**Performance**

**Report**

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| Name: | My Home Care Choices |
| Commission ID: | 301069 |
| Address: | 33 Radnor Drive, DEER PARK, Victoria, 3023 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 5 February 2024 to 6 February 2024 |
| Performance report date: | 13 March 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: 9169 My Home Care Choices Pty Ltd  
Service: 26940 My Home Care Choices

**This performance report**

This performance report for My Home Care Choices (**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 Assessment contact (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives.
* The performance report dated 3 April 2023 in relation to the Quality Audit undertaken from 13 to 15 February 2023.
* the provider’s response to the assessment team’s report received 26 February 2024.

# Assessment summary for Home Care Packages (HCP)

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

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

# Areas for improvement

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

* Requirement 6(3)(d) Feedback and complaints are reviewed and used to improve the quality of care and services.
* Requirement 7(3)(c) The workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles.
* Requirement 7(3)(d) The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.
* Requirement 8(3)(b) The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.
* Requirement 8(3)(c) Effective organisation wide governance systems relating to the following: information management; continuous improvement; financial governance; workforce governance, including the assignment of clear responsibilities and accountabilities; regulatory compliance; feedback and complaints.
* Requirement 8(3)(e) Where clinical care is provided—a clinical governance framework, including but not limited to the following: antimicrobial stewardship; minimising the use of restraint; open disclosure.

# Standard 2

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| Ongoing assessment and planning with consumers | | HCP |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | 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)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

Requirements (3)(a), (3)(b) and (3)(e) were found non-compliant following a Quality Audit undertaken from 13 to 15 February 2023. The service did not demonstrate:

* Assessment and planning, including consideration of risks to the consumer’s health and well-being, informed the delivery of safe and effective care and services.
* The service used validated assessment tools or undertook assessments to inform care delivery through consideration of risks to consumers health or wellbeing.
* Consumer preferences were identified, including language spoken and personal care preferences. Individualised goals were generic, and allied health professional notes were not transferred across consumer files.
* Care and services were reviewed regularly for effectiveness, and when circumstances changed or when incidents impacted on the needs, goals or preferences of the consumer.

The Assessment Team’s report for the Assessment contact undertaken on 5 to 6 February 2024 includes evidence of actions taken by the service in response to the non-compliance. These actions include, but are not limited to:

* Implementation of a comprehensive clinical assessment for all consumers including the implementation of validated clinical assessment tools.
* The introduction of a phone application for staff which includes information they require to provide care and services to all consumers, including documented needs, goals, and preferences.
* Updating care plans to include information regarding advanced care planning or end of life care.
* Implemented six-monthly care plan review processes.

The Assessment Team was satisfied these improvements were effective and recommended Requirements (3)(a), (3)(b) and (3)(e) met.

Care plans illustrated initial assessment and ongoing care strategies which were supported by comprehensive progress notes, and clinical assessments when changes to health and wellbeing were identified. Management and staff described the processes for consumer initial assessment and onboarding, including risk assessments and emergency planning.

Consumers said staff have spoken to them about advance care and end of life planning. Care plans consistently demonstrated identification of consumer’s current needs and preferences, with care planning documentation outlining actions to address consumer needs. Staff said they had sufficient information to provide care and services to all consumers, and case managers were knowledgeable of processes to obtain information about consumers’ needs and preferences.

Management described how they respond to changes needs of consumers or when incidents impact on the needs, goals and preferences of the consumer. Management and staff described the processes for ongoing completion of annual reviews and how the service conducts reviews following incidents and changes to circumstances, including attending a consumer’s home with allied health care providers to support updates to care and service delivery. Documentation demonstrated the service has care planning and assessment policies to guide staff practice to undertake reviews or as circumstances changed.

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

# Standard 3

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| Personal care and clinical care | | HCP |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |

Findings

Requirements (3)(a), (3)(b), (3)(c), (3)(d) and (3)(e) were found non-compliant following a Quality Audit undertaken from 13 to 15 February 2023, as the service did not demonstrate:

* Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that: i) is best practice; and; ii) is tailored to their needs; and; iii) optimises their health and well-being.
* Effective management of high-impact or high-prevalence risks associated with the care of each consumer.
* The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.
* 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.
* 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’s report for the Assessment contact undertaken 5 to 6 February 2024 did not specify actions taken by the service to address the non-compliance. However, the Assessment Team were satisfied the service has addressed the deficits and recommended Requirements (3)(a), (3)(b), (3)(c), (3)(d) and (3)(e) met.

Staff were knowledgeable of risks associated with the care of consumers and were able to describe mitigation strategies. A risk management system is in place to analyse incidents to ensure risks are being monitored and addressed.

Interviews with consumers and representatives showed, and documentation supported, best practice care delivery and effective risk management in relation to medication, wounds, and allied health.

Policies and procedures are in place to guide staff on end of life care and external palliative care services.

Consumers and representatives were confident staff would be able to recognise a change in consumers’ health and deterioration. Staff explained the process of how to recognise and manage deterioration, including escalation processes. Policies and procedures are in place to guide staff and management confirmed all staff were scheduled to receive further training. Documentation showed one consumer’s deterioration was effectively managed.

Consumers and representatives said staff are aware of consumers’ care needs. Staff said they had access to appropriate information which enables them to deliver safe and effective care. Consumer files are maintained both electronically and on paper.

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)(d) and (3)(e) in Standard 3 Personal care and clinical care.

# Standard 6

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| Feedback and complaints | | HCP |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant |

Findings

Requirement (3)(d) was found non-compliant following a Site Audit undertaken from 13 to 15 February 2023 as the service was unable to demonstrate feedback and complaints were captured, reviewed and used to improve the quality of care and services.

At the Assessment Contact undertaken from 5 to 6 February 2024, the Assessment Team found continued deficits relating to capturing and use of feedback and complaints to improve the quality of care and services. The Assessment Team recommended Requirement (3)(d) not met and provided the following evidence relevant to my finding:

* The service had conducted two customer surveys in 2023 based on a Continuous Improvement Plan provided, however the responses from these surveys had not been collated, recorded, or captured for analytical purposes.
* The service continues to receive verbal feedback, complaints and compliments; however, they are not being recorded or consolidated for reviewing and informing quality care.
* The complaints register failed to document outcomes to complaints received.
* Management was unable to identify any improvements the service had made since the previous audit based on consumer feedback and complaints, inclusive of the surveys conducted.

In considering the services response contained within its Standard 6 Table of Responses and Continuous Improvement Register provided 26 February 2024, responses identified included:

* The feedback survey sent to our consumers.
* Evidence of text message reminders sent to consumers encouraging them to participate.
* Record of the survey link being sent and received by all consumers via SMS.
* Data collated from our feedback surveys.

I have considered while information and evidence in the services response shows areas of improvement in capturing consumer feedback in surveys, deficiencies remain regarding the review and use of this feedback to implement improvements.

* The services Continuous Improvement Register (item No 14, date received 13 March 2023), states that when feedback surveys are conducted (every 6 months) the data from surveys is to be analysed and recorded into the continuous improvement plan to monitor and address trends and themes that arise from analysis. A date of completion 10 June 2024 is scheduled (a week after the next survey to be conducted).

In acknowledging the services intent to utilise the results of consumer surveys, at this stage the supporting evidence does not capture the analysis and use of the most recent survey responses in 2023 to improve the quality of care and services.

In coming to my finding, I have considered the Assessment Team’s findings, and information in the Assessment Team’s report, in conjunction with the services Continuous Improvement Register which demonstrates the service still exhibits deficits in feedback capture analysis and review to evidence improved care delivery.

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

# Standard 7

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| Human resources | | HCP |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Not Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Not Compliant |

Findings

Requirements (3)(c) and (3)(d) were found non-compliant following a Site Audit undertaken from 13 to 15 February 2023 as the service was unable to demonstrate the workforce is recruited, trained, equipped and supported to deliver the outcomes and have the relevant skills, experience, and knowledge to meet the needs of all consumers particularly those with complex care needs and where consumer risks are identified.

Requirement (3)(c)

At the Assessment Contact undertaken from 5 to 6 February 2024, the Assessment Team found continued deficiencies relating to qualifications and specialist training relevant to the role. The Assessment Team identified the following:

* The services Continuous Improvement Plan identified commitments to returning to compliance including ensuring the workforce have the skills and qualifications required for their respective roles, and to complete at least two professional developments annually. However, at the time of the Assessment Contact, documentation reviewed indicated that not all staff had completed training, nor provided updated or current qualifications relevant to the role.
* Training in SIRS, and understanding dementia, though evidenced in the services training matrix, had failed to be delivered to all staff.
* Reviews of staff handbooks outlines expectations and mandatory training including manual handling; however, a review of sample staff files reflects this is not being conducted.
* Reviews of staff files both in hardcopy and electronic formats revealed expired and outdated qualifications and police checks. Furthermore, information captured on the workforce competencies were not consistent between both formats.

In considering the services response contained within its Standard 7 Table of Responses and Continuous Improvement Register provided 26 February 2024, responses identified included:

* The inclusion of a 2024 staff education calendar and training log
* Training Plan
* SIRS Course Report, Manual Handling Certificates and Additional Courses completed by Case Managers.
* Scanned copies of Understanding Dementia Certificates.
* Scanned copies of Medication Assistance Certificates.

The Service acknowledges that although performance appraisals have not yet been conducted, appropriate steps to ensure that they are conducted as early as the beginning of March 2024 have been documented in the Continuous Improvement Register.

In coming to my finding, I have considered the Continuous Improvement Register, which demonstrates the services intent to conduct continued training throughout 2024, and further supported by copies of certification provided, however observed that all certification evidence provided was from 2023.

Although I acknowledge that having a workforce with expired qualifications may not impact the type of care and services provided to consumers, appropriate training, and up to date certification of the workforce provides assurances as to their competency to effectively perform their roles. As such, I find the service is non-compliant with Requirement (3)(c) in Standard 7 Human Resources.

Requirement (3)(d)

At the Assessment Contact undertaken 5 to 6 February 2024, the Assessment Team found continued deficiencies relating to training needs, ongoing training and onboarding and supervision of new staff. The Assessment Team identified the following:

* A review of documentation, including the human resources policy, which identifies staff are required to complete annual mandatory training and have a performance appraisal annually, however this has not been conducted. Management advised mandatory training has not occurred and advised they are unaware of what mandatory training should include.
* Reviews of staff files indicated some have expired and/or outdated qualifications or certifications, such as First Aid and Cardiopulmonary Resuscitation, and no evidence of performance appraisals.
* Recent recruited staff had not received induction training, and limited training across aspects of service delivery. Further documentation reviews for this staff member indicated that relevant qualifications and mandatory requirements had not been recorded.

In considering the services response contained within its Standard 7 Table of Responses and Continuous Improvement Register provided 26 February 2024, responses identified included:

* The inclusion of a 2024 staff education calendar and training log
* Training Plan
* SIRS Course Report, Manual Handling Certificates and Additional Courses completed by Case Managers.
* Scanned copies of Understanding Dementia Certificates for all staff.
* Scanned copies of Medication Assistance Certificates for all staff.
* The service provider has also advised in Table 7 the intention to conduct performance appraisals commencing March 2024.

The service further advised reasons for expired/outdated qualifications during the audit can be explained by possible inconsistency between paper file and electronic file due to transition, implying some documents may have expired during the midst of the transition and the updated version may not be in hard copy or may not have been uploaded online yet.

Whilst I acknowledge system limitations may impact the currency or evidencing of staff certification, the additional statement of ‘all staff qualifications and certifications are up to date’ and ‘having a workforce with expired/outdated qualifications or certificates does not reflect the type of care and service provided to our consumers’ may not impact the type of care and services provided to consumers, appropriate training, and up to date certification of the workforce, provides assurances as to their competency to effectively perform their roles. The Service Providers response does not support evidenced qualifications and certifications as current. As such, I find the service is non-compliant with Requirement (3)(c) in Standard 7 Human Resources.

# Standard 8

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

Findings

Requirements (3)(b), (3)(c) and (3)(e) were found non-compliant following a Site Audit undertaken from 13 to 15 February 2023, as the service was unable to demonstrate effective governance systems in relation to information management, continuous improvement, financial governance, workforce governance and feedback and complaints. Furthermore, the service was unable to demonstrate effective system to assess risks to the health, safety and wellbeing of consumers, and providing effective clinical governance frameworks.

Requirements (3)(b)

At the Assessment Contact undertaken 5 to 6 February 2024, the Assessment Team found continued deficiencies relating to theorganisation’s governing body’s promotion of a culture of safe, inclusive, and quality care and services and its accountability for their delivery*.* The Assessment Team identified the following:

* The services Continuous Improvement Plan committed to undertaking actions including analysing, reviewing and investigating feedback and complaints to aid in the promotion of safe, and inclusive quality care. However, as previously identified in Standard 6, Requirement 6(3)(d), the service has failed to adequately implement an effective strategy to capture and analyse feedback and complaints to improve upon and promote inclusive and quality care.
* The service has not commenced registration of a governing body and remain a private limited company with sole directorship.
* The service was unable to produce a strategic plan to effectively illustrate the organisations governing body promotion of safe, inclusive and quality care and services and is accountable for their delivery.
* Management were unable to produce meeting minutes to support engagement between the governing body and managements delivery of services.
* The service was unable to provide supporting policies or procedures to support an incident register and its use in instructing staff.

In considering the services response contained within its Standard 8 Table of Responses and Continuous Improvement Register provided 26 February 2024, responses included:

* A formal system in place to actively seek feedback on the performance of the service. A client feedback survey on the ‘Survey Monkey’ platform. Survey links are sent to clients via SMS. This format ensures all consumers, or their representatives receive the survey.
* 30 November 2023 - Commence registration for a governing body. Ensure that the body aligns with the requirements set out by the Aged Care Commission, including having a majority of independent non-executive members and at least one member with experience in providing clinical care. Expected completion date 1 April 2024.
* The service is currently registering for a governing body. The service acknowledges that governing bodies are vital to the delivery of the best possible aged care and we are committed to ensuring the completion of this as early as possible.
* Staff meetings are conducted informally due to the schedule and locations of staff not being able to align with one another. We always keep in frequent contact with our staff, and they are able to contact the office at any time for any help, issues, or feedback.
* An Incident register in place and aligning policy and procedure to support it. At My Home Care Choices, we recognise the importance of the SIRS and have measures in place for the prevention, management, and reporting of incidents.

In coming to my finding, I have considered the Assessment Team’s findings and Service Providers Continuous Improvement Register and responses, with the following identified.

* The Services Incident register provided is a template without entries.
* The omission of evidence regarding the commencement of registration of a governing body.
* The omission of meeting minutes and agendas to support transparency in the organisation’s governing body promotion of a culture of safe, inclusive, and quality care and services and its accountability for their delivery.
* Staff meetings are conducted informally due to the schedule and locations of staff not being able to align with one another, and as a result the omission of meeting minutes.
* Staff to complete SIRS training.

In acknowledging that the service has responded to previous deficiencies identified, there is no evidence these actions have been fully implemented which demonstrates the service continues to exhibit deficiencies in the organisation’s governing body accountability and promotion of a culture of safe, inclusive, and quality care and services. As such, I find the service is non-compliant with Requirement (3)(b) in Standard 8, Organisational Governance.

Requirements (3)(c)

At the Assessment Contact undertaken 5 to 6 February 2024, the Assessment Team found continued deficiencies relating to effective governance systems in relation to information management, continuous improvement, financial governance, workforce governance and feedback and complaints. The Assessment Team identified the following:

*(i) information management*

* Information management systems were utilised in both hardcopy and electronic formats, with information exchange failing to transfer.

*(ii) continuous improvement*

* The services Continuous Improvement Plan provided was dated February 2023, the timeframe of the previous Quality Audit. The Plan failed to contain updated information regarding the status of inclusions, or substantive outcomes documented in some fields.

*(iii) financial governance*

* Discrepancies in consumer monthly statements, including inconstancies in contravention of guidance provided by myagedcare.gov.au.
* Review of the financial management policy indicates monthly statements to contain information in alignment with the guidance provided by myagedcare.gov.au.

*(iv) workforce governance, including the assignment of clear responsibilities and*

*Accountabilities*

* Discrepancies in staff position descriptions and key performance indicators aligned with that position.
* Conditions of employment specifying compliance with mandatory certification; however, staff records indicate outstanding certifications.
* Human Resources policies specifying annual performance reviews, however staff records, and confirmation by management advise this has not occurred for staff.

*(vi) feedback and complaints*

* The services complaints register, though containing information, fails to demonstrate substantive resolutions or how it is being used to improve service delivery.
* Two consumer surveys conducted failed to have information extracted and analysed for service improvements, with management unable to describe what trends or analysis resulted from the surveys conducted.
* Management could not identify any improvements the service has made since the previous Quality Audit in February 2023, despite feedback and complaints included in the services Continuous Improvement Plan.

In considering the services response contained within its Standard 8 Table of Responses and Continuous Improvement Register provided 26 February 2024, responses identified included:

*(i) information management*

* As stated in the report, we are in the midst of transitioning from paper-based formats to electronic systems. We believe it is important to note that this process cannot be completed overnight. Until the completion of our transition, there may be some inconsistency or misalignment between the two formats.

*(ii) continuous improvement*

* During the audit, we also provided an updated continuous improvement plan that highlighted numerous areas of improvement that we have worked on throughout 2023 following our previous audit. It includes the area of issue, action taken, and resolution/outcome achieved.

*(iii) financial governance*

* Our statements have all the required info without being overly detailed to ensure accessibility and understanding for all of our consumers. We have not had any complaints regarding the layout or format of our statement and all consumers are happy with our method.
* The issue with the ‘incorrect rate’ was simply a mistake that has since been rectified. All consumers are charged the correct rates, and they are able to see this via their statement and can contact us if they have any questions.

*(iv) workforce governance, including the assignment of clear responsibilities and Accountabilities*

* As mentioned in the Standard 7 Table of Responses, all staff hold current and relevant qualifications. This is a recurring theme throughout the report; however, we believe that this misunderstanding is a result of our current transition from paper -format to an electronic paperless system. Because of this, some staff members may have outdated certificates on file, yet their current certificate is uploaded onto our system or vice versa. At My Home Care Choices, we take pride in ensuring our workforce is fully qualified and have all relevant documentation at all times to ensure we provide the upmost level of care and service to our consumers.
* Similarly, yearly performance reviews are a topic that is reoccurring throughout the report. We take full accountability that a vital part of our operations has not yet been conducted and are disappointed in this finding. To rectify this, we have created a performance appraisal template which we will begin to use to conduct yearly reviews on our staff as early as the beginning of March 2024.

*(vi) feedback and complaints*

* As mentioned in Section 6(3)(d) our complaints register documents all received complaints, capturing the details of each issue and the subsequent actions taken to resolve them. By recording this information, we not only demonstrate our commitment to addressing consumer grievances but also create a valuable resource for continuous improvement.

As seen in the attachment, our complaints register clearly states the details of complaint, follow up information, continuous improvement applicability, and resolution.

* The information meticulously recorded in our complaints register serves as a valuable resource for enhancing our services. By analysing the details of each complaint, including the nature of the issue, follow-up actions taken, and the ultimate resolution achieved, we gain insightful perspectives into areas that may require improvement. This data becomes a catalyst for continuous improvement initiatives, allowing us to identify patterns, address recurring issues, and implement strategic changes. The feedback loop created through the complaints register not only helps in rectifying specific concerns but also contributes to the overall refinement of our services. Harnessing this information empowers us to proactively enhance customer satisfaction, strengthen our processes, and cultivate a culture of continuous learning and advancement within our organization.
* Although we have taken action to address our feedback data, we acknowledge that the results of our feedback were not captured within our continuous improvement plan. However, at My Home Care Choices we value accountability and are committed to consistently improving our services and operations, therefore we have promptly included the results of our feedback surveys into our continuous improvement plan following the findings of this report.

In acknowledging that the service has responded to previous deficiencies identified, evidence provided in Standard 8 Table of Responses, exhibits improvements to.

* *(vi) feedback and complaints*, namely the introduction of an updated complaints & feedback register, draft information sheet on how to lodge a complaint and complaints register as of February 2024.
* *(iii) financial governance*, consumer statement examples provided illustrating required information as per *Provider Guide Better Practice Home Care Package Statement*. Version 3 – 1 March 2023, and Monthly statement of available funds and expenditure to be given to care recipient in the *User Rights Principles 2014.*

In coming to my finding, I have considered the Assessment Team’s findings, and Service Providers response which demonstrates the service continues to exhibit deficiencies in *(i) information management, (ii) continuous improvement, and (iv) workforce governance, including the assignment of clear responsibilities and Accountabilities.* There is no evidence these actions have been fully implemented at this stage. As such, I find the service is non-compliant with Requirement (3)(c) in Standard 8, Organisational Governance.

Requirement 8(3)(e)

At the Assessment Contact undertaken 5 to 6 February 2024, the Assessment Team found continued deficiencies relating to the organisation’s clinical governance framework. The Assessment Team identified the following:

* The service does not have policies and procedures on antimicrobial stewardship, minimising the use of restraints, and open disclosure.
* Training relevant to clinical oversight and knowledge was not reflected in staff records, with management confirming this training has not been delivered wholesale to servicing staff.
* The service has commenced assessment processes to identify clinical issues such as falls and risks, however, is yet to update the governance framework to reflect new processes in place.

In considering the services response contained within its Standard 8 Table of Responses and Continuous Improvement Register provided 26 February 2024, responses identified included:

* Policies and procedures on antimicrobial stewardship, minimising use of restraints, and open disclosure.
* Continuous improvement plan regarding training for staff
* The service has implemented policies and procedures on antimicrobial stewardship and this information is communicated to staff during their induction, but training has not yet occurred. This training is being developed for staff and will be conducted.

In coming to my finding, I have considered the Assessment Team’s findings, and Service Providers response which demonstrates improvements, including the introduction of policies and procedures on antimicrobial stewardship, minimising use of restraints, and open disclosure. However, the Service Provider acknowledges further improvements are yet to be implemented including wholesale training relating clinical care provision.

Based on the information summarised above, I find the service is non-compliant with Requirement (3)(e) in Standard 8, Organisational Governance.

Requirement 8(3)(d)

Requirement (3)(d) was found non-compliant following a Quality Audit undertaken from 13 to 15 February 2023. The service did not demonstrate it has effective risk management frameworks to assess risks to consumers or understanding of consumer risk and undertaking appropriate action to support consumer at risk of harm.

The Assessment Team’s report for the Assessment contact undertaken on 5 to 6 February 2024 includes evidence of actions taken by the service in response to the non-compliance. These actions include, but are not limited to;

* The service commencing implementation and use of comprehensive validated assessment tools. Staff can access these tools via a mobile phone app which also provides alerts regarding any risk the consumer may have.
* Staff have commenced receiving SIRS training.
* The implementation of a comprehensive clinical assessment for all consumers including the implementation of validated clinical assessment tools.

The Assessment Team was satisfied these improvements were effective and recommended Requirement (3)(d) met.

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

1. The preparation of the performance report is in accordance with section 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)