**Performance**

**Report**

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| Name: | New Age Home and Community Services |
| Commission ID: | 201313 |
| Address: | 1C Grand Avenue, ROSEHILL, New South Wales, 2142 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 10 September 2024 |
| Performance report date: | 1 November 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.

# Services included in this assessment

Home Care Packages (**HCP**) included:  
Provider: 8956 New Age Community Services Pty Ltd  
Service: 26652 New Age Community Services Pty Ltd

**This performance report**

This performance report has been prepared by D Saunders, 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 services it operates, 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 service outlets, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received 2 October 2024

# Assessment summary for Home Care Packages (HCP)

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| Standard 6 Feedback and complaints | 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.

* Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong
* Feedback and complaints are reviewed and used to improve the quality of care and services
* The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery
* Effective organisation wide governance systems
* Effective risk management systems and practices
* Clinical governance framework

# Standard 6

|  |  |  |
| --- | --- | --- |
| Feedback and complaints | | HCP |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Not Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant |

Findings

Requirement 6(3)(c)

The service was found not compliant in this requirement at audit in February 2024.

At the most recent assessment contact the service could not demonstrate that all complaints were registered, that all complaints were actioned appropriately, or that an open disclosure process was used when things goes wrong.

The Assessment Team identified, and listed, examples of the above in the assessment contact report.

The service in its response to the assessment contact report did not provide evidence that displaces the findings of the Assessment Team.

The Assessment Team also made findings that management system was not embedded, that it was not best practice, and that complaints were not maintained in a manner that allowed for monitoring and review. These issues have greater relevance under other requirements and I place no weight on those observations.

For the reasons listed I find this requirement not compliant.

Requirement 6(3)(d)

The service was found not compliant in this requirement at audit in February 2024.

At the most recent assessment contact consumers and staff interviewed could not identify any instances or examples of care and services being improved arising from review of complaints.

Management could not identify any process of review of complaints to inform service delivery. This was hampered by the absence of a system for consistent registration of complaints.

Whilst the service explained that its feedback register served a similar purpose, the feedback and complaints policy was observed to require that all informal and formal feedback (and also complaints) be documented, which was not occurring.

In the absence of effective capture of complaints, it cannot be demonstrated that they are reviewed and monitored with a view to improving care and services.

The service in its response did not provide any evidence relevant to this requirement.

For the reasons listed I find this requirement not compliant.

# Standard 8

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

Findings

Requirement 8(3)(a)

The service was found not compliant in this requirement at audit in February 2024.

At the recent assessment contact some consumers stated that they provide input into how care and services are delivered. They confirmed the service seeks their views through phone calls and face to face discussions and they feel included in the discussions about their care planning and service provision.

No consumers or representatives were identified that did not feel they were engaged or supported to inform their care and services.

The service could not specifically demonstrate which aspects of corporate practice engaged consumers or supported them in relation to the needs of this requirement.

The service in its response to the assessment contact report explained that it had established a Consumer Advisory Body on 1 October 2024 and provided the consumer members of that body.

On the basis of the positive evidence identified at audit that consumers are engaged in the way required, and in the absence of evidence to the contrary, I accept that the elements of this requirement are met.

I find this requirement compliant.

Requirement 8(3)(b)

The service was found not compliant in this requirement at audit in February 2024.

At the recent assessment contact it was conformed that the service does not have a governing body and, related to that, does not have strategic plans or produce annual reports.

The service had previously – arising from the February 2024 audit – undertaken to establish a governing body so effect could be given to this requirement. That had not occurred at the time of the recent assessment contact.

As the service does not have a governing body - or processes and practices that otherwise give effect to the needs of this requirement – I cannot conclude that the elements of the requirement are met.

I find this requirement not compliant.

Requirement 8(3)(c)

The service was found not compliant in this requirement at audit in February 2024.

At the recent assessment contact the organisation did not demonstrate effective governance process in place to support information management, continuous improvement, workforce governance, regulatory compliance, or feedback and complaints. The organisation does not have a governing body structure to support care and services provided are of a high quality for consumers. The organisation has a human resources manager to oversee workforce recruitment and management. Feedback and complaints are monitored through weekly management meetings, however, there is a deficiency in the information being discussed and monitored according to organisational policy. At the organisation level, there is no evidence to support meetings or regular governance processes are in place to monitor and support the return to compliance in relation to governance systems.

The sharing of weekly meeting minutes with staff or summarisation in staff newsletters was not routinely occurring. Interviews with staff confirmed and review of one staff newsletter provided by management dated April 2024 identified this was not occurring. Management advised the information technology manager was responsible for the monthly staff newsletters. However, management advised they did not review or receive the newsletters and were unaware if or when they had been communicated to staff.

The organisation’s Plan for Contiuous Improvement (PCI) provided to the Assessment Team identified actions relating to the Quality Audit attended 27 February 2024 to 28 February 2024. There was no evidence any other source had informed the PCI. Staff could not describe how review of service data such as incidents or complaints informed continuous improvement activities. The Assessment Team observed deficiency of details in the planned actions and outcomes. In discussing the PCI and non-compliances with management they did not provide detailed responses or evidence to support the actioning of non-compliance identified, despite numerous requests for information by the Assessment Team.

Management advised the organisation does not have a governing body that meets to review accounts and financial outcomes for analysis, monitoring, and tracking. The finance manager advised they provide a list to case managers of consumers’ unspent funds however they do not provide any internal financial monitoring or reporting of unspent funds.

Management could not demonstrate that a formalised and documented process was embedded in the organisation for staff performance appraisals. Overall, staff interviewed said they had not completed a performance appraisal with their manager. Management advised they did not have a register of formalised process for tracking completion.

Overall governance systems were not explicitly demonstrated by the service.

In its response to the assessment contact report the service advised it has employed staff with a specific aim of aligning policies and procedures with current requirements.

In the absence of an effective governing body and effective governance systems I find this requirement is not compliant.

Requirement 8(3)(d)

The service was found not compliant in this requirement at audit in February 2024.

During the assessment contact conducted on 10 September 2024, the Assessment Team found the actions taken in response to the non-compliance have not all been fully implemented or effective. Staff said they had received training in the serious incident response scheme (SIRS) for home care and in identifying and responding to abuse and neglect and could speak to the broad principles. However, the organisation does not have effective risk management practices or an effective incident management system. While there is a policy in place, staff were unfamiliar with it and systems and processes described in the policy were not practiced by the organisation. Risks are identified for individual consumers during assessment and documented in care plans. However, staff could not describe how they have been identifying and managing clinical risk for consumers during the period the registered nurse has been on extended leave. The service maintains an incident register, however, does not collate, trend, or analyse incidents. There was no evidence the organisation uses incident data to identify trends, drive continuous improvement to improve the quality of the care and services, or prevent similar incidents from occurring.

Taking this into consideration I cannot conclude that there exists effective risk management systems and practices in the areas required.

The service, in its response to the assessment contact report, did not provide a substantive explanation or information that displaces this view.

I find this requirement not compliant.

Requirement 8(3)(e)

The service was found not compliant in this requirement at audit in February 2024. The organisation did not demonstrate an effective clinical governance framework. There was a clinical governance policy, however service practices were not in line with this policy.

During the recent assessment contact the Assessment Team found the actions taken in response to the then observed non-compliance have not all been fully implemented or effective.

While the service has a policy relating to clinical governance, the service did not demonstrate they were implementing practices as described in this policy. The registered nurse has been on extended leave and alternative arrangements for clinical oversight and clinical leadership were not provided.

Management stated training had been provided for antimicrobial stewardship, minimising use of restraint, and open disclosure. However, the training register and education calendar were incomplete and did not include record of antimicrobial stewardship or minimising use of restraint. Two case managers were unfamiliar with the term ‘open disclosure’ and were not able to define or describe the meaning, when applicable, or relevance to their work.

The service lacked systems and processes to collate, monitor, trend, analyse, and report clinical information and needs, risks to consumers, or incidents. There were no processes described relating to, or suitably qualified personnel available to speak to clinical governance at the organisation.

In its response to the assessment contact report the service stated it had commenced some training in relation to the deficiencies identified above.

I find this requirement not compliant.

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)