**Performance**

**Report**

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Multicultural Communities Council of Illawarra Incorporated |
| Commission ID: | 200606 |
| Address: | 117 Corrimal Street, WOLLONGONG, New South Wales, 2520 |
| Activity type: | Quality Audit |
| Activity date: | 31 May 2024 to 3 June 2024 |
| Performance report date: | 13 July 2024 |

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

# Service included in this assessment

Home Care Packages (**HCP**) included:  
Provider: 8858 Multicultural Communities Council of Illawarra Incorporated  
Service: 26834 Multicultural Communities Council of Illawarra Incorporated  
Service: 27683 Multicultural Communities Council of Illawarra Incorporated - ACT  
  
Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 7928 Multicultural Communities Council of Illawarra Limited  
Service: 24710 Multicultural Communities Council of Illawarra Incorporated - Care Relationships and Carer Support  
Service: 24712 Multicultural Communities Council of Illawarra Incorporated - Community and Home Support

**This performance report**

This performance report for Multicultural Communities Council of Illawarra Incorporated (**the service**) has been prepared by P.Frangiosa, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Quality Audit report 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 4 July 2024.

# Assessment summary for Home Care Packages (HCP)

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Compliant** |

# Assessment summary for Commonwealth Home Support Programme (CHSP)

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **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

|  |  |  |  |
| --- | --- | --- | --- |
| Consumer dignity and choice | | HCP | CHSP |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant | 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 | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant | 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 | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant | Compliant |

Findings

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

Consumers confirmed care and services are culturally safe, with staff and consumers having similar cultural backgrounds. Staff confirmed they consider the consumer’s cultural background when providing care and services. Management stated all staff are bilingual in the consumers’ languages and there is cultural understanding or commonality between staff and consumers. Survey results confirmed consumers agree the service respects their religious or cultural beliefs.

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

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

Consumers and representatives confirmed consumers receive information about the care and services provide. Staff described strategies used to assist consumers with communication barriers, including using body language and written cues.

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

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

# Standard 2

|  |  |  |  |
| --- | --- | --- | --- |
| Ongoing assessment and planning with consumers | | HCP | CHSP |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant | 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 | 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 | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant | Compliant |

Findings

Requirement 2(3)(a)

The Assessment Team was not satisfied 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. The Assessment Team provided the following evidence to support their assessment:

* Care planning documentation for one consumer did not include any assessment planning interventions relating to back pain, diabetes, mobility, or the GP increasing medication.
  + One of the goals documented in the service planning include ‘Personal Care/Domestic Assistance’.
* Care planning documentation for one consumer identified dementia, and chronic pain due to arthritis, with a registered nursing assessment completed in December 2023. The following health issues were identified.
  + Medium risk of falls
  + Cognitive decline; Dementia
  + Malnourished
  + Restrictive practice
  + Mobility decline
  + Impulses buying when shopping
    - Care planning documentation did not document risk mitigation or response strategies.
* Care planning documentation from May 2024 for one consumer identified ‘bed sores’ and an ‘early pressure sore’, however care planning documentation did not document risk mitigation or response strategies.
* This consumer was also identified as living with dementia, is at risk of falls, experiences occasional dizziness, and can become light-headed when standing due to medications required to take because of chronic pain.
  + Clinical assessments/reassessments were not provided, and care and service planning documents did not include strategies or interventions, such as fall risk assessments.

The provider provided the following information and responses in refutation:

Regarding consumer one, the following information specific to risk mitigation and response mechanisms are provided.

* This consumer receives the following CHSP services from Multicultural Communities Council of Illawarra (MCCI): Flexible Respite, Personal Care, and Exercise Physiology (EP), including.
  + Twice weekly exercise physiology (EP) sessions. The consumer completed a functional assessment with MCCI on intake 23 August 23. This functional assessment was produced in MCCI’s previous client management system (CMS) and attached in their new CMS in October 2023. The functional assessment attachment was available to the audit team however, it appears that the assessor may not have sighted the report.
  + Their care plan was reviewed (as evidenced in the services response viewed), 13 March 2024, with outcomes documented.
* Further exampled information was provided as part of the providers response, including.
* Examples of EP progress notes and outcomes.
* Overall, this consumers care is provided by 7 different providers. A consumer representative requested an ACAT review with My Aged Care (MAC); however, this was declined as the consumer was deemed low risk, and a new RAS assessment was completed on 1 March 2024. The new MAC support plan is inaccurate, however, with relevant information not up to date.
* MCCI has submitted another ACAT review request for this consumer, and the service continues to liaise with this consumers representative.

Regarding another consumer, the service provided the following in response.

* The evidence cited by the assessor relating to one consumer in the Draft Quality Audit Report is factually inaccurate and, we submit, cannot be relied upon to support a conclusion that this standard is ‘Not Met’. We note that the assessor relies on this same inaccurate information about this consumer to draw ‘Not Met’ conclusions in Standards 2a, 2d, 3a, 3b, 3d.
* This consumer receives Level 4 Home Care services from MCCI. Her most recent care plan review was completed on 31 January 2024. The services in place for them include domestic assistance, meals, exercise physiology, personal care, social support, podiatry, personal alarm, continence aids, goods and equipment.
* ‘In respect to the assessor’s observations, we note’:
  + As a result of MCCI’s ongoing monitoring of this consumers care and to give detailed consideration of risks to her wellbeing, a clinical assessment by a Registered Nurse was commissioned by MCCI to review her support needs after consultation with their representative.
  + Clinical assessment was completed on 8 May 2024 and received by MCCI from a Nursing Care provider 20 May 2024.
  + The draft Audit Report incorrectly notes the date of this clinical assessment as 19 December 2023 [and also incorrectly stated as 10 May 2023 (pg. 25), 1 May 2023 (pg. 29), 1 May 2024 (pg. 33)] giving the impression that MCCI has not acted on the clinical assessments’ findings.
  + The consumers services with MCCI were put on hold on 9 May 2024 (which was the day after the clinical assessment was completed and before the report was received by MCCI), as this consumer was admitted into residential respite care for an extended period.
  + After receiving the clinical assessment report on 20 May 2024, including Rowland Universal Dementia Assessment Scale (RUDAS), MCCI’s Care Advisor acted promptly to complete a dementia supplement application on 21 May 2024.
  + Consumer file notes in our CRM were available to the assessor at the time of audit, and they state that a full care plan review will take place once this consumer returns from respite in July. This consumer remains in respite care until at least 19th July 2024.
* In reaching their conclusions, the assessor appears to have overlooked or not sighted the factual evidence from this consumers file (provided in response) relating to their admission to an extended stay in residential respite care. This is only reason why their care plan & service interventions do not reflect the clinical assessment findings as noted in the Draft Quality Audit Report. The assessor’s findings with respect to this consumer, regrettably, appears to flow through their conclusions for 2d, 3a, 3b, 3d.
* Taking into account the above information, all of which was available to the assessor at the time of our audit, we submit that the assessor’s cited evidence does not support a finding of ‘Not Met’ outcome for this standard and can also not be relied upon for other standards above (2d, 3a, 3b, 3d) noted as ‘Not Met’.

Regarding another consumer, the service provided the following in response.

* The assessor’s conclusion that the clinical assessment for this consumer "were not provided and the planning documents did not include strategies or interventions such as falls risk assessments” is factually incorrect. We also believe that the assessor has not considered all information available to them at the time of the audit regarding management of the identified pressure sore issue noted.
* This consumer receives a level 3 Home Care package. Her most recent care plan review was completed on 1st May 2024. The service in place includes domestic assistance, personal care, nursing, respite, home modifications, podiatry, and continence aids.
* In respect to the assessor’s observations, we note:
  + Clinical assessments have been completed in response to the client’s deterioration and falls risk. An OT report was completed on 30 November 2023 and RUDAS completed on 19 September 2023, both of which were available to assessor in the client’s file.
  + The OT assessment noted above was requested by MCCI due to our concern over high falls risk. Following the report, MCCI organised the recommended home modifications and equipment identified in the OT report, including access modifications at the front and rear of the property, bathroom and toilet modifications. This shows clear strategies and interventions (responses) for managing the consumer’s falls risk.
  + A clinical assessment with an RN was discussed with the consumers representative on 1 April 2024. This was declined because they receive visits from their GP clinic regularly and receives a nurse weekly and her GP fortnightly. This information was available to the assessors in the client notes.
  + With reference to the assessors’ conclusion about the management of pressure sores, we note within their consumer file, inclusions by both MCCI and the consumers GP, identifying their GP was responsible for the monitoring of this wound. However, on 7 June 2024 our staff member called for a wellbeing check with the consumers representative and it was agreed at that time that increased dressing changes would be actioned by MCCI. An RN has been organised and a wound management plan is in place. The RN is also supporting the consumer and representative with pressure sore prevention information.

The intent of this requirement is about making sure that assessment and planning are effective. These processes will support organisations to deliver safe and effective care and services.

Supporting evidence provided by the provider identify that relevant risks to a consumer’s safety, health and well-being are being assessed, discussed with the consumer, and included in planning a consumer’s care.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows the service was able to respond to the perceived deficiencies identified previously and provide established evidence unconsidered in the assessment process.

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

Requirement 2(3)(b)

The Assessment Team was not satisfied 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. The Assessment Team provided the following evidence to support their assessment:

* One consumers care planning and assessment document and information did not include gardening preferences as a goal.
* Another consumers care planning and assessment document and information did not include preferences for female workers in administrating support.
* Consumers interviewed stated that end-of-life care or advanced care planning as an option with this service was unfamiliar with them.

The provider provided the following information and responses in refutation:

* The term 'Advance Care Planning’ is not used widely with CALD communities. The nomenclature used by MCCI – that was co-designed with CALD consumers and the PHN – is ‘Planning Ahead’, as outlined in our multilingual booklet that we have produced to encourage conversations with consumers and their families. This booklet is provided to and discussed with every consumer during their intake with our service.
  + ‘Planning Ahead’ is then discussed with consumers as part of their care plan. Where a consumer declines to develop an ACP as part of their care, our operational practice has been to delete this section from the care plan template rather than outline that the consumer had declined this as a goal.
* Within our client management system available to the audit team, there is a substantial body of documented evidence that Advance Care Planning is a routine part of our service delivery and discussed with clients:
  + For example, one consumer care plan states: “I do not have one, but I really want to do one as if something happens, I do not wish to be resuscitated”. MCCI is working with this consumer on an ACP as a result of this.
* Further Improvement Action MCCI recognises that advance care planning is a concept that is new to many people from CALD backgrounds. It is also open a very difficult and taboo subject for the community due to cultural and faith reasons. This has been included as a discussion item for our next Consumer Advisory Group meetings in August.
* Male Support Workers - In respect to the assessor’s commentary that MCCI has a “small number of male support staff”, we note:
  + MCCI has several male support workers in each location. There are 9 male home care support workers (HCSW) in ACT and 3 in the Illawarra.
  + This represents 18.5% of our total HCSW’s which we note is above the industry average of 14% (source: WGEA).
  + MCCI utilises Mable and Hire Up support workers, including male support workers where there may be a specific consumer need or request based on worker gender.
* In response to one consumers gardening preference request.
* In respect to the assessor’s observations that “care planning and assessment document and information did not include gardening as a goal. The Assessment Team could not review evidence of support staff documenting the conversation regarding the decline of services and the reasoning”, we note:
* It would appear the assessor was not aware that services are being provided to both members of this couple who reside together. The conversations with both of them regarding gardening are documented in the partners file on 24 May 2024, as the gardening service provided is from their home care package and not their partner. The relevant note (viewed as supporting evidence within this determination) was available to the assessor at the time of the audit.

The intent of this requirement is ensuring organisations are expected to do everything they reasonably can to plan care and services that centre on the consumer’s needs and goals and reflect their personal preferences.

Supporting evidence provided by the provider identify the consumer’s condition and functional abilities are considered and identifying what help they need to live as well as they can.

Furthermore, as evidenced within their response, listening to and understanding what is important to the consumer and working out how their goals and preferences can be met, and subsequently tailoring an approach to fit the consumer’s cultural and personal preferences and how they want to have care and services delivered.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows the service was able to respond to the perceived deficiencies identified previously and provide established evidence unconsidered in the assessment process.

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

Requirement 2(3)(d)

The Assessment Team was not satisfied 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. The Assessment Team provided the following evidence to support their assessment:

* Care and service documents and plan for one consumer did not include how the organisation would monitor the outcome of the recommendations. The Organisation's client management system documents the consumers risk associated with care as having Dementia and notes that the “Client has dementia and may wander off or become distressed and get upset; please redirect conversation”.

The provider provided the following information and responses in refutation:

* The main evidence cited in the Draft Quality Audit Report for this “not met” standard relates to one specific consumer. MCCI’s care and services to this consumer are outlined in some detail in our response to Standard 2, requirement (3)(a). Particularly, we note the assessor’s reliance upon the clinical assessment evidence that has not been able to be actioned by MCCI due to her residential respite care.
* In respect of another consumers care, we note in our response to Standard 2, requirement (3)(a) that this consumer has regular engagements with their health professionals other than MCCI (e.g. GP Clinic). Their care is under very active management by MCCI.
* We note the assessor’s concern about finding only 10 progress notes against 33 services by MCCI in the period reviewed. To this observation we can advise:
  + Our care workers positively validate their assigned tasks undertaken for a consumer as they complete them via service app.
  + Our approach to progress notes has historically been an ‘exceptions reporting system’ (that is, a progress note for every visit was not required to be entered by our care workers if the consumer’s routine services were implemented & validated in the app as scheduled and there were no new things to report)
  + Our allied health team and subcontractors already provide progress notes at each visit as a way to monitor services.
* Further evidence of continuous improvement included.
* Staff Training
  + As mentioned in the Draft Quality Audit Report, MCCI is currently training all support workers in improved documentation and the updated requirement to have a progress note at every visit.
* Quality of Life Tool
  + MCCI has trialled the ACC-QOL tool to be used with all consumers as part of the intake and review process. After consultation with MCCI’s consumer advisory groups, a first stage trial has been completed with several CHSP clients and is now being trialled with HCP clients.
* Future actions:
  + MCCI implemented a new CRM, in October 2023. Within our subscription is a ‘Family Portal’ that enables greater visibility over care planning and services for consumers and their families. After a period of settling the new system since October 2023, MCCI will be moving to activate the family portal in FY24-25.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows the service was able to respond to the perceived deficiencies identified previously and provide established evidence unconsidered in the assessment process.

The intent of this requirement is to ensure a care and services plan is expected to be documented and reflect the outcomes of assessment and planning for each consumer. Accurate and up-to-date care and services plans are important for delivering safe and effective care and services, as well as positive outcomes for consumers.

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

Requirement 2(3)(c) and 2(3)(e)

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

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

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

# Standard 3

|  |  |  |  |
| --- | --- | --- | --- |
| Personal care and clinical care | | HCP | 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. | Compliant | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant | 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 | 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 | 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. | Compliant | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant | 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 | Compliant |

Findings

Requirement 3(3)(a)

The Assessment Team was not satisfied each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that is best practice; and is tailored to their needs; and optimises their health and well-being. The Assessment Team provided the following evidence to support their assessment:

* one consumer lives with dementia, has chronic back pain due to arthritis, is assessed as a medium fall risk and has a restrictive practice in place due to her dementia and not being able to manage her medications properly. A review of the recent clinical assessment of 1 May 2023 identified a medium risk of falls and cognitive decline; Mini Nutritional Assessment Screening score 0-7 is assessed as Malnourished.
  + The registered nurse recorded six issues and four recommendations including medium risk of falls, Cognitive decline, Dementia, malnourished, Restrictive practice, mobility decline, and Impulse buying when shopping.
  + Recommendations included monitor for falls, apply for dementia supplement, adjust the service for medications for around lunch time to prompt a meal or help make a meal to eat, and review of restrictive practice.
  + Progress notes from support workers noted this consumer advised they has already eaten and completed the tasks the support staff are there for; however, Support staff are not provided with interventions or strategies when they refuse meal preparation services, and the diagnosis of diabetes is not recorded or available in the care and services plan.

The provider provided the following information and responses in refutation:

* The evidence cited in respect of this consumer contains additional factual inaccuracies, as it has throughout the assessment documentation outlined in Standard 2 of the Draft Quality Audit Report.
* This consumer does not have diabetes; therefore, the assessor’s comment that the diagnosis of diabetes is not recorded is not relevant. We note that none of the medications are for diabetes, nor is this condition stated in her clinical assessment or MAC documentation.
* As noted in detail in our response at Standard 2, requirement (3)(a), this consumers clinical assessment was completed in May 2024 (not May 2023 as stated in the report). Their care plan will be reviewed & updated with their representative prior to her discharge from residential respite at the end of July.
* MCCI believes our care planning documentation is clear, and our compliance with this standard is supported by consumer feedback, and feedback from staff and subcontractors performing duties as shown in the evidence conclusions of standards 7 and 8 in the Draft Quality Audit Report.

Falls Management

* MCCI disputes the Draft Quality Audit Report conclusion that we “do not manage and provide best practice care for clients at risk of falls”, and do not feel that we were given any obvious opportunity to demonstrate our approach during the on-site assessment. MCCI works with consumers at risk of falls by recommending and providing interventions that reduce the risk of falls as well as modify identified risk factors. They include:
  + Falls risk assessments through clinical assessments.
  + Functional assessments are completed by our team of ESSA accredited exercise physiologists followed up with exercise programs to build strength and mobility that incorporate the evidence-based NSW Health Stepping On program exercises.
  + Risk assessments of a consumer’s home are done at the point of service intake and options are identified in the care plan to reduce safety / falls risks
  + OT assessments are routinely commissioned for home modifications and equipment supplies that prevent or reduce the risk of falls.
  + There are numerous examples of these interventions that were available to the assessment team during the audit, or which could have been highlighted if the audit team sought further information from MCCI.

Clients displaying behaviours because of dementia and cognitive impairment.

* MCCI disputes the Draft Quality Audit Report conclusion that we “do not manage and provide best practice care for clients displaying behaviours because of dementia and cognitive impairment”, and that “staff are not provided with strategies or interventions”. We do not feel that we were given any obvious opportunity to demonstrate this during the onsite assessment and there is ample evidence available. The evidence to draw this conclusion cited by the assessor relates to only one consumer, for which there are repeated factual inaccuracies throughout the draft Audit Report (see our notes at Standard 2, requirement (3)(a) above).

Examples of interventions documented with other clients’ care plans with cognitive impairment were viewed in support of the services response.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows the service was able to respond to the perceived deficiencies identified previously and provide established evidence unconsidered in the assessment process.

The intent of this requirement sets out the expectation that organisations do everything they can to provide safe and effective personal and clinical care. This means organisations make sure that the personal and clinical care they provide is best practice, tailored to their needs, and optimises the consumers health and well-being. The information provided in response to deficiencies illustrate that the service understands, applies the requirements and outcomes, and reviews the outcomes, adjusting best practice where necessary to respond.

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

Requirement 3(3)(b)

The Assessment Team was not satisfied the service had effective management of high impact or high prevalence risks associated with the care of each consumer. The Assessment Team provided the following evidence to support their assessment:

* One consumers recent clinical assessment identified they was at risk of malnutrition. Mini nutritional assessment scoring of 8-11 and has chronic pain in his back and hip. The registered nurse's three recommendations were recorded:
  + Live life alarm would be beneficial,
  + Monitor for medium falls risk, and
  + Monitor for risk of malnourishment.
* One consumers clinical assessment identified they were at risk of malnutrition. Mini nutritional assessment scoring of 8-11 and has chronic pain in his back and hip. The registered nurse's three recommendations were recorded:
  + Live life alarm would be beneficial,
  + Monitor for medium falls risk, and
  + Monitor for risk of malnourishment.
* The service did not provide evidence demonstrating that the organisation appropriately monitors and manages consumers with high-impact and prevalence risks.

The provider provided the following information and responses in refutation:

* The evidence in the Draft Audit Report contains inaccurate consumer information and has not fully considered the entirety of information available on the consumer's file. This information was available to the audit team at the time of the assessment.
* Consumer one receives HCP L3 services from MCCI. Their most recent care plan review was completed on 16 April 2024. The services in place include domestic assistance, light gardening, physiotherapy, personal care, social support, podiatry, goods and equipment.
* Further support and mitigation information provided identifies that they have mobility barriers due to end stage renal failure and requires standby assistance when walking, and it must be at his pace.
* Further detailed instructions are provided to care workers for the standby shower personal care assistance.
* This consumer resides in the family home and is supported by their family in conjunction they receive haemodialysis 3 times a week and has seen a dietitian in the past who has him on a low salt, low carb, low fat diet. Evidence provided supports discussions indicting this consumer prefers home cooked meals
* Furthermore, OT assessment completed in April 2023 and again February 2024. Recommendations of installing a stair lift, and minor bathroom modifications have been completed to assist with his goal of feeling safe at home.
* Additional support includes physiotherapy to support strength and mobility and reduce his risk of falls.

In regard to consumer two, supporting evidence provided in response supports an array of risk recognition and mitigation measures. Extensive notes in summary.

* The clinical assessment referenced took place on 8 May 2024, the day before this consumer went into residential respite. Commissioning a clinical assessment was a key strategy to effectively manage risks; however, its implementation has not been actioned in their care plan or subsequent service interventions because of residential respite care admission prior to MCCI receiving the report.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows the service was able to respond to the perceived deficiencies identified previously and provide previously established evidence unconsidered in the assessment process. I note that exampled consumers to support the assessment team’s determination of not met are reliant on statements (and evidencing) thus far refuted with comprehensive responses by the service.

The intent of this requirement is to ensure organisations need to do all they can to manage risks related to the personal and clinical care of each consumer. This means following best practice guidance and applying measures to make sure the risk is as low as possible whilst supporting a consumer’s independence and self-determination to make their own choices, including to take some risks in life. The information provided in response to deficiencies illustrate that the service effectively manages of risks of consumers evidenced and is underpinned by clinical governance systems for safety and quality.

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

Requirement 3(3)(c)

The Assessment Team was not satisfied the needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. The Assessment Team provided the following evidence to support their assessment:

* Care planning and assessment documents did not document the delivery of service occurring.

The provider provided the following information and responses in refutation:

It is unclear from the Draft Quality Audit Report which (if any) clients who are receiving end-of- life care were reviewed by the assessor. Therefore, we are unable to respond to any specific examples or evidence that the assessor has relied upon.

* To evidence the services implementation of this standard, exampled evidence of a consumer currently receiving end of life care alongside their care from MCCI was provided. The following is summarised for context.
* HCP L3 consumer receives palliative care for the end stage of stomach cancer.
* MCCI is working actively and closely with the Palliative Care (PC) Team and their GP to ensure services and supports for them, and their family are of high quality, complementary and safe.
* PC team provide pain management and equipment to the client.
* MCCI provides EP services, social support, respite and domestic assistance, in alignment with this consumers ongoing requests.
* MCCI works closely with their principal (main carer) to provide referrals to other services as required e.g. support to get carers payment, EAPA vouchers etc.
* MCCI’s strong commitment to Advanced Care Planning (ACP), examples of consumer conversations, and our processes to support ACP are outlined in our response to Standard 2, requirement (3)(b). We submit that our response to this standard is equally relevant to the assessor’s findings for Standard 3, requirement (3)(c).

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response exampled which illustrates the intent and application of personal and clinical care is delivered at the end of a consumer’s life.

In further determination of a finding of compliance in this requirement, I reflect the statement by the provider, acknowledging the limited information in permitting a fair and balanced response to a specific consumer example given.

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

Requirement 3(3)(d)

The Assessment Team was not satisfied that 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. The Assessment Team provided the following evidence to support their assessment:

* One external support worker reported for one consumer declining to shower or brush their teeth. Support workers advised the consumer did not have a shower Easter Sunday and reported legs were a bit more swollen than usual. However, it was unclear what had occurred since the service received notification of the decline.
* One consumers nursing assessment identified a decline in mobility and cognitive decline, which was reviewed in the clinical assessment completed on 1 May 2024. The Assessment Team could not see evidence that showed the service-appropriate response to the decline, and the deterioration was not included in the care and services plan.
* For consumers sampled, at the time of the Quality Assessment, Evidence of deterioration was unnoticed or not responded to therefore The Assessment Team recommends that this Requirement is not met.

The provider provided the following information and responses in refutation:

* The Draft Audit Report cites evidence in relation to two consumers to draw a conclusion of Not Met. In both cases, the evidence available does not support this finding.
* Regarding the first consumer.
  + MCCI can demonstrate that there was a timely response to the progress note provided by the support worker for this consumer. The note in question suggested that a later time (10am) for the shower may reduce likelihood of the shower being declined. This was actioned immediately by MCCI and can be seen in the service schedule. (provided)
* Regarding the second consumer.
  + As noted in our response to several items in Standards 2 & 3, the evidence relating to this consumer for this standard should not be relied upon due to its repeated inaccuracy throughout the Draft Audit Report.
* Additional Evidence submitted.
* MCCI provided other examples of evidence illustrating the response and mitigation respond to deterioration and change in a timely manner. Indeed, several of the consumer examples cited in response to the Draft Audit Report highlight MCCI’s prompt interventions to assess and address deterioration, Further examples include OT and clinical RN assessments, which are then discussed with consumers and actions prioritised for implementation.
* Progress notes for an additional consumer is provided illustrating recognition of consumer deterioration and response in a timely manner.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s alternate examples which illustrate responding to deterioration or change in a consumer’s mental health, cognitive or physical function, capacity or condition.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 3(3)(d) in Standard 3, personal care and clinical care.

Requirement 3(3)(e)

The Assessment Team was not satisfied 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. The Assessment Team provided the following evidence to support their assessment:

* One consumers clinical assessment records them as diabetic; however, a review of their care documents and clinical assessments does not include the diagnoses.
* Care planning documents for an anonymous consumer did not include follow up with doctors.

The provider provided the following information and responses in refutation:

* The evidence in the Draft Audit Report relating to one consumer identified is factually incorrect and should not be relied upon to draw a ‘Not Met’ conclusion:
* This consumer is not diabetic, and it does not say he is diabetic in the clinical assessment or MAC plan referenced in the report. As such there is no risk due to diabetes and no intervention in his care plan.
* Regarding the anonymous consumer feedback, we are unable to review or provide a specific response on this given we are unaware who the consumer is. To assist with further evidence of our practice, alternative evidence is provided in support of the intent and expectation of service delivery under this requirement.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s alternate examples which illustrate the communication processes that the organisation has, so that their workforce has information about delivering safe and effective personal and clinical care and understanding the consumer’s condition, needs, goals and preferences.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 3(3)(e) in Standard 3, personal care and clinical care.

Requirement 3(3)(f) and 3(3)(g)

Consumers and representatives confirmed staff use personal protective equipment when providing care and services. Staff stated they have completed infection control training to minimise infection. Management advised all staff have completed infection control training and staff have access to personal protective equipment. Documentation showed the service has an emergency management plan inclusive of infection control and outbreak plans.

Consumers and representatives expressed satisfaction the service will refer the consumer to other organisations and providers when required. Management demonstrated an understanding of referral networks and described internal and external referral processes used by the service. Documentation showed the service makes referrals to other organisations and providers where the need is identified.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 3, Personal care and clinical care.

# Standard 4

|  |  |  |  |
| --- | --- | --- | --- |
| Services and supports for daily living | | HCP | 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 | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant | 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 | 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 | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant | Not applicable |

Findings

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

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

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

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

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

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

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

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

# Standard 5

|  |  |  |  |
| --- | --- | --- | --- |
| Organisation’s service environment | | HCP | 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. | Compliant | 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 | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant | Compliant |

Findings

Requirement 5(3)(b)

The Assessment Team was not satisfied the service environment is safe, clean, well maintained and comfortable, and enables consumers to move freely, both indoors and outdoors. The Assessment Team provided the following evidence to support their assessment:

* WHS risk assessments for a service environment location viewed identified that the carpet needs to be replaced.
  + Another location (place of worship) identified staff were unable to find emergency evacuation plans/signage.
  + Another location (place of worship) identified no fire alarms present.
* The Assessment Team made the following observations at multiple service outlets in regard to the safety, cleanliness and comfortability of the service environments, including at one location:
  + There is no accessible bathroom onsite.
  + Access to the building is on a driveway. Ramps in were of a high gradient (steep) and there were no handrails.
  + Items in the first aid kit were unsealed and out of date.
  + Within a four-metre space there were three types of flooring, presenting a tripping hazard.
  + The gyms walls are made of corrugated sheeting and there were holes present in these walls. On the day of the Quality Audit the temperature was observed to be 12 degrees, and there were no heating/cooling facilities in the gym.
  + Some gym tiles were loose presenting a tripping hazard.
* At another social support group location, the following was observed:
  + The location is accessible although entry to the bathroom tiled area is steep, a tripping hazard, and is not identified as such.
  + Emergency evacuation maps were not sighted along with a clearly marked emergency assembly area.
  + None of the food items in the pantry or the fridge (sugar, flour and condiments) had any open date labels. Furthermore, some pantry items were left unsealed.
  + The fridge temperature was 7 degrees Celsius, outside the food safety zone. There were discrepancies between staff and management as to whose responsibility it is to check the temperature and manage the temperatures.
  + Staff were seen serving food not in line with the providers policy of utilising aprons, hairnets and gloves were not changed regularly.

The provider provided the following information and response to the assessment report.

* The Draft Audit Report accurately describes the various service environments in which MCCI operates. For context, we note that the ‘third party property’ venues we utilise comprise a mix of community centres, church halls, and community association-owned premises that are used by a wide range of groups (and not exclusively by MCCI). These venues, many of which have been used by MCCI for decades, have been chosen by our consumers as their preferred social support group meeting places typically because of their cultural familiarity and safety. MCCI conducts a suitability and risk assessment of venues prior to their use for aged care programs, regularly conducts ongoing assessments of same, and seeks improvements or mitigation measures to be made by the venue owners where issues are identified.
  + MCCI verified that the church hall has a current fire safety statement dated 10 May 2024. Administration of this location been informed that the hall is missing the emergency evacuation plan. In the meantime, MCCI is conducting a safety briefing with clients at the commencement of each group as a risk mitigation measure.
  + At the other church It is correct that there is no fire alarm; however, there are working smoke detectors and other fire safety equipment required for the building including fire extinguishers.
* At one social support group location
  + Trip hazard issue: The access to the bathroom has a half tile on a slope. MCCI had not identified this as a trip hazard previously, but it has now been deemed as such and MCCI has requested the church (owner) install hazard tape to identify the hazard as a reasonable mitigation measure.
  + Emergency maps issue: We have contacted the venue regarding the lack of emergency map in the group room (but we note that emergency plans do exist elsewhere in the common areas of the building). While this is rectified, MCCI staff will complete a safety briefing at the start of each group.
  + Pantry food items: Items are now stored and labelled correctly. Staff have been reminded about the food safety policy, and additional training has been organised for the end of July.
  + Fridge temperatures: As a continuous improvement item, MCCI has updated our existing daily food inspection checklist to be used on each occasion of service and provided a thermometer to each venue.
* At another location – principally for use by office staff, and by consumers participating in accredited exercise physiology programs under constant supervision.
  + Following a prior risk assessment completed by MCCI, various safety mitigation/improvements were made to the premises, including:
  + Retrofit installation of 2 internal ramps to mi􀆟gate minor step hazards across the floor levels
  + Rehang of the ground-floor bathroom door so that it is outward opening, to address risk associated with a person falling against the door inside the bathroom
  + Installation of a ‘slimline’ bathroom vanity (replacing existing) to improve accessibility
  + The absence of a fully accessible (e.g. to disability standard) bathroom at the Fyshwick site is mitigated by the gym only being used by consumers who do not have high mobility issues; alternative home-based EP services are offered o clients with high accessibility needs.
  + While the assessor correctly notes the gym space is not air conditioned, the assessor failed to note or record in the draft Audit Report that a free-standing in situ heater (for winter) and fan (for summer) was present at the time of the audit.
  + Scope Home Access (who installed the gym floor tiles) have been contacted by MCCI to complete remediation works on the floor. However, after being alerted to this issue by the audit team, MCCI would dispute that a trip hazard exists, we will nevertheless review the floor tiles with the installer
  + MCCI has obtained quotes and applied for a grant to improve the service environment gym space in Fyshwick. The scope of works includes plaster boarding walls and adding insulation, putting in a false ceiling, and installing an air conditioner. The quotes were obtained by MCCI in March 2024 and the grant application lodged on 4th April 2024.
* Venue Risk assessments
* Post-audit verbal feedback, MCCI has strengthened our visibility and ‘close out’ procedures for identified venue hazards. All inspections & hazards for venues are now entered into our safety management software. This means that the inspections are done straight into the system (rather than on paper), and actions are identified and assigned in the system immediately. This then goes straight into the Corrective Actions Register of our safety management software for monitoring and follow up. Automatic reminders are set up for the recurring inspections and are visible in the Safety Champion dashboard. Responsibility for completing these risk assessments has also been elevated to Team Leader level to ensure a more thorough and consistent approach. Following the audit, MCCI has now completed updated external risk assessments on all venues we use. Identified actions of a minor nature are ‘in progress’.
* First Aid Kits - MCCI was very disappointed to find that venue first aid kits were not complete or in date on inspection by the audit team. To date our approach has been to rely upon our host venue’s first aid kits and to complete a 6-monthly physical check/validation of these kits for our own assurance. To strengthen this system, we have now put in place the following measures.
* Immediately after receiving verbal feedback from the audit team:
  + MCCI will take and be responsible for a first aid kit at all external venues to ensure it is always available and up to date. This now eliminates the risk of 3rd party venue first aid kits not being appropriate. MCCI’s kits will be checked during the venue inspections on a six-monthly basis.
  + The first aid officers in each office will be responsible for checking MCCI venue first aid kits and requesting restocking through the operations team.
  + All first aid kits (venue and bus) have been checked and restocked/ replaced after the recent audit team feedback
  + Staff have been reminded of the importance of reporting first aid kit usage and the need to replace/restock first aid kits.
* Food Safety
  + MCCI was extremely disappointed with the food safety finding, particularly as all social group staff – including the worker we understand was observed - had completed food safety training in early 2024.
  + Our understanding from the audit-close meeting is that the draft Audit Report’s finding on Food Safety relates to a single worker (group facilitator) at our ACT Chinese Social Support Group.
  + Considering the finding, we have now put in place the following measures immediately after receiving verbal feedback from the audit team:
  + Sent MCCI’s food safety policy to all relevant staff. Conducted unannounced ‘spot check’ audits of groups where food is served: this internal audit had overall findings demonstrating staff compliance with food handling. Some improvements were identified at shared venues where food is stored on site. These items have been or are being actioned and monitored currently via our Safety Champion software.
  + Food Safety has been added to the next team meeting agenda for social groups team members Updated the Food Safety daily checklist to be completed prior to all groups where food is served.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a measured and considered response to deficiencies identified. Whilst I acknowledge elements of oversight are the responsibility of other location administers, the service has nonetheless provided responses illustrating engagement with these to ensure risk mitigation and response to ensure safe delivery of services for consumers.

The intent of this requirement is ensuring that the service environment is safe, clean, well maintained and comfortable. It also covers the need for consumers to be able to move freely around the service environment, indoors and outdoors.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 5(3)(b) in Standard 5, The service environment.

Requirement 5(3)(a) and 5(3)(c)

Consumers confirmed they feel comfortable and welcome in the service environments. Staff described how they support consumers to interact and use the service environment to suit their needs. Management described how they know consumers feel welcome by assessing attendance and participation in activities. Consumers were observed participating in activities in the service environment.

Staff and management described the processes for cleaning equipment and escalating issues with furniture.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 5, Organisation’s service environment.

# Standard 6

|  |  |  |  |
| --- | --- | --- | --- |
| Feedback and complaints | | HCP | CHSP |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant | 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 | 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 | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant | Compliant |

Findings

Consumers and representatives confirmed they are aware of how to provide feedback and raise complaints and feel safe to do so. Staff stated they seek feedback from consumers during service delivery and emphasise to consumers the importance of making feedback. Management stated the complaint procedure is explained to consumers. Documentation showed complaint mechanisms and procedures are included in consumer agreements and consumer information manuals.

Consumers and representatives confirmed they are aware other methods for raising and resolving complaints, including knowing how to contact the Commission. Documentation showed the service’s complaints procedure and consumer manuals offer consumers diverse internal and external feedback, complaints and advocacy options, in the consumer’s language of choice.

Consumers and representatives confirmed the service resolved issues or informal complaints they had made. Staff described processes for escalating complaints from consumers. Management described how the service responds to complaints and how it uses open disclosure when issues are identified. Documentation showed the service uses an open disclosure approach to resolve issues, even though the service does not have an open disclosure procedure.

The service’s complaints policy states complaints will be addressed promptly, treated confidentially, and used as an opportunity for improvement. The service’s complaints register is used to trend complaints and improve service, with strategies implemented to avoid the same issues occurring again. Documentation showed complaints are actioned and finalised and, if necessary, improvements to services are implemented.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 6, Feedback and complaints.

# Standard 7

|  |  |  |  |
| --- | --- | --- | --- |
| Human resources | | HCP | 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 | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant | 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 | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant | Compliant |

Findings

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

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

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

Support staff confirmed they undergo regular informal performance appraisal processes with management. Management confirmed support staff undergo regular informal performance appraisal processes with office staff undergoing formal annual appraisal processes. Management stated a review of performance appraisal processes will be undertaken. Documentation showed evidence of performance reviews being completed for office staff.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 7, Human resources.

# Standard 8

|  |  |  |  |
| --- | --- | --- | --- |
| Organisational governance | | HCP | CHSP |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant | 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. | Compliant | 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. | Compliant | 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. | Compliant | 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. | Compliant | Compliant |

Findings

The service has established a consumer advisory body, with consumers invited to attend focus groups and engagement sessions The service seeks feedback from consumers through an annual satisfaction survey and through group sessions to understand the needs of consumers. Consumers are provided newsletters and correspondence to keep them informed of changes in Aged Care. Staff stated the service supports consumers to be engaged in service delivery and development.

The governing body remains informed via established leadership reporting pathways from the service level through the management structure, in order to satisfy itself that the Quality Standards are being met. The governing body meets bi-monthly and considers operational reports presented by management. Feedback, complaints, incidents and deterioration reporting are part of monitoring, with reporting on subcontractors to be incorporated into the monthly governing body reporting processes.

Interviews with consumers, staff and management and documentation showed there are effective organisation wide governance systems in place to support information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints.

The organisation has a risk management framework inclusive of a risk register and risk management procedure. This ensures effective management of high-impact and high-prevalence risks, effective identification and response to abuse and neglect, support for consumers to live their best life and management and prevention of incidents through an incident management system.

The organisation has an infection control plan and all staff have received infection control training and refresher training. Open disclosure is used when things go wrong.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 8, Organisational governance.

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-1)