**Performance**

**Report**

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| Name: | Lingcare |
| Commission ID: | 600474 |
| Address: | 497 South Road, ASHFORD, South Australia, 5035 |
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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: 5224 Lingcare Pty Ltd  
Service: 26937 Lingcare

**This performance report**

This performance report for Lingcare (**the service**) has been prepared by M Glenn, 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, which was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff and management; and
* the provider’s response to the assessment team’s report received 18 April 2024, specifically for Standard 8 which was limited to commentary relating to actions the provider plans to take or has taken in response to some of the deficits identified. The response for Standards 2, 3, 4, 6, and 7 was unable to be accessed, and despite numerous attempts to contact the provider to resubmit the response, this was not forthcoming. As such, the response for these requirements was unable to be considered.

# Assessment summary for Home Care Packages (HCP)

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **Not Compliant** |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

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

# Areas for improvement

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

**Standard 2 requirements (3)(a), (3)(b), (3)(d) and (3)(e)**

* Ensure assessments are undertaken initially and ongoing, and use information gathered to develop care plans which are tailored and reflective of consumers’ current care and service needs.
* Ensure risks to consumers’ health and well-being are identified and appropriate management strategies developed and implemented to enable staff to provide quality care and services.
* Ensure consumers’ goals, needs and preferences, including those related to advance care and end of life planning, where consumers wish to disclose, are identified and appropriate management strategies developed.
* Ensure outcomes of assessment and planning are effectively communicated with consumers and/or representatives, and care plans are discussed with and available to them. Ensure care plans are available to staff at point of service.
* Ensure care plans are reviewed for effectiveness and/or updated in response to incidents and changes in consumers’ circumstances. Ensure care plans are reflective of consumers’ current and assessed needs, preferences and services.
* Ensure policies and procedures in relation to assessment, care planning and review are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to assessment, care planning and review.

**Standard 3 requirements (3)(b) and (3)(e)**

* Ensure staff have the skills and knowledge to identify, manage, monitor and provide appropriate care relating to high impact or high prevalence risks.
* Ensure information relating to consumers’ personal and clinical care needs is documented and effectively communicated to others, and review information exchange processes between the service and other providers to enable effective coordination of care and services.
* Ensure policies, procedures and guidelines in relation to management of high impact or high prevalence risks and information exchange processes are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to management of high impact or high prevalence and information exchange processes.

**Standard 4 requirement (3)(d)**

* Ensure information relating to consumers’ services and supports for daily living is documented and effectively communicated.

**Standard 6 requirement (3)(d)**

* Review processes to ensure all feedback and complaints are captured and regularly reviewed to enable emerging trends and improvement opportunities to be identified.

**Standard 7 requirements (3)(c), (3)(d) and (3)(e)**

* Review processes relating to how staff competency, skills and knowledge are assessed, monitored and tested to ensure staff are competent to undertake their roles.
* Review how staff competence is monitored and how additional training requirements are identified and addressed.
* Ensure staff are provided appropriate training to address the deficiencies identified in six of the seven Quality Standards assessed and completion of training is documented and monitored.
* Ensure regular assessment, monitoring and review of the performance of each staff member is undertaken and accurate records maintained.
* Review and update human resources policies and procedures, including those relating to training and monitoring of performance, to ensure they align with current practice and process.

**Standard 8 requirements (3)(a), (3)(b), (3)(c), (3)(d) and (3)(e)**

* Review processes relating to how consumers are supported and engaged in the development, delivery and evaluation of care and services and that feedback gathered through various avenues is considered.
* To ensure the governing body is aware of and accountable for the delivery of care and services, review communication and reporting processes from the service to the governing body and vice versa.
* Review the organisation’s governance systems in relation to information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints.
* Review the organisation’s risk management processes in relation to managing high impact or high prevalence risks and managing and preventing incidents.
* Review the organisation’s clinical governance framework and ensure it aligns with current practices and includes reporting of key aspects of clinical care to the governing body to ensure effective oversight.

# Other relevant matters:

* Standard 5 was not assessed as part of the quality audit as the service does not provide social support group activities within a service environment. Therefore, this Standard is not applicable.

# Standard 1

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| Consumer dignity and choice | | HCP |
| 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

Consumers and representatives feel consumers are treated with dignity and respect, and their identity and diversity are valued. The service ensures each staff member is aware of the individualised needs of consumers they care for by providing staff a tailored induction to each consumer and their home on the initial service, as well as information relating to consumers’ identity, culture and diversity. In the event consumers provide feedback indicating they are not satisfied with the care provided by a staff member, a different staff member is allocated to ensure both parties are comfortable and satisfied. Staff said they build relationships with consumers they care for and provide care and services personalised to their preferences. Staff spoke about consumers and representatives respectfully, with an understanding of each consumer’s needs.

Consumers and representatives said staff understand consumers and their cultural needs and deliver care and services with this in mind. Staff demonstrated an understanding of consumers' cultural background and described how they ensure care and services reflect consumers’ cultural needs and diversity. Where the service is not able to meet consumers’ needs, required service provision is brokered to other providers, including from consumers’ cultural background, to ensure culturally appropriate care and services are provided.

Staff described how they support consumers’ independence and choice in how their services are delivered by asking them about what they need or want to do during the service, including assisting consumers to undertake their daily lives, taking them shopping, or visiting friends and family. Assessment and planning is undertaken in partnership with the consumers and/or their representatives, with consumers and representatives confirming they contact the service to discuss care and services at any time. One consumer described how choice and decision making is part of the initial onboarding process, and said they were given options for how their care and service could be delivered.

While consumers and representatives did not discuss risks directly, they described how the service supports consumers to maintain their independence and live the best life they can. Where consumers are identified as partaking in an activity which includes an element of risk, consultation with the consumer or representative occurs and a risk form is completed.

Information provided to consumers is current, accurate, timely and clearly communicated in a way which is easy to understand and enables consumers to exercise choice. On commencement of services, consumers are provided with an agreement and consumer handbook which includes information on internal and external complaints mechanisms, services available and the organisation’s fee structure. Consumers described how the service communicates with them, including through email and phone calls, and consumers said monthly statements they receive are accurate and easy to understand. There are processes to ensure each consumer’s privacy is respected, and personal information is kept confidential.

Based on the assessment team’s report, I find all requirements in Standard 1 Consumer dignity and choice compliant.

# Standard 2

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| Ongoing assessment and planning with consumers | | HCP |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Not Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Not Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Not Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Not Compliant |

Findings

The Quality Standard is non-compliant as four of the five requirements assessed have been found non-compliant. The assessment team recommended requirements (3)(a), (3)(b), (3)(d) and (3)(e) in this Standard not met.

**Requirement (3)(a)** The assessment team found care documentation does not include assessments, including validated assessment tools, to identify risks associated with consumers’ care and recommended this requirement not met. Consumers and representatives confirm assessment and planning does not assess for risks associated with consumers’ care, and staff confirm risks to consumers’ care and services are not always included in the care plan. Care planning documents do not show assessment and planning considers the risks, including in relation to falls, behaviour, pain and clinical care, and management strategies have not been implemented. An assessment form within the electronic care system is used for assessment of consumers on commencement and ongoing and only includes broad questions on health status, functional abilities, social and cultural requirements and risks. Management said they will review the assessment form to include validated assessment tools to ensure risk assessment forms part of initial and ongoing assessments.

I acknowledge the provider’s planned actions to address the deficits identified as noted in the assessment team’s report. However, I find assessment and planning processes do not effectively inform delivery of safe and effective care and services, including consideration of risk. Assessment processes have not been undertaken to identify risks, including in relation to falls, behaviour, pain and clinical care, and strategies to manage these risks have not been developed. As such, I find lack of assessment and planning has not ensured consumers are supported to get the best possible care and services or that their safety, health and well-being are not compromised.

For the reasons detailed above, I find requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

**Requirement (3)(b)** The assessment team found care planning documents do not identify or address consumers’ current needs, goals and preferences, including end of life planning and recommended this requirement not met. Care files sampled do not include information on end of life and advance care planning, including for a consumer currently receiving palliative care through an external provider, and another consumer’s care file does not include information or strategies relating to an identified behaviour towards female staff. Goals for care are not consistently completed, and for some consumers, goals are documented as a list of services the consumer receives. Consumers and representatives said while they were involved in assessment and planning on commencement of services, they were not asked about end of life care or advance care planning on commencement or at reviews. Staff and management confirmed assessment and planning does not include discussions on end of life or advance care planning. Management said they would review the assessment form to include end of life and advance care planning, while ensuring goals and preferences are documented.

I acknowledge the provider’s planned actions to address the deficits identified as noted in the assessment team’s report. However, this requirement expects that services do everything they reasonably can to plan care and services that centre on consumers’ goals, needs and preferences, including in relation to advance care and end of life planning. I find the service’s current practices do not ensure this occurs. There is no evidence of discussions with consumers either on commencement or ongoing relating to advance care or end of life planning, in line with consumers’ preferences, and consumers and representatives confirm these discussions have not been undertaken with them. Additionally, goals of care are not consistently identified which does not enable the service to understand what is important to the consumer and identify what assistance they require to live as well as they can.

For the reasons detailed above, I find requirement (3)(b) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

**Requirement (3)(d)** The assessment team recommended this requirement not met as care plans are not available and/or completed. Consumers and representatives said while the service communicates consumers’ required services on commencement, they do not know if they have a care plan in place. Four of 10 care files sampled do not include a completed care plan, and while management confirm care plans are not always completed on the electronic care system, paper based care plans were not provided, with management stating they had been archived. Management acknowledged the missing care plans and proposed a range on interventions to rectify the issue.

I acknowledge, as noted in the assessment team’s report, the provider described a range of interventions to address the deficits identified. However, I have considered the intent of this requirement which states a care and service plan, which includes a person’s needs, goals and preferences, should be available to the consumer in a way they understand. The evidence demonstrates care plans to guide delivery of care at point of care are not available nor are they provided to consumers. This is supported by feedback from consumers and representatives who do not know if a care plan is in place and from management confirming care plans are not always completed on the electronic system. Current practices as outlined in requirement (3)(b) of Standard 3 indicate care and services are not being delivered in line with consumers’ assessed or current needs and preferences, with staff stating most of the care they provide is guided by their previous experiences and by the consumer. As such, I find consumers are not supported to understand and have ownership of the care plan.

For the reasons detailed above, I find requirement (3)(d) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

**Requirement (3)(e)** The assessment team recommended this requirement not met as care and services are not regularly reviewed, including in response to changes in consumers’ circumstance. Consumers and representatives confirm assessments do not occur on a regular basis, and management confirm regular care reviews are not undertaken with changes to care and services only made when the consumer requests.

Care files for three consumers show assessments and care plans are not reviewed annually in line with service policies and procedures. Care documentation for one consumer has not been reviewed since 2019 despite staff reporting changes, and management confirming deterioration in the consumer’s condition. One consumer’s care plan was dated January 2019, with assessments dated December 2018, and another consumer’s care plan was dated March 2023 and did not include any information relating to identified behaviours and mitigating strategies. Scheduled reviews of care and services are also not undertaken, with review of care plans only occurring in response to an incident, change of circumstance, or if a consumer would like to change services. When care plans are reviewed, this only includes a review of the services provided and does not consider review of consumers’ assessments or plans. Care plans are also not updated to include recommendations or assessments by allied health professionals following referrals. Management acknowledged the deficits identified stating a new electronic document system is being implemented which will assist in monitoring and reviewing care documentation, as well as providing alerts for regular care reviews.

I acknowledge the provider’s planned actions to address the deficits identified as noted in the assessment team’s report. However, I find the service has not ensured care and services are regularly reviewed for effectiveness, including in response to changes in condition, circumstance or following allied health reviews. In coming to my finding, I have placed weight on feedback from management who state regular care reviews are not undertaken with changes to care and services only made when the consumer requests, which is not in line with service policy and procedure which state reviews are to occur annually. This was further supported by feedback from consumers and representatives who state assessments do not occur on a regular basis, and by documentation which demonstrates while changes to consumers’ condition have occurred, care plans are not reflective of consumers’ current condition. As such, I find the service’s current practices do not ensure care plans are reflective of consumers’ current circumstance or current care and services requirements.

For the reasons detailed above, I find requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers non-compliant.

**In relation to requirement (3)(c)**, consumers and representatives confirm they are involved in decision making regarding the care and services consumers receive. Initial assessments and ongoing reviews are undertaken in consultation with the consumer, and include the option to have a representative involved if consumers wish. Consultation with external service providers and individuals, including allied health professionals and medical officers, is undertaken.

Based on the assessment team’s report, I find requirement (3)(c) in Standard 2 Ongoing assessment and planning with consumers compliant.

# Standard 3

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

Findings

The Quality Standard is non-compliant as two of the seven requirements assessed have been found non-compliant. The assessment team recommended requirements (3)(b) and (3)(e) in this Standard not met.

**Requirement (3)(b)** The assessment team found high impact or high prevalence risks are not effectively managed and recommended this requirement not met. Management said they identify consumers who live alone or have dementia as high risk on a contact list, however, other high impact or high prevalence risks are not identified, monitored or reviewed. Care documentation does not include mitigating strategies to guide staff in the effective management of high impact or high prevalence risks, including risks relating to falls, oxygen therapy, pain, weight loss, and cognition. Staff cannot describe high impact or high prevalence risks associated with the care of each consumer, stating most of the care they provide is guided by the consumer and their previous experiences. Staff described one consumer as becoming more forgetful and paranoid and confirmed this information is not included in the care plan and they try their best to mitigate the consumer’s behaviours which may not always work. When attending services for another consumer, they identified skin tears resulting from a fall. Staff could not describe how they support this consumer during the service provision to prevent falls. Recommendations from an occupational therapist assessment in February 2023 are not recorded in care documentation and the consumer’s mobility requirements as described by staff do not align with the recommendations. Management acknowledge they do not have an effective system to monitor high impact or high prevalence risks associated with the care of consumers, and said the new electronic system being implemented will have a more comprehensive care system to support them.

I acknowledge the provider’s planned actions to address the deficits identified as noted in the assessment team’s report. However, this requirement expects that services effectively manage high impact or high prevalence risks associated with the care of each consumer. That is, each individual consumer should expect to have high impact or high prevalence risks associated with their care effectively managed. I find this did not occur in relation to risks associated with falls, oxygen therapy, pain, weight loss, and cognition. I consider this has been impacted by the fact that assessments are not undertaken on commencement or ongoing to assist to identify, monitor, and effectively manage high impact or high prevalence risks associated with consumers’ care and to guide staff in the delivery of safe and effective care. Staff could not describe high impact or high prevalence risks associated with consumers, indicating most of the care they provide is guided by the consumer and their previous experiences.

For the reasons detailed above, I find requirement (3)(b) in Standard 3 Personal care and clinical care non-compliant.

**Requirement (3)(e)** The assessment team found care documentation does not include detailed information on consumers’ condition, needs, goals and preferences to guide service delivery and recommended this requirement not met. Four of 10 consumers do not have a completed care plan, and other care plans do not include detailed information on consumers’ care and service needs, goals and preferences. Management said apart from where wound care is provided, there are currently no processes to communicate and receive information from brokered services where care for consumers is shared. Staff confirmed care documentation does not include adequate information to guide service delivery, and they seek instruction from the consumer. Consumers and representatives said staff do not know what they need to do during the service and consumers are required to provide instructions each time. Management acknowledged the deficits identified and proposed to review processes to ensure staff and brokered services are informed of consumers’ condition, needs, goals and preferences.

I acknowledge the provider’s planned actions to address the deficits identified as noted in the assessment team’s report. However, I find information about consumers’ condition, needs and preferences is not effectively documented and communicated to enable effective and consistent delivery of consumers’ care and services. Not all consumers have completed care plans, and where care plans are in place, these are not reflective of current needs and preferences. Staff said they seek instruction directly from consumers which was corroborated through consumer and representative interviews. The evidence also suggests communication between the service and other care providers is not effective. As such, I have considered as assessment processes are not undertaken on an ongoing basis or care plans updated in response to consumers’ changing needs, the workforce does not consistently have access to accurate information to enable coordination and delivery of safe and effective personal and/or clinical care.

For the reasons detailed above, I find requirement (3)(e) in Standard 3 Personal care and clinical care non-compliant.

**In relation to all other requirements**, services are tailored to consumers’ needs and preferences through use of the service’s own staff, or brokered staff when the service is unable to meet consumers care and service needs. While deficits in assessment and planning have been identified, staff described how they support consumers with their personal care and tailor services in line with their needs, goals and preferences. The service responds appropriately to support the needs, goals and preferences of consumers nearing end of life to maximise their comfort and preserve their dignity. Where consumers are identified as requiring end of life support, documentation demonstrates referrals to and consultation with palliative care teams, external care providers and allied health occur.

Consumers and representatives feel confident staff would notice if consumers’ health changed and would respond appropriately, including by initiating referrals with their consent. Staff described processes to report and respond to changes in consumers’ condition, and said management are prompt to organise referrals to allied health, nursing services or the consumer’s medical practitioner in response. For example, in response to a decline in one consumer’s condition, an increase to their daily services was implemented to monitor their nutritional intake and provide welfare checks.

Infection related risks are minimised through implementation of standard and transmission-based precautions to prevent and control infections. Policies and procedures are available to guide staff in the management of infection control, including the use of personal protective equipment and outbreak management. Consumers said staff use personal protective equipment and hygiene techniques to minimise transmission of infections.

Based on the assessment team’s report, I find requirements (3)(a), (3)(c), (3)(d), (3)(f) and (3)(g) in Standard 3 Personal care and clinical care compliant.

# Standard 4

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| Services and supports for daily living | | HCP |
| 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. | Not 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

The Quality Standard is non-compliant as one of the seven requirements assessed has been found non-compliant. The assessment team recommended requirement (3)(d) in this Standard not met.

**Requirement (3)(d)** The assessment team found care documentation does not include detailed information on consumers’ condition, needs, goals and preferences to guide service delivery and recommended this requirement not met. Consumers and representatives said staff don’t know what consumers need done during the service and are required to provide instructions each time. Staff confirm care documentation does not include adequate information to guide service delivery, and they seek instruction from the consumer. Four of 10 consumers do not have a completed care plan, and other care plans do not include detailed information on consumers’ care and service needs, goals and preferences. Management acknowledged the deficits identified and proposed to review processes in place to ensure staff and brokered services are informed of consumers’ condition, needs, goals and preferences.

I acknowledge the provider’s planned actions to address the deficits identified as noted in the assessment team’s report. However, I find information about consumers’ condition, needs, goals and preferences is not effectively documented and communicated to enable effective and consistent delivery of consumers’ services and supports for daily living. Not all consumers have completed care plans, and where care plans are in place, these are not reflective of consumers’ current care and service needs, goals and preferences. Staff said they seek instruction directly from consumers which was corroborated through consumer and representative interviews. As such, I find the workforce does not have the information about delivering safe and effective services and supports for daily living or an understanding the consumer’s condition, needs, goals and preferences.

For the reasons detailed above, I find requirement (3)(d) in Standard 4 Services and supports for daily living non-compliant.

**In relation to all other requirements,** consumers and representatives are satisfied with the services provided and feel they optimise consumers’ independence, well-being and quality of life. Each service is tailored to the consumer’s needs, goals and preferences, including allocating staff who are from a similar cultural background, where appropriate. Staff described how they assist consumers with services and supports, such as domestic assistance or shopping, to enable them to remain as independent at home.

Consumers and representatives said staff know consumers well and described how the services provided promote their emotional, spiritual and psychological well-being. Staff described how they provide emotional support to consumers they support by talking to them or taking them out to the community, and said any changes to a consumer’s psychological well-being are reported to management for review.

Consumers and representatives confirm services and supports for daily living support consumers to participate in their local community, maintain relationships with friends and family, and do things of interest to them. Consumers also confirm referrals to allied health professionals or external social groups are initiated when required to assist in their activities of daily living. Staff and management described how they support consumers to remain active and connected to their community by taking them shopping or for visits to friends and family. Service documentation shows referrals to external groups, such as the Chinese Welfare Association or to social groups coordinated by external providers to ensure consumers remain connected to their community. Consumers funding is also monitored and referrals to My Aged Care are undertaken, where appropriate.

Consumers expressed satisfaction with the meals provided, stating meals meet their nutrition and hydration needs and preferences. Consumers are offered a range of meal services to choose from, including culturally appropriate meals service providers, and consumers can choose to use multiple meal delivery services if they wish.

Consumers said equipment provided is assessed by an allied health professional and is suitable and safe. Allied health professionals are contacted to review consumers’ needs and make recommendations on equipment. A further assessment is undertaken once the equipment arrives to ensure it is suitable for the consumer. Management acknowledge there are currently no processes to monitor equipment for safety, suitability or cleanliness once purchased, and rely on the consumer or representatives to raise concerns. There are processes to manage repairs or replacement of equipment where issues are identified.

Based on the assessment team’s report, I find requirements (3)(a), (3)(b), (3)(c), (3)(e), (3)(f) and (3)(g) in Standard 4 Services and supports for daily living compliant.

# Standard 6

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| Feedback and complaints | | HCP |
| 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

The Quality Standard is non-compliant as one of the four requirements assessed has been found non-compliant. The assessment team recommended requirement (3)(d) in this Standard not met.

**Requirement (3)(d)** The assessment team found feedback and complaints are not reviewed and used to improve the quality of care and services and recommended this requirement not met. A centralised log is not maintained to assist in review of feedback and identification of trends and continuous improvement opportunities on a larger scale across the organisation. The service’s plan for continuous improvement does not include any continuous improvement actions either completed or ongoing, based on consumer or representative feedback. Satisfaction survey data collected in January 2024 has not been reviewed and collated to identify trends and areas for improvement. Neutral and/or negative responses are noted in relation to questions regarding service management, carer performance, and services satisfying consumer needs.Management said a new electronic documentation system to be implemented in April 2024 will include a centralised feedback log, and acknowledge the service can improve capturing of verbal feedback from consumers and representatives.

I acknowledge the provider’s planned actions to address the deficits identified as noted in the assessment team’s report. However, I find a best practice system to manage feedback and complaints was not demonstrated. Complaints data is not reviewed to enable trends and improvements to the quality of care and services to be identified and implemented. I have also considered while satisfaction survey data, collected in January 2024, identifies areas of consumer dissatisfaction in relation to aspects of care and services, this data has not been collated or reviewed or improvement opportunities identified or implemented in response. As such, I find the service is not actively using avenues available to them to enable improvements to the quality of care and services to be identified.

For the reasons detailed above, I find requirement (3)(d) in Standard 6 Feedback and complaints non-compliant.

**In relation to all other requirements**, all consumers and representatives said they provide feedback regularly and feel encouraged to do so. Consumers and others are encouraged and supported to provide feedback through a range of processes, including telephone calls, face-to-face meetings, surveys and feedback forms. Care staff are aware of feedback and complaints mechanisms and said they would support consumers to provide feedback if needed.

Consumers and representatives said they are made aware of advocacy and language services and other methods for raising and resolving complaints during the intake process and ongoing. The client information handbook also includes information about feedback and complaints processes, such as contact details for both internal and external complaints management services. Staff are guided in the complaints management process by policies and procedures which outline the use of advocacy and interpreter services when required.

Consumers and representatives confirm the service is prompt to make contact when things go wrong and the service apologises or expresses regret at these times. They feel complaints are handled well and addressed in a timely manner. Staff are knowledgeable of open disclosure principles.

Based on the assessment team’s report, I find requirements (3)(a), (3)(b) and (3)(c) in Standard 6 Feedback and complaints compliant.

# Standard 7

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

Findings

The Quality Standard is non-compliant as three of the five requirements assessed have been found non-compliant. The assessment team recommended requirements (3)(c), (3)(d) and (3)(e) in this Standard not met.

**Requirement (3)(c)** The assessment team found all staff do not have all required qualifications to effectively perform their roles and recommended this requirement not met. Four of five staff do not have current cardio pulmonary resuscitation (CPR) or first aid training certificates as required by the service as part of the mandatory training requirements. Identified gaps in staff knowledge regarding risks associated with the care of consumers, assessment, care planning and review processes, and ongoing performance reviews to gauge competence levels have not been conducted in line the service’s policies and procedures.

In coming to my finding, I have considered the workforce is not sufficiently competent nor do they have the knowledge to effectively perform their roles. Not all staff have the requisite training, as required by mandatory training requirements. Outcomes for consumers highlighted in Standard 3 Personal care and clinical care indicate staff skills and knowledge are not adequate to support the delivery of safe and effective personal and clinical care, with high impact or high prevalence risks not effectively managed. Deficits have also been found in the assessment, planning and review of consumers’ care and services, with four of five requirements in Standards 2 found non-compliant.

For the reasons detailed above, I find requirement (3)(c) in Standard 7 Human resources non-compliant.

**Requirement (3)(d)** The assessment team found the workforce is not trained, equipped and supported to deliver the outcomes required by these Standards and recommended this requirement not met. The service’s human resources policy and procedure states the provider has a staff training spreadsheet which will include a training calendar, training provided, staff training attendances for mandatory and other training, and evaluation of training events. A training spreadsheet is not maintained and no specific staff training programs are provided within the organisation. Staff are required to undergo training through external providers and provide evidence of this this training annually. Four of five staff do not have current CPR or first aid training certificates which the staff handbook identifies as mandatory annual training. One care staff said they have not completed manual handling training within the past 12 months and are currently still receiving shifts. All care staff interviewed said they have not completed any training specific to the Quality Standards. Management said in house training programs as stated in the staff handbook are not provided and only training specific to individual consumers needs is provided as part of the orientation process for new starters on commencement of employment. A financial report for the last financial year shows no funds have been spent on education, training and quality control.

In coming to my finding, I have considered the service has not ensured the workforce is supported to undertake training, learning and development opportunities to meet the requirements of their role or to deliver the outcomes required by these Standards. Only training specific to individual consumers needs is provided as part of the orientation processes. Training is not conducted on an ongoing basis to ensure staff are equipped and supported to undertake their role, and while there is a requirement for staff to complete and provide evidence of mandatory training components annually, four of five staff files do not evidence completion of this training. As such, I find the organisation has not ensured staff are supported to take up training, learning and development opportunities to enable them to meet the needs of their role.

For the reasons detailed above, I find requirement (3)(d) in Standard 7 Human resources non-compliant.

**Requirement (3)(e)** The assessment team found regular assessment, monitoring and review of the performance of each member of the workforce is not undertaken. Three care staff said they have not had a performance development review conducted annually since commencement of their employment. Management confirm staff performance development reviews have not been conducted in line with service policies and procedures, however, said informal conversations are held with individuals when issues arise. While management said they conduct random six-monthly monitoring of staff performance in consumers’ homes, this process is not documented in policies and procedures and was not confirmed through consumer, representative or staff interviews. There are no formal performance monitoring processes for sub-contracted workers and management rely on processes of the sub-contracted organisation or feedback received from consumers. Management said tracking of staff completion and adherence with required training is currently a manual task and a new electronic system to be implemented in April 2024 will assist in ensuring all staff are compliant with required training and will prevent staff from being rostered for shifts if found to be non-compliant.

I acknowledge the provider’s planned actions to address the deficits identified as noted in the assessment team’s report. However, in coming to my finding, I have considered the intent of the requirement which expects the performance of all members of the workforce to be regularly evaluated to identify, plan and support any training and development needs. Feedback from management and staff, as well as the service’s current systems and practices have not ensured this has occurred, including for sub-contracted staff. I have also considered the process of informal discussions with staff as issues arise has not been effective, as deficits in staff practice highlighted across six of the seven Quality Standards assessed have not been sufficiently identified.

For the reasons detailed above, I find requirement (3)(e) in Standard 7 Human resources non-compliant.

**In relation to requirements (3)(a) and (3)(b)**, management described processes to ensure the workforce is planned and the number and mix of staff deployed enables delivery of quality care and services. A master roster is maintained and overseen by the management team, and daily review of staffing allocations are conducted to ensure staff skill mix across all areas of care and services meet consumers’ needs and preferences. Staff said they have sufficient workforce to provide care and services, with staffing shortfalls managed through backfilling with permanent and casual staff, extension of shift times and agency staff. All consumers and representatives interviewed said care and services are provided in a timely manner, consistent with agreed timeframes and consumers have not experienced staffing shortfalls.

All consumers and representatives confirm staff interactions with consumers are kind, caring and respectful of their identity, culture and diversity. They described staff as ‘respectful’ and ‘beautiful people’ and were also complimentary of management. Orientation processes are conducted specific to each consumer on commencement of service which includes an orientation and meeting with the consumer and their representative (if required) to assist in understanding the unique needs of each person, including their identity, culture and diversity. Rostering processes support consumers’ gender, diversity, language and preference needs. Care staff are knowledgeable of individual consumers’ unique qualities, culture, and diversity, and described how they adjust care to meet individual needs, such as the provision of gender specific or familiar staff. Feedback from consumers or representatives regarding poor staff interactions is addressed promptly, however, there have been no recent occurrences of poor staff behaviour.

Based on the assessment team’s report, I find requirements (3)(a) and (3)(b) in Standard 7 Human resources compliant.

# Standard 8

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

Findings

The Quality Standard is non-compliant as all five requirements assessed have been found non-compliant. The assessment team recommended all requirements in this Standard not met.

**Requirement (3)(a)** The assessment team found consumers are not engaged or supported in the development, delivery and evaluation of care and services and recommended this requirement not met. The organisation did not demonstrate active steps have been taken to develop a quality care advisory committee or consumer advisory committee in line with legislative requirements. And while an annual survey is conducted, no continuous improvement actions have been implemented in response to consumer or representative feedback.

The provider’s response indicates the Board ensures that the service will support and engage consumers in development, delivery and evaluation of care and services. The response indicates the organisation has taken steps to establish and continue a quality care advisory body, and lists the guidelines, record keeping requirements, members and description of members in the response.

I acknowledge the provider’s response. However, I find the organisation’s processes do not ensure consumers are effectively engaged in development, delivery and evaluation of care and services or supported in that engagement. While there are feedback processes and surveys to engage consumers, these avenues have not been effectively used to identify improvements to the overall quality of care and services consumers receive. Complaints data is not reviewed to enable trends and improvements to be identified and implemented, and while survey data from January 2024 identifies consumer dissatisfaction with aspects of care and service provision, improvement opportunities have not been identified or implemented in response. As such, I find the organisation’s current processes have not ensured consumers’ experience and quality of care and services has been considered in the development, delivery and evaluation of care and services.

In relation to establishing a quality care advisory committee or consumer advisory committee, I consider this evidence is more aligned to the organisation’s compliance with and actioning of changes in legislation and have considered the evidence in my finding for requirement (3)(c) in this Standard.

For the reasons detailed above, I find requirement (3)(a) in Standard 8 Organisational governance non-compliant.

**Requirement (3)(b)** The assessment team found the organisation’s governing body does not promote a culture of safe, inclusive and quality care and services or is accountable for their delivery and recommended this requirement not met. Management said they do not provide a written report to the Board to convey information across a range of care, service and operational subject topics, such as feedback and complaints, incident data or clinical statistics, and described anecdotal discussions with the chairman of the Board regarding care and service needs of individuals. Board meeting minutes between June 2023 and February 2024 include limited discussions of organisational governing topics, focusing mainly on staff wages, financial reports and pricing. Minutes do not include standing agenda items reflective of key indicator data across all areas of service provision to ensure the governing body is informed of and accountable for all aspects of care and service provision.

The governing board did not commence taking action to establish a quality of care advisory body until February 2024 and have not actively sort consumer or representative representation. Additionally, they have not taken action to establish a consumer advisory body. Organisational governance policies and procedures indicate scheduled audits are used to identify areas of the organisation’s operations that may not be operating effectively or in accordance with documented practices and the Quality Standards and the full range of audits are conducted each year. Management confirmed internal audits have not been conducted and an auditing schedule is not in place.

The provider’s response indicates the Board ensures that it promotes a culture of shape (sic), inclusive quality care and services and is accountable for their delivery. The response indicates the organisation has taken steps to establish and continue a quality care advisory body. The provider states the organisation understands, as an approved provider, it must submit a statement of compliance for a reporting period that complies with the requirements specified in legislation to the Department every four months and the provider’s response goes on to list the requirements of the statement in a standardised approved form.

I acknowledge the provider’s response. However, I find the organisation has not effectively demonstrated the governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. Reporting processes from service management to the governing body are not sufficient to ensure the governing body is aware of and accountable for the delivery of care and services nor do they ensure the governing body has sufficient oversight of the service’s performance to enable improvements to the quality of care and services to be identified. While policies and procedures describe a scheduled audit program, internal audits are not conducted and a schedule for audits does not exist. I find such practices do not ensure the governing body is aware of whether it is meeting what consumers, the workforce and others expect for safe, inclusive and quality care and services from the organisation.

I have also considered the findings of non-compliance in relation to 16 requirements across six of the seven Quality Standards assessed indicates the governing body may not sufficiently understand their responsibilities as they relate to monitoring and improving the performance of the organisation against the Quality Standards.

In relation to establishing of a quality care advisory committee or consumer advisory committee, I consider this evidence is more aligned to the organisation’s compliance with and actioning of changes in legislation and have considered the evidence in my finding for requirement (3)(c) in this Standard.

For the reasons detailed above, I find requirement (3)(b) in Standard 8 Organisational governance non-compliant.

**Requirement (3)(c)** The assessment team found while some organisation wide governance systems and processes are in place these systems are not fully embedded into practice and recommended this requirement not met. Inconsistencies in information conveyed to staff and consumer/representatives in handbooks were identified, and there are inconsistencies between policies and procedures and actual organisational practices in relation to staff training and performance reviews, and to services not provided, such as the Commonwealth Home Support Program (CHSP). Care plans are not in place to convey key information regarding consumers’ care and service needs and review of care is not consistently undertaken to ensure care plan information is a current.The continuous improvement plan does not include any activities based on consumer/representative feedback. Of the 21 improvements, there is limited information of actions taken to implement, and only five actions have planned completion dates. Board meeting minutes do not include continuous improvement as a standing agenda item or discussion of continuous improvement progress or outcomes.

There is no embedded training program for staff development, staff outstanding for mandatory training are continuing to be rostered for shifts and performance development reviews are not conducted. Consumers’ monthly statements do not align with current legislative requirements in relation to additional charges for sub-contracted service, not all staff have a current police check and the governing body has taken limited steps to establish a quality of care advisory and consumer advisory body as required by legislation. Board meeting minutes do not include regulatory compliance as a standing agenda item or reflect discussion of regulatory compliance changes. Feedback and complaints systems and processes do not enable verbal feedback to be captured and feedback mechanisms have not led to continuous improvement actions based on consumer and representative feedback.

The provider’s response indicates the Board ensures steps are taken to improve information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints are effectively managed. The response states the organisation has taken steps to amend information regarding the Aged Care Code of Conduct and Aged Care Charter of Rights (sic) in the consumer and staff handbook.

I acknowledge the provider’s response. However, I find the service and organisation have not demonstrated effective organisational governance systems relating to information management, continuous improvement, workforce governance and regulatory compliance. Information to guide staff in provision of care and services is not based on consumers’ current needs, goals or preferences as supplementary assessments are not completed on commencement of services and ongoing and care plans are not available to guide staff in the delivery of care. Policy and procedure documents are not reflective of the organisation’s current practices and processes. While a continuous improvement plan is maintained, it does not include any improvements derived from consumer and/or representative feedback and there are no formal processes to monitor the plan or to track progress with improvement activities. I have also considered reporting from the service to the governing body is not sufficient to enable the governing body to identify where quality and safety is at risk or to enable improvement opportunities to be effectively identified.

The findings of non-compliance in three of five requirements in Standard 7 indicates the organisation’s workforce governance systems are not effective. The organisation’s processes have not ensured the workforce is competent, or supported to deliver safe and quality care and services to consumers, or that their performance is regularly reviewed. Processes to monitor and implement changes to legislative requirements are not effective. Appropriate and timely steps have not been taken to establish a quality of care advisory and consumer advisory body as required by legislation, not all staff have a current police clearance, and monthly consumer statements do not align with legislative requirements. I have also considered findings of non-compliance in relation to 16 requirements across six of the seven Quality Standards assessed indicates the organisation are not complying with their regulatory obligations. In relation to feedback and complaints, there are currently no formal reporting processes relating to feedback and complaints data to ensure the governing body has oversight and awareness of complaints raised or to enable trends and continuous improvement opportunities to be identified.

In relation to financial governance, I have considered information in the assessment team’s report indicates there are related governance systems in place to ensure oversight by the governing body, and Board meeting minutes reflect discussions of wages, pricing and quarterly financial reports.

For the reasons detailed above, I find requirement (3)(c) in Standard 8 Organisational governance non-compliant.

**Requirement (3)(d)** Risk management systems and practices relating to identifying and responding to abuse and neglect and supporting consumers to live the best life they can were demonstrated. However, the assessment team recommended this requirement not met as effective risk management systems and practices relating to managing high impact or high prevalence risks and management and prevention of incidents were not demonstrated.

High impact or high prevalence consumer risks are not identified, planned for or communicated. Staff were unable to describe risks associated with individual consumers, recommendations from allied health professionals to assist in preventing falls incidents were not included in a plan for care, and information regarding risks associated with the care of each consumer was not effectively communicated where responsibility is shared.

An incident management system consistent with processes outlined in organisational governance policy and procedure is not in place. Management confirmed no reports are developed to report incident data to the Board, and committees noted in policy have not been established. Incident data sampled consisted of two incidents occurring in May and August 2023. The May 2023 incident includes an allegation that a consumer had been inappropriate toward a sub-contracted care worker when providing care. The incident report was completed by the sub-contracted service using their own internal reporting mechanisms and had been forwarded to the provider. While management said the incident has been investigated, allegations made by the care worker discussed with the consumer’s representative and the consumer’s care plan has been updated to include information regarding inappropriate behaviours, no evidence of the investigation was provided, and the consumer’s care plan does not include information relating to the incident.

The provider’s response indicates the organisation will effectively manage risk, including, but not limited to, high impact or high prevalence risk; respond to abuse and neglect; managing and preventing incidents; and supporting consumers to live the best life they can through embedded systems and practices. The provider states the incident management system has been reviewed, with policies and procedures based on a set of guidelines and protocols outlining how incidents should be reported, recorded, managed and resolved. Regular education sessions are organised to prepare management, carers and workers to understand these policies and systems.

I acknowledge the provider’s response. However, I find risk management systems and practices relating to managing high impact or high prevalence risks and managing and preventing incidents are not effective. I have considered high impact or high prevalence risks are not monitored overall to enable emerging trends to be identified and timely actions to be implemented. Assessments to identify risks have not undertaken to inform staff of consumer risks and strategies to manage or mitigate risks have not developed, therefore, not ensuring preventable harm to consumers is identified and managed. As such, I consider such practices do not ensure the possibility of risks and the impact to consumers is reduced. Current incident management processes are not effective, nor are they aligned with the organisation’s or service’s actual processes and practices. There are currently no formal reporting processes relating to incident data to ensure the governing body has oversight and awareness of incidents that are occurring or to enable trends to be identified, drive continuous improvement and prevent similar incidents from occurring. I have also considered where incidents have occurred, these have not been appropriately actioned, nor appropriate safeguards implemented to ensure risks to consumers’ health and well-being are minimised and/or eliminated.

For the reasons detailed above, I find requirement (3)(d) in Standard 8 Organisational governance non-compliant.

**Requirement (3)(e)** The organisation has a clinical governance framework, supported by policies and procedures, which includes, but is not limited to, antimicrobial stewardship, minimising use of restraint and open disclosure. However, the assessment team recommended this requirement not met as clinical care governance processes described within the framework do not align with actual practice and the governing body does not have oversight of clinical issues impacting consumers.

Key aspects of the clinical governance framework as outlined in organisational governance policy and procedure are not embedded into practice. The service does not develop a report for the improvement committee and quality advisory committee which includes clinical governance issues, improvement actions/updates, risk controls or incident data. Internal audits are not conducted to identify areas for improvement in clinical care provision. A clinical care committee, responsible for review of clinical governance processes, clinical indicators and performance regarding medication management and infection prevention and control practices has not been established. While clinical governance framework processes outlined in policies and procedures include responsibilities of clinicians, clinicians are not directly employed by the organisation. Management confirmed a report which includes clinical indicator or incident data is not provided to the Board, with clinical advice provided verbally to them by the chairman of the Board who is a medical officer.

The provider’s response indicates the organisation will ensure it is governed by a clinical governance framework that includes antimicrobial stewardship, minimising the use of restraint, open disclosure, senility, mental health issues and encouraging an active lifestyle.

I acknowledge the provider’s response. However, I find the organisation’s current clinical governance framework is not effective, nor is it aligned with the organisation’s or service’s actual processes and practices. I have also considered there are currently no formal reporting processes relating to clinical indicator data or incidents to ensure the governing body has oversight and awareness of the clinical care and services being delivered or to ensure good clinical results for consumers are achieved and maintained.

For the reasons detailed above, I find requirement (3)(e) in Standard 8 Organisational governance non-compliant.

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)