**Performance**

**Report**

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| Name: | Nambucca Valley Care Ltd |
| Commission ID: | 201161 |
| Address: | 20 Riverside Drive, NAMBUCCA HEADS, New South Wales, 2448 |
| Activity type: | Quality Audit |
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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: 1609 NVC Group Limited  
Service: 26903 Nambucca Valley Care Limited

Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 7428 Nambucca Valley Care Limited  
Service: 27953 Nambucca Valley Care Limited - Care Relationships and Carer Support  
Service: 23806 Nambucca Valley Care Limited - Community and Home Support

**This performance report**

This performance report for Nambucca Valley Care Ltd (**the service**) has been prepared by J Durston, 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.

# Assessment summary for Home Care Packages (HCP)

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| --- | --- |
| Standard 1 Consumer dignity and choice | Not 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 | **Not applicable as not all requirements were assessed** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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| Standard 1 Consumer dignity and choice | Not 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 | **Not applicable as not all requirements were assessed** |
| **Standard 6** Feedback and complaints | **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 1(3)(d) – develop and implement an effective system and process that supports consumers to take risks to enable them to live the best life they can.
* Requirement 7(3)(a) – ensure the number and mix of the workforce enables the delivery and management of safe and quality care and services.
* Requirement 7(3)(d) – develop and implement an effective system and process to ensure the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.
* Requirement 7(3)(e) – develop and implement an effective system and process to ensure each member of the workforce is regularly assessed, monitored and reviewed.
* Requirement 8(3)(b) – ensure the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

# Standard 1

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| --- | --- | --- | --- |
| 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. | Not Compliant | Not 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

The Quality Standard has been assessed as non-compliant as five of six specific requirements are compliant for the service.

**Findings of non-compliance**

Requirement 1(3)(d)

The Assessment Team found the service did not demonstrate it supports consumers to take risks in order to live their best life. Consumers and representatives said consumers had not been supported to take risks to enable them to live the life they choose. Management said they were not aware of the procedure to support consumers to take risks. The service does not have a dignity of choice policy but was able to create a dignity of choice assessment form after receiving feedback from the Assessment Team. There was no evidence that consumers who have refused the recommendation of a speech pathologist for a modified diet had the risk explained to them and that they understood the risk. This evidence was considered in Requirement 3(3)(b).

In their response to the Assessment Team report the provider advised the service has recently purchased a safety and quality management system containing the organisation’s forms, policies and processes including risk management and dignity of choice. System training has commenced and the system forms are being reviewed to be consistent with the organisation’s approach. The provider stated that in April 2024 staff were educated on the new system, dignity of choice and risk management policies and the risk notification form to capture client risks on commencement and throughout their receipt of service. Attendance records for the training were not supplied. The provider stated each site now has a client risk register. A blank risk register document was supplied as evidence. The provider advised a named consumer assessed as a high falls risk has a dignity of risk form in place because they refused an emergency alarm. The provider advised the progress notes for another named consumer who informed the Assessment Team they wanted to do more tasks at home, did not mention the consumer wanting to do so, and that the notes showed the consumer was requesting additional services.

While I acknowledge the service has taken steps to support consumers to take risks, I consider it will take time for its new systems and processes for dignity of risk to be embedded and sustained in practice.

Accordingly, I find Requirement 1(3)(d) non-compliant.

**Compliant Requirements**

Requirement 1(3)(a)

Consumers and representatives said consumers were treated with dignity and respect and felt services provided were culturally safe. Staff were familiar with consumers’ cultural background and diversity which was captured in care planning documents.

Requirement 1(3)(b)

All consumers and their representatives said they felt services were culturally safe and would feel comfortable in raising any cultural needs. Care plans included information on consumers’ cultural needs, such as any translation support needed and/or impact of cognitive decline on meeting their cultural needs.

Requirement 1(3)(c)

Documentation reflected consumers’ choices are respected. Consumers said they could make decisions about their own care and services They described how they are able communicate their decisions and are making and maintaining relationships with people of choice. The service’s rostering system showed that workers were matched to consumers based on consumers’ preferences regarding support worker attributes.

Requirement 1(3)(e)

The Assessment Team found the service did not demonstrated information provided to each consumer is current, accurate and timely, communicated clearly and is easy to understand, enabling them to exercise choice. HCP consumers felt they were not provided with information on how surplus funds within their package could be utilised but said they do receive monthly statements. One consumer advised they did not know which services or products they could access under their HCO because they were not given the information.

In their response the provider advised that HCP consumers are provided with information about the services available and inclusion and exclusion of services are outlined in the service agreement, and the Home Care brochure, which was provided as evidence. The provider stated when surplus funds are available the home care coordinator visits the consumer to discuss whether they require more services or wish to save the funds to purchase necessary support equipment, and consumers can contact the home care coordinator any time to discuss their package and surplus funds. The provider stated that the consumer who said they were unaware of services and products they could access with their HCP, lives with Dementia and has difficulty remembering information provided. However, the consumer’s family member who has power of attorney, enduring guardian, has been provided with the information, and an action item has been added to the PCI to provide consumers with updated budgets.

While I acknowledge this feedback from HCP consumers, there is insufficient evidence to determine if lack of information on surplus funds resulted in consumers not being able to exercise choice. I have placed weight on the evidence in the Quality Audit report that all consumers said they receive statements that were accurate and correct, Management demonstrated how the service’s electronic management system generates monthly invoices and statements and how these are sent to consumers or their chosen representatives. Management also described how they tailor the information so that it can be understood by all consumers. The provider’s response clarified that the representative of the named consumer who said they were unaware of HCP products and services, receives the consumer’s information, as the consumer lives with Dementia and has difficulty remembering information provided. On the balance of evidence, I find this requirement compliant.

Requirement 1(3)(f)

Consumers said they could make decisions about their own care and their privacy was respected. Staff were able to describe how they practiced confidentiality. Documentation reflected consumers’ choices were respected.

Based on the information summarised above, I find the service compliant in Requirements 1(3)(a), (3)(b), (3)(c), and 1(3)(e) and1(3)(f).

# Standard 2

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| --- | --- | --- | --- |
| 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

The Quality Standard has been assessed as compliant as five of five specific requirements have been assessed as compliant for the service.

Requirement 2(3)(a)

Staff outlined the process for undertaking assessment and planning and how this included identifying and addressing consumers’ needs, goals and preferences and consideration of risks to their health and well-being. This was consistent and reflected in care planning documents. Coordinators demonstrated how the client consultation assessment considers

additional information such as the ACAT or the GP summary to inform services for the consumer and the use of validated tools completed by the service’s clinical staff. The registered nurse said clinical staff conduct all HCP reviews and CHSP by exception based on risks, and environmental risk assessments are completed for each consumer.

Requirement 2(3)(b)

All consumers interviewed said their goals were based on receiving services to stay at home for as long as possible. Coordinators and the rostering office staff discussed what is important for the consumer, and how the service is tailored to meet their needs and preferences, such as time of service delivery and/or gender of staff. Advance care planning information is provided to all consumers within the client handbook. Care plans reviewed by the assessment team were individualised, set out clear needs, goals and preferences and where provided, advanced care planning documentation was present.

Requirement 2(3)(c)

All consumers confirmed they participated in and were able to involve their representatives in the care planning and assessment of their care. Coordinators said they ask the consumer who they wish to have involved and seek permission before making contact.

Requirement 2(3)(d)

Documentation showed consumers were provided with a copy of their care plan, consistent with feedback from consumers. The rostering officer and staff interviewed said the services care management system has the capacity to share care plans with care workers and they are sent text messages and emails with updates.

Requirement 2(3)(e)

Staff described the process for, and provided examples of how care and services are reviewed and changes in consumer circumstances are communicated. Consumers confirmed ongoing communication from staff occurs when there is a change in circumstances.

Based on the information summarised above, I find the service compliant in all requirements in Standard 2.

# Standard 3

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| --- | --- | --- | --- |
| 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

The Quality Standard has been assessed as compliant as seven of seven specific requirements are compliant for the service.

Requirement 3(3)(a)

The Assessment Team found the service did not demonstrate consumers get personal and clinical care that is safe and right for them. The service was in the process of transitioning to a new electronic management system at the time of the Quality Audit. Less than 30% of care planning documents had been uploaded to the new system. However, the Assessment Team found review of care planning documents that were uploaded demonstrated those consumers were receiving safe and tailored personal and clinical care. The Assessment Team noted some care planning documents did not identify consumer risks or medical history. However, no further information or evidence was provided to support this. The Assessment Team report also states the Assessment Team reviewed care planning documents which did demonstrate comprehensive information pertaining to consumer care needs was captured.

In their response to the Assessment Team report the provider confirmed all consumers have been transferred to the new care management system and there is only one system in use. The provider acknowledged previously care plans did not identify risks to consumers. However, since transitioning all the plans into the new system, risks and medical histories are now available. This was confirmed by a consumer’s help (care) plan submitted as evidence. Screen shots were provided as evidence to show alerts now appear on the front page of the mobile application used by staff, and they can also view the entire help plan which provides detailed information on consumer needs, preferences, strategies and interventions to mitigate consumer risks. They can also look at the notebook (progress notes).

I consider the Quality Audit report did not bring forward sufficient evidence that consumers are receiving unsafe and/or ineffective personal and/or clinical care. Management and staff outlined what information they rely on to deliver the care needs of consumers and how they ensure care delivered aligns with best practice. Care planning documentation uploaded to the new electronic system demonstrated consumers were receiving safe and tailored care. The provider has confirmed all consumer care plans including risks and mitigation strategies are now uploaded to the new care management system. Hence the risk of multiple sources of and incomplete consumer information has been removed.

Having considered the information in the Assessment Team report including the lack of evidence of unsafe /ineffective care and negative impact, I am more persuaded by the provider’s response including supporting documentary evidence that consumers are getting the personal and clinical care that is right for them. Therefore, on balance I find Requirement 3(3)(a) compliant.

Requirement 3(3)(b)

The Assessment Team found the service did not demonstrate effective management of high impact high prevalence risks associated with the care of each consumer. Care planning documentation accessed by staff through a mobile application, did not easily identify consumers’ high impact or high prevalence risks. Staff advised they relied on their experience, initiative, and talking to consumers and consumer familiarity to manage to minimise risks to consumers. There were discrepancies noted in care planning documents which management said was due to the transition to the new electronic management system. The Assessment Team found the care plan of one consumer did not record any risks, despite having had recent falls and escalating behaviours.

However, I note there was no evidence in the report to demonstrate that staff could not access this information. Further staff access to care planning documents containing information on consumer risk via a mobile application is considered in Requirement 3(3)(e) where it is more relevant. The Assessment Team report did not bring forward evidence regarding negative impacts for consumers related to observed discrepancies in care planning documents, nor whether it resulted in ineffective management of high impact or high prevalence risks. The report did not provide evidence of negative impact for the consumer with escalating behaviours and recent falls. and whether this resulted in ineffective management of their risks. Further, the report stated staff were aware the consumer’s behaviour can escalate, and could describe strategies used to mitigate risks from the escalated behaviour. However, this information was not documented, which is considered in and more relevant to Requirement 3(3)(e).

In addition, staff demonstrated awareness of high impact high prevalence risks. They described actions taken to minimise risks based on their experience and talking with consumers, despite this information not being available through the new electronic management system. Staff said if they require more information they could contact the service, this was consistent with documentation. Care planning documents demonstrated assessments are undertaken with validated assessment tools in response to incidents to identify other significant risks, and the service was able to identify high impact and high prevalence risks, and there was evidence that clinical staff and management monitor consumers.

In their response to the Assessment Team report the provider advised, that a consumer who informed the Assessment Team the service did not ask if they needed help when they had several falls using their walking stick, had since been reviewed by a registered nurse. A FRAT was completed on 18 April 2024. The consumer’s care plan was updated on 19 April 2024 to include information on mobility and falls management with a request for further occupational therapy and physiotherapy review, and a request for a support package review. However, I note evidence supplied by the service indicated there was a 2-month delay in their response to the consumer’s falls risk raised during the Quality Audit of 6 to 7 February 2024.

I have considered the information in the Assessment Team report and placed weight on the feedback from staff regarding their knowledge of consumer risk and mitigation strategies, and the care planning documentation that showed validated assessment tools were used following incidents to identify further risks and risk management strategies for consumers. I encourage the provider to ensure that identified consumer risks are identified and managed in a timely manner. There was insufficient evidence of negative consumer impact to make a finding non-compliance. Therefore, on the balance of evidence before me, I find Requirement 3(3)(b) compliant.

Requirements 3(3)(c)

Staff described what they would do if they noticed a change in a consumer’s health and provided examples. Staff described, and provided an example, of how they work with the palliative care team to provide care needed when consumers display signs of end of life.

Requirements 3(3)(d)

Consumer’s said staff identify when they are feeling low or unwell. The service’s electronic management system had a mechanism to alert clinical staff when staff have documented in progress notes changes in a consumer’s health, to ensure each alert is investigated and actioned.

Requirement 3(3)(e)

The Assessment Team found the service did not demonstrate that information about consumers’ condition, needs and preferences is documented within the organisation and with others with shared responsibility for their care. Staff said under the new electronic management system, which they can access via a mobile application, they are unable to access as much information, such as previous progress notes or summary of consumers’ preferences and required supports. Evidence brought forward under Requirement 3(3)(b) identified staff are not alerted to the risks to consumers and strategies to mitigate risks. Evidence brought forward under Requirement 3(3)(b) demonstrated that staff were aware of risks to a consumer and strategies to mitigate those risks, however this was not documented. Management acknowledged this and said the consumer’s care plan would be reviewed.

In their response to the Assessment Team report the provider advised that there is now a high impact high prevalence risk register in place. A blank page of the register was submitted as evidence. All care staff can access client care plans including risk information and mitigation strategies on the organisation’s mobile application, and all consumers’ care plans have been updated to include risk information.

While I acknowledge the evidence brought forward in the Assessment Team report, I also acknowledge the provider confirmed in their response that all consumers’ files have been transferred to the new care management system, that includes the mobile application for staff in the field, and there is only one system in use. Therefore, on the balance of evidence before me, I find Requirement 3(3)(e) Compliant.

Requirements 3(3)(f)

Consumers and/or representatives described how the service assists them to access allied health and other services. This was consistent with evidence in documentation. Management advised that the service regularly liaises with other organisations and providers of care and services.

Requirements 3(3)(g)

The service had processes to ensure consumers and staff are safe and infection related risks are minimised. Consumer’s said staff wear masks when undertaking services and this was consistent with staff interviews.

Based on the information summarised above, I find the service compliant with all requirements in Standard 3.

# Standard 4

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| --- | --- | --- | --- |
| 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. | Not applicable | Not applicable |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant | Compliant |

Findings

The Quality Standard has been assessed as compliant as six of seven specific requirements are compliant for the service and one requirement is not applicable.

Requirements 4(3)(a)

Consumers and their representatives said consumers receive safe and effective services and supports. Care planning documents included information about consumer’s needs, goals and preferences and staff demonstrated awareness of this information.

Requirements 4(3)(b)

Care planning documents included consumers’ emotional, spiritual and psychological well-being needs. Staff demonstrated an awareness of these needs and consumers confirmed the services considers their psychological and emotional well-being.

Requirements 4(3)(c)

Staff described how they support consumers to remain engaged with their local community. Consumers said they were supported to have social and personal relationships and do things of interest to them. The service was supported by organisational policies on consumer choice and decisions, including around relationships.

Requirements 4(3)(d)

Consumers said the service knew their needs and conditions. Management said the new electronic management system will target relevant information to relevant staff. Staff said that despite the transition to the new electronic management system, they were still able to access all (new and old) systems to view information they need.

Requirements 4(3)(e)

Consumers said they were happy with the referrals related to supports of daily living. Documentation confirmed timely and appropriate referrals, including alternative options to reflect cost and/or consumer choice.

Requirement 4(3)(g)

The Assessment Team found the service did not demonstrate where equipment is provided it is safe, suitable, clean and well maintained. Management said they have not considered how the service is able to support consumers with equipment and there was no policy to support providing safe, suitable, clean and well-maintained equipment. One consumer who recently purchased equipment said no one has discussed with them equipment cleaning and maintenance. However, one staff member said they visually check equipment is working, safe and clean.

In their response to the Assessment Team report the provider advised there is an action item in the continuous improvement plan to implement an equipment register to be completed by 30 July 2024 to ensure servicing and cleaning of equipment are scheduled and recorded when attended. The provider stated the service has new policies and processes for consumer equipment, home modification and maintenance provision, and the Quality and education team will provide education to the community care team on the new policies and processes. A copy of the revised policy document was supplied as evidence.

I commend the provider for the improvements it has implemented and plans to make in relation to this requirement. The Quality Audit report did not bring forward sufficient evidence of equipment provided by the service that was not safe, suitable, clean and well-maintained. Therefore, on balance I find Requirement 4(3)(g) compliant.

Based on the information summarised above, I find the service compliant in Requirements 4(3)(a), 4(3)(b), 4(3)(c), 4(3)(d) and 4(3)(e) and 4(3)(g). Requirement 4(3)(f) is not applicable as the service does not provide meals.

# Standard 5

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| 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. | Not applicable | Not applicable |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Not applicable | Not applicable |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Not applicable | Not applicable |

Findings

Consumer services are not delivered in a service environment, as such, the Standard is Not Applicable.

# 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

This Quality Standard has been assessed as compliant as four of four specific requirements are compliant for the service.

Requirement 6(3)(a)

Consumers said they have no hesitation contacting the service if they had any issues. However, they said they have no reason to complain. Staff outlined the various ways consumers are encouraged and supported to provide feedback and make complaints.

Requirement 6(3)(b)

Documentation evidenced consumers are provided information on advocacy services as welling as other methods for raising a complaint. This was consistent with feedback from consumers. Staff outlined the advocacy and language services available to consumers and how they can lodge complaints externally.

Requirement 6(3)(c)

Documentation and staff demonstrated that appropriate action is taken in response to complaints. Staff were able to provide examples of open disclosure. The Quality Audit report included feedback from one consumer who provided an example of their complaint not being completely resolved. However, documentation demonstrates that the complaint was actioned appropriately.

Requirement (6)(3)(d)

The Assessment Team found the service did not demonstrate feedback and complaints are reviewed and used to improve the quality of care and services. Several complaints made to one staff member were not registered. The Assessment Team noted that, from viewing other registered complaints, this was not consistent with how the service responds to other complaints received. It is also noted that the service has taken some action to address those complaints.

The Assessment Team found the Board has not previously considered feedback and complaints in relation to home services. However, the Assessment Team noted the Board is now aware of this and strategies are being developed to ensure they do.

In their response to the Assessment Team report the provider advised a draft service report has been developed for the home and community care manager to submit monthly to the board. This was supplied as evidence. The provider stated the Board is yet to endorse the draft report. If approved by the CEO and board the home and community care manager, will also submit a quarterly report to the Care and Quality Meeting and the Risk Management Committee meeting. The staff member that failed to register several complaints no longer works for the organisation.

I commend and encourage the provider’s planned actions to introduce home services reports to the board, care and quality meeting and the risk management committee meeting to inform board decisions on strategic improvements to the quality of care and services provided to consumers. While I acknowledge the evidence brought forward by the Assessment Team, I have placed more weight on the following evidence in the Quality Audit report in determining my finding. Management demonstrated awareness of trending complaints, and this was consistent with the complaint register, and the service was able to demonstrate review of complaints had been undertaken and resulted in improvements being made. Therefore, on the balance of evidence before me, I find Requirement 6(3)(d) compliant.

Based on the information summarised above, I find the service compliant with all requirements in Standard 6.

# Standard 7

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

Findings

This Quality Standard has been assessed as non-compliant as two of five specific requirements are compliant for the service.

**Findings of non-compliance**

Requirement 7(3)(a)

The Assessment Team found the service did not demonstrate effective workforce planning to enable the right number and mix of staff to deliver and manage safe, quality care and services. In the month prior to the site assessment there were 187 unfilled staff shifts. Management said they have a casual workforce resulting in many employees leaving at short notice. The service does not have a current policy or system to determine workforce numbers and the range of skills needed. Most consumers said they have not had consistent staff and have experienced cancelled shifts with not replacement. Management said recruitment is ongoing. Staff described the process of allocating care workers to consumers based on their needs. However, if no care workers are available, consumers are put on a wait list which is not monitored for the development of workforce strategies.

In their response to the Assessment Team report the provider submitted the organisation’s current Human Resources Workforce Management policy. The approved provider supplied a revised plan for continuous improvement, that includes action items to review the recruitment, onboarding and orientation process to ensure the required mix of staff to meet client service requirements, and to add an agenda item to be added to the monthly meetings to consider planning to analyse workforce numbers, sick leave and casual pool to predicted staffing requirements each month.

The provider noted the challenges of sourcing suitable staff, including brokered staff, in rural locations to provide client services. The provider is working with the local college to assist with having staff ready to work through the Care Ready program. While I acknowledge recruitment is ongoing, and the service is working towards improving its workforce planning in a challenging recruitment environment, I consider it will take time for the improvements to be embedded and sustained in practice.

Accordingly, I find Requirement 7(3)(a) non-compliant.

Requirement 7(3)(d)

The Assessment Team found the service did not demonstrate the workforce is recruited, trained, equipped and supported to deliver the outcomes required by the standards. As noted in Requirement 7(3)(c), most consumers felt the organisation does not train care workers. Management described training provided to staff at induction but could not describe ongoing monitoring of training. Care staff interviewed said they were sent reminders for training but had to complete eLearning after their work hours and were unsure if they would be paid. Management said new staff complete 2 or 3 buddy shifts. However, they acknowledged there is no formal monitoring of staff on buddy shifts.

In their response to the Assessment Team report the provider submitted the organisation’s Human Resources – Employee Development policy, and the revised plan for continuous improvement, including action items to develop a second day of orientation for home services staff. This will include incident management, risk management, consumer choice, cultural diversity, responding to deterioration and the ‘no response’ to visit process. The provider advised a new clinical education specialist is commencing in mid-May 2024, the buddy sheet has been reviewed for improved uniformity of information and education. The provider stated competencies will be reviewed and standardised such as PPE donning and doffing, manual handling, wound management and dressings by end June 2024 and review of mandatory training will be completed by end July 2024.

While I acknowledge provider is working towards improving it’s training systems and processes, I consider it will take time for the improvements to be embedded and sustained in practice. Further I note that the provider did not address the issue of staff completing their training after hours in its response. The Assessment Team report did not confirm if this was paid or unpaid time, nor was staff feedback documented regarding satisfaction with the system. However, this issue has the potential to negatively impact the recruitment and retention strategy, acknowledged by the provider as a challenge in their rural location.

Accordingly, I find Requirement 7(3)(d) non-compliant.

Requirement 7(3)(e)

The Assessment Team found the service demonstrated regular assessment, monitoring and review of the performance of each staff member. However, this appears to be an error as the report stated management said staff performance was monitored, but not formally documented and consistently monitored on an ongoing basis to ensure opportunities for improvement are identified and actioned, especially for care staff. Staff advised they felt supported and the level of supervision was adequate.

In their response to the provider submitted the organisation’s plan for continuous improvement including an action to modify the organisation’s performance appraisal forms to incorporate annual competencies, eLearning and education attendance. However, the plan did not include a planned finish date for the action, nor information on progress towards achievement.

I acknowledge the provider’s planned improvements to its performance monitoring and review process. However, with the lack of clarity provided in their response on progress towards and the implementation timeframe for this improvement, I consider it will take time for the improvements to be embedded and sustained in practice.

Accordingly, I find Requirement 7(3)(e) non-compliant.

**Compliance findings**

Requirement7(3)(b)

The assessment Team found the service demonstrated staff interactions with consumers are kind, caring and respectful of their identity, culture and diversity. This was confirmed by consumers and representatives. Documentation demonstrated the service uses various methods for employing the right staff and monitoring their interactions with consumers.

Requirement 7(3)(c)

The Assessment Team found the service did not demonstrate the workforce is competent and staff have the qualifications and knowledge to effectively perform their roles. Most sampled consumers said seven of ten consumers interviewed said they felt the organisation does not train or support care workers. The Assessment Team found the service’s policy states it monitors current registrations of clinical staff but does not support the scope of practice for care staff who provide personal care and other services.

In their response to the Assessment Team report the provider advised scope of practice for care staff will be developed and distributed to all existing and onboarding staff. Competencies and mandatory training as per the Human Resources – Employee Development Policy will be put into action. There will be 2 Clinical Educators to assist with ensuring competencies are attended and successfully completed.

Having considered the Assessment Team’s findings and the provider’s response, I note a significant portion of the evidence provided in this requirement relates to staff training which is considered in and more relevant to Requirement 7(3)(d). While the Assessment Team found the scope of practice for care staff is not supported. The provider has advised it will develop and provide a documented scope of practice statement for care staff. Overall, I consider there was insufficient relevant evidence to make a finding of non-compliant. Therefore, on balance I find Requirement 4(3)(g) compliant.

Based on the information summarised above, I find the service compliant in Requirements 7(3)(b) and 7(3)(c)

# Standard 8

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| --- | --- | --- | --- |
| 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. | Not Compliant | 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. | 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**

This Quality Standard has been assessed as non-compliant as four of five specific requirements are compliant for the service.

**Findings of non-compliance**

Requirement 8(3)(b)

The Assessment Team found the service did not demonstrate the organisation’s governing body promotes and is accountable for a culture of safe, inclusive and quality care and service delivery. Board meeting minutes did not include home services trends in consumer and representative feedback and complaints and other information that would identify issues such as consumer risk, to improve the safety and quality of care and services. Management said this issue has been identified and as a result management and clinical staff from home services will join the risk management committee and the care and quality committee.

In their response to the Assessment Team report the provider acknowledged the board had not been receiving robust information from community care – home services. The Board’s focus had been on the other key divisions overseen by the organisation. The provider advised a draft Community Care Manager Service report has been developed to provide comprehensive information on HCP and CHSP services, complaints, feedback, staffing requirements and concerns/issues, and audits, clinical concerns and risks, continuous Improvement Plans and all other regulatory requirements. This is also an action on the continuous improvement plan with a completion date of end June 2024. The provider noted the Home and Community Care manager is a member of several committees and attends meetings covering areas such as medication advisory, quality and Work Health and Safety. The quarterly care and quality meeting and the risk management committees are also attended by some board members and the CEO.

I commend the provider’s planned improvement actions to address the areas of non-compliance identified in this requirement. However, I consider it will take time for the new board reporting processes for HCP and CHSP services to be embedded and outcomes of board strategic guidance and decisions to be realised and sustained in relation to ensuring culturally safe, inclusive, quality care and service delivery.

Accordingly, I find Requirement 8(3)(b) non-compliant.

**Compliance findings**

Requirement 8(3)(a)

The Assessment Team found the service engaged supported consumers to contribute to the development, delivery and evaluation of care and services. Consumers and/or representatives said they had been invited to participate in the consumer advisory committee established by the service.

Requirement 8(3)(c)

The Assessment Team found the service did not demonstrate effective organisation wide governance systems in the areas of continuous improvement, and feedback and complaints. Board does not have oversight of the service’s continuous improvement plan and the service does not provide detail information to the Board in relation to complaints and feedback.

This evidence has been considered under Requirement 8(3)(b) where it is relevant and resulted in a finding of non-compliant. Therefore, there is insufficient evidence to make a finding of non-compliant in this requirement.

Requirement 8(3)(d)

The Assessment Team found the service did not demonstrate effective risk management systems and practices. Information on consumer risk is not provided to the Board to inform Board decision-making and strategic directions in relation to effective management of high impact high prevalence risk. However, this evidence was considered under Requirement 8(3)(b) where it resulted in a finding of non-compliant.

The Assessment Team also found that as the service is transitioning to a new electronic management system, staff have experienced some challenge accessing information, including risks to consumers and risk mitigation strategies. However, this relates to documentation and communication of consumer’s condition, needs and preferences within the organisation, and with others where responsibility for care is shared. It has therefore been considered under Requirement 3(3)(e) where it is more relevant.

I have also put weight on the following evidence in the Quality Audit report in determining my finding:

* The organisation had a range of systems and processes in place to manage risks, including the use of validated assessment tools.
* Staff had received training in relation to abuse and neglect and the Serious Incident Response Scheme.
* The new electronic management system has a mechanism to identify and alert whenever a new risk is identified.
* The service has an incident register which is used to trend incidents.

In their response to the Assessment Team report the provider advised the service’s mobile application has a risk alert feature to flag consumer risks with help plans attached to guide staff on strategies to mitigate risk. A risk register has been developed and implemented (confirmed on the continuous improvement plan). Overall, there was insufficient evidence to make a finding of non-compliant in this requirement. Therefore, on balance I find Requirement 8(3)(c) compliant.

Requirement 8(3)(e)

The Assessment Team found the service has a clinical governance framework where clinical care is provided. Staff have received training and information in relation to restrictive practices and open disclosure. The organisation has an advisory committee which discusses various matters quarterly, including antimicrobial stewardship.

Based on the information summarised above, I find the service compliant in Requirements 8(3)(a), 8(3)(c), 8(3)(d) and 8(3)(e).

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