**Performance**

**Report**

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Kura Yerlo |
| Commission ID: | 600165 |
| Address: | 12 McLaren Parade, PORT ADELAIDE, South Australia, 5015 |
| Activity type: | Assessment contact (performance assessment) – non-site |
| Activity date: | on 8 April 2024 |
| Performance report date: | 15 May 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: 7798 Kura Yerlo Council Inc  
Service: 24491 Kura Yerlo Council Inc - Community and Home Support

**This performance report**

This performance report for Kura Yerlo (**the service**) has been prepared by P.Frangiosa, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Assessment contact (performance assessment) – non-site report was informed by review of documents and interviews with staff, consumers/representatives and others.

The service did not provide a response to the Assessment contact report.

# Assessment summary for Commonwealth Home Support Programme (CHSP)

|  |  |
| --- | --- |
| Standard 2 Ongoing assessment and planning with consumers | Not Compliant |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

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

# Areas for improvement

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

* Requirement 2(3)(a).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.
* 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.
* 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.
* Requirement 6(3)(d).Feedback and complaints are reviewed and used to improve the quality of care and services.
* 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.
* Requirement 8(3)(c). Effective organisation wide governance systems relating to the following information management, continuous improvement, workforce governance, regulatory compliance, and feedback and complaints.

# Standard 2

|  |  |  |
| --- | --- | --- |
| 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)(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 |

Findings

Requirement 2(3)(a) was found non-compliant following a Site Audit undertaken from 4 to 9 August 2023 as the service was unable to demonstrate 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.

At the Assessment Contact undertaken from 8 April 2024, the Assessment Team found continued deficits relating to assessment and planning, and information to guide staff in the delivery of safe and effective care and services. The Assessment Team recommended Requirement 2(3)(a) not met and provided the following evidence relevant to my finding:

* Management advised the service had developed draft assessment support planning documentation to capture consumers’ risk and mitigation strategies, based on the findings of the previous site audit in 2023. However, the new draft assessment had not been implemented at the time of the assessment contact.
* Management demonstrated an understanding of the assessment and planning process to identify risks to consumers and strategies to manage risk, however consumer support planning documentation viewed, failed to capture information regarding consumers risk and mitigation strategies, including.
  + Support planning documentation for one consumer documented the consumers Emphysema and use of portable oxygen cylinders, and mobility restrictions and use of a walking frame. This information is provided as an alert in the services electronic management system, however there is limited information to support staff in the field, with strategies advising the oxygen bottle is well secured, and supervision is required when the consumer is using their walking frame. No further documented guidance was provided.
  + Support planning documentation for another consumer identifies them as residing alone and having early stages of Alzheimer’s disease. This information is provided as an alert in the services electronic management system, however there are no documented strategies regarding risk mitigation and support when participating in social support groups, or community outings.
* Validated risk assessment tools are not used in the support planning assessment process to guide risk mitigation and response for the range of services provided.
* Management advised information from My Aged Care (MAC) is used to inform the initial assessment such as medical diagnosis, mobility, cognitive deficits, transport, and social support needs. Management advised there has been a change in leadership which has impacted the new assessment/support planning documentation approval and implementation.

I have considered the information and evidence in the assessment teams report, and while I acknowledge the intent of the service to implement updated assessment support planning documentation, I note at the time of my finding, these actions have not been fully implemented or embedded. I further acknowledge that all consumers and representatives interviewed were satisfied with the assessment and planning process, and staff could describe individual consumers’ needs and risks and have access to consumers’ support planning documentation to deliver support services to consumers.

However, the intent of this requirement is ensuring that assessment and planning are effective. These processes will support organisations to deliver safe and effective care and services. Relevant risks to a consumer’s safety, health and well-being need to be assessed, discussed with the consumer, and included in planning a consumer’s care, and at point of delivery. Sufficient detail ensures staff are supported to provide point of care delivery, with consideration to risk mitigation strategies. Arrangements to protect consumers require assessment, documentation in care and services plans, informed consent and regular monitoring and review, in line with best practice and legislation.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 2(3)(a) in Standard 2 Ongoing assessment and planning with consumers.

Requirement 2(3)(b) was found non-compliant following a Site Audit undertaken from 4 to 9 August 2023 as the service was unable to demonstrate 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.

At the Assessment Contact undertaken from 8 April 2024, the Assessment Team found continued deficits relating to the service not identifying the consumer’s needs, goals and/or preferences adequately when undertaking assessments. The Assessment Team recommended Requirement 2(3)(b) not met and provided the following evidence relevant to my finding:

* Management advised that consumers and staff were provided with a seminar on advanced health directives from a guest speaker from Aboriginal health services, however acknowledged the service is still working on a policy and process for advanced health directives and how this would be captured in consumers’ support plans.
* Identification of consumers goals is included in the draft assessment support planning documentation but is yet to be introduced.
* Management advised consumers goals and preferences are captured in the 3 monthly planning reviews. However, documentation evidenced that goals, needs and preferences within support plans are not consistently documented to inform staff when providing services.
  + Consumers support planning documentation reviewed did not include information on consumers goals, needs and preferences.

I have considered the information and evidence in the assessment teams report, and while I acknowledge the intent of the service to implement policies and processes for advanced health directives, and introducing updated assessment support planning documentation, I note at the time of my finding, these actions have not been fully implemented or embedded. Positive strategies including seminars for consumers to empower them to make an informed decision about their care and services, is welcomed. However, at this stage, appear isolated until the implementation of supportive policies and processes to embed consumer preferences can be effectively captured and documented in care plans.

The intent of this requirement is ensuring organisations are expected to do everything they reasonably can to plan care and services that centre on the consumer’s needs and goals and reflect their personal preferences. This includes considering the consumer’s condition and functional abilities and identifying what help they need to live as well as they can, listening to and understanding what is important to the consumer and working out how their goals and preferences can be met, and, tailoring an approach to fit the consumer’s cultural and personal preferences and how they want to have care and services delivered.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 2(3)(b) in Standard 2 Ongoing assessment and planning with consumers.

Requirement 2(3)(d) was found non-compliant following a Site Audit undertaken from 4 to 9 August 2023 as the service was unable to demonstrate 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.

At the Assessment Contact undertaken from 8 April 2024, the Assessment Team found continued deficits relating to communicating the outcomes of assessment and planning to relevant parties, including consumers and their representatives. The Assessment Team recommended Requirement 2(3)(d) not met and provided the following evidence relevant to my finding:

* Though consumers and representatives interviewed advised a copy of the support plan is provided to them and staff communicate with them regularly, viewed support planning documentation for nine consumers were MAC historical assessments from 2020-2022, with no updated service support plans or reviews conducted.
* Three consumer service support plans did not capture risk mitigation strategies, despite references to allied health referrals.
* Management acknowledged service support plans are not up to date due to staff replacements and changes in the management team, and advised they would action them as soon as possible.

While I acknowledge managements intent to implement the new draft assessment/support planning documentation process, and their acknowledgement it should have been implemented for the service to ascertain its effectiveness, I note at the time of my finding, these actions have been introduced.

Even though consumers and representatives said support plans are accessible to them, and there has not been any impact on consumers, there is insufficient information documented within service support plans to show the outcomes of the assessment and planning are tailored and current.

The intent of this requirement is to ensure a care and services plan is to be documented and reflect the outcomes of assessment and planning for each consumer. Accurate and up-to-date care and services plans are important for delivering safe and effective care and services, as well as positive outcomes for consumers. Relevant current risks to a consumer’s safety, health and well-being need to be documented in the care and services plan to make sure their safety isn’t compromised. This includes things such as allergies and other risks relating to the consumer’s needs.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 2(3)(d) in Standard 2 Ongoing assessment and planning with consumers.

# Standard 6

|  |  |  |
| --- | --- | --- |
| Feedback and complaints | | CHSP |
| 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)(d) was found non-compliant following a Site Audit undertaken from 4 to 9 August 2023 as the service was unable to demonstrate the feedback and complaints are reviewed and used to improve the quality of care and services.

At the Assessment Contact undertaken from 8 April 2024, the Assessment Team found continued deficits relating to feedback and complaints being used to improve the quality of care and services. The Assessment Team recommended Requirement 6(3)(d) not met and provided the following evidence relevant to my finding:

* Multiple examples of complaints reported to the service, documented, however failing to be analysed or reviewed to improve quality of care and services.
  + One incident involving uninvited relatives attending the service, resulting in other consumers becoming distressed. Information viewed advised that management held discussions with all staff and members involved, and strategies were agreed with the team leader. The event was not recorded in the continuous improvement register as an opportunity to drive improved care and service delivery.
* Management was unable to provide an example of feedback or a complaint that had led to an improvement in the quality of care and services since the previous audit in August 2023.
* Management advised that feedback and complaints are recorded, investigated and outcomes reported to the Board. Minutes viewed from leadership and board meetings record complaints with an action, however, are not identified as aged care or NDIS.
* The service’s continuous improvement register does not contain any items related to consumer feedback.
* Management advised that a quality coordinator will be commencing on 15 April 2024 and will be responsible for reviewing and trending feedback and complaints and translating these into continuous improvement opportunities as part of their role.
* Board meeting minutes for January 2024 contain the following item.
  + Key priority for an Elders pamphlet, which had recently been created and printed ready for distribution.
  + However, the assessment team identified that this information had not been recorded on the continuous improvement register. Management acknowledged this information should have been recorded in the continuous improvement plan.

In considering the evidence within the assessment report, I acknowledge managements intent to introduce a dedicated quality coordinator, and intent to capture information within the service’s continuous improvement plan. I note at the time of my finding, these actions are yet to be introduced or embedded.

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

# Standard 7

|  |  |  |
| --- | --- | --- |
| Human resources | | CHSP |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

Requirement 7(3)(d) was found non-compliant following a Quality Audit undertaken from 4 to 9 August 2023. The service did not demonstrate the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

The Assessment Team’s report for the Assessment contact undertaken on 8 April 2024 includes evidence of actions taken by the service in response to the non-compliance. These actions include, but are not limited to, the workforce undertaking facilitated training, as well as the Commissions Aged Care Learning Information Solution (ALIS) and MAC training relevant to their roles. The Assessment Team was satisfied these improvements were effective and recommended Requirement 7(3)(d) met.

Staff described completing training and being supported in their roles. Management described recruitment and onboarding processes, including mandatory training relevant to the role, and ongoing support and training opportunities. Documentation viewed evidenced the service maintains a training matrix and training records to ensure the workforce is up to date with training expectations. Management advised, and documentation viewed by the Assessment Team confirmed the service has a system to track annual performance appraisals for staff and a performance management process, if required.

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

# Standard 8

|  |  |  |
| --- | --- | --- |
| Organisational governance | | CHSP |
| 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. | Compliant |

Findings

Requirement 8(3)(b) was found non-compliant following a Site Audit undertaken from 4 to 9 August 2023 as the service was unable to demonstrate the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

At the Assessment Contact undertaken from 8 April 2024, the Assessment Team found continued deficits relating to lack of effective board oversight and accountability of inclusive and quality services. The Assessment Team recommended Requirement 8(3)(b) not met and provided the following evidence relevant to my finding:

* The service has employed a quality coordinator who will commence on 15 April 2024. Management advised this role will be responsible for monitoring feedback and complaints, incidents and risk data and trending information for management and the Board allowing the board to strategically improve the quality of care and services for its consumers.
* Management advised, and documentation showed that management communicate regularly with the Board and provide monthly reports at Board meetings, which are inclusive of both NDIS and CHSP, but not identified in isolation
  + Board meeting minutes from January 2024, acknowledge receipt of a CHSP report from the CEO. On review of the CEO’s report there is no identified information for CHSP for this period.
* The service's Quality management policy (August 2019) describes how the Board and management are responsible for monitoring of risks, feedback and complaints, incidents, and continuous improvement, however, as demonstrated in requirement 6(3)(d), the service does not effectively analyse and trend this data for CHSP consumers to identify opportunities for improvement to care and services.

In considering the evidence within the assessment report, I acknowledge managements intent to introduce a dedicated quality coordinator, and intent to capture information within the service’s continuous improvement plan. I note at the time of my finding, these actions are yet to be introduced or embedded. The service did not respond to the findings of the assessment report.

The intent of this requirement states the governing body of the organisation is responsible for promoting a culture of safe, inclusive and quality, care and services in the organisation. The governing body of the organisation is also responsible for overseeing the organisation’s strategic direction and policies for delivering care to meet the Quality Standards. This includes evidence that the governing body asks for and receives the information and advice it needs to meet its responsibilities under this requirement, and strategic, business and diversity action plans that describe the priorities and strategic directions for inclusive care endorsed by the governing body. Evidence of how the organisation implements, monitors and improves these is critical.

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

Requirement 8(3)(c) was found non-compliant following a Site Audit undertaken from 4 to 9 August 2023 as the service was unable to demonstrate effective organisation wide governance systems in relation to information management, continuous improvement, workforce governance, regulatory compliance, feedback and complaints.

At the Assessment Contact undertaken from 8 April 2024, the Assessment Team found continued deficits relating to effective organisation wide governance systems in relation to information management, continuous improvement, feedback and complaints. The Assessment Team recommended Requirement 8(3)(c) not met and provided the following evidence relevant to my finding:

* The organisation did not demonstrate effective information management related to assessment and communication of consumer risks.
* Evidenced consumer support plans contain risk assessment information, however, there is no detailed documentation regarding risk mitigation strategies.
* A new assessment support planning documentation guide, currently in draft to capture consumers risk and strategies to manage the risk, has yet been utilised and implemented.
* Ineffective systems to identify, analyse or trend opportunities to improve care and services for reporting to its governing body.
* Management advised the service uses various mechanisms to identify opportunities for continuous improvement, including surveys, feedback and incident monitoring, but does not analyse or trend this information for continuous improvement or advice to the Board.
* Management advised that the service has a quality coordinator commencing on 15 April 2024, whose role will be to effectively identify, trend and provide data to the Board for continuous improvement to care and services of consumers.
* The continuous improvement register contained historical entries from the previous audit in August 2023, with no additional items relating to improvements for CHSP consumers.
* Management advised that they do not currently subscribe to updates from the Department of Health and Aged Care or the Community of practice through the Commission, however advised they will investigate these options.
* The organisation did not demonstrate that feedback and complaints are reviewed and analysed to improve the quality of care and services.

In considering the evidence within the assessment report, I acknowledge managements intent to introduce a dedicated quality coordinator, and intent to capture information within the service’s continuous improvement plan. I note at the time of my finding, these actions are yet to be introduced or embedded. The service did not respond to the findings of the assessment report.

The intent of this requirement is about how an organisation applies and controls authority below the level of the governing body. This includes effective information management systems and process that give appropriate members of the workforce access to information that helps them in their roles.

Continuous improvement systems and processes assess, monitor, and improve the quality and safety of the care and services provided by the organisation. This includes the experiences of consumers. These systems help the organisation to identify where quality and safety is at risk. They also help an organisation to respond appropriately and promptly to these risks. Organisations must have a plan for continuous improvement and check their progress against this plan to improve the quality and safety of care services.

Feedback and complaints systems and processes actively look to improve results for consumers.

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

Requirement 8(3)(d) was found non-compliant following a Quality Audit undertaken from 4 to 9 August 2023. The service did not demonstrate effective risk management systems and practices, including but not limited to managing high-impact or high-prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers, supporting consumers to live the best life they can, and managing and preventing incidents, including the use of an incident management system.

The Assessment Team’s report for the Assessment contact undertaken on 8 April 2024 includes evidence of actions taken by the service in response to the non-compliance. These actions include but are not limited to the service implementing an incident management system to include the capture and reporting of incidents, including SIRS, trending and reporting to the board. Staff described elements of elder abuse and relevant training. Documentation reviewed noted elder abuse training is incorporated into orientation for all staff. The service has a risk management process and management advised of the identification of risk mitigation strategies which is discussed at management meetings.

The Assessment Team was satisfied these improvements were effective and recommended Requirement 8(3)(d) met.

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