**Performance**

**Report**

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| Name: | Mid North Community Passenger Network |
| Commission ID: | 600619 |
| Address: | 4 Gleeson Street, CLARE, South Australia, 5453 |
| Activity type: | Quality Audit |
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| Performance report date: | 15 August 2024 |

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

# Service included in this assessment

Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 9909 Clare and Gilbert Valleys Council  
Service: 27837 Clare and Gilbert Valleys Council - Community and Home Support

**This performance report**

This performance report for Mid North Community Passenger Network (**the service**) has been prepared by R Falco, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the quality audit report, which was informed by a site assessment, observations at the service, review of documents and interviews with staff, management, clients and others; and
* the provider’s response to the assessment team’s report received 29 July 2024 stating they have commenced resolving the issues identified.

# 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 | **Not Compliant** |
| **Standard 4** Services and supports for daily living | **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) and (3)(d)**

* Ensure identified risks to clients’ health and well-being are assessed and appropriate management strategies developed and implemented to enable staff to provide quality care and services, specifically in relation to those with mobility, cognition or other health related issues to support delivery of safe transport services.
* Ensure outcomes of assessment and planning are effectively communicated to clients and documented in a care plan that is readily available to the client.

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

* Review processes to ensure all feedback and complaints are captured to identify emerging trends and improvement opportunities.

**Standard 7 requirement (3)(d)**

* Review processes and monitoring to ensure staff are trained, equipped and supported to deliver outcomes of the Quality Standards including the serious incident response scheme (SIRS) and manual handling.

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

* Establish reporting mechanisms to ensure the governing body is aware of and accountable for the delivery of care and services.
* Establish and embed organisational governance systems in relation to information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints.
* Establish and embed organisational risk management processes in relation to managing high impact or high prevalence risks and managing and preventing incidents.

# Other relevant matters:

* The service provides CHSP transport services across selected regional local government areas.
* Quality Standard 3 Personal care and clinical care, and requirement (3)(e) in Standard 8 Organisational governance were not assessed as the service does not provide personal and/or clinical care.
* Requirement (3)(f) in Quality Standard 4 Services and supports for daily living was not assessed as the service does not provide meals to clients.
* Quality Standard 5 Organisation’s service environment was not assessed as the service does not deliver care and services from their own service environment.

# 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

Clients confirmed the service recognises and values their identity, culture and diversity and staff treat them with dignity and respect. Clients were confident they can make decisions about the care they receive and are supported to take risks to live the best life they can.

Care documentation recorded clients’ cultural needs and preferences and confirmed clients’ choice in service provision and involvement of others. Staff demonstrated knowledge and understanding of clients’ culture and were respectful and kind when discussing their needs. Observations showed care documentation is password protected and clients expressed satisfaction with how their information is managed.

Clients confirmed information is provided to them on commencement of services. Documentation showed the information provided to clients included a welcome letter, the Aged Care Charter of Rights, pamphlets of services available and how to raise a complaint. Policies and procedures are in place to guide staff, and cultural safety and awareness training is undertaken.

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

# 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. | 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. | 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. | Compliant |

Findings

The Quality Standard is not compliant as 2 of the requirements have been found non-compliant. The assessment team recommended requirements (3)(a) and (3)(d) not met.

**Requirement (3)(a)**

The assessment team recommended requirement (3)(a) not met as assessment and planning did not consider the risks associated with clients, specifically those with mobility, cognition or other health related issues. The assessment team’s report provided the following evidence relevant to my finding:

* For 3 named clients, information regarding their chronic health conditions and related mitigation strategies, such as diabetes, epilepsy and shortness of breath, were not assessed or recorded in care documentation whilst noting all 3 consumers are being provided transport services to attend a specified activity.
* Coordinators acknowledged identified risks were not assessed, documented or mitigation strategies implemented.

I acknowledge the provider’s response. In coming to my finding, I find the service did not demonstrate assessment and planning, including the consideration of risk, informs the delivery of safe and effective care and services. I have considered information in the assessment team’s report where assessments to identify risks to 3 named clients were not undertaken, nor strategies implemented to minimise risks. Additionally, I have considered information from requirement (3)(d) of Standard 8, where staff described undertaking steps to identify risks to clients prior to transport activities, however, these were not based on formalised assessment processes.

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

**Requirement (3)(d)**

The assessment team recommended requirement (3)(d) not met as care planning documentation was not readily available to clients or others who provide care and services. The assessment team’s report provided the following evidence relevant to my finding:

* Five clients confirmed they had not been offered or given a copy of their transport schedule.
* Two staff confirmed they are only verbally informed about clients’ transport requirements and do not have access to additional information.
* Client files do not include transport schedules and only coordinators and their assistant have access to client files and information.
* Coordinators confirmed staff do not have access to client files, and service requirements are communicated by phone to staff.

I acknowledge the provider’s response. In coming to my finding, I find the service did not demonstrate outcomes of assessment and planning are documented in a care and services plan that is readily available to clients, and where services are provided. I have considered the information in the assessment team’s report, and the feedback provided from clients and staff, which confirmed information was not available where care and services are provided as only coordinators and their assistant have access to clients’ care file information. Clients confirmed a copy of a services plan was not provided to them and evidence provided showed clients’ needs are communicated within the service verbally and via mobile telephone, and drivers do not have access to clients’ full information to guide them to ensure safe and effective delivery of services.

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

**In relation to requirements (3)(b), (3)(c) and (3)(e)**

Care files showed clients’ current care and service needs and preferences are assessed and documented. Coordinators confirmed some clients provide advance care directive information; however, this is not included in assessment and care planning. Coordinators stated they did not know advance care planning was required under the Quality Standards and stated all clients will be asked if they wished to discuss advance care planning and end of life wishes at their next review or phone contact.

Clients confirmed they are involved in making decisions about the services they receive. Care files showed information regarding clients’ external health professionals or external providers are documented. Coordinators described assisting clients with information regarding health services within the region and provide transport to these services.

Care files showed services are regularly reviewed and updated when there are changes to clients’ needs, goals and preferences. Clients confirmed the service undertakes reviews and changes their services in line with their needs or circumstances. Coordinators confirmed clients’ needs are documented in their care file and updated when they are advised of changes.

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

# 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)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Clients are satisfied the services provided enables them to optimise their independence, well-being and quality of life. Staff described how they ensure the service they provide meets the clients’ needs, goals and preferences, such as assisting clients with mobilising to the vehicle. Coordinators confirmed clients have choice in the transport services they receive and how services are tailored to their needs. Care files confirmed services are tailored to the clients’ needs, goals and preferences, to optimise their independence and quality of life.

Clients described how their emotional and psychological well-being is enhanced and confirmed staff know them well. Staff and coordinators were knowledgeable about clients and described strategies in place to support their emotional, spiritual and psychological well-being. Care files included information pertaining to clients’ emotional well-being, changes in behaviour, mood, and overall health.

Coordinators described how transport services encourage and enhance clients’ independence and described how clients can choose the structure of their services to do the things of interest to them. Staff described supporting clients with social and personal relationships and clients confirmed the services provided allows them to do things of interest to them, such as meeting friends or attending medical appointments.

Coordinators described various processes to communicate the condition, needs and preferences of clients with staff and external providers. Coordinators confirmed they communicate with other councils to provide transport services if they are unable to assist clients. Staff confirmed the coordinators communicate any changes or needs of clients, including rescheduling of services.

Referral processes are utilised by staff when the service is unable to undertake the transport themselves. Clients confirmed the service provides referrals to external providers if they are unable to provide the service they require. Coordinators confirmed utilising local councils, referring clients to them in line with their needs and preferences.

Clients confirmed service vehicles and equipment are safe, suitable, clean and well maintained. Observations of service vehicles showed equipment, including lazy sue cushions were clean and suitable, and documentation showed registration and insurances are current.

Based on the assessment team’s report, I find all requirements in Standard 4 Services and supports for daily living compliant, therefore, the Quality Standard is compliant.

# 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

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

**Requirement (3)(d)**

The assessment team recommended requirement (3)(d) not met as feedback and complaints are not consistently recorded, analysed and trended to improve the quality of services. The assessment team’s report provided the following evidence relevant to my finding:

* Three clients provided examples of feedback and complaints raised with the service, which were not documented in a feedback register.
* Staff confirmed feedback has been provided to the service regarding service delivery and car cleanliness, and this had not been recorded on a feedback register.
* Coordinators confirmed feedback is not documented on a feedback register although a complaints policy and procedure states feedback provided will be documented by the coordinator to identify trends.

I acknowledge the provider’s response. In coming to my finding, I find the service did not demonstrate feedback and complaints are reviewed and used to improve the quality of care and services. I have considered the information in the assessment team’s report and placed weight on documentation and management comments which confirm the service does not consistently document feedback and complaints to enable the analysis and trending of information to improve the quality of care and services.

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

**In relation to requirements (3)(a), (3)(b) and (3)(c)**

Clients confirmed they receive information regarding feedback processes upon commencement of the service and feel confident in raising issues if needed. Staff and coordinators described how they encourage and support clients in providing feedback and complaints. Documentation showed complaints and feedback policies are in place, while staff duty statements include requirements for staff to provide feedback on experiences and services. A survey completed in 2022 showed 100 clients were invited to participate, with 75 clients completing the survey.

Coordinators confirmed clients are provided with a welcome pack on commencement which includes the Aged Care Charter of Rights and the contact details for translating and interpreting services. Clients confirmed they are provided with the Aged Care Charter of Rights and brochures are displayed in the council lobby on advocacy services. Processes for clients to contact advocacy and complaints services are in place should they be unhappy with the response or outcome of their complaint.

Clients confirmed appropriate action is taken when feedback has been provided to the service. Staff described escalating complaints to coordinators when they receive feedback and complaints from clients during services. Documentation showed complaints which were recorded, had appropriate actions taken in response. Coordinators confirmed responding to feedback and complaints in a timely manner, although they are not consistently documented.

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 | | 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. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The Quality Standard is not compliant as one of the requirements has been found non-compliant. The assessment team recommended requirements (3)(a) and (3)(d) not met.

**Requirement (3)(a)**

The assessment team recommended requirement (3)(a) not met as planning of the workforce to enable the delivery of safe and quality services was not demonstrated. The assessment team’s report provided the following evidence relevant to my finding:

* Systems to report transport activities undertaken are not used to inform workforce planning. The governing body said the workforce had last been reviewed 2 years ago, and there is no documented contingency plan for the continuation of services should coordinators be absent.
* All clients were satisfied with the number and mix of staff.
* Coordinators stated they do not have adequate time to perform all duties required of their role, including ensuring staff qualifications and competencies are current.
* Steering committee reports show transport services increased by 40 trips from February 2023 to February 2024 and includes systems for planned leave and ongoing recruitment initiatives.

I acknowledge the provider’s response. Based on the information included in the assessment team’s report; I have come to a different view from the assessment team and find the service demonstrated it has the right number and mix of staff to deliver care and services. In coming to my finding, I have considered all clients sampled reported satisfaction with the number and mix of staff, confirming services are delivered in a way that meets their needs, goals and preferences. I have placed weight on the evidence that shows the service has an effective system of rostering staff, including unplanned leave. Further, I have considered information in requirement (3)(e) in Standard 4 that shows the service has systems and processes in place to refer clients to another transport provider or council when they are unable to provide services.

In relation to the service not having documented contingency plans, and the corporate services officer feedback regarding training, I have considered these in requirement (3)(d) of Standard 7 and requirement (3)(c) of Standard 8, where it is more aligned.

For the reasons above, I find requirement (3)(a) in Standard 7 human resources compliant.

**Requirement (3)(d)**

A recruitment and induction process was demonstrated; however, the assessment team recommended requirement (3)(d) not met as the training provided did not support the workforce deliver outcomes for clients in line with the Quality Standards, specifically in relation to manual handling and SIRS. The assessment team’s report provided the following evidence relevant to my finding:

* Six staff confirmed they have not been provided with education on elder abuse or manual handling by the service.
* Coordinators confirmed staff receive information sheets on correct manual handling techniques, however, no training has been provided in relation to manual handling or elder abuse.
* Corporate staff stated they had not received training in relation to the Quality Standards and had limited knowledge.
* Senior management showed limited knowledge in relation to SIRS and elder abuse and confirmed they had not received training in relation to these areas, or the Quality Standards.
* The SIRS policy and procedure outlines mandatory training in relation to incident reporting for all staff which has not been undertaken, with the requirement for incident reporting not included in duty statements.

I acknowledge the provider’s response. In coming to my finding, I have considered the information in the assessment team’s report, and I have placed weight on feedback provided by staff confirming training had not been consistently provided on manual handling, SIRS, or elder abuse. The intent of this requirement is to support the workforce in their day-to-day practice to minimise risk and improve the care outcomes for clients. Whilst clients felt staff were well trained and felt safe when services occurred, I find the training was not adequately provided to the workforce to support all areas of their roles and responsibilities.

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

**In relation to requirements (3)(b), (3)(c) and (3)(e)**

Clients confirmed staff treat them with respect, courtesy and they feel valued. Staff described clients in a kind manner and provided examples of catering to their individual needs. Coordinators and documentation showed recruitment processes to outline the organisation’s values, expected behaviour and standards.

Clients confirmed staff are competent and they feel safe when they are being transported to their appointments or activities. Staff confirmed screening processes, including driving tests, medical exams and pre-screening checks are undertaken prior to commencing. Coordinators confirmed induction processes include an assessment of competencies and qualifications. A spreadsheet is maintained to monitor application processes during recruitment and completion of competencies.

Coordinators and staff confirmed performance appraisals are undertaken annually in line with organisational processes. Staff confirmed they undertake driving assessments every 5 years and maintain their driver’s licence. The governing body confirmed staff undergo annual performance appraisals with outstanding appraisals discussed at senior management meetings. Management meeting minutes show human resource issues are discussed and includes reminders for staff to completed performance appraisals.

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

# 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 |

Findings

The Quality Standard is not compliant as 3 of the requirements have been found non-compliant. The assessment team recommended requirements (3)(b), (3)(c) and (3)(d) not met.

**Requirement (3)(b)**

The assessment team recommended requirement (3)(b) not met as accountability of the governing body for the quality and safety of services provided was not demonstrated. The assessment team’s report provided the following evidence relevant to my finding:

* The governing body does not have knowledge of the transport service’s performance in relation to the Quality Standards as it is not a part of core council business, and it is the corporate services officer’s responsibility to oversee the service in relation to the Quality Standards.
* Senior management does not attend any steering committee meetings and does not have knowledge of reporting obligations for SIRS.
* A strategic plan for 2020 to 2025 is in place, however, does not include evidence of evaluation and monitoring against the identified performance measures.

I acknowledge the provider’s response. In coming to my finding, I have considered the organisation’s governing body does not promote a culture of safe, inclusive and quality care and services and is accountable for their delivery. The governing body does not have oversight over transport services, or performance in relation to the Quality Standards. Additionally, management and the governing body do not have clear accountabilities for oversight of service delivery and performance.

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

**Requirement (3)(c)**

The organisation has a financial governance system in place, however, the assessment team recommended requirement (3)(c) not met as effective organisational governance systems for information management, workforce governance, regulatory compliance, continuous improvement and feedback and complaints were not demonstrated. The assessment team’s report provided the following evidence relevant to my finding:

* Organisational policies and procedures are not tailored to outcomes required by the Quality Standards in relation to assessment and planning, complaints, incident management, elder abuse, and SIRS.
* Organisational systems have not been effective to identify deficits in workforce management.
* The governing body does not have systems or processes in place to ensure they are updated in relation to regulatory change.
* Systems to record, monitor and evaluate feedback and complaints were not utilised by the transport service to facilitate analysis and trending of data.
* Continuous improvement processes are in place, however, they are not consistently used.

I acknowledge the providers response. In coming my finding, I have considered deficits in governance systems which included ineffective recording, reporting and analysing of data to ensure the governing body has oversight of the service’s performance. In relation to information management systems, I have considered information in Standard 2, which outlines insufficient policies and procedures to guide staff practice in assessment and planning and information systems which do not facilitate the documentation or communication of care plans to staff and others. In relation to workforce governance, I have considered information in Standard 7, where it was identified the organisation did not have a contingency plan if coordinators are unavailable, or training to ensure the workforce has the skills and knowledge required to undertake their roles. In relation to feedback and complaints, while the organisation has documented processes in relation to feedback and complaints, the service does not use them and oversight processes did not identify that feedback and complaints were not being documented, trended or analysed.

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

**Requirement (3)(d)**

Clients are supported to live the best life they can, however, the assessment team recommended requirement (3)(d) not met as effective risk management systems and practices were not demonstrated. The assessment team’s report provided the following evidence relevant to my finding:

* Risk management policies do not consider risks relating to clients engaged in transport services in relation to assessment and planning or scheduling and prioritising services.
* Staff confirmed no training or formal process exist to identify risks prior to transport activities and currently use common sense to identify and mitigate risks.
* Coordinators confirmed an incident register was not used to monitor, assess and prevent incidents by the transport service.
* All staff confirmed they had not received training in relation to elder abuse. They confirmed they would escalate to the coordinator if they suspected abuse was occurring.

I acknowledge the provider’s response. In coming to my finding, I have considered the information in the assessment team’s report and documentation, which did not include the use of risk or incident registers to demonstrate how risks to clients are monitored by the governing body. I have placed weight on evidence stating the governing body does not understand the risks associated with transport services and feedback confirming processes in relation to incident management, the assessment and identification of risk, and training were not implemented. Service policies and procedures do not include risks for clients receiving transport services.

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

**In relation to Requirement (3)(a)**

Clients confirmed they are involved in designing services to meet their needs and confirmed the results from past surveys were utilised to improve the service provided. Coordinators described processes to engage clients in the development and delivery of services. The governing body includes representatives from the council and staff, however, does not include clients. The governing body confirmed clients can access council processes through various mechanisms, including the website, and community forums.

Based on the assessment team’s report, I find requirement (3)(a) in Standard 8 Organisational governance 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)