**Performance**

**Report**

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Killarney and District Meals on Wheels |
| Commission ID: | 700428 |
| Address: | 6 Cedar Street, KILLARNEY, Queensland, 4373 |
| Activity type: | Quality Audit |
| Activity date: | 5 March 2024 to 7 March 2024 |
| Performance report date: | 16 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

Home Care Packages (**HCP**) included:  
Provider: 1558 Killarney Memorial Aged Care Ltd  
Service: 26213 KMAC Home Care Services  
  
Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 8081 Killarney Memorial Aged Care Ltd  
Service: 24595 Killarney Memorial Aged Care Ltd - Community and Home Support

**This performance report**

This performance report for Killarney and District Meals on Wheels (**the service**) has been prepared by T Wurf, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Quality Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others, and
* the provider’s response to the assessment team’s report received 3 April 2024.

# Assessment summary for Home Care Packages (HCP)

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **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** |

# Assessment summary for Commonwealth Home Support Programme (CHSP)

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Not 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.

* Requirement 2(3)(a) – ensure assessment and planning processes are effective and consider consumers’ individual needs and risks to their health and well-being.
* Requirement 2(3)(b) – ensure assessment and planning identifies and addresses consumers’ current needs, goals and preferences.
* Requirement 2(3)(c) – ensure consumers and/or their representatives are effectively involved in assessment, planning and review of consumers’ care and services.
* Requirement 2(3)(d) – ensure consumers are familiar with their care plan and the outcomes of assessment and planning processes, including what care and services were available to them.
* Requirement 2(3)(e) – embed a structured, planned and effective process to review care and services, including following a change in a consumer’s condition or when an incident occurs.
* Requirement 3(3)(a) – ensure consumers’ personal and clinical care needs are documented and met.
* Requirement 3(3)(b) – implement a process to identify and manage high impact, high prevalence risks to consumers, including risks associated with wounds and falls.
* Requirement 3(3)(d) - ensure the service’s processes enable deterioration or change in a consumer’s cognitive or physical function to be recognised and responded to in a timely manner.
* Requirement 3(3)(e) – embed systems to ensure information about consumers is documented and communicated in a systematic and consistent way to staff and others involved in the care of consumers.
* Requirement 4(3)(a) – embed systems to identify and provide services and supports for daily living for consumers based on individualised need, capabilities and interests.
* Requirement 4(3)(c) – ensure things of interest and meaningful activities for individual consumers are assessed and consumers are supported to do those things where appropriate.
* Requirement 4(3)(d) – ensure information about consumers is documented and communicated.
* Requirement 6(3)(a) – ensure consumers are encouraged and supported to provide feedback and complaints.
* Requirement 6(3)(b) – ensure consumers are informed about advocacy services and external complaints mechanisms.
* Requirement 6(3)(c) – embed an effective feedback and complaints management system that ensures all feedback and complaints are documented and actions taken are recorded.
* Requirement 6(3)(d) – ensure feedback and complaints are documented, reviewed and used to improve the quality of care and services.
* Requirement 7(3)(c) – embed processes to ensure staff have the required knowledge and competence to effectively perform their roles and tasks.
* Requirement 7(3)(d) – ensure training delivered to staff is effective in supporting staff to deliver care and services and the outcomes required by the Quality Standards.
* Requirement 7(3)(e) – ensure the performance of managers and staff is regularly assessed, monitored and reviewed.
* Requirement 8(3)(a) – actively engage consumers in the development, delivery and evaluation of care and services.
* Requirement 8(3)(b):
  + ensure the governing body provides effective stewardship in returning the service to full compliance with the Quality Standards, and
  + establish processes to ensure the Board has a focus and oversight of the community care service and is accountable for safe, inclusive and quality care and services.
* Requirement 8(3)(c) – embed effective organisation-wide governance system relating to information management, continuous improvement, workforce governance, and feedback and complaints.
* Requirement 8(3)(d) – embed effective risk management systems and practices, including to effectively manage high impact and high prevalence risks and incidents.
* Requirement 8(3)(e) – develop, implement and embed a clinical governance framework.

# Other relevant matters:

Killarney Memorial Aged Care (KMAC) is a community-owned and operated aged care service provider located in Killarney, Queensland. KMAC operates several aged care services, including:

* two residential services (Kadimah Nursing Home and Leslie Place Hostel)
* Home Care Packages (37 clients), through KMAC Home Care Services
* Commonwealth Home Support Programme (Killarney and District Meals on Wheels - 10 clients), through Killarney Memorial Aged Care Ltd - Community and Home Support

This Quality Audit was conducted in relation to the Home Care Packages (HCP) and Commonwealth Home Support Programme (CHSP). It does not involve an assessment of the residential aged care services against the Quality Standards, but does consider the residential service environment (Standard 5) in which HCP consumers access to undertake leisure, lifestyle and social activities that the organisation provides.

In response to the Quality Audit Report, the approved provided submitted a detailed response, which included evidence of improvements to various systems and processes. Many of these improvements were relevant and referred to across requirements and standards. These are summarised below and broadly referenced throughout the Performance Report.

* **Implemented a new electronic care management system (ECMS)** on 12 March 2024 that replaced the previous manual system. The provider reported this has improved the service’s information, documentation and assessment and planning processes. Staff have access to the ECMS via an electronic tablet and have been trained in the use of the ECMS and their tablet. All assessments, care plans and progress notes are now recorded directly into the system.
* **Implemented revised policies and procedures, checklist, and forms** specifically related to assessment and care planning, and feedback and complaints. Staff have been trained on these and have access via their tablets. The checklist ensures assessment and care planning actions, forms and questions are completed and used during assessment and review processes.
* **Updated review processes, including implementation of a review checklist.** Consumers care and services are reviewed annually, with a quarterly review for HCP consumers and six-monthly for CHSP consumers. A checklist includes specific questions, information and matters to be covered during the review process.
* **Delivered staff training and information** on the new ECMS, updated policies and procedures relevant to assessment and planning, care plan review checklist, feedback and complaints, deterioration, progress notes, and incidents.
* **Updated position descriptions to clearly define staff roles and responsibilities**, including related to risk management, incident management and complaints management. Developed a work program for each key management role.
* **Established monitoring systems,** including daily review of consumer progress notes, audits and surveys, various meeting agenda items, and reporting mechanisms.

The approved provider’s response under various requirements stated that issues were not raised by the Assessment Team with management during the quality audit in relation to CHSP, except for Standard 6. Whilst I acknowledge the provider’s stated concern, which is contrary to verbal advice provided by the Assessment Team, I am satisfied that the provider has been afforded natural justice in relation to these matters. Concerns raised during the quality audit in relation to HCP were the same concerns relevant to CHSP, and the provider was provided a copy of the Quality Audit Report that detailed the Assessment Team’s findings, for which the provider had sufficient time to consider and respond to. I have not considered this matter further in my decision.

# Standard 1

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

Findings

Having considered the Quality Audit Report and approved provider’s response, I have assessed this Quality Standard and associated requirements as compliant.

I have made this decision based on the following analysis.

Requirement 1(3)(e)

Whilst the Quality Audit Report found requirement 1(3)(e) not met in relation to HCP, I have decided it is compliant based on the approved provider’s response that included both clarifying information and evidence of improved system and process.

The Quality Audit Report included mixed feedback from consumers about information provided to them and identified several HCP consumers that did not find information easy to understand or sufficient to enable them to make informed choices. Examples provided included consumers not aware of monthly statements, HCP account balances, and what could be purchased with HCP funds. Also, assistance was not provided to a consumer with specific communication needs.

The approved provider’s response provided clarifying evidence in relation to information provided to HCP consumers, and evidence of improved information systems and processes.

The provider’s response clarified:

* Consumers are given information in a ‘client folder’ with copies of their HCP agreement and information booklet, budget, care routine, and complaints materials, which is shown and explained to consumers upon signing of their agreement. However, acknowledged some consumers may not recall where their folders are kept or its contents.
* Consumers are provided monthly statements and the named consumers had received their statements, which included HCP expenditure, account balances and information about what can be purchased through HCP funds.
* Staff assist consumers understand their HCP funding and finances and inclusions and exclusions, however noted these conversations had not been specifically recorded.

To improve information to consumers, the provider implemented the following systems and processes:

* Updated assessment and planning policies and processes to ensure HCP budgets are addressed with consumers during assessment and review processes, and that staff determine whether a consumer requires an interpreter, advocate or cultural support.
* Implemented a new review checklist that prompts staff to help consumers understand and locate information, including information in their client folder and HCP budgets and statements.
  + All HCP level 3 and 4 consumers have had their care plan review completed, which included questions required by the checklist, and all consumers are scheduled to be reviewed by 5 May 2024.
* Updated various forms and information provided to consumers, including the handbook.
* Implemented a new ECMS and staff will now record conversations with consumers about their HCP.

Based on the Quality Audit Report and the approved provider’s response, I am satisfied that, prior to the audit, the provider had processes to provide information to consumers and whilst some HCP consumers reported they did not find information easy to understand or access, improved systems and processes have been established. Therefore, I have decided this requirement is compliant.

Requirements 1(3)(a), 1(3)(b), 1(3)(c), 1(3)(d), and 1(3)(f)

The Quality Audit Report included evidence that the remaining requirements in this Quality Standard were compliant.

Consumers said they are treated with dignity and respect by staff, and their identity, culture and diversity are known and valued by staff. Consumers said staff take the time to speak with them and get to know them. Staff spoke respectfully about the consumers and reported that because they live in a small town and have provided care and services to consumers for some time, they have gotten to know them well through conversation.

The Assessment Team interviewed consumers, representatives, staff and management, all who expressed they are proud members of their small country community. Consumers said staff know their background and culture and how it can affect their preferences. Staff and consumers said this understanding is gained through their ongoing verbal communication during care and service delivery, and this results in a culturally safe approach to delivery of care and services.

Consumers felt supported to make decisions about the care and services they receive, and said they are encouraged to include those they want involved with their care. All HCP consumers said they can make requests or changes to their services by making a phone call to the service. Management and staff described how consumers are supported to make informed decisions.

Consumers said they feel supported to live the life they choose. Management said they discuss identified risks with the consumer and complete dignity of risk assessment documentation in consultation with the consumer where required.

Consumers said they are informed about how their personal information will be used, and this is also outlined in the home care agreement. Printed copies of consumer information are retained in the consumer’s home and staff carry some consumer documentation with them*.* Consumer information is also stored electronically in a secure database. Consumers said staff are respectful of their personal privacy. Staff described how they maintain privacy and confidentiality of consumer information.

Whilst the Assessment Team identified deficiencies in care planning documentation these are addressed in Standard 2.

# Standard 2

|  |  |  |  |
| --- | --- | --- | --- |
| Ongoing assessment and planning with consumers | | HCP | CHSP |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Not Compliant | 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 | 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 | 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 | 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 | Not Compliant |

Findings

Having considered the Quality Audit Report and approved provider’s response, I have assessed this Quality Standard as non-compliant as I am satisfied all associated requirements are non-compliant. Non-compliance was based on:

* Ongoing assessment did not occur, and planning did not address consumers’ individual needs and risks.
* Assessment and planning did not consistently identify or address consumers’ needs, goals and preferences.
* Consumers and/or representatives were not consistently or effectively involved in ongoing planning and review processes.
* Most consumers were not familiar with their care plan, and what care and services were available to them.
* The service did not have a structured, planned or effective review process. Care plans were not reviewed following a recorded change in a consumer’s condition or following an incident.

I have made this decision based on the following analysis.

The Quality Audit Report identified the service was not meeting each requirement of this Quality Standard. For example:

Requirement 2(3)(a)

Notwithstanding the consumer’s initial assessment and information gathered upon entry, ongoing assessment did not occur, and planning did not address consumers’ individual needs and risks. For example:

* Consumers’ had a one-page basic care plan that mostly recorded a schedule of service delivery. Information was not detailed or sufficient to guide staff in the delivery of care and services, or reflective of assessed needs. Risks to consumers were not assessed or evident in care planning documents.
* Staff were not aware of any policies or procedures relevant to assessment and planning and provided inconsistent feedback about the processes they undertake.
* Overall, consumers did not feel their services were individualised to their specific needs and preferences.
* Several consumers had progress note entries that identified individualised needs or indicated cognitive decline, however, no assessment or planning was undertaken in response to these.

Requirement 2(3)(b)

Consumers’ care planning documentation showed evidence of advanced care directives and end of life planning, and consumers generally stated end of life planning had been discussed with them.

However, assessment and planning did not consistently identify or address the consumer’s current needs, goals and preferences. Consumers reported that the service did not ask them about their needs, goals and preferences and provided specific examples of this. For example, progress note entries for a consumer identify numerous needs and preferences that had not been addressed by the service, including in relation to pain, social activities and communication needs.

Requirement 2(3)(c)

Consumers and representatives reported they were not consistently involved in ongoing planning and review processes. Some consumers who reported some involvement in assessment and care planning process, felt their participation was not utilised effectively to identify needs and plan care and services. The service had not consistently included feedback and observations made by family members or other staff in assessment and planning.

Requirement 2(3)(d)

Whilst a copy of a consumer’s care plan is stored in their home, most consumers and representatives interviewed by the Assessment Team said that they had not seen the care plan and were unaware about what was in their care plan and what care and services were available to them. For a consumer with specific communication needs, the service did not have strategies to communicate the outcomes of planning and assessment to them.

Requirement 2(3)(e)

The service did not have a policy and procedure to guide staff in undertaking care plan reviews. Consumers’ care plans did not reflect a structured, planned or effective review process. Care plans were not reviewed following a recorded change in a consumer’s condition or following an incident. For example:

* Care plans had a variable range of review date intervals over 3 months and almost all care plans reviewed stated ‘nil changes’.
* Where progress notes recorded a change in a consumer’s condition (for example, decline in cognition or mobility), or suggestions for reassessment of service, these did not prompt a review or where a review was completed, the review did not appear to consider the reported change.

Approved provider’s response to the Quality Audit Report

The approved provider’s response included details about several system improvements relevant to all requirements in this Quality Standard, and stated these are working well and have improved in quality and frequency of assessment, planning and care documentation. Actions included:

* Implemented a new ECMS for which staff have access via a tablet.
  + All assessments, care planning information and progress notes are now recorded directly into the system and are available to staff.
  + Staff have access to the service’s policies and procedures via their tablets, and have been trained in how to access these.
* Implemented revised assessment and planning policies and procedures. Updated staff roles and responsibilities relevant to assessment and planning processes.
  + The provider has commenced assessments for all consumers under the new assessment and planning process, to be completed by May 2024 and will update care plans to include more comprehensive information.
* Implemented a new checklist to ensure assessment and care planning actions, forms and questions are completed.
* Updated care and service review processes to include an annual review with interim follow-up discussions:
  + quarterly for HCP consumers to review needs, goals and preferences, and
  + six-monthly for CHSP consumers to record more thorough information, check satisfaction with meals and update needs, preferences and allergies.
* Trained staff on the ECMS and assessment and planning processes and documenting progress notes. CHSP volunteers have also been trained in how and what concerns/information to escalate.

The provider’s response also addressed specific aspects of requirements. Whilst I accept some clarifying information and evidence in relation to some named consumers, these were isolated examples and did not provide evidence of established and effective assessment and planning systems and processes. The provider also reported that the service has partnered with consumers, representatives and others in assessment and planning, however, acknowledged this was not well documented. I have placed weight on consumer feedback on this matter and the lack of documentary evidence of partnerships. The service has since implemented a new process to ensure documented evidence of partnerships and engagement with others, and timely management of referrals.

Based on the Quality Audit Report and the approved provider’s response, I am satisfied that:

* At the time of the quality audit, the service’s assessment and care planning was ineffective.
* The approved provider has taken and commenced several actions to address the system deficits related to assessment and planning (described above). These actions will take some time to embed in practice and culture, and be tested for effectiveness and sustainability.

For these reasons, I have decided all requirements, and the overall Quality Standard are non-compliant.

# Standard 3

|  |  |  |  |
| --- | --- | --- | --- |
| Personal care and clinical care | | HCP | CHSP |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Not Compliant | Not Applicable |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant | Not Applicable |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant | Not Applicable |
| 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 | Not Applicable |
| 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 | Not Applicable |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant | Not Applicable |
| 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 | Not Applicable |

Findings

This standard does not apply to the service’s CHSP.

Having considered the Quality Audit Report and approved provider’s response, I have assessed this Quality Standard as non-compliant in relation to HCP as requirements 3(3)(a), 3(3)(b), 3(3)(d) and 3(3)(e) are non-compliant. Non-compliance is based on:

* Consumers’ personal and clinical care needs were not adequately documented or met.
* The service did not have a process to manage high impact, high prevalence risks to consumers, and risks associated with wounds and falls were not adequately recorded or managed.
* Deterioration in consumers’ cognitive capacity or health condition were not recognised and responded to in a timely manner.
* Information about consumers was not documented and communicated in a systematic or consistent way and was not shared with others in a timely manner.

I have made this decision based on the following analysis.

The Quality Audit Report identified the following evidence in relation to these requirements.

Requirement 3(3)(a)

The Quality Audit Report evidenced that consumer care documentation did not accurately describe consumers’ personal and clinical care needs with sufficient detail to guide care staff in the delivery of care and services, and care delivered was not effectively meeting the needs of consumers.

Requirement 3(3)(b)

The Quality Audit Report identified that consumers’ wounds and falls were recorded in progress notes, however these were not further investigated or acted upon. The service did not demonstrate high impact, high prevalence risks to consumers are managed effectively through documenting, reporting or clinical review. Management identified that the service did not have a process to manage high impact, high prevalence risks.

Requirement 3(3)(d)

The Quality Audit Report identified that deterioration in a consumer’s capacity or condition was not recognised and responded to in a timely manner. Staff had entered progress notes to indicate deterioration or change to a consumer’s health or capacity, however the reported events had not been acted upon. Progress notes recorded significant events such as a consumer that had trouble breathing, another consumer had difficulties eating and several consumers where cognitive decline was indicated. Care staff were unable to describe how they recognise deterioration. Management and registered nurses said staff did not always escalate concerns to them.

Requirement 3(3)(e)

Information about consumers (including deterioration, events, incidents or wellbeing) was not documented and communicated in a systematic or consistent way and was not shared with others in a timely manner. Progress notes are primarily documented and stored in the consumer’s home, with a time delay before being stored electronically, and therefore are not readily available to others within the organisation or other providers of care. The service’s plan for continuous improvement (PCI) identified in October 2022 that ‘Homecare Incidents and adverse events are not documented in the clients’ file or on a risk register’. However, the PCI entry had not yet been closed.

Approved provider’s response to the Quality Audit Report

The approved provider’s response claimed that consumers were receiving appropriate care but acknowledged deficiencies in the service’s systems. The response, however, did not include sufficient evidence to persuade me that consumers received appropriate care. I am satisfied that the provider has identified improvement actions taken and commenced addressing deficiencies identified in the Quality Audit Report. Actions included:

* Implemented the new ECMS.
* Updated assessment and planning policies, procedures and checklists. Existing consumers will have a care assessment and new assessment and planning process, to be completed by 5 May 2024.
* Updated staff roles and responsibilities, and monitoring processes.
* Trained staff on recognising and responding to deterioration, documenting progress notes, and responding to incidents and feedback.

Requirements 3(3)(c), 3(3)(f), and 3(3)(g)

The Quality Audit Report included evidence (summarised below) that the service is compliant with these requirements.

Although the service documents consumers’ needs, goals and preferences in relation to end of life care, the service has limited involvement in palliative care as consumers are generally transferred to hospital for end of life care. Consumers and representatives said advance care planning and end of life wishes are discussed with them on entry to the service. The service holds community ‘Open days’ to provide information on end of life and support is provided where appropriate for consumers nearing end of life.

Care planning documentation included evidence of referrals to other organisations and providers, including allied health professionals and geriatricians. Consumers advised they had been seen by various allied health providers. Whilst a number of consumers had been identified by the Assessment Team as warranting consideration of a referral to others, this has been considered under requirements 2(3)(c) and 2(3)(d).

Management and staff understand practical ways to minimise the transmission of infections including the risks associated with influenza and COVID-19. Staff received mandatory infection control training and have access supplies such as hand sanitiser and personal protective equipment which is stocked in every vehicle. The registered nurse works with medical officers to monitor the use of antibiotic medications.

Based on the Quality Audit Report and the approved provider’s response, I am satisfied that:

* Requirements 3(3)(c), 3(3)(f), and 3(3)(g) are compliant.
* At the time of the quality audit, the service was not adequately identifying and/or managing consumers’ personal and clinical care needs, clinical risks, and deterioration, or documenting and communicating consumer information.
* The approved provider has taken and commenced actions to address the system deficits related to these areas (described above). These actions will take some time to embed in practice and culture, and be tested for effectiveness and sustainability.

For these reasons, I have decided requirements 3(3)(a), 3(3)(b), 3(3)(d) and 3(3)(e) and the overall Quality Standard are non-compliant.

# Standard 4

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

Findings

Having considered the Quality Audit Report and approved provider’s response, I have assessed this Quality Standard as non-compliant as I am satisfied requirements 4(3)(a), 4(3)(c) and 4(3)(d) are non-compliant. Non-compliance is based on:

* The service had not consistently identified or provided individualised services and supports for consumers based on need, capabilities and interests.
* Things of interest or meaningful activities to individual consumers were not assessed or explored in terms of how the service could support consumers to do those things.
* Information about consumers was not well documented or communicated.

I have made this decision based on the following analysis.

The Quality Audit Report identified the following evidence in relation to these requirements.

Requirement 4(3)(a)

Although staff generally knew consumers’ background and supported consumers to undertake generic activities (such as transport to appointments), the service had not consistently identified individualised and meaningful services and supports for daily living for consumers. Consumers’ care plans were basic, generic and did not contain detail about consumers’ needs, goals and preferences related to daily living, level of independence and function, and those things important to them. Progress notes identified some consumers struggling with activities of daily living (showering and eating) but did not include relevant assessment or support strategies.

Requirement 4(3)(c)

The service invites consumers to join activities and events at the residential aged care service (such as bingo, men’s shed, significant events), and organised group bus outings in the community (such as to local auxiliary groups, and local events such as the Carnival of Flowers).

However, care planning documentation did not identity things of interest or meaningful activities to individual consumers. Despite staff being aware of some consumers’ particular interests, these were not assessed or explored in terms of how the service could support those consumers to do those things.

Requirement 4(3)(d)

Information about consumers was not well documented or communicated. Care plans contained scant information about consumers. Whilst staff could generally describe care and services provided to consumers, this knowledge was often informally gained through verbal conversation between staff and consumers. Representatives said some information was not effectively communicated, such as, staff contact details and roster and staff changes.

Approved provider’s response to the Quality Audit Report

The approved provider’s response stated that updated assessment, planning and review processes include a focus on services and supports for daily living and will ensure more comprehensive information is documented about significant dates and events, support networks, community roles, activities and interests, emotional and mental health. For CHSP consumers, choice of things they enjoy as it relates to their meal service will be discussed and reviewed regularly.

The response also referred to other system improvements including the implementation of the new ECMS. Additionally, the response identified:

* Consumers receive a monthly newsletter that includes a monthly calendar of activities and invitations to local community events.
* All equipment is approved by an OT as suitable for consumers. The new referral process is working with allied health and others.
* Existing consumers will have a care assessment and new assessment and planning process completed.

I note the clarifying information provided in relation to some named consumers under requirement 4(3)(a) and whilst I accept this information, it does not demonstrate a robust system was in place. I also note the provider, in respect of requirement 4(3)(c) refuted some information and stated all consumers are able to contact the office and shift changes are either filled or communicated. Whilst I am unable to draw a conclusion on these matter, I am satisfied that there is sufficient evidence that information about consumers was not well documented and communicated.

Requirements 4(3)(b), 4(3)(e), 4(3)(f), 4(3)(g)

The Quality Audit Report included evidence (summarised below) that the service is compliant with these requirements.

Consumers and representatives stated they are satisfied with services and supports for consumers’ emotional, psychological and spiritual well-being, and expressed appreciation for the social support provided by staff. Progress notes demonstrated staff support consumers with one-on-one time or provide some respite for home carers. The service offers community-based activities and networking opportunities for consumers. Whilst care plans lacked detail about consumers, this is addressed under requirements 2(3)(a) and 4(3)(a). I am satisfied that, despite deficiencies in care documentation, consumers and staff provided feedback about a range of supports that consumers receive and consumers were satisfied with those supports.

Management described the process for referrals to other organisations and individuals involved in the consumer’s care and services. Care documentation evidenced that consumers had been referred to other organisations, such as mental health support groups, dementia support services and respite care.

Consumers and representatives were satisfied with the quality, quantity, and variety of meals received by consumers, including from the meals on wheels service. There is a process to identify and communicate consumers’ dietary requirements, allergies, and preferences.

Consumers provided examples of equipment purchased through their HCP such as a stair lift, shower chair, motorised scooter, walker, exercise bike and sit-to-stand aid. Management said consumers are assisted to purchase equipment to meet their needs. Staff ensure equipment is safe and well maintained and consumers are reminded in the staff newsletter to report faulty equipment.

Based on the Quality Audit Report and the approved provider’s response, I am satisfied that:

* Requirements 4(3)(b), 4(3)(e), 4(3)(f), and 4(3)(g) are compliant.
* At the time of the quality audit, the service was not adequately assessing, documenting or addressing individualised aspects of services and supports for daily living.
* The approved provider has taken and commenced actions to address the system deficits related to these areas (described above). These actions will take some time to embed in practice and culture, and be tested for effectiveness and sustainability.

For these reasons, I have decided requirements 4(3)(a), 4(3)(c) and 4(3)(d) and the overall Quality Standard are non-compliant.

# Standard 5

|  |  |  |  |
| --- | --- | --- | --- |
| Organisation’s service environment | | HCP | CHSP |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant | Not Applicable |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant | Not Applicable |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant | Not Applicable |

Findings

The Quality Audit Report included evidence (summarised below) that the service is compliant with this standard and associated requirements in relation to HCP. This standard does not apply to the service’s CHSP.

The service invites HCP consumers to participate in activities delivered in the KMAC residential aged care service buildings. Activities are typically held in the Kadimah room (in the residential service) or Cedar room (community space) in the adjacent building. The Assessment Team observed these areas to be modern, spacious and accessible for people of differing levels of mobility. HCP consumers are greeted at the residential aged care service’s reception and are connected with lifestyle staff to ensure they are welcomed and know where they are going.

The service environment was clean, well maintained and comfortable with ample natural light. The community space centre was easy to access with parking for consumers and visitors. Processes are in place to ensure the environment is clean and well maintained. Cleaning and maintenance are scheduled and attended to.

Furniture, fittings and equipment in the two areas used by HCP consumers were observed to be safe, clean, well-maintained and suitable for consumers of differing levels of mobility and function. The service vehicles for used for consumer transport are regularly maintained.

# Standard 6

|  |  |  |  |
| --- | --- | --- | --- |
| Feedback and complaints | | HCP | CHSP |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant | 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 | 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 | Not Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant | Not Compliant |

Findings

Having considered the Quality Audit Report and approved provider’s response, I have assessed this Quality Standard as non-compliant as I am satisfied all associated requirements are non-compliant. Whilst requirement 6(3)(a) is compliant for HCP, it is non-compliant for CHSP. Non-compliance is based on:

* The service did not actively encourage feedback and complaints from CHSP consumers.
* Consumers were unaware of advocacy services and external complaints mechanisms available to them to raise and resolve complaints.
* The service did not have an effective feedback and complaints management system and complaints were not consistently documented.
* The service did not document, review, analyse and trend feedback and complaint data, and use this to improve quality of care and services.

I have made this decision based on the following analysis.

The Quality Audit Report identified the service was not meeting each requirement of this Quality Standard. For example:

Requirement 6(3)(a)

All HCP and CHSP consumers interviewed by the Assessment Team said they felt comfortable providing feedback or making a complaint and would contact the service via telephone to speak to staff or management. The service has processes to seek feedback from HCP consumers and this was confirmed by HCP consumers. However, all CHSP consumers interviewed said they had not been actively encouraged to provide feedback, or informed by the service of the feedback and complaints process available to them.

Requirement 6(3)(b)

Whilst information about complaints and advocacy networks is provided to HCP consumers on commencement in their HCP agreement, all HCP and CHSP consumers and representatives interviewed by the Assessment Team said they were unaware of advocacy services and external complaint mechanisms available to them to raise and resolve complaints.

Requirement 6(3)(c)

The service did not have an effective feedback and complaints management system. The service’s feedback and complaints management policy and procedure was for the organisation’s residential care service and had not been adapted to the community care setting.

Consumers and representatives were satisfied that when they raised feedback and complaints, staff responded and resolved their matters in a timely manner and provided examples of this. However, feedback and complaints were not routinely documented or recorded, including actions taken and outcomes, which was acknowledged by the organisation’s governing body (the Board) members and staff. The feedback and complaints register evidenced only three entries for the previous 6-month period.

Management and staff understood open disclosure processes and examples of where this had been applied were evident.

Requirement 6(3)(d)

The service was not routinely documenting feedback and complaints. As a result, the service was unable to review, analyse and trend feedback and complaint data, and use this to improve quality of care and services. The Board meeting agenda and minutes did not include items about feedback and complaints.

There was an entry in the service’s PCI dated January 2022, to improve the complaints management process, however, no actions in response were recorded against this improvement item.

Approved provider’s response to the Quality Audit Report

The approved provider’s response stated that consumers receive information about the service’s feedback and complaints process upon commencement with the service and in the handbook provided. Following the quality audit, the provider has reminded consumers about feedback and complaints processes via phone message and mail.

The response included evidence of an action plan to improve feedback and complaints processes. Actions have commenced and will be completed by 30 July 2024 and included:

* Updated the service’s feedback and complaints policies, procedures, forms and information. Updated forms and information are available to consumers in the consumer handbook.
* Provided staff training and information on the service’s feedback and complaints policy and procedure, including their responsibility to encourage, manage/escalate and record feedback and complaints in the centralised register.
* Updated assessment, planning and review processes to ensure staff use these to:
  + provide consumers with information about feedback and complaints processes, advocacy and interpreter services, and determine any cultural indicators requiring support, and
  + actively seek feedback from consumers, including CHSP consumers regarding satisfaction with meals and updated preferences and allergies.
* Included feedback and complaints as a standing agenda item on meetings.
* Updated the Board report template to include feedback and complaints.
* Established various monitoring and review processes, such as daily review of progress notes, audits and surveys, meeting agenda items, and reporting to the internal governance committees on trend analysis.

The response also included evidence of increased reporting and recording of feedback and complaints in March 2024.

Based on the Quality Audit Report and the approved provider’s response, I am satisfied that:

* At the time of the quality audit, the service’s feedback and complaints management systems and processes were ineffective.
* The approved provider has commenced actions to address deficiencies and has shown evidence of early signs of positive progress. However, there are improvement actions yet to be implemented and others are in their infancy. These will take some time to embed in practice and culture, and be tested for effectiveness and sustainability.

For these reasons, I have decided that whilst requirement 6(3)(a) is compliant for HCP, it is non-compliant for CHSP and all other requirements in Standard 6 are non-compliant for both HCP and CHSP.

# Standard 7

|  |  |  |  |
| --- | --- | --- | --- |
| Human resources | | HCP | CHSP |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Not Compliant | Not Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Not Compliant | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Not Compliant | Not Compliant |

Findings

Having considered the Quality Audit Report and approved provider’s response, I have assessed this Quality Standard as non-compliant as I am satisfied requirements 7(3)(c), 7(3)(d), and 7(3)(e) are non-compliant. Non-compliance is based on:

* The service did not have processes to ensure all staff have required knowledge and competence to effectively perform their roles and tasks.
* Training has not been effective in equipping or supporting staff to deliver care and services and outcomes required by the Quality Standards.
* Staff performance was not regularly assessed or monitored, and the performance of managers was not assessed, monitored or reviewed.

I have made this decision based on the following analysis.

The Quality Audit Report identified the following evidence in relation to these requirements.

Requirement 7(3)(c)

Whilst the service has processes to check the formal qualifications of staff and sub-contractors and position descriptions for staff, it does not have processes to ensure all staff have the required knowledge and competence to effectively perform their roles and tasks. Management and staff were undertaking tasks outside the scope of their role for which they did not have the required knowledge or competence.

Requirement 7(3)(d)

The service has staff recruitment processes and delivers a range of relevant training (orientation, mandatory and role-specific). However, training has not been effective in equipping or supporting staff to deliver the outcomes required by the Quality Standards, including in areas such as assessment and planning, monitoring and review, management of deterioration, care documentation, information management and incident management. Refer to Standards 2, 3, 6 and 8 for further information.

Requirement 7(3)(e)

The service has processes to formally review staff performance through an annual performance appraisal, and address performance issues as they arise. However, staff performance was not regularly assessed or monitored. For example, staff diversion from organisational policies and procedures were not identified, including in relation to feedback and complaints, assessment and planning and incident reporting. The performance of managers at the service was not assessed, monitored or reviewed.

Approved provider’s response to the Quality Audit Report

The approved provider’s response referenced the impact of the delayed implementation of the new ECMS on these requirements and made broad reference to improvements addressed elsewhere in this report, including the new ECMS and updated policies, procedures and checklists. Additionally, the response evidenced specific improvements made to address deficiencies in this requirement, which included:

* Modified position descriptions to clearly define roles and responsibilities, including related to the management of risk, incidents and complaints.
* Developed a work program for each key management roles, which align with the service’s performance framework.
* Delivered staff training and information on various topics, including the ECMS and updated policies and procedures.

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

The Quality Audit Report included evidence (summarised below) that the service is compliant with these requirements.

The service has processes to schedule staff to deliver the care and services consumers are funded to receive under their HCP and/or CHSP programs. The service manages a fortnightly base roster, which incorporates contingencies to cover unexpected staff absences. Consumers and representatives reported staff arrive on time and are not rushed in undertaking their duties. Staff said there are enough staff to provide care and services to consumers, they never feel rushed and have enough time to undertake their allocated tasks and responsibilities.

Consumers and representatives said staff are kind, caring, respectful, and gentle. The described how staff engage in conversation with them. Staff and management knew consumers well.

Based on the Quality Audit Report and the approved provider’s response, I am satisfied that:

* Requirements 7(3)(a) and 7(3)(b) are compliant.
* At the time of the quality audit, the service’s human resource systems and processes were ineffective in ensuring staff were competent, knowledgeable and effectively trained to perform their role, and that the performance of staff and managers was assessed, monitored and reviewed.
* The approved provider has undertaken actions to address these deficiencies by improving clarity of staff roles and responsibilities and providing staff training and information. However, these actions will take some time to embed in practice and culture, and be tested for effectiveness and sustainability.

For these reasons, I have decided requirements 7(3)(c), 7(3)(d) 7(3)(e) and the overall Quality Standard are non-compliant.

# Standard 8

|  |  |  |  |
| --- | --- | --- | --- |
| Organisational governance | | HCP | CHSP |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Not Compliant | 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 | 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 | 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 | Not Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Not Compliant | Not Compliant |

Findings

Having considered the Quality Audit Report and approved provider’s response, I have assessed this Quality Standard as non-compliant as I am satisfied all associated requirements are non-compliant. Non-compliance is based on:

* Consumers were not actively engaged in the development, delivery and evaluation of care and services.
* The Board did not promote and was not accountable for safe, inclusive, and quality care and services. The Board lacked a focus on matters related to community care and the Quality Standards.
* The organisation’s governance systems relating to information management, continuous improvement, workforce governance, and feedback and complaints were ineffective.
* The organisation did not have effective risk management systems and practices, specifically in relation high impact and high prevalence risks and management of incidents.
* High-impact and high-prevalence risks to consumers were not effectively identified, monitored or managed. Refer to requirement 3(3)(b) for further information.
* The service did not have a documented clinical governance framework.

I have made this decision based on the following analysis.

The Quality Audit Report identified evidence that the service was not meeting each requirement of this Quality Standard. The approved provider’s response to this Quality Standard was brief and mostly made broad references to various improvements noted in respect of other standards and requirements.

Requirement 8(3)(a)

The Quality Audit Report found consumers were not actively engaged in the development, delivery and evaluation of care and services. Whilst management and staff said consumer feedback is sought during care plan reviews and through feedback and complaints mechanisms, this was not demonstrated.

The approved provider’s response referred to improvements in respect of Standard 6 and stated that the Board analyses and acts on feedback and complaint trends.

Requirement 8(3)(b)

The Quality Audit Report found the Board, was unable to demonstrate how it promotes and is accountable for safe, inclusive, and quality care and services. Board meeting minutes were brief and demonstrated a focus on local property acquisitions within the community rather than matters related to the community care service and quality care and services required by the Quality Standards. There was a lack of reporting between the Board and service on significant matters related to the community care service, including feedback and complaints and serious and clinical incidents. Service management felt the service was at risk of proper oversight and governance by the Board and a Governance Improvement Plan 2024 was under development.

The approved provider broadly stated various improvements have been made and advised the Board was taking part in the Governing for Reform in Aged Care program that covers board reporting, clinical governance, and provides tailored coaching to strengthened governance capability and leadership in aged care.

Requirement 8(3)(c)

The Quality Audit Report identified evidence of effective governance systems relating to financial governance and regulatory compliance. However, information management, continuous improvement, workforce governance, and feedback and complaints were not effective. For example:

* Information management systems were ineffective and inconsistent and relied on a mix of verbal, paper-based records stored in consumers' homes and an ECMS not available to all staff. Record keeping methods were inconsistent and care documentation did not contain sufficient information to guide staff practice.
* Regarding continuous improvement, whilst the service has a plan for continuous improvement with entries dating back to 2022, these had not been actioned and did not list planned actions, including for the entries marked as ‘completed’. Feedback, complaints and incidents are not documented, analysed and trended and therefore do not inform continuous improvement.
* Regarding workforce governance, processes relevant to staff competence, knowledge, training and performance were not effective. Refer to Requirements 7(3)(c), 7(3)(d) and 7(3)(e) for further information.
* The service does not have an effective feedback and complaints management system or process. Refer to Standard 6 for further information.

The approved provider’s response broadly stated that the assessment and planning processes have completely changed, and a new ECMS has been implemented and staff have an electronic tablet through which they can directly access the ECMS, including consumer information. I have also considered the provider’s response in relation to standard 6 and 7. However, the response did not specifically address continuous improvement processes. The provider’s response and associated evidence of improvement actions demonstrates the organisational capacity to undertake continuous improvement, however, I do not have evidence or information about the organisation’s continuous improvement system or any actions taken by the provider to address deficiencies with the system.

Requirement 8(3)(d)

The Quality Audit Report identified the service did not have effective risk management systems and practices, specifically in relation to sub-requirements (i) and (iv). For example:

* High-impact and high-prevalence risks to consumers were not effectively identified, monitored or managed. Refer to requirement 3(3)(b) for further information.
* The service’s incident register dated 28 February 2024 for the previous 5-month period did not record any incidents that involved consumers. Staff and management did not have a shared understanding of the service’s incident management processes and staff were unfamiliar with how to identify, record and report incidents.

The approved provider’s response broadly stated that position descriptions have been modified to define roles and responsibilities as it relates to risk management, incident reporting and feedback and complaints, and work programs have been developed for key roles in the organisation (registered nurse, community coordinator, and community care manager).

Requirement 8(3)(e)

The Quality Audit Report identified the service did not have a documented clinical governance framework. A framework was being developed, and relevant policies and procedures being reviewed, updated and implemented. A strategic review completed in 2023 identified the need to establish a governance committee and clinical advisory group, but these had not been implemented.

The approved provider’s response did not directly address this requirement and instead referred to governance reporting processes related to feedback and complaints. It also stated that new systems, policies and procedures and monitoring activities will improve overall operations and outcomes for consumers.

Based on the Quality Audit Report and the approved provider’s response, I am satisfied that:

* At the time of the quality audit, the service’s organisational governance was ineffective.
* The approved provider’s response broadly referred to various improvements referenced in other standards/requirements to systems, policies and procedures that will improve overall operation and outcomes for consumers. I have considered, and accept, other improvement actions addressed in Standard 1, 2, 3, 4, 6, 7, however, note some of these are yet to be implemented and others are in their infancy. These will take some time to embed in practice and culture, and be tested for effectiveness and sustainability.
* The approved provider’s response does not adequately address deficiencies in relation to 8(3)(c)(ii), 8(3)(d) or 8(3)(e).

For these reasons, I have decided all requirements, and the overall Quality Standard are non-compliant.

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)