Response Scheme reporting requirements.
* Consumer care plans reviewed by the Assessment Team did not identify or provide strategies/risk management processes to guide staff care and service delivery.

*Response from provider received 22 February 2024*

* *Killara Audit Response 1 – 8,* noting the intention to develop and implement a system to capture, monitor and control incidents.

I acknowledge the additional evidence submitted by the provider. I note that the improvements and strategies identified as part of the audit response at the time of the Audit and provider response yet to be implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the requirement. I find that the service does not have high impact high prevalence risk management systems and/or policies or procedures in place to manage information or guide staff. The Assessment Team identified that staff are sometimes identifying falls risk, some clinical conditions, validated assessments are not occurring, and external services are not involved. Staff are therefore not mitigating risk or discussing with consumers or their representative’s choice and independence associated with dignity of risk. Staff are not provided training in elder abuse and neglect to assist them in identifying this. In the absence of these skills, staff are less likely to be able to assist consumers to live the best life they can.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 8(3)(d)

Requirement 8(3)(e)

The Assessment Team assessed this Requirement ‘not met’ as clinical governance framework and systems were not identified to ensure quality safe and effective clinical care was being performed for consumers. The following summary of additional information and examples was identified:

* The service has no documented policy or procedures in place for antimicrobial stewardship, minimising the use of restraint or open disclosure. As a result of this staff do not have access to education or guidance and are not appropriately trained.
* Clinical assessments and review of consumers, with the use of validated assessment tools are not being undertaking and there is no policy or procedure guiding staff.
* Consumers and staff are not provided with education or training in antimicrobial stewardship to promote informed choices when using antibiotics.
* The service has no restrictive practice policy, staff are not trained in minimising the use of restraint measures. The service was unaware of what constitutes restrictive practice including but not limited to, environmental restrictive practice. It was noted by the Assessment Team that the service is currently utilises environmental restrictive practice due to being unaware what it constituted. When advised, management undertook to rectify the situation through the continuous improvement plan.
* The service has no policy or procedure around collecting or reporting on clinical indicators; therefore, the governing body is unable to have oversight of them.
* Staff receive regular infection control training and the Assessment Team confirmed this via staff files; however, the service has no outbreak management policy or procedure specific to Killara.

The provider response included additional documentation which evidenced the following pieces of information relevant to my finding:

* *Killara Audit Response 1 – 8,* which identified the services intention to develop further policies and procedures around antimicrobial stewardship, minimising the use of restraint and open disclosure and then implement training for staff.

I acknowledge the additional evidence submitted by the provider on 22 February 2024. I note that this is yet to be implemented or embedded into operational practice.

In coming to my finding, I have considered the Assessment Teams report, the providers response, and the intent of the Requirement. I find that no policies or procedures were in place in relation to clinical governance frameworks at the time of the Quality Audit and evidence was not later supplied by the provider to indicate differently. The service does not provide consumers or staff education or training in antimicrobial stewardship to promote the appropriate use of antibiotics in a community setting. The service is noted to provide consumers with medication assistance and prompting which fall under clinical services. The service was found to be using a form of restrictive practice by way of a locked entry/exit door, which means that consumers are unable to enter/exit the location without staff assistance. Consumers have not been assessed for a lesser form of restriction or consented to the risk associated with the restriction as the service does not assess for risk or capture mitigation strategies within consumer support plans. The service does not have open disclosure policy or procedure and although management said that open disclosure is discussed in staff meetings, indicated that staff meetings haven’t been occurring and could not provide an example of when it had occurred or how it is applied.

Based on the information summarised above, I find the provider, in relation to the service, non‑compliant with Requirement 8(3)(e).

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