**Performance**

**Report**

**1800 951 822**

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| Name: | LIFETEC AUSTRALIA LIMITED |
| Commission ID: | 700471 |
| Address: | level 3, 19 Lang Parade, MILTON, Queensland, 4064 |
| Activity type: | Quality Audit |
| Activity date: | 18 September 2024 to 20 September 2024 |
| Performance report date: | 4 November 2024 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

# Services included in this assessment

Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 7618 LifeTec Queensland Inc.  
Service: 23935 LifeTec Queensland Inc. - Community and Home Support

**This performance report**

This performance report has been prepared by Peter Frangiosa, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the services it operates, 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 service outlets, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 25 October 2024.

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Not Assessed** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Not Assessed** |
| **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 6(3)(d)** Feedback and complaints are reviewed and used to improve the quality of care and services.
* **Requirement 7(3)(e)** Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.
* **Requirement 8(3)(b)** The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.
* **Requirement 8(3)(c)** Effective organisation wide governance systems relating to the regulatory compliance and feedback and complaints.
* **Requirement 8(3)(d)** Effective risk management systems and practices, including but not limited to identifying and responding to abuse and neglect of consumers and managing and preventing incidents, including the use of an incident management system.

# Standard 1

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| Consumer dignity and choice | | CHSP |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | 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 |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Requirement 1(3)(e) was found not met following a Quality Audit undertaken from 18 September 2024 to 20 September 2024. The service did not demonstrate:

* 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

The Assessment Team was not satisfied the provider could demonstrate that each consumer is provided with the information required to ensure they are fully informed and empowered to make decisions about services they receive. The Assessment Team provided the following evidence to support their assessment:

* Consumers had not been informed of the Quality Audit or provided with the Notice of Collection. Management acknowledged this had not been completed as the instruction had been missed, however, informed as many consumers as possible after the initial meeting. Although management took initiatives to contact consumers, not all consumers were contacted.
* Sampled consumers receiving maintenance services confirmed they are not provided with a welcome pack or the charter of aged care rights. Management and staff confirmed this has not been provided to consumers receiving maintenance services as they only get ‘a magnet with service contact number’.
* Sampled consumers confirmed they do not get any information on advocacy services and translation services contact details. The Assessment Team noted this vital information is not outlined in the welcome pack to enable consumers to readily access these services.
* Information on external feedback and complaints processes is not provided to consumers to ensure they are empowered to raise concerns and the pathways available.

The Provider outlined the following in response to the Assessment Team’s report.

* Regarding Consumer Contact for Audit, the provider apologized for the oversight, with additional information including impacting internal and external factors including site relocation and personal impacts to staff and management.
* Actioning the inclusions within the consumer welcome pack. This will ensure all consumers are aware of the required resources on the Commission, advocacy, language services and complaints etc. This has been actioned with urgency.
* Regarding interpreter services, when working with individuals at intake, we ask them if they require an interpreter service. It is a question on our Intake Form (which we go through with our consumers) and allows us to engage with an interpreter as we identify from the intake process and book them in for the appointments we undertake as needed. The provider has an aged care account with The Translating and Interpreting Service (TIS).
* Determining consumer needs in our initial contacts so we can arrange interpreters as needed with our appointment bookings. We have never had an issue with a need for interpreters that was not determined from our intake process, and do not have long-term care arrangements with consumers where this matter may arise during their service provision. Nonetheless, TIS information has now been included in welcome packs for consumer’s use.
* Regarding advocacy, the provider with advocacy services regularly, including the Older Persons Advocacy Network (OPAN). Highlighting that the nature and limited appointment-based time of our engagement with consumers significantly reduces exposure to those who are looking for advocacy assistance. When consumers undertake a specific job, whether this is a Home Mods assessment, or some work undertaken by a tradesman. Nonetheless, the provider has already included the information on Advocacy services within our new welcome packs.

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with information provided in response. I acknowledge the provider has responded to the deficiencies, particularly with mitigating circumstances impacting the providers ability to deliver consistent services.

The intent of this requirement is to ensure timely and easily understood information vital for consumers to be able to make informed choices is provided. It’s expected that organisations communicate clearly and supply helpful resources about their care and services, including the care and services they offer, commitments and obligations.

I appreciate the provider’s response regarding identified deficiencies and timeliness in responding to them. Within the Assessment Team report, Management said they will ensure that all welcome packs include the charter of aged care rights, details on the external complaints process, and resources on advocacy networks. This item was sighted in Continuous Improvement Plan (CIP) with a completion target set for 30 September 2024.

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

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

Consumers and representatives stated consumers are treated with respect by staff. Staff described how they treat consumers with dignity and respect. Documentation showed detailed recognition of consumers’ identity, culture and diversity, with each consumer’s background, social, cultural, language and family composition recorded.

Consumers and representatives confirmed the service supports consumers to exercise choice and independence, with staff ensuring the consumer is provided opportunities to decide on services and care provided. Staff described how they support consumers to make day-to-day choices. Management discussed how the service has ongoing discussion with consumers to support consumer choice and independence. Documentation showed the service captures details about whom the consumers wish to be involved in decisions.

Consumers and representatives confirmed consumers feel confident to take risks around mobilising in the community. Staff confirmed they encourage consumers to undertake challenging tasks. Documentation showed the service has a dignity of risk procedure and waiver process for consumers undertaking higher risk activities.

Consumers and representatives confirmed staff respect and protect the consumer’s privacy. Staff described how they maintain consumer privacy and confidentiality by not sharing information with others who are not authorised to receive it. Management described the process for sharing personal and sensitive information only with those who require the information. Documentation confirmed the service uses a privacy consent process prior to sharing information with others.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 1, Consumer dignity and choice.

# Standard 2

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| Ongoing assessment and planning with consumers | | CHSP |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | 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. | 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. | 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. | 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. | Compliant |

Findings

Consumers and representatives confirmed assessment and care planning occurs. Care planning documentation showed assessment and planning considers risks to consumer health and well-being. The service uses validated tools to assess risks to guide the delivery of safe and effective care and services. Risks assessed include falls, pain, wounds and cognition. Staff confirmed they have access to care planning documentation to guide them on the care and services provided.

Consumers and representatives confirmed assessment and planning outcomes are reflective of what is important to the consumer to meet their needs and goals. Staff demonstrated awareness of what is important to each consumer, including the consumer’s needs and preferences for care. Staff and management described how assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and (palliative) end of life planning if the consumer wishes. Management explained care planning documentation is updated regularly based on ongoing assessment and planning processes. Documentation showed clear directives for staff to support the consumer based on the consumer’s assessed needs and goals.

Consumers and representatives confirmed the service involves them, and others they wish involved, in the care planning and assessment process. Staff and management demonstrated how assessment and planning occurs in partnership with consumers, the service and other health care professionals where necessary. Documentation showed assessment and planning involves the consumer and others the consumer agrees to be involved, including other organisations, individuals and other providers.

Consumers and representatives confirmed they receive assessment and care planning information and documentation, and staff know what they are doing. Staff confirmed they have access to care planning documentation to guide the care and services they provide for consumers. Documentation showed staff at the social support groups have access to clear directives in care plans to support consumers with their interests, likes, dislikes and medical conditions and HCP care plans have clear directives for staff.

Staff confirmed they receive access to updated care plans when services change with clear directives included. Management described how care is formally reviewed at regular intervals and when circumstances change or when incidents occur. Documentation showed regular reviews are conducted. Management advised they will ensure it is clearly documented new and updated care plans are provided to consumers.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 2, Ongoing assessment and planning with consumers.

# Standard 3

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

Findings

Standard 3 was not assessed as the Provider is not funded to deliver personal or clinical care.

# Standard 4

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| Services and supports for daily living | | CHSP |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | 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 |
| 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. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Consumers and representatives confirmed the services and supports for daily living the consumers receive support the consumers to optimise their independence and well-being. Staff described how individualised and effective services and supports for daily living meet each consumer’s needs, goals and preferences. Management stated feedback from consumers on activities would be part of the service’s activities calendar. Documentation showed assessments and care plans identify services and supports for daily living which promote individual consumer’s independence and enhanced quality of life.

Consumers and representatives expressed satisfaction with the supports for daily living received by consumers. Staff described how they recognise and support consumers’ emotional, spiritual and psychological well-being and how services provided meet those needs. Management demonstrated an understanding of supporting consumers in their emotional, spiritual and psychological well-being. Documentation showed evidence of support strategies to meet individual consumer’s emotional, spiritual and psychological well-being.

Consumers and representatives confirmed consumers participate in activities of interest to them in their homes and in the community. Staff stated they access information about consumers on the mobile application to guide them on how to support the consumer in their personal relationships. Management described processes used by the service to meet the social and personal needs of consumers. Documentation showed services and supports for daily living support consumers to participate in the community, do things of interest to them and have social and personal relationships.

Consumers and representatives confirmed the consumer’s needs and preferences are communicated during the assessment process. Staff confirmed they have access to each consumer’s needs and preferences through a mobile application. Management advised consumer care plans are available to staff through a mobile application and to subcontracted services through a service request process. Documentation showed care plans include clear directives about the consumer’s condition, needs and preferences.

Consumers and representatives confirmed the service supports consumers to access other services, including other lifestyle services where appropriate. Staff stated they will document concerns about consumers for management to review and make referrals where necessary. Management discussed processes used to refer consumers for additional care and higher-level packages. Documentation demonstrated the service refers consumers to organisations and providers for additional services and supports when necessary.

Consumers confirmed the food provided is satisfying and nutritious. Staff described how the service ensures appropriate meals are provided based on consumer needs and preferences, including allergies and likes and dislikes. Documentation showed the service has a documented emergency plan which identifies allergies, likes and dislikes of consumers and there are special directives for consumers with diabetes.

Consumers and representatives confirmed consumers have received equipment, which is safe, and suitable. Management described the assessment and ongoing processes to ensure equipment provided is suitable and safe for the consumer. Management stated equipment is checked at reassessment and will be serviced or replaced as necessary. Documentation showed equipment is selected for safety and suitability on the recommendations of allied health professionals.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 4, Services and supports for daily living.

# Standard 5

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| Organisation’s service environment | | CHSP |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Not Assessed |
| 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 Assessed |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Not Assessed |

Findings

Standard 5 was not assessed as the Provider does not have a physical service environment where care and services are delivered.

# Standard 6

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

Findings

Requirement 6(3)(b) - was found non met following a Quality Audit undertaken from 18 September 2024 to 20 September 2024.The service did not demonstrate:

* Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.

The Assessment Team was not satisfied the Provider was making consumers aware of external avenues to make complaints, advocacy and interpreting services available. Review of documents demonstrated consumers are not provided information in relation to external complaints mechanisms and advocacy services. Staff could not demonstrate how to access advocacy and translation services.

The Assessment Team provided the following evidence to support their assessment:

* Information on the external compliant mechanisms, advocacy services, translation services and communication support services are not made available to consumers. The relevant contact details are not provided in order to enable the consumer to independently engage with these services should they wish to do so.
  + The consumer welcome pack does not contain contact details for TIS, Auslan interpreting service or the NRS (National Relay Service) to communicate with the provider or with the Aged Care Quality and Safety Commission.
  + The consumer welcome pack does not include Commission contact details, however, does contain a link to My Aged Care (MAC) Website which is listed as the Commission’s contact as an avenue to make complaints.

The Provider outlined the following in response to the Assessment Team’s report.

* *The response to this standard is the same as the above.*
* The provider acknowledged their oversight, implying impacting factors contributed to these deficiencies.
* Management also advised the team have been very overwhelmed with the all the work around reforms, on top of our site relocation and office set up. I do note that the team worked flat out to try and ensure most of the consumers were contacted at short notice.
* Additionally, the Provider believes the audit was not impaired in any significant way by our teams’ oversight at this incredibly busy time.
* Explaining the inclusions within the consumer welcome pack, including information to ensure all consumers are aware of the required resources on the Commission, advocacy, language services and complaints etc. This has been actioned with urgency.
* Regarding interpreter services, when we work with individuals at intake, we ask them if they require an interpreter service. It is a question on our Intake Form (which we go through with our consumers) and allows us to engage with an interpreter as we identify from the intake process and book them in for the appointments we undertake as needed. The provider has an aged care account with The Translating and Interpreting Service (TIS).
* The provider likes to determine the needs in our initial contacts so we can arrange interpreters as needed with our appointment bookings. The provider has never had an issue with a need for interpreters that was not determined from our intake process, and do not have long-term care arrangements with consumers where this matter may arise during their service provision. Nonetheless, TIS information has now been included in welcome packs for consumer’s use.
* Regarding advocacy, the provider has engaged with advocacy services regularly, including the Older Persons Advocacy Network (OPAN). Highlighting that the nature and limited appointment-based time of our engagement with consumers significantly reduces our exposure to those who are looking for advocacy assistance. The provider engages with consumers to undertake a specific job, whether this is a Home Mods assessment, or some work undertaken by a tradesman. Nonetheless, the provider has already included the information on Advocacy services within our new welcome packs.

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with information provided in response. I acknowledge the Provider has responded to the deficiencies, particularly with mitigating circumstances impacting the providers ability to deliver consistent services.

The intent of this Requirement is intended to make sure that all consumers can easily make a complaint, whatever their culture, language or ability. The organisation’s complaints system should give every consumer equal access to make a complaint.

Consumers may have barriers to using the complaints system, such as diversity of culture or language. Poor vision, hearing loss, or cognitive impairment can also make it difficult for some consumers to make a complaint.

It is expected consumers are also made aware of and supported to access services that can assist them to make a complaint. This includes support to access alternative, external complaints handling options, including the Aged Care Quality and Safety Commissioner.

I appreciate the provider’s response regarding identified deficiencies and timeliness in responding to them.

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

Requirement 6(3)(d) - was found not met following a Quality Audit undertaken from 18 September 2024 to 20 September 2024.The service did not demonstrate:

* Feedback and complaints are reviewed and used to improve the quality of care and services.

The Assessment Team was not satisfied the provider could demonstrate all complaints and feedback are documented, trended and escalated to management for improving service delivery. Management and staff confirmed that not all feedback and complaints data is collated and analysed for quality improvement. The Assessment Team provided the following evidence to support their assessment:

* The complaints register lists 3 complaints since January 2024; however, staff discussed that consumers do provide feedback about service delivery waiting period for consumers, but this is resolved with an explanation. The staff confirmed these discussions are often noted on the consumer’s progress notes but not on a central register as this is management’s responsibility.
* The service’s continuous improvement plan (CIP) does not indicate improvements identified through the collation of feedback or complaints for use to improve service provision for consumers.
* 13 consumer surveys were viewed by the assessment team; however, the board was unaware if these surveys are being completed or exist.
  + Therefore, the provider was unable to demonstrate that feedback captured through the survey has been used to improve services.
* The Assessment Team gave feedback to management, who acknowledged this was an area for improvement.
  + Management said they aim to capture all feedback and complaints in the complaints register for better reporting.
  + This task has been added to the service’s CIP, with a completion target of 18 October 2024.

The Provider outlined the following in response to the Assessment Team’s report:

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with information provided in response. Whilst I acknowledge the Providers response to the deficiencies, the nature of the services assessment and response processes is not in question.

Furthermore, I have chosen to respond to specific statements made in the providers response, by highlighting the intent of this Requirement including.

* ‘These are a part of our clinical processes, and we don’t think another layer of red tape and trying to capture all of these individual and incredibly varying conversations in a register, often very specific to the site and individual and their activities, is really going to achieve anything in terms of improving the process. Our improvement process is part of the clinical framework, and vice versa.’
* ‘I recall in the audit meeting I stated that this “would take us down the rabbit hole” and this was met with concern by the auditors. This is about perspective. There are literally thousands of things we might discuss across the provision of our clinical services in the clinical setting’.
* ‘If people complain, which happens very rarely as a result of the effort put into our best practice pathway and the conversations we have, then we certainly do take their complaint very seriously, we engage positively and again explain our clinical reasoning in our response – which is a professional clinical response.’

The intent of this Requirement is to ensure the organisation has a best practice system to manage feedback and complaints. Organisations should use this system to improve how they deliver care and services.

* As well as encouraging complaints and asking for feedback, the organisation should provide timely feedback to the organisation’s governing body, its workforce and consumers on complaints and the actions the organisation took. It’s expected that the organisation will use information from complaints to make improvements to safety and quality systems and regularly review and improve how they manage complaints.
* From the perspective of assessment, at organisational level, evidence that the organisation monitors feedback and complaints, and that that complaints are escalated so that they go to a member of the organisation with authority to make a change is clear.
* Furthermore, evidence of how the organisation monitors, reports and keeps improving its performance against this requirement is necessary.

The scope of this Requirement extends beyond the nature and composition of what constitutes information capture and retention. The value of a single repository (or register) of feedback and complaints, or enquiries from consumers ensures the information can be collated and for tracking purposes, utilised to better improve serve delivery beyond the individual piece of feedback and individual.

The benefit of using this process leads to continuous improvement within service delivery, and ensure organisational governance has oversight and can track and trend to identify inconsistencies and possible risk and respond accordingly.

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

Requirements 6(3)(a) & 6(3)(c)

Consumers and representatives confirmed they are aware of how to provide feedback and raise complaints and feel safe to do so. Staff stated they seek feedback from consumers during service delivery and emphasise to consumers the importance of making feedback. Management stated the complaint procedure is explained to consumers.

Consumers and representatives confirmed the service resolved issues or informal complaints they had made. Staff described processes for escalating complaints from consumers. Management described and documentation showed the service uses an open disclosure approach to resolve issues.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirements 6(3)(a) & 6(3)(c) in Standard 6, Feedback and complaints.

# Standard 7

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

Findings

Requirement 7(3)(e) - was found not met following a Quality Audit undertaken from 18 September 2024 to 20 September 2024.The service did not demonstrate:

* Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.

The Assessment Team was not satisfied the provider could demonstrate annual performance reviews had not been completed for each staff member. Although the service demonstrated regular and ongoing performance is monitored and reviewed for most staff members, other staff members could not recall the last time they had a performance review. Management acknowledged annual performance reviews had not been completed for each staff member.

The Assessment Team provided the following evidence to support their assessment:

* 3 staff interviewed advised of inconsistencies with regular performance reviews and engagement.
* Management stated having a primary focus on supporting Allied Health staff for learning and development opportunities and acknowledged the deficiency of regular assessment and review of performance for non-clinical staff.
  + When requested by the Assessment Team, management was not able to provide performance review documentation for 2 staff. Management stated due to a recent change in management and information systems they were unable to locate previous performance reviews for these staff or when their last review was conducted.
* Management confirmed they were aware of outstanding performance reviews for identified staff. However, at the time of the Quality Audit these staff performance reviews remained incomplete and unscheduled.

The Provider outlined the following in response to the Assessment Team’s report:

* Advising that the services Administration and Admin manager had not undertaken formal PPRs recently, however; said they had staff in one-on-one meetings, where they undertook salary reviews and discussed the work challenges, made role changes, and Jenn discussed LifeTec needs as part of the relationship. So, while this was not a formal PPR as such it did represent an effective discussion of work undertakings, performance and expectations. Capacity, Competency and Resilience issues were discussed and pay rises and work instructions were provided. We support these staff very appropriately with opportunities to raise matters/concerns, training, provision of updates and other information and discussions through regular and ongoing meetings.
* Key discussions have been undertaken (which we can detail) and that the team are currently working through the formal PPRs for these staff.

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with information provided in response.

The intent of this Requirement is to ensure all members of the workforce have an appropriate person regularly evaluate how they are performing their role, and identify, plan for and support any training, and development they need. This Requirement looks at how organisations need to regularly assess the performance and the capabilities of the workforce as a whole. Performance reviews can also support continuous improvement and development of the members of the workforce.

From an organisational level, evidence that the organisation regularly assesses and monitors the performance of members of the workforce, including during probation periods.

Additionally, evidence the organisation uses performance assessments to work out training needs. It also uses performance assessments to review duties and responsibilities and maintain the workforce’s overall ability to provide safe and quality care and services.

This can be supported by records or schedules that detail the percentage of staff with completed performance reviews and follow up of those who don’t take part.

At this stage, though some processes have been implemented to engage staff with performance reviews, it has not been fully embedded or completed.

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

Requirements 7(3)(a), 7(3)(b), 7(3)(c), and 7(3)(d)

Consumers and representatives confirmed consumers feel respected. Staff described how they relate to consumers respectfully. Results from a survey conducted by the service showed consumers feel they are treated with integrity and respect.

Consumers stated staff are competent. Staff described the minimum qualifications required for their roles. Management described the service’s processes for determining staff competency, including for subcontracted staff. Documentation showed evidence of minimum qualifications and knowledge required for each role.

Staff confirmed they receive induction training and ongoing mandatory training. Management explained the service uses an online training system for staff. Documentation showed the service maintains up-to-date training and competency records for staff.

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

# Standard 8

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| Organisational governance | | CHSP |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Not Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Not Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Not Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Not applicable |

Findings

Requirement 8(3)(b) - was found not met following a Quality Audit undertaken from 18 September 2024 to 20 September 2024.The service did not demonstrate:

* The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

The Assessment Team was not satisfied the provider could demonstrate the Board promotes a culture of safe, quality care and services and is accountable for the delivery. Management described how they provide necessary information to the Board through formal governance, leadership and reporting pathways. However, further interviews with management, a member of the Board and documentation reviewed confirmed the Board does not receive the information it needs to lead a culture of quality improvements. Deficiencies identified included inadequate reporting on incidents, feedback & complaints trends and the outcomes of the consumer satisfaction surveys.

The Assessment Team provided the following evidence to support their assessment:

* As identified in Standard 6, Requirement (3)(d), and Standard 8, Requirement (3)(c), the service does not have a system to identify, capture and analyse all feedback and complaints provided by consumers.
  + Management acknowledged because of the deficiencies in the feedback and complaints system, the Board is unable to receive accurate reporting data on feedback and complaints trends.
* A Board member interviewed were asked if they receive reports regarding the outcomes of the consumer satisfaction surveys. The Board member stated they were unaware of the surveys being conducted and confirmed they do not receive this information.
* Document review of the Quality Management System meeting minutes for March 2024 and July 2024 evidenced agenda items to discuss the complaints register, incident register, survey results and the continuous improvement register.
  + Review of Board meeting minutes between March 2024 and August 2024 did not evidence standing agenda items or report of feedback and complaints trends, incidents, survey results and as a result no discussion of continuous improvement in response to these areas.

The Provider provided the following in response to the Assessment Team’s report:

* Advising this was an oversight to the Board and are implementing this in the Board process with some classifications of incidents and complaints to undertake an annual review of these.
* Advisement that complaints are reviewed in our QMS meetings and we undertake a simple process of review of the very small number of incidents we receive.
* Regarding survey information and collation, responding with the following. You may recall from our recent continuous improvement items, we went through a number of processes to ensure we captured more feedback of our consumers without unduly adding to our costs. We committed to survey calls and have been undertaking this process. I note that in our former systems, where we were struggling with getting feedback (explained in our CI register), It was a simple process to examine the responses.
  + Now we have a more robust process we will undertake review though our QMS process and provide this information to the Board. This may still be on a quarterly or other basis dependent on the returns (it is better to work off a larger sample when reviewing such data).
* The senior team, in our policies are responsible for reporting reportable/critical or serious incidents and are aware of all the reporting requirements of the different programs. We do not expect our front-line staff to be able to recall all the specific reports (as noted in the Reportable Incident Matrix in our policies). This is undertaken, usually by the CEO or the Quality and Compliance Manager, who have attended all the various program briefings are aware of all the reporting requirements.
* Regarding SIRS, and the use of Commission terms or acronyms in policies and procedures. We note such incidents as reportable incidents as these are more commonly used terms across the programs we deliver. Understanding that we work across many funding areas, and to avoid confusion we use the “reportable incident” term which actually specifies its importance (as an action word) and people are aware of. Our senior team are aware of SIRS as a process in aged care and we are aware of all the reports required in SIRS.

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with information provided in response.

The intent of this Requirement states the governing body of the organisation is responsible for promoting a culture of safe, inclusive and quality, care and services in the organisation. The governing body of the organisation is also responsible for overseeing the organisation’s strategic direction and policies for delivering care to meet the Quality Standards.

A culture of safe inclusive and quality care and services is one that is embedded in all aspects of organisational life and owned by everyone. It is the organisation’s governing body that enables this through it’s leadership, decisions made and directions set for the organisation. It will be reflected in how the organisation communicates it’s meaning and purpose to the workforce, consumers and those outside the service.

Indifferent of the size or composition of the organisation providing care, the governing body needs to display it’s committed to, and leads, a culture of safety and quality improvement in the organisation.

From an organisational perspective, evidence that the governing body asks for and receives the information and advice it needs to meet its responsibilities under this Requirement is crucial.

Further evidence that the governing body understands and sets priorities to improve the performance of the organisation against the Quality Standards and consistent with the Charter of Aged Care Rights is essential.

At this stage, though the Provider has explained processes, this has not been evidenced to support its implementation to improve exposure to the governing Board regarding their oversight and response in alignment with their requirements. Thus, it has not been fully embedded or completed.

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

Requirement 8(3)(c) - was found non-compliant following a Quality Audit undertaken from 18 September 2024 to 20 September 2024.The service did not demonstrate:

* Effective organisation wide governance systems relating to regulatory compliance and feedback and complaints.

The Assessment Team was not satisfied the provider could demonstrate their regulatory compliance system effectively informs management of their responsibilities, to ensure effective communication of change and compliance with relevant legislation.

The Assessment Team provided the following evidence to support their assessment:

* Viewed policies, procedures, and induction records evidenced no references to the Commissions SIRs.
  + The incident management policies reviewed referred to reportable incidents however was missing key information under the SIRs.
* Identification during the initial meeting consumers had not been informed of the Quality Audit or provided with the Notice of Collection.
  + Management acknowledged this had not been completed as the instruction had been missed. Although the provider was responsive in contacting as many consumers as possible to notify them of the Quality Audit not all consumers were able to be contacted.
* As outlined in Standard 6, Requirement (3)(d), the process to capture feedback and complaints on the register does not include the feedback provided to staff and entered progress notes.
  + Management and staff confirmed progress notes are not reviewed or monitored by management to capture this information and transfer it to the feedback and complaints register.

The Provider provided the following in response to the Assessment Team’s report:

* Referring to the previous response regarding feedback and complaints (re progress notes), within the clinical feedback processes. (Requirement 6(3)(d)).

The intent of this Requirement relates to organisation wide governance. It determines how the organisation applies and controls authority below the level of the governing body. Authority flows from the governing body to the Chief Executive Officer (or similar role), then, to the executive or management team and throughout the organisation. This Requirement lists the key areas that an organisation needs for effective organisation wide governance systems. These systems should consider the size and structure of the organisation. They should also help to improve outcomes for consumers.

Regulatory compliance systems and process make sure the organisation is complying with all relevant legislation, regulatory requirements, professional standards, and guidelines.

This Requirement doesn’t measure how an organisation complies with other legislative frameworks but provides an understanding of whether the organisation itself undertakes this task. In doing so, the Provider has failed to evidence how it is doing so.

Feedback and complaints systems and processes actively look to improve results for consumers. The system used is relevant and proportionate to the range and complexity of care and services the organisation delivers, as well as its size and scale.

The system follows principles of transparency, procedural fairness, and natural justice and meets best practice guidelines.

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with information provided in response. The responses provided in Standard 6, Requirement 6(3)(d) fail to align with the intent of Requirement 8(3)(c). Please refer to the intent of the requirement, as it relates to best practice systems to manage feedback and complaints. I have elaborated on the intent of Requirement 8(3)(c) below, on the application of reflective considerations, and examples of action and evidence.

The organisation is expected to have a documented whole-of-organisation governance framework, which includes personal and clinical care if delivered. Evidenced through systems and processes, from the care and service level through to the governing body level, for managing and governing all aspects of care and services.

The organisation is expected to have systems to monitor and evaluate how they perform against strategic and other objectives for safe and quality care and services. This is best achieved through performance monitoring records given to the governing body show whether the organisation is performing at peak level and meeting its policy, planning, and operational goals. This can be used in conjunction with committee and meeting records to show management of the organisation and the governing body have information, data, and options to make informed decisions.

The organisation is expected to have effective governance systems relating to regulatory compliance, which includes compliance with jurisdictional public health orders, and record-keeping and reporting requirements under the Accountability Principles 2014 and Records Principles 2014. Evidence that the organisation is mindful of the key risks associated with the service and the individual people receiving care at the service and can demonstrate how this has influenced their outbreak management planning and response.

At the time of my determination, this was not provided as evidence, and as such, based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 8(3)(c) in Standard 8, Organisational governance.

Requirement 8(3)(d) - was found not met following a Quality Audit undertaken from 18 September 2024 to 20 September 2024.The service did not demonstrate:

* Effective risk management systems and practices relating to identifying and responding to abuse and neglect of consumers and managing and preventing incidents, including the use of an incident management system.

The Assessment Team was not satisfied the provider did not demonstrate effective risk management systems are in place to identify and respond to abuse and neglect of consumers or to effectively manage and prevent incidents. The Assessment Team provided the following evidence to support their assessment:

* Reviewed staff induction checklists evidenced staff are required to read through the incident management policy and procedure during induction. Review of the incident management policy evidenced references to staff responsibilities for reportable incidents. However, these did not evidence or describe SIRS.
* Reportable incidents listed in the policy did not include all 8 types of incidents under the SIRS, relevant to the services being provided.
  + Management and staff confirmed access to policies and procedures however advised no ongoing training/ education in relation to incident management is provided to staff.
* Reviewed contractor’s agreement which does not outline the contractor’s reporting responsibilities if they witness an incident, nor the time frame in which they are expected to report incidents.
* Reviewed induction checklist, policy and procedures, which evidenced the service does have an Abuse, Neglect and Exploitation policy in place which staff are required to read during induction. However, the policy scope references people with a disability only.
* Management acknowledged how the deficiencies identified may lead to unreported or delays in reporting incidents and how this affects them to fulfil their reporting obligations as an approved provider. Management spoke of plans to review and update policies and procedures relating to consumer risk, sighted on the updated CIP with a planned completion date of 11 October 2024.

The Provider provided the following in response to the Assessment Team’s report.

* Management refute the inference made in the Assessment Team findings, namely that the deficiencies identified may lead to underreporting or delays in reporting incidents. If it was stated by another staff member it is a misunderstanding, and an area where clarification should have been sought.
* Reference to previous responses in Requirement 6(3)(d).

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with information provided in response. The responses provided in Standard 6, Requirement 6(3)(d) fail to align with the intent of Requirement 8(3)(d).

The intent of this requirement is to ensure organisations have systems and processes that help them identify and assess risks to the health, safety and well-being of consumers. If risks are found, organisations are expected to find ways to reduce or remove the risks in a timeframe that matches the level of risk and how it’s affecting consumers.

It is expected that the organisation’s risk management system identifies and evaluates incidents and ‘near misses’ (both clinical incidents and incidents in delivering care and services). A near miss is when an occurrence, event or omission happens that does not result in harm (such as injury, illness or danger to health) to a consumer or another person but had potential to do so. It’s also expected that the organisation uses this information to improve its performance and how it delivers quality care and services.

Organisations are expected to escalate risks to the health, safety and well-being of their consumers within the organisation or to a relevant external service or organisation. It’s also expected that organisations continue to monitor risks to consumers and others and take action if a risk has increased.

In regard to identifying and responding to abuse and the neglect of consumers the organisation is expected to have systems to provide appropriate protections and safeguards around the delivery of care and services, to respond effectively to incidents of abuse, to report this according to the law, and to raise awareness in the organisation to lower the risk of elder abuse.

In regard to managing and preventing incidents, including the use of an incident management system, organisations are expected to effectively prevent and manage incidents, including through the use of an incident management system that enables incidents to be identified, responded to, and notified to the Commission (as required).

Incidents should be resolved in consultation with consumers and staff, and incident data should be used to identify trends, drive continuous improvement to improve the quality of the care and services, and prevent similar incidents from occurring.

I have used information provided in Requirement 8(3)(b), to apply consideration to making a determination on compliance. In doing so, I acknowledge that the service has systems in place to recognise incidents, albeit not using terms or acronyms in policies and procedures associated with SIRS. However, I also note, gaps in training, identification and oversight of SIRS. I further note that management provided assurances to review and update policies and procedures relating to consumer risk, sighted on the updated CIP with a planned completion date of 11 October 2024. An updated CIP was not provided as part of the Providers response to show the status of this proposal.

Evidence to support compliance with this requirement would include.

* Records show the organisation continually monitors risks to consumers and takes appropriate action if a risk has increased.
* Evidence that the organisation uses incident data and information to identify and analyse trends and common incidents, and that quality improvements are made as a result.
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* Evidence that the organisation uses incident data and information to identify and analyse trends and common incidents, and that quality improvements are made as a result.

I have considered the provider’s response, however, at the time of my finding, these actions have not been fully implemented or embedded.

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

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