**Performance**

**Report**

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| Name: | Larrakia Nation Aged Care Service |
| Commission ID: | 600283 |
| Address: | 76 Dick Ward Drive, COCONUT GROVE, Northern Territory, 0810 |
| Activity type: | Quality Audit |
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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: 2360 Larrakia Nation Aboriginal Corporation  
Service: 17933 Larrakia Nation Aged Care Service

Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 7743 Larrakia Nation Aboriginal Corporation  
Service: 23845 Larrakia Nation Aboriginal Corporation - Community and Home Support

**This performance report**

This performance report for Larrakia Nation Aged Care Service (**the service**) has been prepared by A. Grant, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* The assessment team’s report for the Quality Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* The provider’s response to the assessment team’s report received 31 October 2023.

# Assessment summary for Home Care Packages (HCP)

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| Standard 1 Consumer dignity and choice | Not Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Not Compliant** |
| **Standard 5** Organisation’s service environment | **Not 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)

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| Standard 1 Consumer dignity and choice | Not Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Not Compliant** |
| **Standard 5** Organisation’s service environment | **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 1(3)(d)**

* Implement training, systems and processes for all staff around dignity of risk.
* Better implement dignity of risk when providing services for consumers.

**Requirement 1(3)(e)**

* Improve the clarity and simplicity of statements for consumers.
* Respond and resolve queries in relation to statements and debts quickly to minimise effect to the consumer or their services.

**Requirement 2(3)(a)**

* Ensure assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective services.
* Ensure care planning documentation includes sufficient detail about assessed needs and risks to the consumer to guide staff in managing the risks for consumers.

**Requirement 2(3)(b)**

* Ensure care planning documentation consistently provides staff guidance regarding preferences for consumers care and services.
* Document end of life planning discussions when undertaken with consumers.

**Requirement 2(3)(c)**

* Ensure assessment and planning is consistently occurring with ongoing consultation with the consumer, representatives and others involved in the care of the consumer.
* Ensure adequate oversight and communication for consumers residing in rural areas.

**Requirement 2(3)(d)**

* Ensure copies of care plans are provided to consumers and/or representatives.
* Ensure care plans capture all aspects of a consumer’s health and wellbeing and are available at the point of care to guide staff practice.

**Requirement 2(3)(e)**

* Ensure when reviews are completed, they are always effectively identifying risks to consumers.
* Ensure reviews are completed following incidents, hospital discharges, or when circumstances have changed.

**Requirement 3(3)(b)**

* Ensure effective process are implemented to assess, action and mitigate risks associated with the care of each consumer.
* Ensure staff are available that have sufficient knowledge and experience in providing and overseeing clinical care.

**Requirement 3(3)(d)**

* Ensure any deterioration or change of consumers mental health, cognitive function, or physical function is actioned in a timely manner.
* Ensure progress notes are recorded and uploaded to consumer files post services being completed.

**Requirement 3(3)(e)**

* Ensure information about consumer’s needs, preferences, conditions, and changes are consistently and effectively documented and communicated within the organisation, and with others where responsibility for care is shared.

**Requirement 3(3)(f)**

* Ensure referrals are actioned in a timely manner so consumers can receive the care and services they require.

**Requirement 4(3)(a)**

* Ensure sufficiently trained and resourced staff so consumers receive 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.
* Ensure the service has sufficient staff to undertake take the domestic duties consumers are assessed for.

**Requirement 4(3)(b)**

* Ensure supports are in place to promote each consumer’s emotional, spiritual and psychological wellbeing for consumers.
* Ensure feedback from consumers in relation to their emotional, spiritual and psychological wellbeing is documented and actioned in a timely manner.

**Requirement 4(3)(d)**

* Ensure information relating to consumers’ needs, conditions, goals, and preferences is documented and communicated within the organisation, and with other organisations where responsibility for care is shared.
* Ensure procedures and processes are established in implemented in relation to referrals.

**Requirement 4(3)(e)**

* Ensure timely and appropriate referrals to individuals, other organisations and providers occur for consumers.
* Ensure effective systems and processes are in place to ensure an effective network of external providers that you can refer to, or collaborate with, to meet the needs of consumers for their daily living.

**Requirement 5(3)(b)**

* Ensure maintenance requests are documented and followed through with.
* Ensure sufficient oversight and monitoring of vehicle usage and maintenance.
* Ensure asset register is accurate and up to date.

**Requirement 6(3)(d)**

* Ensure feedback and complaints are effectively reviewed and used to improve the quality of care and services.
* Look to update feedback register from paper based too an electronic system.

**Requirement 7(3)(a)**

* Ensure 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 services.
* Ensure sufficient staff to meet the assessed needs of consumers in particular in the rural areas.

**Requirement 7(3)(d)**

* Implement adequate systems and processes to ensure that staff complete the requisite training to ensure staff are equipped and supported with policies and procedures to guide their practice.
* Ensure time for staff to undertake and complete training modules available to them.

**Requirement 7(3)(e)**

* Ensure regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.
* Ensure new time frames for performance reviews identified by the Human Resource Manager are implemented and followed up on.

**Requirement 8(3)(b)**

* Ensure board has appropriate oversight of the service.
* Ensure any review into financial viability and eventual outcomes the review consider the impacts to the consumers care and services.
* Look to implement all twenty-seven recommendations from the Service Development Assistance Panel Support project.

**Requirement 8(3)(c)**

* Ensure all policies and procedures are distributed to staff for implementation.
* Utilise, update, track and implement the plan for continuous improvement register and the items listed on them.
* Ensure adequately established and implemented financial management processes to ensure appropriate financial governance in place for the delivery and oversight of the CHSP and HCP services.
* Ensure effective workforce planning is in place, and that the workforce is competent, supported and developed to deliver safe and quality care and services to consumers.
* Roll out SIRS training and awareness sessions. Establish SIRS policies and processes and distribute them to all staff.
* Ensure effective systems and processes to monitor, analyse and report feedback and complaint data to improve the quality of care and services.

**Requirement 8(3)(d)**

* Ensure effective risk management systems and practices are in place, 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.
* Ensure processes are in place to identify and respond to abuse and neglect of aged care consumers, and that staff have allocated time to complete the online module for elder abuse education, and this is monitored for completions.
* Ensure there are effective policies, procedures, and processes in place to assess and consult with consumers for them to live their best life and be supported to take risks.

**Requirement 8(3)(e)**

* Ensure an effective clinical governance framework is in place to maintain oversight of clinical care provided to consumers.
* Ensure coordinators have sufficient clinical skills and training to undertake their role.

# Standard 1

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| --- | --- | --- | --- |
| 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. | **Not Compliant** | **Not Compliant** |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | **Not Compliant** | **Not Compliant** |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | **Compliant** | **Compliant** |

Findings

**Requirements 1(3)(d) and 1(3)(e) – Not Compliant**

*Requirement 1(3)(d)*

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that each consumer is effectively supported to take risks to enable them to live the best life they can. The service demonstrated that consumers are supported to make decisions about their care and services, including when their choice involve elements of risk. However, the service was not able to demonstrate that consumers had been informed of risks and possible consequences of their decisions, to enable them to make informed decisions; and that the service had discussed with consumers strategies to manage the risk whilst supporting them to live their best life. For example:

* The Assessment Team noted both HCP and CHSP consumers at the social support group stated to the Assessment Team that they had wanted to go fishing as an activity and that they had requested this a number of times as the majority of the group love fishing. The consumers stated they have always been told by the service that ‘it's too hot to go fishing’. One consumer explained that they had fished their whole life and could wear hats and take water. The Assessment Team noted staff still refuse to include the activity;
* During interviews with the Assessment Team staff were unable to explain dignity of risk and/or provide any examples of where risk and consequences had been discussed with any consumer;
* The Assessment Team noted the service was not able to demonstrate how they had actively supported the consumers to understand the risks and possible consequences, to enable them to make informed decisions about taking the risk and to refuse ongoing services and care did not demonstrate that risk mitigation strategies had been implemented; and
* The Assessment Team noted the service was not able to demonstrate that systems and processes currently in place are effective to guide staff about supporting consumers to take risks. The Assessment Team noted whilst the service does have a Choice and Dignity of Risk policy, and access to online training, staff sampled were not aware of it, nor had training in dignity of risk or strategies for mitigation of risk.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

*Requirement 1(3)(e)*

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that 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. Some consumers and/or representatives when interviewed by the Assessment Team described how communication is not timely when they have queries and/or concerns over their statements. For example:

* A consumer (CHSP) when interviewed by the Assessment Team stated they had a large ongoing debt with the service, and they had been trying to get it sorted for a long time. The consumer stated the service sent a coordinator to discuss the debt with the consumer, but there were language issues, and the consumer was no clearer on how the debt came about;
* Two consumers when interviewed by the Assessment Team stated they found it hard to understand their coordinator due to language barriers. Another two CHSP consumers when interviewed by the Assessment Team stated they had queried their statements and were still waiting on answers from the service; and
* A staff member when interviewed by the Assessment Team stated that a CHSP consumer had a large debt, which they had queried numerous times and had now stopped coming to social support group due to the shame around having the outstanding monies and not having an explanation for the debt. Staff stated they worry about this consumer as she is vision impaired and has little other social connection.

The Decision Maker notes while the examples above related to CHSP services the evidence included in the Assessment Team Report substantiated these systemic deficiencies across both HCP and CHSP services.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

**Requirements 1(3)(a), 1(3)(b), 1(3)(c) and 1(3)(f) – Compliant**

*Requirement 1(3)(a)*

Evidence analysed by the Assessment Team showed the service was able to demonstrate each consumer is treated with dignity and respect, with their identity, culture and diversity valued, for both HCP and CHSP consumers. Consumers and representatives described staff as kind, caring and respectful. Management and staff spoke about consumers in a respectful manner, and described how they provide a personalised service by understanding consumers’ circumstances. The Assessment Team observed staff talk to consumers in a respectful manner during the social support group. The Assessment Team noted staff spoke to consumers about their families and home lives in a familiar manner and were aware of what was important to the individual consumer. Management described, and documentation confirmed, that staff have access to online training in dignity and respect and while the service has access to relevant policies, these are not implemented.

*Requirement 1(3)(b)*

Evidence analysed by the Assessment Team showed the service was able to demonstrate services are culturally safe for both HCP and CHSP consumers. Consumers interviewed stated that staff understand their needs and preferences and deliver care and services with this in mind. The Assessment Team noted staff demonstrated understanding of consumer’s cultural background and described how they ensure services reflect consumers’ cultural needs and diversity. Management when interviewed described, and staff confirmed how they are supported to provide a culturally safe service. The Assessment Team noted staff have access to consumers cultural information to better understand their background, staff then undertake online cultural training that aligns with the consumers’ background. During interviews management advised that the service provides care and services to a culturally diverse range of consumers and have been able to meet the cultural needs of consumers, for example, one Thai consumer has been matched with a Thai support worker.

*Requirement 1(3)(c)*

Evidence analysed by the Assessment Team showed the service was able to demonstrate how each consumer is supported to exercise choice and independence, make decisions about their care and services including when others should be involved, and communicate their decisions, for both HCP and CHSP consumers. Consumers when interviewed confirmed that the service involves them in making decisions about the care and services they receive. Staff during interviews described measures they implement to ensure they support consumers to exercise choice and make decisions about their care and services. Documentation analysed by the Assessment Team reflected consumers choices about who should be involved when decisions are made about the services they receive.

*Requirement 1(3)(f)*

Evidence analysed by the Assessment Team showed the service was able to demonstrate each consumer’s privacy is respected and personal information is kept confidential, for both HCP and CHSP Consumers. The Assessment Team noted the service demonstrated they have effective systems in place to protect consumers’ privacy and personal information. Consumers interviewed by the Assessment Team were confident that their privacy is respected whilst receiving services. Staff during interviews described various ways they maintain consumer confidentiality, including paper-based files being kept in locked cabinets. Staff stated during interviews that they have access to consumer information that is limited and relevant to their role and management stated that systems are protected by passwords and that staff can only access information specific to consumers they provide services to.

# Standard 2

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

**Requirements 2(3)(a) to 2(3)(e) – Not Compliant**

*Requirement 2(3)(a)*

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective services. For some consumers sampled, while key risks had been identified through My Aged Care (MAC) assessments and some information was transferred to the Assessment Form, these had not been assessed by the service’s staff, and strategies to manage those risks were not effectively considered or documented. The Assessment Team noted care planning documentation did not include sufficient detail about assessed needs and risks to the consumer to guide staff in managing the risks for consumers. The Assessment Team reviewed care plans for ten sampled HCP and CHSP consumers and noted the service had identified some risks to a consumer’s health and wellbeing, for example, mobility issues, medical conditions and pain, assessment and planning documentation, however, did not demonstrate the service is including the consideration and assessment of risks to the consumer’s health and well-being to inform the delivery of safe and effective services. For example:

* During interviews with the Assessment Team a representative described a consumer (CHSP) they represent as being very thin, having a pressure area on the consumers body which they have had for many months and a diet which often consists of oysters and ice cream. The Assessment Team noted the consumer receives regular transport to a wound care clinic where staff at the clinic attend to the consumers wound dressing in addition to the consumer receiving social support for shopping. The Assessment Team noted in an assessment undertaken by the coordinator in January 2023, it was documented that the consumer:
  + Was independent with cooking, the Assessment Team noted no changes in eating, weight or food issues were identified;
  + No documentation regarding the consumer being under weight or requiring a clinical or allied health check;
  + Had experienced a change in mobility due to one fall approximately one year ago when getting up at night, with documentation stating the consumer could not remember and this had not discussed it with her health care provider;
  + Chronic back pain and osteoarthritis were noted and utilises a walking stick most of the time or a four wheeled walking frame when out of the house; and
  + There was no further follow up or assessment regarding this fall or the consumers mobility requirements.

Coordinators and management stated during interviews that the service uses information from MAC assessments and GP summaries to inform the planning and delivery of services however acknowledged that they do not routinely use validated assessment tools when completing these assessments. Coordinators when interviewed described to the Assessment Team that an assessment is undertaken in person at the consumer’s home at commencement of service. The Assessment Team noted one of the three coordinators has some clinical background experience while the other coordinators do not and are both new to their positions.

The Decision Maker notes while the example above related to CHSP services the evidence included in the Assessment Team Report substantiated these systemic deficiencies across both HCP and CHSP services.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

*Requirement 2(3)(b)*

Evidence analysed by the Assessment Team showed the service was not able to demonstrate assessment and planning identifies and addresses the consumer’s current needs, goals and preferences including advance care planning. While some consumers interviewed indicated that they were happy with the care they received, other consumers verbalised that the service provided were not meeting their needs, goals, and preferences. The Assessment Team noted care planning documentation generally captured consumers’ goals, however, did not consistently provide staff guidance regarding preferences for their care and services. For example:

* A consumer (CHSP) advised the Assessment Team that the domestic assistance they receive from the service was reduced from two hours to one hour per week in October 2022, despite providing doctors reports and a medical letter to support that due to ongoing back pain from past surgery they are unable to bend or lift and the consumer lives alone; and
* Care documentation sampled for eight HCP consumers, showed that while the care plans describe consumer goals, there was no documentation to detail consumers’ preferences about how they would like their care and services delivered, and no information to direct support workers at point of care. The care plan for a consumer (HCP L4) dated November 2022, stated that the consumer is blind in one eye and has low vision in the other eye. The consumer receives transport for shopping and medical appointments, domestic assistance, medication prompting and receives Meals on Wheels. The Assessment Team noted there was limited information about the consumers assessed needs and preferences to guide support workers in the safe delivery of care and services. The Assessment Team noted the consumers services included transport, social support and domestic assistance while all the care plan stated was ‘LNAC staff to assist’. The Assessment Team noted for meals, there was no information in the care plan regarding any dietary requirements or preferences for the consumers meals.

The Assessment Team noted while a brochure for advanced end of life planning is included in the welcome pack for consumers, there was no documentation to support discussions were undertaken with consumers.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

*Requirement 2(3)(c)*

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that assessment and planning is consistently occurring with ongoing consultation with the consumer, representatives and others involved in the care of the consumer. While coordinators described how they involve a consumer's representative in the assessment process where a consumer requests it, they were not able to demonstrate this collaboration is ongoing throughout the consumer's time with the service, particularly where services are involved in the rural area. Most consumers and/or representatives interviewed confirmed they are involved in the ongoing assessment and planning of care and services and the service provided examples of communication between other service providers for urban HCP consumers including letters and email correspondence between the coordinator, General Practitioners (GP), specialists and those providers brokered to attend wound care. However, for consumers residing in the rural catchment area and CHSP consumers, there was poor oversight and communication between others involved in care of the consumers. Communication between the service and consumers receiving fully brokered services was not being undertaken. For example:

* A consumer (HCP L3) who had a medical history of stroke, decline in cognitive function, asthma and was legally blind, commenced on a fully brokered home care package in May 2023, following the resignation of a support worker servicing the rural area. The consumer was receiving personal care, social support, and domestic assistance through the brokered service. Records show this consumer passed away in August 2023;
  + The Assessment Team sighted an email sent to the service from the rural subcontracted provider dated 11 August 2023, confirming the death of the consumer. The Assessment Team noted it was the final line of an email regarding another matter and provided no further details around what had occurred leading up to the consumers death. Management acknowledged to the Assessment Team this email had been initially overlooked; and
  + Documentation analysed by the Assessment Team showed the most recent correspondence on file from the subcontracted service was dated 31 May 2023, and stated ‘showered, breakfast’. There were no further entries to suggest deterioration in the consumers condition at this time. The Assessment Team noted at the time of the audit, management were still unable to provide any further detail around the events leading to the death of the consumer.
* The Assessment Team noted that the three HCP rural consumers were not listed on the current consumer list for August 2023, that was provided to the Assessment Team leading to potential lack of communication and oversight; and
* The Assessment Team noted while there are a range of care and services being provided to CHSP consumers, including personal care, wound care, and other services for activities for daily living, there was no evidence of ongoing communication with the subcontracted services, consumers and representatives to ensure ongoing assessment and planning is effective.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

*Requirement 2(3)(d)*

Evidence analysed by the Assessment Team showed the service was not able to demonstrate the outcomes of assessment and planning are effectively documented, and these documents are not available to consumers and the workforce at point of care. Consumers and/ or representatives interviewed in relation to this requirement confirmed a care plan is not provided to them. Review of care documentation identified that, the service does not provide a comprehensive care plan that captures all aspects of a consumer’s health and wellbeing available at the point of care to guide staff practice. Consumers and/or their representatives advised that the service did not provide a care plan which was available in their home, and they give verbal instruction to support workers, when required. For example:

* A consumer advised the Assessment Team that the support worker assists to apply cream to their psoriasis on their legs and back. The consumer was not aware of a care plan to direct the support worker in how to do this, however, the consumer advised that he instructed them verbally if required. Service plan review for this consumer (HCP L4) stated ‘cream for psoriasis. Apply cream for them.’ The Assessment Team noted the service plan did not provide details of where to apply the cream or specific instruction on how to do this, e.g., the wearing of gloves for effective infection prevention and control protection;
* The Assessment Team analysed ten service plans for both HCP and CHSP consumers which provided limited instructions to staff including generic terms such as wellness check, personal care and medication prompt. However, the Assessment Team noted service plans did not provide further detail in how to provide this care; and
* Coordinators when interviewed advised the Assessment Team that although a care plan is generated for consumers, this is only accessible by the coordinators. This information is then used by coordinators to generate a brief service plan which is accessed by staff via telephone mobile application. Care plans are not routinely available in the home of the consumer or accessible by the support workers.

Following feedback from the Assessment Team, management acknowledged that current service plan instructions do not provide sufficient information to support workers to guide their practice.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

*Requirement 2(3)(e)*

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals, or preferences of the consumer. Care planning documentation analysed for sampled consumers showed that, when reviews were completed, these were not always effectively identifying risks to consumers, including following incidents, hospital discharges, or when circumstances changed. Although most consumers and /or representatives interviewed recalled a staff member attending their home to review services, analysis of documentation for both HCP and CHSP consumers showed that while a reassessment is performed, often it was not completed, or identified risks were not actioned. For example:

* In a reassessment undertaken for a consumer (HCP L3) in March 2023 there were a number of risks identified. These had not been recorded in previous assessments, however, there was no further evidence to show that these identified risks were then effectively managed;
* Review of progress notes for a consumer (CHSP) showed that they were hospitalised in July 2023. The Assessment Team noted although the support group coordinator visited the consumer in hospital to provide social support, there was no evidence of the CHSP coordinator undertaking a reassessment, upon the consumers return home to assess for changes in the consumers care needs; and
* The Assessment Team noted the HCP/CHSP review report showed that 40 of 111 consumer’s care and services annual reviews were overdue. Of the overdue CHSP consumers one was due for a review in 2020, four CHSP consumers were due for review in 2021 and eighteen CHSP consumers were due in 2022. Of the HCP consumers, one was due for review in 2021 and three in 2022. Of the rural (CHSP and/or HCP) consumers, six were due for review in 2022.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

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

Findings

**Requirements 3(3)(b), 3(3)(d), 3(3)(e) and 3(3)(f) – Not Compliant**

*Requirement 3(3)(b)*

Evidence analysed by the Assessment Team showed the service was not able to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. The Assessment Team noted the service does not have an effective process to assess, action and mitigate risks associated with the care of each consumer, to ensure safe and effective delivery of personal and clinical care, as demonstrated through care documentation reviewed by the Assessment Team. For example:

* An Intake Assessment form completed in April 2023 for a consumer (HCP L4) identified that the consumer had experienced three falls in the past year due to loss of balance. The Assessment Team noted there was no evidence of a falls assessment being performed or follow up to mitigate the consumers risks for future falls. Following intake, the consumer was then transferred to the fully subcontracted service for their care and services and there was no communication with the subcontracted service since May 2023 regarding effective falls management interventions;
* Progress notes for a consumer (CHSP) show in early August 2023 that the consumer was feeling off balance and didn’t want to go anywhere, and in early September 2023 the consumer was unsteady on their feet. The Assessment Team noted there was no further documentation or follow up sighted by the Assessment Team to investigate the consumers balance issues; and
* One coordinator when interviewed by the Assessment Team advised that if they have concerns regarding cognitive function or other identified high risks of a consumer, they generally refer back to the consumer’s GP for assessment, however, this was not evident throughout any documentation analysed by the Assessment Team.

Following feedback from the Assessment Team, management acknowledged that notwithstanding one coordinator that has some clinical background, the service does not have the knowledge and experience in providing and overseeing clinical care and this is a gap that will require addressing.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

*Requirement 3(3)(d)*

Evidence analysed by the Assessment Team showed while the service was able to demonstrate that in some cases a deterioration or change of consumers mental health, cognitive function, or physical function for both HCP and CHSP consumers was recognised, it was not able to demonstrate that this consistently had been responded to in a timely manner. For example:

* In a Client Reassessment form dated in March 2023 undertaken for a consumer (HCP L3) mobility is documented as ‘no change’ however it was also documented that the consumer had experienced two falls in the last year and had slipped over due to swollen feet. The Assessment Team noted although it was documented as a yes response to the question ‘Have you talked to your health provider about the falls’, no further information was provided as to the outcome or follow up regarding the falls or the issue of swollen feet; and
* Progress notes for a consumer (HCP L3) sighted by the Assessment Team completed in June 2023 by a support worker documented that the urine bag was a hot purple colour. The consumer advised the support worker that this was from their medication, however, there was no further documentation to support that this was followed up.

One coordinator described that support workers who visit the consumers they manage, write progress notes after every visit which are then sent through via email and read by them at the commencement of each day. This enables them to action any changes. Support workers also speak with this coordinator or call to discuss any concerns regarding consumers. This assures that any deterioration is followed up. However, the Assessment Team noted:

* This does not occur for all consumers as rural support workers do not attend the office prior to their shift which results in the above transfer of information not occurring;
* One support worker interviewed advised that they complete notes and also send an email to their coordinator however are concerned that sometimes the information passed on, is not actioned; and
* One coordinator advised that staff attending CHSP consumers only, document progress notes intermittently.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

*Requirement 3(3)(e)*

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that information about consumer’s needs, preferences, conditions, and changes are consistently and effectively documented and communicated within the organisation, and with others where responsibility for care is shared. For example:

* A consumer (HCP L4) advised that sometimes he needs to direct the staff in how to apply their psoriasis cream, the Assessment Team identified the reason for this being insufficient notes and directions within the care plan for care workers.
* A discharge letter from Royal Darwin Hospital for a consumer of the service dated in September 2023 showed the diagnosis of lower leg aneurysm, the letter also stated if the consumer experiences any red flags such as increasing pain or skin tenting the consumer should present to the emergency department for urgent review and possible surgical intervention. The Assessment Team noted this important information from the hospital staff regarding signs to observe for, and act on immediately, were not documented on the consumer’s service plan to alert support workers.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

*Requirement 3(3)(f)*

Although the service was able to demonstrate timely and appropriate referrals to individuals, other organisations and providers are made for some consumers, the service was not able to demonstrate that this is happening consistently for every consumer. Consumers and/or representatives interviewed by the Assessment Team described how the service has not actioned referrals to ensure they receive the care they need. For example:

* A consumer (HCP L2) when interviewed by the Assessment Team advised that they are just ‘sort of managing’. The consumer described their balance as ‘hopeless’ and explained that they currently utilise an office chair to mobilise in their home and an electric scooter to mobilise when out of the house due to their limited movement. The consumer stated that they were supposed to have an OT assessment in June 2023, but it didn’t happen. The consumer advised the Assessment Team they had since relinquished their HCP and will be receiving services on a private basis; and
* The Assessment Team noted an assessment for consumer (HCP L3) in March 2023 showed that they were experiencing urinary incontinence and this had not been previously documented. There was no evidence to support that this had then prompted a referral for an assessment with a GP or for a continence assessment. A support worker advised the Assessment Team that the consumer had been experiencing urinary continence for many months prior to this assessment and had been using paper towel in his underwear to absorb the urine. They had spoken to the coordinator regarding this multiple times and requested referral for continence aids, however there had been no intervention for many months until another coordinator stepped in to assist in accessing continence aids.

The Decision Maker notes while the examples above related to HCP services the evidence included in the Assessment Team Report substantiated these systemic deficiencies across both HCP and CHSP services.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

**Requirements 3(3)(a), 3(3)(c) and 3(3)(g) – Compliant**

Requirement 3(3)(a)

Evidence analysed by the Assessment Team showed the service was able to demonstrate that they ensure each consumer gets safe and effective clinical care that is best practice, tailored to their needs, and optimises their health and well-being. Consumers expressed satisfaction with the care and services they receive. Notwithstanding the deficiencies identified in Standard 2, the service demonstrated consumers who are assessed as requiring personal and clinical care, receive the care to meet their needs to optimise their health and well-being. Support workers and coordinators demonstrated an understanding of consumer’ service needs and preferences as they knew the consumers well. Support workers interviewed could discuss consumer’s needs regarding their personal care and advised they get to know their consumers over time to ensure they are providing the care they require. Staff and management interviewed from fully subcontracted services providing care to rural consumers advised the Assessment Team that they have an RN and an Enrolled Nurse (EN) on staff who oversee the clinical and personal care and use standardised assessment tools when assessing consumers.

The Decision Maker determines this requirement to be met based on the care the majority of consumers sampled received was safe, effective and best practice. The service has a significant number of deficiencies in relation to Standard 3 in particular involving documentation, however these deficiencies have been recorded in the above Requirements.

Requirement 3(3)(c)

Evidence analysed by the Assessment Team showed the service was able to demonstrate they respond appropriately to support the needs, goals and preferences of consumers nearing the end of life to maximise their comfort and preserve their dignity. One coordinator when interviewed described, and provided documentation confirming, how they supported one consumer nearing end of life and through palliative care. Care planning documentation analysed by the Assessment Team for a consumer (HCP L4) showed that the service maintained ongoing communication with the consumers’ GP, community palliative care team and with the consumer’s son and daughter in law including in relation to comfort care and respite for family.

Requirement 3(3)(g)

Evidence analysed by the Assessment Team showed the service was able to demonstrate they minimise infection related risks through the implementation of standard and transmission-based precautions to prevent and control infections. Consumers and/or representatives advised that staff keep them safe with the use of masks and health checks. Staff and management described the service’s processes for minimising risks of infection including policies, procedures, and education. Staff and management advised that staff are provided PPE to wear when attending consumers’ home and documentation analysed by the Assessment Team included evidence of staff infection prevention and control training, vaccinations and organisational policies and procedures including Infection Control, Antimicrobial Stewardship and an Epidemic Pandemic Response plan.

# Standard 4

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

**Requirements 4(3)(a), 4(3)(b), 4(3)(d) and 4(3)(e) – Not Compliant**

Requirement 4(3)(a)

Evidence analysed by the Assessment Team showed the service was not able to demonstrate 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. Consumers were not satisfied that the services provided at home and in the community, help support the consumer’s independence, wellbeing and quality of life. Consumers when interviewed by the Assessment Team stated they often did not receive the services they need as there were no staff undertake the services. Both HCP and CHSP consumers stated they generally required more domestic assistance, but the service was not able to provide it. For example:

* A consumer (CHSP) stated when interviewed that their domestic assistance was dropped to one hour in October 2022. The consumer has queried this and still has no response from the service. The Assessment Team noted the consumer has medical reports and records that they have forwarded to the service, which state the consumer needs more domestic assistance due to their injury. The service informed the consumer they do not have the staff to support more than one hour per week. The consumer stated this is not enough and gets embarrassed when their home is not clean, and this affects their well-being;
* A consumer (CHSP) stated during interviews with the Assessment Team they had told the service a number of times that they have to boil a kettle and carry the hot water in a bucket on their walking frame to wash in the shared amenities at the premises the consumers reside at. Staff when interviewed stated they have addressed this with the co-ordinator, but nothing has been done. The consumer explained that this is distressing for them as they are frightened to carry the water, so the consumer rarely bathes, which also affects their independence and dignity; and
* During interviews with the Assessment Team staff described how they often don’t document all conversations on consumer files and that not all notes are followed up when they do. Little to no documentation results in changes to the needs of services and supports for daily living being missed for both HCP and CHSP consumers.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

Requirement 4(3)(b)

Evidence analysed by the Assessment Team showed the service could not demonstrate that it has supports in place to promote each consumer’s emotional, spiritual and psychological wellbeing for consumers. Although staff demonstrated that they are aware of individual consumer’s needs in relation to their emotional, spiritual and psychological well-being, it is not always documented or followed up. For example:

* Care planning documentation for CSHP clients sampled did not show referrals to social workers or counselling for consumers requiring additional emotional support;
* During interviews with the Assessment Team management could not describe nor provide a policy and/or procedure for staff to follow if they observe a consumer who is feeling low, and further stated that there is also no policy on documenting notes of this nature into the care planning system used for consumers; and
* A staff member stated that a consumer (CHSP) has stopped attending the social support group due the emotional stress caused by an outstanding debt that the consumer is unable to get clarified by the service. There is no evidence to show the service has implemented measures to resolve the issue or manage the emotional and psychological wellbeing of the consumer.

The Decision Maker notes while the examples above related to CHSP services the evidence collected and analysed by the Assessment Team substantiated these systemic deficiencies across both HCP and CHSP services.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

Requirement 4(3)(d)

The service was not able to demonstrate that information about consumers’ needs, conditions, goals, and preferences is documented and communicated within the organisation, and with other organisations where responsibility for care is shared, for both HCP and CHSP consumers. Staff and management described ongoing communication with consumers and/or their representatives, allied health staff and subcontracted service providers, but this was not documented for all consumers. For example:

* While one co-ordinator described how they communicate consumer information to other staff within the service, and external medical professionals, organisations, and service providers, through email and on electronic systems where required, this was not consistently evidenced for other coordinators managing CHSP and HCP consumers. During interviews with the Assessment Team one coordinator advised they did not follow the above processes, due to being new to their role;
* The Assessment Team noted there is no documentation on any CHSP consumers sampled that show where other services are sharing care; and
* Staff and coordinators explained that there is no procedure to follow when it comes to referrals, they just suggest what services they know, both for HCP and CHSP consumers.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

Requirement 4(3)(e)

Evidence analysed by the Assessment Team showed the service was not able to demonstrate timely and appropriate referrals to individuals, other organisations and providers occur for consumers. Consumers interviewed in relation to this requirement advised they would seek referrals from other organisations, such as My Aged Care or their medical practitioner. The service did not demonstrate effective systems and processes to ensure an effective network of external providers they can refer to, or collaborate with, to meet the needs of consumers for their daily living. For example:

* There are currently no processes in place for referrals and due to inexperienced staff being in coordinator roles, many are being missed;
* Staff when interviewed described instances of informing coordinators of consumers who needed to be referred for another service or allied health area but stated these rarely got followed up by all coordinators;
* Staff, coordinators, and management were not aware of complimentary community services available in the area to be able to refer consumers, to meet or assist in the needs of their daily living; and
* Management was not aware that staff could view equipment that is available to the elderly and those with mobility issues, so staff had no knowledge of what products were available to consumers post referrals.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

**Requirements 4(3)(c), 4(3)(f) and 4(3)(g) - Compliant**

Requirement 4(3)(c)

Evidence analysed by the Assessment Team showed the service was able to demonstrate services and supports for daily living assist consumers to participate in their community, have social relationships, and do things of interest to them. Consumers and/or representatives when interviewed confirmed that social support and transport services enable them to participate in their community and maintain relationships. Coordinators described how they encourage and support consumers to access and participate in their community. For example:

* Coordinators when interviewed described how they develop a monthly calendar of group activities in consultation with consumers to support their interests, and outlined the range of activities, services and supports provided to consumers. The Assessment Team noted consumer feedback is always sought following group activities and day trips to inform future outings.

Requirement 4(3)(f)

Evidence analysed by the Assessment Team showed the service was able to demonstrate that where meals are provided, they are varied and of suitable quality and quantity. Consumers interviewed in relation to this requirement advised they contribute to menu options when they attend social support group activities and expressed satisfaction with the meals provided. Consumers receiving meal delivery services when interviewed by the Assessment Team stated they were satisfied with the quality of the meals provided. For example:

* Staff and co-ordinators advised that meal plans are rotated in consultation with consumers to identify their preferences; and
* The Assessment Team viewed information documented and clearly displayed at the point of service delivery regarding consumers’ dietary requirements and preferences.

Requirement 4(3)(g)

Evidence analysed by the Assessment Team showed the service was able to demonstrate that, when equipment is provided, it is safe, suitable, clean, and well maintained. Consumers sampled in relation to this requirement confirmed that equipment received and/or installed was suitable to their needs. Coordinators and staff when interviewed by the Assessment Team described the processes related to the assessment, procurement and maintenance of equipment and home modifications, and this was confirmed through service planning documentation viewed by the Assessment Team. For example:

* Consumers interviewed stated that they were very happy with equipment provided and that it was clean and suitable for their needs;
* Coordinators interviewed confirmed they undertake a visual inspection of the consumer’ equipment as part of their review process. Whilst it is not always documented, they do ensure its suitability and condition; and
* Staff interviewed stated when they notice a consumer has equipment that requires maintenance or replacement, they notify the coordinator.

# Standard 5

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

Findings

**Requirements 5(3)(b) – Not Compliant**

Requirement 5(3)(b)

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that the service environments are well maintained. While the service environments, including the activity room, transport vehicles and kitchen were clean and enabled consumers to move around freely, the service could not demonstrate there are effective systems in place to ensure the environments were safe. Staff and management described the process for cleaning and consumer safety, however, could not provide maintenance registers to evidence this. For example:

* The Assessment Team noted staff have an ‘eyes on’ approach and fix any maintenance issues as they occur and fix where possible. Staff do not document or report this anywhere;
* Staff when interviewed were unable to describe the process of logging a maintenance request, other than informing the Aged Care Manager of any issues. The Assessment Team noted there is no way to monitor if these issues are addressed;
* Whilst there is a vehicle booking section in the current electronic system used by the service, this is not always utilised to monitor correct usage of vehicles. Staff when interviewed explained that often they just ‘grab whichever vehicle they can find the keys to’. The Assessment Team noted there is no oversight in vehicle usage or maintenance needs and the service was unable to demonstrate how they monitor maintenance of all the vehicles in their fleet.
* The Assessment Team noted the service was unable to demonstrate monitoring and oversight on asset maintenance due to lack of correct information on assets based on having an insufficient asset register.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

**Requirements 5(3)(a) and 5(3)(c) – Compliant**

Requirement 5(3)(a)

Evidence analysed by the Assessment Team showed the service was able to demonstrate the service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. Consumers when interviewed confirmed they feel welcome when they attend the social support group sessions. Coordinators and staff described how they ensure consumers feel welcome and observations confirmed the social group environment was easy to understand, welcoming and functional. For example:

* The Assessment Team observed posters and brochures in multiple languages available to consumers, a clean and tidy reception area and a large bright room and garden areas for consumers to freely socialise; and
* The Assessment Team observed consumers arriving for social support group and noted staff and coordinators were friendly and helpful, assisting consumers into chairs and storing walking frames and other mobility equipment out of the way of thoroughfares.

Requirement 5(3)(c)

Evidence analysed by the Assessment Team showed the service was able to demonstrate fittings and equipment are safe, clean, well maintained, and suitable for the consumer. Consumers expressed satisfaction with the fittings and equipment provided. Management described processes to ensure tools and equipment are clean and well maintained, this was confirmed through observations. Whilst there is no accurate asset register or maintenance log at the date of the quality audit, staff are very aware and proactive in the cleanliness and maintenance of furniture, fittings and equipment.

* Staff and co-ordinators described the process for checking all equipment for the social support group activities, cleaning and ensuring it is fit for purpose;
* Staff and coordinators advised that they are provided with hand sanitiser and wipes to ensure the equipment is clean; and
* The Assessment Team observed fittings, furniture and equipment to be safe, clean and operating functionally.

# Standard 6

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

Findings

**Requirement 6(3)(d) – Not Compliant**

Requirement 6(3)(d)

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that feedback and complaints were effectively reviewed and used to improve the quality of care and services. The Assessment Team noted the service does not have an effective feedback and complaints management system to inform continuous improvement activities.

Evidence analysed by the Assessment Team showed the service currently utilises a paper-based feedback register that was recently updated to include greater detail including action taken, progress, outcome and date completed. However, the Assessment Team noted, and management acknowledged that it is difficult to capture the information in this format to enable effective oversight, trending and reporting of feedback to executive management.

The service presented two continuous improvement plans, one was last updated in May 2022 and the other was on an electrotonic platform that held three actions. However, these documents had not been updated or utilised to capture any further work to be implemented to review the service’s systems or processes to improve the quality of care and services for consumers.

Review of meeting minutes at support worker, coordinator and manager level did not evidence that feedback and complaints are discussed to understand trends and take appropriate action to ensure that outcomes for consumers are improved.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

**Requirements 6(3)(a), 6(3)(b) and 6(3)(c) – Compliant**

Requirement 6(3)(a)

Evidence analysed by the Assessment Team showed the service was able to demonstrate consumers and their care partners are encouraged and supported to provide feedback and make complaints. All consumers and representatives interviewed stated they are encouraged to provide feedback to the service. Staff and management described their processes for encouraging and obtaining feedback from consumers regarding the services delivered. For example:

* The Client Handbook provides detailed information regarding processes for internal and external reporting of feedback and complaints. While the Handbook outlines that annual surveys are conducted, the service advised this has not occurred and will be something they will consider in the future.

Requirement 6(3)(b)

Evidence analysed by the Assessment Team showed the service was able to demonstrate that consumers are made aware of, and have access to advocates, language services and other methods for raising and resolving complaints. Staff and management discussed processes to ensure consumers have access to advocates and language services if required, and consumers are made aware of other methods for raising and resolving complaints. For example:

* Staff advised they are aware of translating and interpreting services, and external complaints avenues, and would support consumers and representatives to raise concerns through to the relevant complaint bodies; and
* The Client Handbook is written in easy English and has pictorial prompts to assist consumers who may have limited literacy.

Requirement 6(3)(c)

Evidence analysed by the Assessment Team showed the service was generally able to demonstrate appropriate action is taken in response to complaints and open disclosure process is used when things go wrong. Consumers and/or representatives stated that the service generally acts on feedback provided. While management described how consumer feedback is addressed and documented for consumers and/or representatives, documentation showed that complaints were not consistently documented and actioned in a timely manner and elements of open disclosure were not consistently implemented to ensure satisfactory resolution for complainants. For example:

* A consumer (HCP L2) advised they had been frustrated with understanding the application of the Income Tested Care Fees since March 2023, that they were required to pay and has been working with the service and their advocate to come to some resolution regarding this. Further confusion has been attributed to the consumers monthly statements not clearly stating the fees. A complaint was also lodged with the Commission however, the consumer was unsure of the outcome. The consumer has nominated to receive their current services as of September 2023 through a private arrangement with the subcontracted staff and will relinquish their Home Care Package at this stage, until such time that the consumer identifies that they require further assistance;
* The Assessment Team noted the feedback register held mainly feedback and complaints regarding the variety of meals and the Meals on Wheels Coordinator was able to demonstrate their processes for ensuring that feedback was actioned, and ongoing consultation was held with consumers to ensure their individual preferences were generally met; and
* While the service has a complaints and feedback policy dated October 2023 which provides staff guidance regarding the timely resolution of simple, regular and urgent complaints, the Assessment Team noted through review of progress notes for sampled consumers that not all feedback and complaints were being captured in the Feedback Register to enable aged care management to have the appropriate oversight of the resolution of the complaints.

Notwithstanding the deficiencies identified by the Assessment Team regarding the management of complaints, no impact was identified for current consumers, and management acknowledged this could be an area for continuous improvement. Therefore, the Decision Maker finds that, on balance, this requirement is compliant. As deficiencies were accounted for in Requirement 6(3)(d).

# Standard 7

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

**Requirements 7(3)(a), 7(3)(d) and 7(3)(e) – Not Compliant**

Requirement 7(3)(a)

Evidence analysed by the Assessment Team showed the service was not able to demonstrate 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 services. Some consumers and/or their representatives sampled, and documentation showed the service cannot consistently meet the assessed needs of consumers due to staff availability, particularly in the rural areas, however, management described issues of over resourcing and over servicing of consumers. Support workers and coordinators discussed some issues with timeliness of rosters and the ability to provide care and services against consumers’ assessed needs. For example:

* As detailed in Standard 2, a consumer (CHSP) advised the Assessment Team that they had requested assistance with personal care, however, had been advised that the service does not have staff available to assist.

Evidence analysed by the Assessment Team showed the service could not demonstrate effective rostering processes in place for both CHSP and HCP consumers’ care and services to ensure unassigned and cancelled shifts are monitored, and any impacts to consumers are understood and reported to management to further refine the service’s workforce strategy. For example:

* The Unassigned Visits report for the period 15 August to 12 September 2023 showed forty-two services were unassigned, including medication prompt visits, social support individual, domestic assistance and transport services for both CHSP and HCP consumers in both the metropolitan and rural areas. The Assessment Team noted the service could not describe the reason for the unassigned shifts.

Management described financial viability issues due to an organisational understanding that there has been some overservicing occurring with some consumers, based on their requests for services. In addition, they advised the service is over resourced, however, neither the service nor the organisation could demonstrate how they undertake effective workforce planning to determine the number and mix of staff they require to meet the assessed needs of their consumers.

Following feedback from the Assessment Team, both aged care management and management acknowledged that they are limited in the service’s understanding of the workforce requirements to meet the assessed needs and deliver care and services for consumers and will undertake actions to better address this in the future.  
The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

Requirement 7(3)(d)

Evidence analysed by the Assessment Team showed the service was not able to demonstrate that the workforce is recruited, trained, equipped and supported to deliver the outcomes required by the Quality Standards. Management could not demonstrate systems and processes to ensure that staff complete the requisite training and could not demonstrate how staff are equipped and supported with policies and procedures to guide their practice.

While the service could demonstrate that management, coordinators, and support staff have the requisite qualifications as required by the organisation, there were ineffective systems in place to train, equip and support staff to enable them to be effective in their roles to manage, coordinate and deliver the care and services to their aged care consumers. For example:

* The service has access to an online training platform to provide training to staff. The Assessment Team noted that approximately forty modules were allocated as mandatory modules for staff to complete. However, only two of twenty-four staff were compliant in completing all modules allocated; and
* One staff member when interviewed stated that while they are aware of the training available, they do not have the time to undertake this training due to prioritising their work in their work time. However, while support workers do attend the office and may be allocated to complete some online training, this is not monitored for completion.

Management advised that following four resignations of aged care management and coordination staff in May 2023, the organisation has promoted from within, to appoint an aged care manager, a senior care coordinator, and three coordinators. While four of the five staff appointed had worked within the aged care service in other roles, the Assessment Team noted through interviews with staff and review of care documentation that staff have not been supported by the organisation to understand the breadth and complexity of their roles, have defined key performance indicators regarding their increased responsibilities in order for the staff to be able to deliver the outcomes for consumers, as required by the Quality Standards. For example:

* Care documentation did not demonstrate that coordinators are effectively documenting their contacts with consumers and representatives, and other organisations providing care, and subsequent actions undertaken as a result of the contact to ensure continuity of care and to enable appropriate oversight by aged care management.
* The Assessment Team noted varying levels of skill and competence of coordinators and aged care management with using the electronic systems, to enable reports to be run and provide appropriate oversight of the delivery of care and services for consumers.

While the service has recently implemented coordinator and support worker meetings, one support worker advised they could not attend the meeting and did not receive an update or the minutes for them to stay updated on what had been discussed. The Assessment Team noted minutes recorded minimal information to enable staff who have not attended to understand what was discussed at the meeting.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

Requirement 7(3)(e)

Evidence analysed by the Assessment Team showed the service was not able to demonstrate regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. The Assessment Team viewed documentation that showed while there is a system to monitor performance reviews and development of staff, this has not been effectively managed to ensure staff receive formal feedback, and identify training and support needs of staff.

One support worker when interviewed stated they have not participated in a formal performance review since commencing with the service in early 2022 and would like the opportunity to speak to someone about further training and support options.

The human resource manager advised they have recently changed the timeframes for performance reviews from anniversary date to July and December to better oversee the completions of the performance reviews for staff. The Assessment Team viewed the Staff Details Spreadsheet which showed of twenty-four aged care staff recorded:

* Six aged care staff with no date identified for when their annual performance is due. Five staff had been employed for longer than one year; and
* Fourteen staff are recorded as being currently overdue for a performance review.

The Assessment Team noted the service does not have implemented systems in place to monitor the performance of subcontracted services providing care and services to their consumers.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

**Requirements 7(3)(b) and 7(3)(c) – Compliant**

Requirement 7(3)(b)

Evidence analysed by the Assessment Team showed the service was able to demonstrate workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture, and diversity. Consumers and/or their representatives interviewed, advised staff were kind, caring, supportive and respectful of their respective cultures. A consumer (CHSP) advised that staff are ‘absolutely fantastic’ and nothing is ever too much of a bother for them. The consumer stated that he calls the service to praise and compliment the staff whenever they receive a good service. The Assessment Team noted the feedback register showed a compliment from a consumer complimenting the lifestyle coordinator on the wonderful job they are doing. Staff described, and the Assessment Team observed, how they provide care and services to consumers in a kind and respectful manner including how they respect their privacy and decisions.

Requirement 7(3)(c)

Evidence analysed by the Assessment Team showed the service was generally able to demonstrate the workforce is competent and has the knowledge to effectively perform their roles. Consumers when interviewed by the Assessment Team advised they felt the workforce is competent and skilled. Management when interviewed demonstrated that staff employed have the requisite qualifications as determined by the organisation. The Assessment Team noted:

* All consumers and representatives when interviewed described in various ways that they are confident in the staff’s skills and ability to deliver care and services;
* Management described and documentation showed that staff employed have either completed the Certificate III in Individual Support or are in the process of completing it. In addition, four staff members are currently being supported to update their qualification to a Certificate IV through a local registered training organisation; and
* Management advised and documentation analysed showed how the organisation maintains a register to monitor currency of driver licences, national police checks, first aid training and cardiopulmonary resuscitation updates for aged care staff.

# Standard 8

|  |  |  |  |
| --- | --- | --- | --- |
| Organisational governance | | HCP | CHSP |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | **Compliant** | **Compliant** |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | **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

**Requirements 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e) – Not Compliant**

Requirement 8(3)(b)

Evidence analysed by the Assessment Team showed the organisation was not able to demonstrate that the governing body promotes a culture of safe, inclusive, and quality care and services and is accountable for their delivery. While management could describe how they have been monitoring the financial aspect of the aged care service and how they have recently engaged with an external consultancy service to provide guidance on organisational governance and mentoring for the recently appointed acting aged care manager, evidence provided did not demonstrate that there is appropriate oversight of the aged care service.

Following ongoing financial losses in the aged care service over the past four financial years, a paper was presented to the Board on 17 August 2023. The paper outlined the key issues, current concerns, and remedial actions taken to address the financial viability of the operations of the aged care service, however, the Assessment Team noted this does not include a review to ensure the quality and safety of care and services of consumers is not jeopardised in this process.

The Assessment Team noted the organisation does not currently request the aged care service to report on any quality and clinical indicators to ensure the accountability of the care and services to consumers is being appropriately monitored by the organisation and the Board. The organisation was involved in a Service Development Assistance Panel Support (SDAP) project from February 2022 to February 2023 undertaken by the external consultancy service. The scope of the project was to address key concerns and consult on the aged care service including assistance to update their policies and procedures, handbooks, and operational guides, financial processes to support timely reporting and management of funds and improvement on the delivery of quality care supported by sound practices. While the report with twenty-seven recommendations was received in February 2023, aged care management and executive management could not describe what action was undertaken to review, consider and implement the recommendations contained in the report.

While the external consultancy service’s paper on ‘Governance for Aged Care’ outlines the essential information that the Board requires to effectively govern the aged care service, no current reporting has been implemented since the 10 May 2023 Board meeting, when this information was presented.

The organisation was not able to demonstrate that appropriate procurement and oversight has been undertaken for subcontracted services currently delivering care and services to ensure that the services are delivered in line with the Quality Standards, other regulatory requirements, and best practice.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

Requirement 8(3)(c)

*Information management:*

The organisation was unable to demonstrate effective information management systems and processes are in place to support staff in their roles and to meet the outcomes required by the Quality Standards. While the organisation has organisational policies and procedures, and the service has 105 aged care specific policies and procedures, executive management interviewed did not have knowledge of these aged care policies and procedures in order to have the appropriate oversight. The Assessment Team noted aged care management advised the policies and procedures are available on the hard drive, which coordinators have access to and advised support workers have access to a folder in the office. When the Assessment Team asked to view the folder, aged care management were unable to locate it. The service could not articulate which position would be responsible for reviewing the aged care policies and procedures and ensuring they are fully implemented into their systems.

As documented in Standard 2 the service develops and updates a service plan when the consumer is assessed, however, the service plan is only accessible to the coordinators on the electronic system. Support workers have access to service notes on their mobile phone application, which contains limited information regarding consumers’ risks, assessed needs and preferences and does not provide detailed guidance on strategies to provide care and services to minimise risks to consumers.

*Continuous Improvement:*

The organisation service was not able to demonstrate an effective continuous improvement system and processes in place to assess, monitor and improve the quality and safety of care and services provided by the service. While the service provided a plan for continuous improvement, the Assessment Team noted it was dated 23 November 2021, and did not show that this document was being utilised to document and track planned improvements being undertaken by the service.

Aged care management showed the Assessment Team a separate quality and compliance mapping system, coverage, which was introduced by the external consultancy service to provide awareness of the Quality Standards and document planned actions, however, this was not being utilised by the service or the organisation to track planned improvements and evaluate completed actions for effectiveness.

The organisation did not demonstrate that following the receipt of the SDAP report in February 2023, they utilised this information to map the twenty-seven recommendations and document decisions and actions against each recommendation.

*Financial Governance:*

The organisation was not able to demonstrate that it has established financial management processes to ensure appropriate financial governance in place for the delivery and oversight of the CHSP and HCP services.

While the service could demonstrate how changes to the HCP fees introduced on 1 August 2022 had been communicated to consumers, no evidence was provided regarding the communication to CHSP consumers for changes to client contributions implemented prior to and updated on 1 March 2023. Management stated this is explained to consumers in person by their support workers when they deliver the fact sheets to consumers, however, could not describe how they have equipped support workers to enable them to explain fees and charges to consumers.

As documented in Standard 1 some CHSP consumers interviewed, and staff described how debts have accumulated following the implementation of client contributions and how for two consumers, they have chosen not to attend the social support group due to shame regarding their debts. The Assessment Team viewed the receivables reconciliation report dated 1 September 2023 which showed:

* Eighty-four CHSP consumers have recorded debts totalling $45,144.03, a further forty-two consumers were owed a total of $12,944.08 as a result of automatic Centrepay deductions that had been actioned when care and services had not been delivered.

The chief financial officer advised they have an established process regarding the refunding of deductions for consumers who did not receive the service, however, for thirty-five consumers, their reimbursement has been outstanding for over ninety days.

While the service has a Client Fees, Budgets and Deductions policy dated October 2022, which outlines that in charging fees, consumers will be assessed regarding their capacity to pay a fee and where a consumer does not have a capacity to pay, may have their fee reduced. A verbal explanation of fees and fee breakdown will be provided as part of the initial agreement and whenever fee changes occur, and a written copy of the Fees policy and any related information will be provided where requested by the consumer or their representative. In addition, consumers living in their homes and receiving the aged pension will be expected to contribute no more than 17.5% of the current basic aged pension for a single person. The Assessment Team and aged care management confirmed:

* The fees for CHSP charges are within the reasonable range of client contributions as outlined in the CHSP Manual 2023 to 2024;
* The service does not have a Fees policy;
* No assessment of the consumers’ capacity to pay has been undertaken at initial assessment or when their circumstances change;
* Executive management were not aware of the Client Fees, Budgets and Deductions policy; and
* Neither aged care management nor executive management could identify the monetary value of 17.5% of the current basic aged pension for a single person.

*Workforce governance, including the assignment of clear responsibilities and accountabilities:*

While the organisation has policies and procedures in place in relation to workforce governance, the organisation was not able to demonstrate that there is effective workforce planning in place, and that the workforce is competent, supported and developed to deliver safe and quality care and services to consumers.

As documented in Standard 7 the organisation does not have a clear understanding of the number of staff required to provide care and services against the assessed needs of consumers. As documented in Standard 7 the organisation has not ensured recent staff promoted to aged care coordination and management positions have the requisite skills, knowledge, experience and support to ensure the effective management, coordination, delivery and oversight of consumers receiving services. While the aged care manager is currently receiving mentoring support from the external consultancy service, the organisation has not ensured there are effective systems in place and executive management support to enable the new incumbents to perform their duties effectively and in accordance with the requirements of the Quality Standards.

*Regulatory Compliance:*

Evidence analysed by the Assessment Team showed the organisation did not demonstrate effective systems and processes in place to support the service to meet regulatory requirements in respect to the implementation and monitoring of regulatory and contractual requirements as required for the delivery of HCP and CHSP service delivery.

Aged care management and executive management advised they receive information to ensure compliance with all relevant legislation, regulatory requirements, and guidelines through the external consultancy service and subscription to Australian Government emails, webinars, and other relevant correspondence. However, the Assessment Team noted that this has not been effective to recognise and meet mandatory reporting requirements for the Serious Incident Report Scheme (SIRS) and Aged Care Code of Conduct. For example:

* In March 2023, a consumer (HCP L4) requested to be taken to a shopping centre following a medication prompt service. The support worker did not request approval for this additional service and did not ensure the consumer had their mobility aid with them when being dropped off. Following the progress note being entered by the support worker regarding the unfamiliar location of where the consumer was taken, the coordinator became aware and concerned that the consumer would not be able to find his way back home. The service directed some staff members to look for the consumer, advised the CEO, provided photographs of the consumer to the Bus link and Transit security and provided his description to the Larrakia night patrol for assistance with locating the consumer. Police were not notified of the consumer being missing until the morning of the next day. The consumer was subsequently found at their home by the police two days after the initial departure;
* The service did not recognise their requirement to make a SIRS report regarding the consumer being missing; and
* Following a review of the incident which included recommendations, the previous aged care manager identified ‘Note from 1.12.2022 a new Aged Care Worker Code of Conduct was instituted, and it could be suggested that Code items D and F were not followed on this occasion.’ There was no evidence provided to the Assessment Team that the organisation recognised their responsibility to report this incident to the Commission.

While the organisation could demonstrate a system for the responsibility for ensuring a current police check is monitored for staff at the service, there was no evidence provided to support the monitoring of police checks for executive decision makers, including Board directors.

*Feedback and Complaints:*

Evidence analysed by the Assessment Team showed the organisation was not able to demonstrate effective systems and processes to monitor, analyse and report feedback and complaint data to improve the quality of care and services. As documented in Standard 6 the service could not demonstrate there is an effective complaints management system that ensures complaints are documented in a format that allows the oversight of the complaint to ensure it is addressed in a timely manner to a satisfactory outcome for consumers and that an open disclosure process is used when things go wrong. The organisation does not request or review consumer feedback and complaints to understand trends to improve the delivery of care and service to consumers.

Executive management acknowledged that their governance systems have not been effective to support the organisation to have the appropriate oversight and monitoring to support the aged care service. They advised they will map and action the identified deficiencies to ensure that effective systems are implemented in order to have the requisite oversight of the provision of safe and quality care and services to their consumers.

Requirement 8(3)(d)

The organisation was not able to demonstrate effective risk management systems and practices in place, 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.

*Managing high-impact or high-prevalence risks associated with the care of consumers:*

The service did not adequately demonstrate effective risk management systems to manage and monitor high impact or high prevalence risks to inform the delivery of safe and effective care for each consumer. The Assessment Team noted that consumer risks are inconsistently identified in assessment processes, and while some information informs the care plan, information on the service note that staff receive was not consistently sufficient to enable them to mitigate the risks for consumers at point of care.

Staff and management described how they triage consumers to ensure they receive prompt interventions to manage their assessed needs. This includes discussion of consumers requiring assistance ongoingly with coordinators, staff and management. While management advised alerts are entered for consumers with associated risks, the service could not identify consumers with high impact and high prevalence risks for the Assessment Team to sample.

Aged care management advised they are in the process of developing a register to identify consumers at risk, which will be accessible to coordinators and discussed at monthly meetings.

*Identifying and responding to abuse and neglect of consumers:*

The service could not demonstrate processes are in place to identify and respond to abuse and neglect of aged care consumers, and that while staff had been allocated the online module for elder abuse education, this was not monitored for completions. As document above, while the previous Aged Care Manager identified possible breaches of the Aged Care Code of Conduct relating to a consumer being a missing person for over 48 hours, no report was made to the Commission. In addition, the representative of the consumer expressed concerns to the Assessment Team regarding the welfare of their family member, following an unrelated person moving in with this consumer and accessing his money. While the representative advised they have discussed this with the consumers coordinator on more than one occasion, progress notes viewed from 1 February 2023 to 15 September 2023 showed the consumer stating to support workers they were often hungry and did not have anything to eat in the home, however, did not evidence the discussions held between the representative and coordinator, nor any actions taken. Management advised it was a very complex family situation.

*Supporting consumers to live the best life they can:*

The service was not able to demonstrate there are effective policies, procedures, and processes in place to assess and consult with consumers for them to live their best life and be supported to take risks, as documented in Standard 1. Management and staff could not describe how they consult with consumers when risks are identified to support them to continue to maintain their independence with their activities of daily living, access the community, and have social interactions, whilst managing the risks, wherever possible. While the service has a choice and dignity of risk policy, coordinators were not aware of the policy.

*Managing and preventing incidents, including the use of an incident management system:*

The service was unable to demonstrate it has an effective incident management system, to ensure a systemic approach is taken to minimise the risk of incidents occurring. While the service demonstrated they record and respond to individual incidents, they were unable to demonstrate how they consistently undertake investigations and analysis to ensure corrective actions implemented are effective for the consumers impacted, and any reviews are undertaken to mitigate risks for other consumers, identified from lessons learnt.

The current incident register is a paper-based document that does not identify the consumer, does not provide sufficient detail to document immediate and remedial actions, nor allow for trending and reporting of incidents to the organisation for appropriate oversight.

While the service has Incident Management policies and procedures which provides detailed guidance on actions staff are required to follow, these policies are not fully implemented to ensure all responsibilities of the hierarchy of the organisation are embedded into their systems. The organisation could not evidence that consumer incidents are managed in accordance with the aged care legislation, including where incidents are required to be notified to the Commission as a reportable incident and, in some circumstances, the police.

Following feedback from the Assessment Team, management acknowledged there is room for improvement to ensure that the organisation implements and monitors effective risk management systems and practices to ensure the safety and quality of consumers’ care and services.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

Requirement 8(3)(e)

Evidence analysed by the Assessment Team showed the organisation was unable to demonstrate an effective clinical governance framework is in place to maintain oversight of clinical care provided to consumers.

While the service could demonstrate it has a documented clinical governance policy, the organisation was not able to demonstrate that systems and processes are fully implemented to have the appropriate oversight to ensure the reliability, safety and quality of the clinical care consumers receive.

The external consultancy service’s paper on ‘Governance for Aged Care’, which was included in the 10 May 2023 Board pack, provided guidance to the organisation and Board regarding the requirements for effective policies, procedures and systems in place to support effective clinical governance. However, at the time of the Quality Audit, this had not been actioned nor been planned for future development.

The CEO described, and the SDAP report dated February 2023 documented that, whilst the organisation does not have a requirement to establish a Quality Care Advisory Body as they are an approved Aboriginal Community Controlled Organisation, a decision has been made to establish the body as part of best practice.

As documented in Standard 7, while there is one coordinator who has undertaken the majority of their nursing degree, there are no other staff employed by the service who has clinical skills. While coordinators do receive support from the coordinator with clinical knowledge, this is not formalised.

While the service has an Open Disclosure policy, this is not fully implemented. In addition, staff and management could not describe how they recognise and minimise restrictive practices, as applicable in the delivery of home care services.

The Decision Maker notes the services responded proactively to the Assessment Teams findings and planned and/or already implemented corrective action. While on this occasion the additional details and evidence provided by the service in their response was insufficient for the Decision Maker to find the requirement compliant the Decision Maker notes these should make a positive difference, and result in far more compliance at the next Assessment Contact activity.

**Requirement 8(3)(a) - Compliant**

Requirement 8(3)(a)

Evidence analysed by the Assessment Team showed the organisation was able to demonstrate consumers and care partners are engaged in the development, delivery, and evaluation of services. Consumers and representatives described how they have input about services provided and management and staff described how consumer feedback received through formal and informal channels is used to influence the delivery of services.

Consumers and representatives sampled described in various ways how they engage with the service through feedback and discussions with staff providing services to modify the care and services consumers receive.

Management advised how they engage consumers and their representatives through the invitations to the organisation’s annual general meetings, and other events, including Christmas parties and barbeques to receive feedback regarding the quality of care and services. In addition, the Chief Executive Officer advised they visit the social support groups on a regular basis to connect with consumers and provide them the opportunity to provide feedback.

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)