Performance

Report

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| Name of service: | Performance report date: |
| Milang and Clayton Community Care | 8 September 2022 |
| Commission ID: | Activity type: |
| 600034 | Quality audit |
| Approved provider: | Activity date: |
| Milang and District Community Association Incorporated | 5 July 2022 to 8 July 2022 |

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.

**This performance report**

This performance report for Milang and Clayton Community Care (**the service**) has been considered by M Murray, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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.

# Services included in this assessment

**Home Care:**

* Lower Lakes Home Care, 26477, 24 Daranda Terrace, MILANG SA 5256

**CHSP:**

* Domestic Assistance, 4-7XBT8AA, 24 Daranda Terrace, MILANG SA 5256
* Home Maintenance, 4-7XC4E3U, 24 Daranda Terrace, MILANG SA 5256
* Meals, 4-7XC4EGV, 24 Daranda Terrace, MILANG SA 5256
* Social Support - Group, 4-7XC4EPF, 24 Daranda Terrace, MILANG SA 5256
* CHSP Personal Care, 4-7XC4ELU, 24 Daranda Terrace, MILANG SA 5256
* Social Support - Individual, 4-7XCA3C2, 24 Daranda Terrace, MILANG SA 5256
* CHSP Transport, 4-7XCA3GD, 24 Daranda Terrace, MILANG SA 5256

# Material relied on

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

* the assessment team’s report for the Quality audit, the Quality audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received 16 August 2022.

# Assessment summary

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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 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

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

# Areas for improvement

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

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

Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.

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

Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.

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

The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.

**Requirement 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

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

Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:

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

Effective management of high impact or high prevalence risks associated with the care of each consumer.

**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.

**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.

**Requirement 6(3)(a)**

Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.

**Requirement 6(3)(c)**

Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

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

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

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

The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

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

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

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

Effective organisation wide governance systems.

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

Effective risk management systems and practices, including but not limited to the following:

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

Where clinical care is provided—a clinical governance framework, including but not limited to the following:

# Other relevant matters:

The approved provider has been continuously non-complaint with Standard 2 and Standard 8 since 12 November 2019.

# Standard 1

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| --- | --- | --- |
| Consumer dignity and choice | | Compliant |
| 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

I have relied on the evidence of the Assessment Team’s report in my findings of compliance as outlined in the table above and do not intend to detail the evidence again in this report. A summary of the Assessment Team’s evidence is set out below.

The Assessment Team’s report outlines consumers and representatives considered that consumers are treated with dignity and respect. Consumers said they are supported to maintain their independence and live the life they choose.

Consumers and representatives told the Assessment Team the service understands what is important to consumers in their day to day lives and described how services are delivered in a culturally safe way.

Staff described to the Assessment Team how they respect each consumer’s identity and culture while providing services, and how they support consumers to make informed choices about their care and services. This includes if they wish to take risks and who else they wish to involve in decisions about their care.

The Assessment team reviewed the policies and procedures the service has to support an inclusive, consumer-centred and culturally safe approach to the delivery of consumers’ care and services and were satisfied these are applied in practice.

The Assessment Team is also satisfied that care assessments and care planning are undertaken in partnership with the consumer and the service has processes to ensure each consumer’s privacy and confidentiality is maintained.

Staff, contractors and volunteers described to the Assessment Team how they promote choice and independence to consumers, and documents confirmed, in most cases, how consumers had been consulted in making decisions about their care and services.

The Assessment Team received some consumer feedback that consumers are not satisfied with communications about fees and communications about reductions in gardening services.

The approved provider submitted letters that had been sent out to consumers.

While consumers are dissatisfied with the content of communications from the approved provider, I am satisfied, based on all the relevant evidence, that the service is complying with requirement 1(3)(e).

I have considered other evidence provided in the Assessment Team’s report under requirement 1(3)(e) in my compliance findings in Standard 6.

# Standard 2

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| --- | --- | --- |
| Ongoing assessment and planning with consumers | | Not Compliant |
| 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 Assessment Team reviewed care planning documentation for 13 consumers receiving either Commonwealth Home Support program (CHSP) funding or receiving a home care package (HCP).

The Assessment Team’s report provides evidence that relevant assessments had not been completed for all consumers and, for some HCP consumers, where a clinical assessment had been completed in the last 12 months, relevant risks did not have corresponding strategies in place to minimise or mitigate these risks for the consumer.

Further, consumers living with dementia and / or with complex care needs did not have care plans which evidenced an individualised dementia care approach.

The Assessment team interviewed CHSP and HCP consumers about their needs and found care plans did not always reflect their current care needs as described by the consumers. As such, staff using these care plans to direct their actions would not be fully informed as to how to deliver safe care for these consumers. Representatives told the Assessment Team care plans are not always available at the point of care when care is being delivered in the consumer’s home.

The approved provider’s response notes that assessment and planning procedures are being updated to ensure all care plans have sufficient and tailored information to inform care delivery.

Individual protocols are also being developed for areas of complex health care, for example skin integrity and wound management.

I am satisfied based on all the relevant evidence, which includes evidence outlined in the Assessment Team’s report in Standard 3, that the approved provider does not comply with the requirements as outlined in the table above.

I have relied on the evidence of the Assessment Team’s report in my finding of compliance for the requirement 2(3)(c).

The approved provider’s response generally accepts the Assessment Team’s findings and I acknowledge the continuous improvement plan submitted by the approved provider and the actions planned.

# Standard 3

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| --- | --- | --- |
| Personal care and clinical care | | Not Compliant |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Not 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

I have relied on the evidence of the Assessment Team’s report in my findings of compliance in requirements 3(3)(c); 3(3)(f) and 3(3)(g) and do not intend to detail the evidence again in this report. A summary of the Assessment Team’s evidence is set out below.

The Assessment Team’s report outlines consumers and representatives feel consumers get the personal care and clinical care they need through either their CHSP funding or their HCP. All consumers advised the Assessment Team they have access to their doctor and other health care professionals when they need access.

Staff described to the Assessment Team how the personal and clinical care being provided to consumers is tailored to their needs and optimises the consumer’s health and well-being.

Management demonstrated to the Assessment Team processes to ensure, if a consumer requires palliative care or end of life care, the service can work collaboratively with a specialist palliative care team to manage the consumer’s end of life needs.

While management satisfactorily described the processes in place to ensure safe and effective personal and clinical care for consumers, such as the employment of clinical staff to oversee the clinical care for consumers, the Assessment Team’s report also evidences consumers are being impacted by unsatisfactory clinical management.

The report outlines an example of changed behaviours for a HCP consumer living with dementia where staff appear to be left to their own devices to try to manage the situation. It was not evident to the Assessment Team from interviewing staff that they are adopting an agreed best practice approach to de-escalate the consumer’s dementia related behaviours. While strategies being deployed were not always effective, a formal review had not occurred to test out other possible approaches. Telephone contact numbers for specialised dementia services were provided to the family, however, the service itself took no active role in seeking out specialist advice to support their staff or the well being of the consumer.

The report also outlines two consumers recently hospitalised with deteriorating health have not had re-assessments of their care needs undertaken.

Clinical staff and management advised the Assessment Team that unwitnessed falls are the greatest risk for consumers receiving CHSP and HCP services, however the Assessment Team’s report outlines that staff did not take action to mitigate the risk of falls for consumers when their risk of a further fall occurring was known to be increasing.

Staff told the Assessment Team they rely on their own knowledge and/or feedback from consumers/representatives to minimise consumers’ risks rather than the documented care plan.

The evidence in the Assessment Team’s report and the approved provider’s response in relation to follow up of the consumer living with dementia is in conflict and has not been tested through interviews with the individual consumer or their representative. The service asserts that additional services have been offered to the consumer, however the consumer / representative has declined.

The approved provider’s response provides further details on the background of the two consumers recently hospitalised as noted in the Assessment Team’s report. The approved provider asserts that the service’s follow up of consumers with deteriorating health is adequate.

I am satisfied based on all the relevant evidence that the service is not providing best practice dementia care and does not comply with requirement 3(3)(a). I am persuaded by the evidence of the Assessment Team which includes direct feedback from staff.

I am satisfied based on all the relevant evidence that the approved provider does not comply with requirement 3(3)(b). The approved provider accepts the Assessment Team’s findings.

Based on all the relevant evidence I find the service complies with requirements 3(3)(d). I note both consumers named in the Assessment Team’s report had been discharged from hospital in the week of the audit. I also note that some additional services had already been put in place, the service had visibility to hospital discharge information and that a clinical review was planned in the coming days. I consider the service response is reasonable and the timeframe of their actions is reasonable.

I have relied on the evidence of the Assessment Team in my finding of non-compliance with requirement 3(3)(e) which includes direct feedback from staff that documentation is not generally relied upon to deliver services. The approved provider accepts the Assessment Team’s findings

I acknowledge the continuous improvement plan submitted by the approved provider and the actions planned.

# Standard 4

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

## Findings

I have relied on the evidence of the Assessment Team’s report in my findings of compliance as outlined in the table above and do not intend to detail the evidence again in this report. A summary of the Assessment Team’s evidence is set out below.

The Assessment Team’s report outlines consumers are satisfied they are supported to maintain their independence and do the things they want to do.

Consumers told the Assessment Team they receive services for daily living that optimises their independence, wellbeing and quality of life, and enables them to participate in the community and have social relationships.

Consumers and representatives are satisfied services and supports for daily living promote consumers’ emotional, spiritual and psychological well-being. Consumers described to the Assessment Team how staff support them when they are feeling low. Management described the welfare checks put in place to meet consumer’s emotional and psychological needs during government restrictions related to COVID-19.

The Assessment Team are satisfied that plans for services of daily living are developed in consultation with the consumer and/or representative, and are informed by the consumer’s needs, goals, and preferences.

Staff are satisfied with the level of information they receive about consumers and said to the Assessment Team that information is generally communicated verbally.

Management’s approach to service delivery is outlined in the Assessment Team’s report which evidences the service works with staff and volunteers to help consumers follow their interests, and remain connected to the community.

In relation to 4(3)(a) the Assessment Team’s report outlines, 10 of 13 consumers and/or their representatives described they are reluctant to follow up with the service regarding their requests for services and supports for daily living, as requests are not acted on in a timely manner.

Four consumers and/or their representatives advised the Assessment Team they have been requesting window cleaning for an extended period of time and there has been no communication from the service regarding this. Three further consumers advised they are awaiting information and clarification on meal services. An additional consumer stated they are not aware of the social activities on offer by the service and they would like to participate in activities.

The approved provider’s response outlines the introduction of a newsletter to better inform consumers of lifestyle services and supports that are available at the centre. The response also outlines the impact of COVID-19 on contracted services delivering gardening and maintenance and that this accounts for the majority of the delays. There has been a recent meeting in regard to meals that can be purchased though a home care package and the service will continue to promote this option through its proposed newsletter.

I acknowledge the actions of the approved provider; however, I am persuaded by the consumer feedback in the Assessment Team’s report and find the service does not comply with requirement 4(3)(a).

The approved provider’s response generally accepts the Assessment Team’s findings and I acknowledge the continuous improvement plan submitted by the approved provider and the actions planned.

# Standard 5

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| Organisation’s service environment | | Compliant |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

## Findings

I have relied on the evidence of the Assessment Team’s report in my findings of compliance as outlined in the table above and do not intend to detail the evidence again in this report. A summary of the Assessment Team’s evidence is set out below.

Consumers told the Assessment Team they feel welcome and safe in the service environment and the buildings and their surrounds are clean and well maintained.

The Assessment team also observed the environment to be clean and comfortable and spoke to management about how maintenance is managed. While the service could not demonstrate an effective monitoring process for preventative maintenance, management could demonstrate actions taken to address individual reactive maintenance issues as they occur, as well as some preventative actions. The Assessment team accepted the advice of management at the time of the audit that the centre will implement a preventative maintenance process.

**Standard 6**

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| Feedback and complaints | | Not Compliant |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Not 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. | Not Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant |

## Findings

The service demonstrated to the Assessment Team that they encourage consumers to provide feedback and make a complaint; however, a number of consumers noted in the Assessment Team’s report expressed a reluctance to complain and felt complaints would not remain confidential.

The Assessment Team’s review of the complaints register notes 3 complaints registered in the previous seven months, it was not clear to the Assessment team how complaints had been closed out and one consumer interviewed felt, while some actions had been taken, their satisfaction with the outcome was not sought. I note at the time of the audit the service had approximately 200 consumers. I also note feedback throughout the Assessment Team’s report of consumer complaints about gardening, maintenance and fees that have not been sufficiently captured by the service’s complaint’s management system.

Management were unable to identify an improvement to the Assessment Team that had been considered or actioned as a result of consumer feedback.

The approved provider’s response outlines a new procedure for managing complaints has been developed and management will monitor the complaints data monthly to ensure the policy is being applied. Staff have been provided with training on complaints management to support them to record and manage complaints and to seek the consumer’s level of satisfaction with the outcome.

A new feedback form has been developed to send to all clients to encourage them to provide feedback, the form includes the option to remain anonymous if desired.

I have relied on the evidence of the Assessment Team’s report (summarised above) in my finding of compliance for requirement 6(3)(b). The Assessment Team’s report states they viewed the information provided to consumers on entry to the service which included brochures on Aged Rights Advocacy Services and the Aged Care Quality and Safety Commission.

The approved provider’s response generally accepts the Assessment Team’s findings. I note the approved provider’s assertion that, notwithstanding record keeping deficits, that they do take ownership of resolving complaints and I acknowledge the continuous improvement activities as outlined above.

I am satisfied based on all the relevant evidence that the approved provider does not comply with the requirements as outlined in the table above.

**Standard 7**

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| Human resources | | Not Compliant |
| 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

I have relied on the evidence of the Assessment Team’s report in my findings of compliance as outlined in the table above and do not intend to detail the evidence again in this report. A summary of the Assessment Team’s evidence is set out below.

The Assessment Team’s report notes that the service was able to demonstrate the workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.

Most consumers and representatives told the Assessment Team they are satisfied with the number of staff available to deliver the consumer’s services, and staff interviewed said in various ways staff levels generally reflect the workload.

Consumers and representatives told the Assessment Team that staff treat them with respect and are responsive to their needs. The Assessment Team observed staff and volunteers at the social support group interacting with consumers in a kind, caring and respectful manner.

The Assessment Team was satisfied with how the service described their human resource system and described the processes in place to ensure that the employee that is hired is competent to perform the requirements of the role.

In relation to requirement 7(3)(d) the Assessment Team’s report outlines three of five staff interviewed had not had an induction upon commencement with the service.

The service began using an online training system in 2021 and some staff, contractors and volunteers told the Assessment team they did not feel they have had all of the relevant training required to undertake their roles.

The approved provider’s response outlines that online induction training has now been completed by all outstanding staff. The service has also uploaded the employee handbook, the staff induction book, and policies and procedures onto the service’s information management system. All support workers can access this system remotely.

Management will also conduct training on the information management system, including how to access information and complete relevant items such as an incident report.

In relation to requirement 7(3)(e) management was able to demonstrate to the Assessment Team that all direct employees had received a performance review within the past 12 months. The Assessment Team’s report notes that volunteer appraisals are not up to date. The approved provider’s response outlines performance appraisal for volunteers are somewhat behind due to challenges in engaging a volunteer coordinator.

I am satisfied that the service does not comply with requirement 7(3)(d) as care coordination staff do not have the relevant training in assessment, care planning and maintaining health records. Direct care staff also reported they did not feel fully equipped to undertake their role.

Based on all the relevant evidence I am satisfied the service complies with requirement 7(3)(e). I am persuaded that the service has a system for monitoring the performance of staff. I have considered the evidence of the Assessment Team about the performance management of staff working for the service via brokered arrangements in Standard 8.

**Standard 8**

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

## Findings

I have relied on the evidence of the Assessment Team’s report in my finding of compliance for requirement 8(3)(a) and do not intend to detail the evidence again in this report. In summary the Assessment Team’s report evidences surveys are periodically undertaken and consumers said they attend meetings at the service to provide their input into service development.

In relation to other Standard 8 requirements, the Assessment Team’s report identifies the governing body has significantly failed. The service was unable to demonstrate to the Assessment Team how oversight for achieving the requirements of the Quality Standards is maintained and how any failure is detected through the service’s own internal quality systems.

In terms of quality and safety, the Assessment Team’s report outlines difficulties in establishing what efforts the governing body has made to ask for information so that it can satisfy itself that safe care and services are occurring.

An organisational risk of note in the Assessment Team’s report is the service operates a brokerage model with arrangements for allied health and other tasks to be undertaken by third party providers. However, in the Assessment Team’s system review it identified the service does not have established reporting and monitoring requirements for these third parties to ensure consumers are receiving safe and effective care and services.

Similarly, the Assessment Team’s report outlines while there is evidence that critical information is discussed at a local level there is little evidence the governing body is analysing information to improve quality and safety in the organisation.

The Assessment Team’s report outlines conflicting evidence regarding the organisation’s financial governance system. While management was able to describe to the Assessment Team oversight of the service’s income, expenditure and financial position, consumers and representatives complained to the Assessment Team about a lack of consultation and transparency regarding service fees. Consumers and representatives also told the Assessment Team they were reluctant to provide feedback or make complaints on areas of concern citing confidentiality concerns.

The Assessment Team found deficits with the service’s risk management systems and regulatory reporting requirements including non-reporting of reportable issues. I also note the service has not self-identified the deficiencies in the Standards outlined in this report through its own risk management systems.

In regard to clinical governance, the Assessment Team noted a clinical governance policy is in place, however, relevant staff could not describe how this is applied in day to day practice.

The approved provider’s response generally accepts the Assessment Team’s findings.

The approved provider’s response notes that training on open disclosure has occurred, while antimicrobial stewardship and minimising the use of restraint training is planned and the service is seeking to appoint a member to the governing body who has a clinical background.

There is conflicting evidence in regard to sub requirement 8(3)(c)(iii) financial governance. The approved provider’s response notes they have reviewed all consumers named in the Assessment Team’s report in regard to fee charges and argue that fees have been applied appropriately in all instances.

I am not required to make an individual compliance finding for each sub requirement. I am satisfied based on all the relevant evidence that the approved provider does not have effective risk management systems and practices in place and I find the approved provider does not comply with requirement 8(3)(c). I am also satisfied based on the relevant evidence, summarised above, that the approved provider does not comply with the other requirements as outlined in the table above.

1. The preparation of the performance report is in accordance with section 57 of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)