**Performance**

**Report**

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| Name of service: | Mission Australia - HACC Transport |
| Service address: | 1 Carey Street DARWIN NT 0800 |
| Commission ID: | 600316 |
| Home Service Provider: | Mission Australia |
| Activity type: | Quality Audit |
| Activity date: | 4 August 2023 to 10 August 2023 |
| Performance report date: | 25 October 2023 |

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 Mission Australia - HACC Transport (**the service**) has been prepared by J Renna, 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.

# Services included in this assessment

**CHSP:**

* Community and Home Support, 23795, 1 Carey Street, DARWIN NT 0800

# 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; and
* the provider’s response to the Assessment Team’s report received on 8 September 2023 and 15 September 2023.

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| --- | --- |
| Standard 1 Consumer dignity and choice | Non-compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Not applicable** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Not applicable** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Non-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 1 Requirement (3)(f)

* Ensure processes are in place to consumers’ privacy and confidentiality is maintained.
* Ensure the organisation’s processes in relation to consumer privacy and confidentiality, are effectively understood and followed by staff.

Standard 2 Requirements (3)(a), (3)(d) and (3)(e)

* Ensure staff have the skills and knowledge to recognise risks associated with consumers’ health and well-being and initiate assessments, implement and/or review strategies and monitor effectiveness.
* Ensure consumer care plans are updated and reflective of consumers’ current and assessed needs and preferences to enable staff to provide quality services.
* Ensure policies and procedures in relation to assessment, care planning and review are effectively understood and followed by staff.

Standard 6 Requirement (3)(d)

* Ensure feedback and complaints, including those received verbally are documented on the feedback register and appropriately actioned.
* Ensure feedback and complaints data is regularly reviewed to identify trends and improvement opportunities to the quality of care and services.

Standard 8 Requirements (3)(a), (3)(b), (3)(c) and (3)(d)

* Ensure consumers and representatives are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.
* Ensure the governing body effectively monitors the timelines of implementation of actions to address deficiencies related to the non-compliance with the Quality Standards, including ensuring regular reporting from management.
* Ensure the governing body receives adequate information to ensure safe and quality care is being provided to consumers.
* Review the organisation’s governance systems in relation to information management, continuous improvement, regulatory compliance and feedback and complaints.
* Review the organisation’s risk management processes in relation to managing high impact or high prevalence risks associated with the care of consumers, incident management and managing and responding to abuse and neglect of consumers.

# 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. | Non-compliant |

Findings

Requirement (3)(a)

While the Assessment Team was satisfied each consumer is treated with dignity and respect, with their identity, culture and diversity valued, they assessed this Requirement not met, as this information is not routinely captured or documented. The Assessment Team provided the following evidence to support their assessment:

* Consumers described staff as kind, caring and respectful. One consumer said their specific cultural needs and preferences are not known or documented by staff.
* All consumer assessments sampled shows consumers identify as Australian, however, they represent varied cultures and identities. Assessments did not include questions to understand if consumers identify with a specific culture or identity.
* The permanent staff demonstrated extensive knowledge of consumers’ cultural needs and preferences, however, other staff said they do not have access to information to support their role.

The provider does not agree with the Assessment Team’s assessment and maintains the expectations of this Requirement are met. The provider’s response includes the following additional information and/or evidence to support its assertion:

* Explanation that while the Assessment Team identified information about consumers’ culture, identity and diversity isn’t routinely captured, their report states that ‘the service was able to demonstrate each consumer is treated with dignity and respect, and ‘consumers described staff as kind, caring and respectful.
* The organisation’s policies, procedures and strategies relating to diversity, inclusion, good working relationships and reconciliation, which were in place prior to the Quality Audit.
* Explanation that the organisation’s intake and assessment forms have been updated to include diversity questions, including LGBTQI, ethnicity, gender and language. Furthermore, a full audit of consumer information will commence in September 2023 to ensure all relevant information is captured and documented.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response, which demonstrates each consumer is treated with dignity and respect, with their identity, culture and diversity valued.

While assessments sampled did not include questions to understand consumers’ cultural and/or diversity needs, there was no evidence indicating this led to disrespectful or undignified treatment, or that consumers’ identity, culture and diversity had not been valued.

Some non-permanent staff said they do not have access to sufficient information to perform their role. However, there is no indication of how many staff made this assertion, whether this has impacted care delivery, or whether they deliver care and services to consumers.

The Assessment Team noted all consumer assessments stated they identify as Australian; however, they represented varied cultures and identities. I have considered that no corroborating evidence was provided to support this assertion, including that they identify as a culture other than Australian and any resultant impact.

I have placed weight on feedback from consumers who said staff are kind, caring and respectful, and the Assessment Team’s observation that staff were knowledgeable of consumers’ cultural needs and preferences. I have also placed weight on evidence in the provider’s response demonstrating frameworks were in place prior to the Quality Audit to guide staff on the treatment of consumers and ensure their identity, culture and diversity is valued.

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

Requirement (3)(d)

While no consumers provided any negative feedback in relation to dignity of risk and management was able to describe how they would support consumers to take risks, the Assessment Team assessed this Requirement not met, as there was no documentation to support where this had occurred. The Assessment Team provided the following evidence to support their assessment:

* Client risk plans form part of initial assessment processes, however, completed forms were not observed.
* Transport sheets did not reflect potential risks or how consumers are encouraged to take risks.
* Staff were knowledgeable of dignity of risk principles.
* Management acknowledged current systems and processes were not effectively guiding staff and supporting consumers in relation to dignity of risk.

The provider does not agree with the Assessment Team’s assessment and maintains the expectations of this Requirement are met. The provider’s response includes the following additional information and/or evidence to support its assertion:

* Explanation that systems and practices are in place to identify risks associated with consumers and respect their decisions and choices.
* The organisation’s policies, processes and frameworks in relation to clinical and care governance, records and data management, and recovery-oriented practice, which were in place prior to the Quality Audit.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response, which does not demonstrate deficits in relation to this Requirement.

While sampled risk plans and transport sheets did not capture consumers’ risks and/or mitigation strategies, there was no evidence indicating consumers who want to take risks are not supported to do so. I find this evidence relates to deficits in the organisation’s assessment and planning processes and have therefore considered it under Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers.

I have placed weight on the Assessment Team’s evidence demonstrating consumers did not provide negative feedback in relation to dignity of risk and management was able to describe how they would support consumers to take risks.

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

Requirement (3)(f)

The Assessment Team assessed this Requirement not met, as they were not satisfied consumers’ private and personal information is kept confidential, as data was observed not to be stored according to best practice processes. The Assessment Team provided the following evidence relevant to my finding:

* Run sheets were observed to be unsecured.
* Staff said they had not been given any direction on what to do with consumers’ run sheets at the end of their shift, so they leave them in the bus or take them home. The bus can and is used by the organisation’s other out of hour’s programs.
* Management advised they suspect some consumer files were at a staff member’s home.
* Management was unable to provide any policies or procedures relating to information or documentation security, or managing requests for information.

The provider does not agree with the Assessment Team’s assessment and maintains the expectations of this Requirement are met. The provider’s response includes the following additional information and/or evidence to support its assertion:

* Explanation that policies and procedures relating to confidentiality of information was provided to the Assessment Team. Copies of the organisation’s policies and procedures relating to privacy, records management, consent, access control and data breaches were provided to support they were in place at the time of the Quality Audit.
* Explanation that staff are required to undertake refresher training on information security, privacy and confidentiality, and data breaches.
* Explanation that follow up of training concepts will be provided during monthly staff supervision, and staff will also be provided additional training in relation to requests for information.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response, which demonstrates each consumer’s personal information is not kept confidential.

I acknowledge that at the time of the Quality Audit, policies and procedures relating to privacy, records management, consent, access control and data breaches were in place. However, I have placed weight on the Assessment Team’s observations and statements from staff and management indicating these policies and procedures are not consistently followed.

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

Requirements (3)(b), (3)(c) and (3)(e)

Consumers said staff understand their needs and preferences, and deliver services with this in mind. Staff were knowledgeable of consumers’ cultural backgrounds and described how they tailor services to meet their needs.

Consumers said they can make decisions about their services. Staff described how they support consumers to exercise choice, including being able to select their destination of social outings. Processes are in place to ensure consumers can decide who is involved in discussions about service provision.

Consumers said they are provided with timely and relevant information. A welcome pack is provided to consumers on commencement, which includes information about giving feedback and making complaints. Staff were knowledgeable of processes for communicating updates and information to consumers.

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

# Standard 2

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

Findings

Requirement (3)(a)

The Assessment Team assessed this Requirement not met, as they were not satisfied assessment and planning processes consistently considered risks to consumers’ health and well-being to inform the delivery of safe and effective services. The Assessment Team provided the following evidence relevant to my finding:

* Five of seven sampled consumers did not have assessment forms completed. These forms are used at commencement to understand consumers’ medical condition.
* Documentation for seven consumers showed that while consumers’ risks were identified, sufficient information and strategies to guide staff practice were not documented.
* Two consumers provided examples of various medical conditions that would impact their ability to safely receive services. While staff were knowledgeable of these conditions, there were no strategies documented to guide staff in managing any associated risk.
* Information and evidence in the Assessment Team’s report under Requirement (3)(a) in Standard 2 shows completed client risk plans were not able to be observed and transport sheets did not reflect potential risks or how consumers are encouraged to take risks.

The provider acknowledges that assessment and planning is an area of continual training and supervision for staff, however, maintains that systems and processes are robust. The provider’s response includes the following additional information and/or evidence to show deficits have been rectified:

* Explanation that relevant risks to consumers’ safety, health and well-being are assessed and discussed with them, and used to create a care plan.
* Explanation that all consumers’ risks are included on the organisation’s system, and this information is now included in documentation used during transport service provision.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response, which demonstrates assessment and planning does not consider risks to consumers’ health and well-being to inform the delivery of care.

This Requirement expects organisations to assess risks to a consumer’s safety, health and well-being, discussed them with the consumer, and include them in planning their care. This supports consumers to get the best possible care and services, and ensure their safety, health and well-being aren’t compromised. I find this did not occur, as while sampled care files identified consumers’ risks, there were no documented strategies to ensure potential impact is minimised.

I acknowledge that the provider has taken actions to address deficits identified by the Assessment Team, however, there is no evidence they have been effectively implemented or embedded.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers.

Requirement (3)(b)

The Assessment Team assessed this Requirement not met, as they were not satisfied assessment and planning identifies and addresses the consumer’s needs, goals and preferences, including advance care planning and end of life planning. The Assessment Team provided the following evidence to support their assessment:

* Consumers described how assessment and planning identifies their needs, goals and preferences, and how it is used to plan and deliver services.
* Care planning documentation for sampled consumers did not identify their needs, goals and preferences, or provide instructions for staff on how they can be achieved.
* One consumer provided an example of how they are unable to undertake an activity of choice due to their condition. Their file was unable to be located by staff or management.
* Care planning documentation for one consumer demonstrated they have a sensory deficit and detailed one intervention in place. There was no further information to guide staff on how they can effectively communicate with them.
* Consumers and management said, and documentation showed, advance care and end of life planning are not discussed with consumers. Documentation provided to consumers at intake did not include any information to guide consumers in relation to this matter.

The provider acknowledges that assessment and planning is an area of continual training and supervision for staff, however, maintains that advance care and end of life planning are outside of the organisation’s scope. The provider’s response includes the following additional information and/or evidence:

* Explanation that consumers are supported through assessment processes to identify and address their transport and social needs.
* Acknowledgement that all assessments were not up to date at the time of the Quality Audit and work is currently underway to ensure improvements are made, including provision of regular supervision and training.
* A sample assessment template and care plan were provided to demonstrate improvements have been implemented.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response, which does not demonstrate deficits in relation to this Requirement.

I agree with the provider’s assertion that advance care and end of life planning are outside of the organisation’s scope. It is not proportionate to place this expectation on an organisation who provides transport and social services alone. I have also considered there was no evidence demonstrating staff would not be able to guide consumers where to find this information if requested.

I have considered that while the Assessment Team’s report states care planning documentation did not identify consumers’ needs, goals or preferences, or guide staff on how they can be achieved, only two supporting examples were provided. One of the examples did not demonstrate how the consumer’s inability to undertake an activity of choice was as a result of a failure in assessment and planning processes. The other example did not demonstrate current interventions were ineffective, resulting in the need for the organisation to document further communication strategies. I therefore do not consider it proportionate to find the organisation’s whole assessment and planning process to be ineffective based on these examples alone.

I have placed weight on statements from consumers demonstrating assessment and planning identifies their needs, goals and preferences, and it is used to plan and deliver services.

While the provider acknowledges all assessments were not up to date at the time of the Quality Audit, the provider’s response includes evidence of actions taken to address the issue. While there was no evidence these actions have been fully implemented or embedded, it is reasonable to accept the provider’s assertion based on the low associated risk.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement (3)(b) in Standard 2 Ongoing assessment and planning with consumers.

Requirement (3)(c)

The Assessment Team assessed this Requirement not met, as they were not satisfied assessment and planning is consistently occurring with the consumer, representatives or others involved in the consumer’s care. The Assessment Team provided the following evidence to support their assessment:

* Two consumers said they had a family member present at the initial assessment, however, did not recall any further contact between the service and family.
* Care planning documentation for one consumer did not show further consultation with the consumer or others following a fall.
* Staff and management said they do not review consumers’ service needs when circumstances change. As a result, there is no ongoing consultation with consumers, representatives or others involved in their care.

The provider refutes the Assessment Team’s assertion and maintains the expectations of this Requirement are met. The provider’s response explains that consultation with consumers and representatives does occur, however, it’s not being consistently documented. This is being addressed through additional staff supervision and training.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response, which does not demonstrate deficits in relation to this Requirement.

I find the core deficit relates to assessment and planning review processes, rather than a failure to consult with consumers and representatives. As a result, I have considered this evidence in my finding under Requirement (3)(e) in this Standard.

Furthermore, I do not find it proportionate to determine the organisation’s referral system to be ineffective based on one example alone. While there was no evidence of ongoing consultation with the consumer or other care providers following a fall, no further context was provided to demonstrate systemic failure.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement (3)(c) in Standard 2 Ongoing assessment and planning with consumers.

Requirement (3)(d)

The Assessment Team assessed this Requirement not met, as they were not satisfied outcomes of assessment and planning are documented in a care and service plan that is readily available to consumers and where services are provided. The Assessment Team provided the following evidence relevant to my finding:

* All consumers said they had not received a document that described how they would like their services delivered. One consumer was unaware there was a documented plan for staff to follow.
* Information and evidence under Requirement (3)(f) in Standard 1 and Requirements (3)(a) and (3)(b) in Standard 2, shows multiple occasions where the service was unable to provide details of consumers’ services to the Assessment Team, as the files could not be located.
* Information and evidence under Requirement (3)(d) in Standard 4 shows information about the consumer’s condition, needs and preferences is not documented in the daily transport/run sheet to guide staff practice.

The provider acknowledges areas for improvement in relation to the documentation of assessment and planning activities. The provider’s response includes additional information to demonstrate actions taken and/or planned to address deficits identified by the Assessment Team. These actions include, but are not limited to, implementation of quarterly care plan and documentation reviews, staff training and development, ensuring all documents are offered to consumers, and documenting consumer information in both hard and soft copy formats.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response, which demonstrates the outcomes of assessment and planning are not 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.

I have considered that consumers were unaware they had a care and service plan, or what it included. I have also considered that a number of consumer files could not be located and information about consumers’ needs, goals and preferences were not documented at point of service delivery, which poses risk of harm to consumers, as information about their needs, goals and preferences was not readily available to staff. I acknowledge the organisation has taken and/or planned a number of actions to address the issue, however, there was no evidence demonstrating these have been effectively implemented or embedded.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement (3)(d) in Standard 2 Ongoing assessment and planning with consumers.

Requirement (3)(e)

The Assessment Team assessed this Requirement not met, as they were not satisfied 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. The Assessment Team provided the following evidence relevant to my finding:

* All consumers said they had not completed a service review since commencement.
* Management said, and documentation showed, service reviews have not been undertaken for any consumer, either on a regular basis or when circumstances change. Management said they rely on staff knowledge of consumers to identify whether service needs are to be changed.

The provider acknowledges areas for improvement in relation to the review of consumers’ service needs, goals and preferences. The provider’s response includes additional information to demonstrate actions taken and/or planned to address deficits identified by the Assessment Team. These actions include, but are not limited to, implementation of quarterly care plan and documentation reviews, staff training and development, establishment of roles and responsibilities for incident management, and communication to consumers and representatives.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response, which demonstrates care and services are not regularly reviewed.

I have considered that care and service reviews had not been undertaken for any consumer to ensure their service needs and preferences were met. I acknowledge the organisation has taken and/or planned a number of actions to address the issue, however, there was no evidence demonstrating these have been effectively implemented or embedded.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement (3)(e) in Standard 2 Ongoing assessment and planning with consumers.

# Standard 3

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| Personal care and clinical care | | CHSP |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Not applicable |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not applicable |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Not applicable |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Not applicable |
| 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 applicable |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Not applicable |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Not applicable |

Findings

Standard 3 was not assessed by the Assessment Team as the service does not provide personal or clinical care to consumers.

# Standard 4

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| Services and supports for daily living | | CHSP |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Requirement (3)(d)

The Assessment Team assessed this Requirement not met, as they were not satisfied information about the consumer’s condition, needs and preferences is communicated with the service, and with others where responsibility for services and supports for daily living is shared. The Assessment Team provided the following evidence to support their assessment:

* One consumer said they have sensory impairment and staff know their needs well. The daily transport/run sheet described the consumer’s sensory impairment, however, did not include further details to guide staff in relation to their needs.
* Staff and management said they verbally share information regarding consumers’ needs at a weekly meeting, however, there was no documentation to support this.
* Staff and management described the process for sharing information with others involved in consumers’ care, such as family and service providers, however, confirmed this is not documented.

The provider acknowledges areas for improvement in relation to the documenting of consumers’ service needs, goals and preferences. The provider’s response includes additional information to demonstrate actions taken and/or planned to address deficits identified by the Assessment Team. These actions include, but are not limited to, full review of consumer information to ensure it is current, and staff education and training.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response, which does not demonstrate deficits in relation to this Requirement.

I have considered that while information about consumers’ condition, needs and preferences was not effectively documented, there is no evidence indicating the communication of this information did not occur with those who deliver services. On the contrary, staff and management were able to describe communication processes and one consumer said their needs were known. I have also considered that no poor consumer outcomes were identified as a result of a lack of communication to those who deliver services.

I find the core deficit relates to the documentation of assessment and planning outcomes, and have therefore considered the evidence under Requirement (3)(d) in Standard 2 Ongoing assessment and planning with consumers.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement (3)(d) in Standard 4 Services and supports for daily living.

Requirement (3)(e)

The Assessment Team assessed this Requirement not met, as they were not satisfied timely and appropriate referrals to individuals, other organisations and providers of other care and services were considered and/or undertaken for consumers. The Assessment Team provided the following evidence to support their assessment:

* Documentation and staff interviews showed two consumers’ conditions have not been referred to an external organisation to provide them with support. One of the two consumers’ conditions impairs them from being able to utilise transport services. The Assessment Team did not interview these consumers, despite attempts to contact one of them.
* Management was unable to provide an example where consumers had been supported to access services from other external service providers.

The provider maintains that referrals to other providers of care and services does occur, however, acknowledges that it is ad hoc and not consistently documented. For one of the two sampled consumers, the provider asserts that external service providers were not contacted at the consumers’ request. The provider’s response includes additional information to demonstrate actions taken and/or planned to address deficits identified by the Assessment Team. These actions include, but are not limited to, staff education and training, documentation of external service providers, and development of procedures to guide staff practice.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response, which does not demonstrate systemic deficits in relation to this Requirement.

I have considered that while evidence shows areas for improvement in documenting referrals undertaken, there was no evidence indicating consumers wanted a referral and did not receive one. While the Assessment Team noted two occasions that referrals did not occur, there was no evidence indicating these consumers wanted a referral to support their condition.

I have placed weight on the provider’s assertion that referrals do occur but are not consistently documented and that an external service provider was not contacted for one of the two sampled consumers at their request.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement (3)(e) in Standard 4 Services and supports for daily living.

Requirements (3)(a), (3)(b), (3)(c), (3)(f) and (3)(g)

Consumers said they were satisfied with the services they receive and provided examples of how they are supported to maintain independence. Staff were knowledgeable of consumers’ needs, goals and preferences and described how they optimise their independence, health, well-being and quality of life.

Consumers said staff would recognise and provide support if they were feeling low, and provided examples of when this had occurred. Staff felt they had good knowledge of consumers and described how they encourage them to express their feelings so they can provide support.

Consumers provided examples of how they are supported to participate in their community, have social and personal relationships, and do things of interest to them. Staff explained that transport is provided based on individual needs, including for consumers to attend day respite groups held by another provider, the hairdresser, and social groups.

Consumers said they are satisfied with the quality and quantity of meals, and said they can exercise choice about what they eat and where they dine. A dining service was observed and noted to be good quality and plentiful. While staff were knowledgeable about consumers’ dietary needs, they were not consistently documented. I have considered this information under Requirement (3)(a) in Standard 2, as the core deficit is more relevant to assessment and planning processes.

The vehicle used for transport services was observed to be clean and well maintained. There was a wide doorway for ease of access, as well as ample spacing between seats and an area to store walking aids. Consumers said vehicles used are suitable for their needs.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirements (3)(a), (3)(b), (3)(c), (3)(f) and (3)(g) in Standard 4 Services and supports for daily living.

# Standard 5

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

Findings

This Standard was not assessed as the organisation does not provide a physical service environment.

# 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. | Non-compliant |

Findings

Requirement (3)(a)

The Assessment Team assessed this Requirement not met, as they were not satisfied consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. The Assessment Team provided the following evidence to support their assessment:

* Consumers said feedback and complaints are resolved verbally, however, one consumer said they had not received any information about how to provide feedback or make a complaint.
* There was no evidence demonstrating processes are in place for consumers or representatives to provide feedback or make a complaint, or how they would be addressed.
* The most recent evaluation forms sampled were dated 2019 or prior.
* Information and evidence under Requirement (3)(e) in Standard 1 shows information about feedback and complaints processes are provided to consumers in the welcome pack.

The provider did not agree with the Assessment Team’s assessment and maintains that the expectations of this Requirement are met. The provider’s response includes the following additional information and/or evidence to refute the Assessment Team’s assertions:

* The organisation’s policies and procedures to guide staff and brochures to inform procedures regarding feedback and complaints management, which were in place prior to the Quality Audit.
* Explanation that staff undertake mandatory training in relation to complaints handling.
* Explanation that the Assessment Team interviewed Human Resources about this Requirement, however, they do not have oversight of feedback and complaints processes.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response, which does not demonstrate systemic deficits in relation to this Requirement.

Information relating to feedback and complaints processes is provided to consumers through brochures and the welcome pack. I have placed weight on evidence in the provider’s response demonstrating policies and procedures were in place at the time of the Quality Audit, to guide staff on what to do when they receive feedback or a complaint. While evaluation forms and/or surveys have not been undertaken, this does not demonstrate consumers are not supported to provide feedback or make a complaint.

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

Requirement (3)(c)

The Assessment Team assessed this Requirement not met, as they were not satisfied appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. The Assessment Team provided the following evidence to support their assessment:

* The organisation’s procedure does not guide staff on actions to be taken when consumers make a complaint.
* Education and training have not recently been provided to staff to guide them on documenting, reporting and escalating consumers’ complaints.
* Staff said and documentation showed complaints are not consistently recorded. Staff said they deal with complaints verbally at the time it occurs.
* There was no evidence open disclosure had been used in response to complaints.
* Information and evidence in the Assessment Team’s report under Requirement (3)(a) in this Standard shows consumers said complaints are raised and resolved verbally.

The provider did not agree with the Assessment Team’s assessment and maintains that the expectations of this Requirement are met. The provider’s response includes the following additional information and/or evidence to refute the Assessment Team’s assertions:

* The organisation’s policies and procedures in place at the time of the Quality Audit, which guides staff on actions to take on receipt of a complaint.
* Explanation that staff undertake mandatory training in relation to complaints handling.
* Explanation that the Assessment Team interviewed Human Resources about this Requirement, however, they do not have oversight of feedback and complaints processes.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response, which does not demonstrate systemic deficits in relation to this Requirement.

At the time of the Quality Audit, processes were in place to guide staff on action to take when a complaint is received. While evidence in the Assessment Team’s report shows areas for improvement in documenting complaints and associated outcomes, there is no evidence indicating appropriate action has not been taken in response to complaints. I have placed weight on statements from consumers, as shown in the Assessment Team’s report under Requirement (3)(a) in this Standard, which show complaints are raised and resolved verbally. Furthermore, consumers did not demonstrate dissatisfaction with how their complaints have been handled.

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

Requirement (3)(d)

The Assessment Team assessed this Requirement not met, as they were not satisfied feedback and complaints are reviewed and used to improve the quality of services. The Assessment Team provided the following evidence to support my finding:

* Management said there had been no feedback or complaints about the service.
* Statements from consumers and staff, as evidenced in the Assessment Team’s report under Requirements (3)(a) and (3)(c) in this Standard shows feedback and complaints are raised and resolved verbally.
* Management was unable to describe how the service recorded, analysed or acted on feedback and complaints to improve the quality of services.
* There was no evidence demonstrating how complaints are monitored to identify improvements.

The provider did not agree with the Assessment Team’s assessment and maintains that the expectations of this Requirement are met. The provider’s response includes the following additional information and/or evidence to refute the Assessment Team’s assertions:

* Explanation that no feedback or complaints have been received in relation to the service.
* Explanation that staff undertake mandatory training in relation to complaints handling.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response, which demonstrates feedback and complaints are not reviewed and used to improve the quality of services.

This Requirement expects organisations to use information from complaints to make improvements to safety and quality systems, and regularly review and improve how they manage complaints. I find this did not occur, as feedback and complaints are not recorded, they are unable to be accurately analysed and trended. While the provider maintains feedback and complaints have not been received, I have placed weight on staff and consumer statements that they have been made verbally.

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

Requirement (3)(b)

Consumers and management said consumers are given information about interpreter services. Consumers are provided a welcome pack on commencement, which includes information about external complaints and advocacy services.

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

# Standard 7

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| Human resources | | CHSP |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirement (3)(a)

The Assessment Team assessed this Requirement not met, as they were not satisfied the workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery of safe and quality care and services. The Assessment Team provided the following evidence to support their assessment:

* One representative provided one example of where they had to transport the consumer to an appointment, as the full-time staff member was on leave.
* One staff member provided an example of an occasion where a consumer requested to go shopping and they were not available on the day or time requested. No further alternatives were considered and management were not notified.
* The program coordinator said for one sampled month, eight to nine shifts were unfilled due to being unable to backfill the full-time staff member. They said they have three other substitute staff available. Management denied there were any unfilled shifts.
* Senior management said they do not maintain oversight of the workforce delivering CHSP services.

The provider did not agree with the Assessment Team’s assessment and maintains that the expectations of this Requirement are met. The provider’s response includes the following additional information and/or evidence to refute the Assessment Team’s assertions:

* Explanation that evidence of emails regarding staff coverage of CHSP services during staff leave was provided to the Assessment Team.
* Explanation that the Assessment Team held discussions regarding rostering with the Human Resources team but should have received this information from management. As a result, they received incorrect information.
* Explanation that rosters are prepared on a weekly basis based on consumers’ needs. Changes require one week’s notice at minimum, as late changes impact other consumers and may not be possible due to availability and other consumer bookings. As only one full time support worker is employed, careful planning is essential for continuity of services.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response, which does not demonstrate systemic deficits in relation to this Requirement.

While the program coordinator said there were eight to nine unfilled shifts during the one month sampled period, there is no evidence of how this impacted care delivery. Furthermore, as the advice was an approximate number as opposed to definite, I question the reliability of the evidence. I have therefore placed weight on management’s view that there were no unfilled shifts and the provider’s assertion that the Assessment Team received incorrect information.

I have also considered that while the Assessment Team identified two occasions where staff were unavailable to provide services, there was no evidence demonstrating whether they were isolated or ongoing issues.

I have also considered the overall positive feedback from consumers, as demonstrated throughout the Assessment Team’s report indicating staffing numbers are sufficient.

While on this occasion I err in favour of the provider, I recommend the provider monitor their performance against this Requirement to ensure systems and processes for managing staffing numbers and backfilling unplanned leave are effective.

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

Requirement (3)(c)

The Assessment Team assessed this Requirement not met, as they were not satisfied the workforce is competent and members of the workforce have the appropriate qualifications and knowledge to effectively perform their role. The Assessment Team provided the following evidence to support their assessment:

* Three staff members used to fill periods of leave said they have not participated in an induction program relevant to CHSP subsidised services, and felt they would benefit from further training and information to support consumers. One staff said they would have liked to have had time to look at care files and understand consumers’ needs before commencement.
* Senior management were not aware of the need to seek and manage overseas certification of staff who were a resident of a country other than Australia over the age of 16 years.

It was unclear whether the provider agreed or refuted the Assessment Team’s assessment. The provider’s response includes the following additional information to demonstrate actions taken and/or planned in relation to this Requirement:

* Explanation that training for staff delivering CHSP subsidised services has been reviewed and an electronic platform is being used for learning and mandatory training in relation to infection prevention and control, elder abuse, manual handling, the Serious Incident Response Scheme (SIRS), restrictive practices and the Quality Standards.
* Explanation that induction training, including in relation to the Quality Standards, Code of Conduct, CHSP program manual, restraint, dementia and first aid, was offered to staff and evidence of this was provided to the Assessment Team.
* Explanation that staff who are affected by the oversees certifications requirement will complete the statutory declaration as a matter of urgency.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response, which does not demonstrate systemic deficits in relation to this Requirement.

While a number of staff said they had not received induction, I find this is more relevant to recruitment and training processes and have therefore considered this evidence under my finding for Requirement (3)(d) in this Standard.

The Assessment Team noted a lack of understanding by the service in relation to managing certifications for staff who were a resident of a country other than Australia when they were over 16 years of age. There is no evidence indicating any staff fit this criterion and were working without appropriate certifications. Furthermore, it is not proportionate to find this Requirement non-compliant due to this one deficit alone.

I find actions taken by the provider in relation to this Requirement, as described in their response, are satisfactory and addresses the Assessment Team’s concerns.

I have also considered the overall positive feedback from consumers, as demonstrated throughout the Assessment Team’s report indicating staff are competent and have the appropriate knowledge to effectively perform their role.

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

Requirement (3)(d)

The Assessment Team assessed this Requirement not met, as they were not satisfied the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these Standards. The Assessment Team provided the following evidence to support their assessment:

* Mandatory training modules are in place in relation to workplace security, manual handling, and health and safety induction risk management. Other non-mandatory training modules include mental health first aid, behaviour management, and gender and sexual diversity in aged care.
* Initial and ongoing training is not routinely provided to staff in relation to identifying and responding to changes in consumers’ condition, the SIRS, the Quality Standards, Code of Conduct, feedback and complaints, restraint, and consumer risk and incident management. Staff were unable to demonstrate an understanding of these topics or their obligations.
* Staff were unable to describe the processes and procedures for entering information into the organisation’s electronic documentation systems, such as incidents or feedback and complaints. One staff said they would welcome training in ageing, consumer support and dementia and while documentation showed this training was offered, the staff was on leave at the time.
* Information and evidence in the Assessment Team’s report under Requirement (3)(c) in this Standard shows three staff members used to fill periods of leave said they have not participated in an induction program relevant to CHSP subsidised services, and felt they would benefit from further training and information to support consumers.

The provider refutes the Assessment Team’s assertions and maintains expectations of this Requirement are met. The provider’s response includes the following information and/or evidence to support their view:

* Explanation that training for staff delivering CHSP subsidised services has been reviewed and an electronic platform is being used for learning and mandatory training in relation to infection prevention and control, elder abuse, manual handling, the Serious Incident Response Scheme, restrictive practices and the Quality Standards.
* Processes have been implemented to ensure handover notes and instructions when staff are on leave will include any missed training. It is reasonable that the service had not followed up on the staff member who missed the training during leave, as this only occurred two weeks prior to the Quality Audit.
* Explanation that induction training, including in relation to the Quality Standards, Code of Conduct, CHSP program manual, restraint, dementia and first aid, was offered to staff and evidence of this was provided to the Assessment Team.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response, which does not demonstrate systemic deficits in relation to this Requirement.

While a number of staff said they had not received induction, there was no corroborating evidence supplied, such as training records, confirming their statements.

Furthermore, the Assessment Team noted that some training is not routinely provided, however, there was no evidence demonstrating when the training was last provided or that the lack of training has resulted in deficits in care.

I find actions taken by the provider in relation to this Requirement, as describe in their response, satisfactorily addresses the Assessment Team’s concerns.

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

Requirements (3)(b) and (3)(e)

All consumers and representatives were satisfied with staff delivering services and said they are kind, caring and respectful. Staff were observed interacting with consumers in a positive manner and were knowledgeable about their needs and preferences.

Annual staff performance appraisal processes are in place, and management is prompted by the organisation’s electronic system when discussions are due. Staff confirmed they are provided an opportunity to discuss performance related matters, and a formal process is completed annually.

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

# Standard 8

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| Organisational governance | | CHSP |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Non-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. | Non-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. | Non-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. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Not applicable |

Findings

Requirement (3)(a)

The Assessment Team assessed this Requirement not met, as they were not satisfied consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. The Assessment Team provided the following evidence relevant to my finding:

* All four consumers and representatives interviewed about this Requirement said they are not engaged in the development, delivery and evaluation of consumers’ services.
* Management said annual consumer satisfaction surveys are conducted, however, staff said this survey has not yet been distributed.
* The feedback and complaints register showed there had been no local entries for 12 months, and the continuous improvement plan did not demonstrate any improvements to service delivery.
* The service does not undertake consumer meetings.
* Management said senior management and members of the Board are scheduled to visit Darwin and will be engaging with consumers during that time.

The provider refutes the Assessment Team’s assertions and maintains expectations of this Requirement are met. The provider’s response includes the following information and/or evidence to support their view:

* Explanation that organisational procedures and processes are in place to include consumers and communities, and to enable them to exercise choice in how the service is delivered, planned and practiced.
* The organisation’s National Service Charter, Client Participation Framework, Strengthening Communities Framework, Diversity and Inclusion Policy, and Speak Up and Speak Out Statement, which were in place prior to the Quality Audit.
* Explanation that staff will be provided further education, and documentation of consumer feedback and input will be documented on the organisation’s information management system.
* Explanation that a consumer advisory group will be considered.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response, which demonstrates consumers are not engaged or supported in the development, delivery and evaluation of services.

This Requirement expects organisations to seek input from a wide range of consumers about their experience and the quality of services they receive. I find this did not occur, as consumers and representatives said they had not been asked for input about service delivery, and staff said consumer surveys have not yet been distributed. I have also considered that consumer meetings are not held, and there was no evidence of improvement made in the feedback and complaints and continuous improvement registers.

While I acknowledge that the organisation has multiple frameworks and policies in relation to consumer engagement which were in place prior to the Quality Audit, there was no evidence demonstrating they had been followed or that consumer engagement had occurred.

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

Requirement (3)(b)

The Assessment Team assessed this Requirement not met, as they were not satisfied the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for that delivery. The Assessment Team provided the following evidence relevant to my finding:

* The service does not routinely identify or gather information, data or statistics regarding consumers’ services and is therefore unable to provide information to the governing body.
* Board meeting minutes for two sampled months did not include review or discussion about the organisation’s CHSP service.
* Audit and risk committee meetings for 2023 did not include oversight of incidents.

The provider refutes the Assessment Team’s assertions and maintains expectations of this Requirement are met. The provider’s response includes the following information and/or evidence to support their view:

* Explanation that cultural competence is embedded at every level of the organisation, through strong values, targeted policies and procedures and structured training.
* Explanation that the service will gather information, data and statistics on consumers’ services and provide a summary to senior management for reporting to the board as appropriate.
* Explanation that Board Audit and Risk Committee meets quarterly and is informed of critical incidents when they occur and receives reports on incident statistics at each meeting. As there have been no critical incidents for CHSP in 2023, no CHSP information has been reported to the Board.
* The organisation’s policies, procedures and frameworks in relation to national service, client participation, strengthening communities, diversity and inclusion, reconciliation, medication management, behaviours, supervision, consultation and governance, which were in place prior to the Quality Audit.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response, which demonstrates the organisation’s governing body is not accountable for the delivery of safe, inclusive and quality services.

I have placed weight on evidence in the Assessment Team’s report, which shows the Board does not consistently discuss the service at its meetings. The provider’s response did not include any additional evidence to persuade me that this does occur or that the governing body has any additional oversight of service delivery. While I acknowledge that the organisation has multiple frameworks and policies in place to promote a culture of safe, inclusive and quality services, there was no evidence demonstrating they had been followed.

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

Requirement (3)(c)

The Assessment Team assessed this Requirement not met, as they were not satisfied the organisation’s governing systems were effective in relation to continuous improvement, workforce governance, regulatory compliance and feedback and complaints. The Assessment Team provided the following evidence relevant to my finding:

* Information management:
  + The service operates a paper-based system for documenting consumer information.
  + Information and evidence under Requirement (3)(f) in Standard 1 and Requirements (3)(a), (3)(b) and (3)(d) in Standard 2, shows multiple occasions where the service was unable to provide details of consumers’ services to the Assessment Team, as the files could not be located.
  + Information and evidence under Requirement (3)(d) in Standard 4 shows information about the consumer’s condition, needs and preferences is not documented in the daily transport/run sheet to guide staff practice.
* Continuous improvement:
  + The organisation was unable to provide any recent examples of improvements to consumers’ services, and does not routinely seek feedback from consumers or review data and statistics in order to identify areas for improvement.
* Financial governance:
  + The service is supported by the organisation’s finance personnel.
* Workforce governance:
  + The Assessment Team referred to their assessment under Requirements (3)(a), (3)(c) and (3)(d) in Standard 7 which shows the service has insufficient staff and a lack of training.
* Regulatory compliance:
  + Management was unable to provide examples where the governing body has enacted service level improvements as a result of changes to aged care regulatory requirements. Discussions regarding regulatory compliance were not evident in local, regional or governing body level documentation.
  + Management said no action had been undertaken in relation to the introduction of the SIRS.
* Feedback and complaints:
  + The consumer transition and exit section of the organisation’s governance compliance checklist shows feedback had not been sought from consumers prior to exiting the service.
  + Discussions regarding feedback and complaints were not evident in local, regional or governing body documentation.
  + Management was unable to provide examples of where the governing body had oversight or enacted improvements as a result of feedback and complaints.

The provider refutes the Assessment Team’s assertions and maintains expectations of this Requirement are met. The provider’s response includes the following information and/or evidence to support their view:

* The organisation’s Quality Assurance Framework, which was in place at the time of the Quality Audit, was provided to demonstrate checklists are in place for managers to self-assess compliance against governance and service delivery. Explanation that management will ensure these checklists are correctly completed going forward.
* Explanation that staff will have refresher training, including in relation to the Quality Assurance Framework and complaints, and regulatory obligations. Staff have commenced training in relation to the SIRS, Quality Standards, open disclosure, Code of Conduct and risk management.
* Explanation that the service’s roster will be reviewed to ensure sufficient staffing.
* Explanation that the service has had no incidents that are considered reportable under the SIRS.
* Explanation that a full review of the CHSP Program Manual was undertaken to ensure all mandatory requirements are complied with. Senior management and staff will receive updates on any changes to regulatory requirements, processes and procedures.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response, which demonstrates that while organisation wide governance systems are effective in relation to financial and workforce governance, they are not effective in relation to information management, continuous improvement, regulatory compliance and feedback and complaints.

I have considered that information management systems and processes did not give appropriate members of the workforce access to information that helps them in their roles. Information and evidence in the Assessment Team’s report under Standards 1, 2 and 4, shows multiple occasions where staff were not able to provide the Assessment Team with information about consumers, as they were unable to locate their file. Management said they suspect staff had taken the files home.

This Requirement expects organisations to have effective continuous improvement systems and processes to assess, monitor and improve the quality and safety of the services provided. I find this did not occur, as the organisation was unable to provide any examples of recent improvements to consumers’ services and does not routinely seek feedback from consumers or review data and statistics in order to identify areas for improvement.

While the Assessment Team was not satisfied workforce governance systems were effective, this conclusion was drawn as a result of their not met assessment under Requirements (3)(a), (3)(c) and (3)(d) in Standard 7. I came to a different view from the Assessment Team and found these Requirements were compliant. Based on this finding and as the Assessment Team’s report did not include any further evidence linking the deficits to a failure in the organisation’s governance systems, I do not find them to be ineffective. This is supported by the overall positive feedback from consumers, as demonstrated throughout the Assessment Team’s report, indicating satisfaction with staffing numbers and performance.

The organisation does not have effective systems to ensure it understands and is complying with relevant legislation. I have placed weight on evidence in the Assessment Team’s report showing discussions about regulatory compliance were not demonstrated in any documentation at a local, regional or governing body level.

I have also considered that feedback and complaints systems were not effective in ensuring improved services for consumers. Systems in place did not follow principles of transparency or best practice guidelines, as complaints, actions and resultant outcomes were not consistently recorded. Furthermore, there was no evidence demonstrating discussions about feedback and complaints had been held at a local, regional or governing body level.

I acknowledge the provider’s response and actions taken to address deficits by the Assessment Team, however, there was no evidence to support the provider’s assertions nor that improvements have been effectively implemented or embedded.

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

Requirement (3)(d)

The Assessment Team assessed this Requirement not met, as they were not satisfied risk management systems and practices were effective in relation to identifying and managing risk associated with the care of consumers, managing and preventing incidents, and identifying and responding to abuse and neglect of consumers. The Assessment Team provided the following evidence relevant to my finding:

* The incident register showed four incidents occurred in 2023, however, two of these were incorrectly recorded and one related to someone other than a consumer. For one sampled incident, while staff said the consumer was checked for injury at the time and regular check-ins occurred, it had not been recorded.
* Staff were unable to describe the processes and procedures in relation to consumers’ risks and incidents.
* Sampled running sheets used by staff to understand consumers’ risks were noted to exclude information such as allergies, loss of mobility and sensory impairment. Consumers’ risks are not routinely assessed or identified to ensure their safety is maintained. The Assessment Team were unable to locate a completed ‘client risk plan’.
* As staff do not routinely input consumer information into designated systems, the organisation was unable to demonstrate local, regional or organisation-wide oversight of consumer risks and incidents.
* Staff said they have not received training in relation to incident management.
* The organisation does not have any processes or procedures to identify and support vulnerable consumers. Management said the service does not currently have any consumers who are at risk.
* Management said they do not capture or review consumer incidents and this aspect is still in the development phase. Furthermore, the current incident management system is expected to be rolled out in 2024 and staff will receive training.

The provider refutes the Assessment Team’s assertions and maintains expectations of this Requirement are met. The provider’s response includes the following information and/or evidence to support their view:

* Explanation that staff have commenced training in relation to the SIRS, Quality Standards, open disclosure, Code of Conduct and risk management.
* Explanation that the running sheets have been reviewed and updated to include health needs and medical requirements of consumers, and client risk plans have been uploaded and are accessible to all staff who need them.
* Explanation that strong risk and incident management processes are in place and are followed. There are minimal or nil risks to report. Any that occur are risk assessed and escalated to the appropriate level within the organisation.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response, which demonstrates risk management systems and practices are in place in relation to managing high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers, and managing and preventing incidents, including the use of an incident management system.

This Requirement expects organisations to have systems and processes that help them identify and assess risks to the health, safety and well-being of consumers. If risks are found, organisations are expected to find ways to reduce or remove the risks in a timeframe that matches the level of risk and how it’s affecting consumers. I find this did not occur, as information used to guide delivery of services did not include consumers’ risks or mitigation strategies. I have also considered the organisation’s failure to identify deficits in assessment and planning processes, as demonstrated in the Assessment Team’s report in Standard 2, shows the organisation’s risk management systems and practices are ineffective.

This Requirement also expects organisations to identify and evaluate incidents and ‘near misses’ and use this information to improve service delivery. I acknowledge that the new incident management system had not yet implemented at the time of the Quality Audit, however, there was no evidence demonstrating interim measures were in place whilst the organisation was waiting for that to occur. I have placed weight on statements from management that they do not capture or review consumer incidents.

In relation to identifying and responding to abuse and neglect of consumers, I have placed weight on evidence in the Assessment Team’s report showing there are no processes or procedures to identify and support vulnerable consumers.

I acknowledge the provider’s response and actions taken to address deficits by the Assessment Team, however, there was no evidence to support the provider’s assertions nor that improvements have been effectively implemented or embedded.

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

Requirement (3)(e)

This Requirement was not assessed, as the service does not provide clinical care to consumers.

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)