**Performance**

**Report**

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Northern Coalfields Community Care Association (NeighbourCare) Limited |
| Commission ID: | 200375 |
| Address: | 2 Mount View Road, CESSNOCK, New South Wales, 2325 |
| Activity type: | Quality Audit |
| Activity date: | 13 December 2023 to 14 December 2023 |
| Performance report date: | 19 January 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

Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 7891 Northern Coalfields Community Care Association (NeighbourCare) Limited  
Service: 24548 Northern Coalfields Community Care Association (NeighbourCare) Limited - Community and Home Support

**This performance report**

This performance report for Northern Coalfields Community Care Association (NeighbourCare) Limited (**the service**) has been prepared by Nigel Wapling, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Quality Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received 5 January 2024

# Assessment summary for Commonwealth Home Support Programme (CHSP)

|  |  |
| --- | --- |
| Standard 1 Consumer dignity and choice | Not Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **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.

Standard 1 Requirement 1(3)(a)

* Ensure consumers are treated with dignity and respect, recognising their needs and continuity in communication.
* Ensure consumer identity, culture and diversity are recognised and considered through assessment and planning.

Standard 1 Requirement 1(3)(e)

* Ensure communication is clear when providing consumers with information that is current, accurate and timely.
* Recognise and ensure consumer choice is delivered.

Standard 2 Requirement 2(3)(a)

* Ensure consumer risk mitigation strategies are included in individual care plans.

Standard 2 Requirement 2(3)(e)

* Ensure reviews of services and care occur regularly, when consumer conditions change or when an incident occurs with impact on consumer function.

Standard 6 Requirement 6(3)(c)

* Acknowledge, record and address all consumer complaints and feedback.

Standard 6 Requirement 6(3)(d)

* Ensure complaints and feedback are reviewed and used to improve services and care where able to.

Standard 7 Requirement 7(3)(a)

* Ensure the service monitors and manages workforce numbers and skill mix to enable the delivery of safe and quality services and care.

Standard 8 Requirement 8(3)(a)

* Support consumers to engage in the development, delivery and evaluation or services and care.

Standard 8 Requirement 8(3)(b)

* Ensure the service provides the Board with the required information to ensure a culture of safe, inclusive and quality services and care is promoted, and the Board is accountable for their delivery. Information and data include incidents, feedback and complaints, services and care delivered, workforce, and other operational matters.

Standard 8 Requirement 8(3)(c)

* Ensure the continuous improvement governance system is effective with driving improvements of services and care, including the trending of incidents.
* Ensure the feedback and complaints governance system acknowledge, document, report, and investigate all complaints, practice open disclosure where required and where there is an opportunity, transition to continuous improvement initiatives.

Standard 8 Requirement 8(3)(d)

* Demonstrate effective risk management systems and practices.

# Standard 1

|  |  |  |
| --- | --- | --- |
| Consumer dignity and choice | | CHSP |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Not Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Not Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Requirement 1(3)(a)

The Assessment Team assessed this requirement as Not Met:

The service did not always demonstrate how they value identity, culture and diversity.

* In relation to culture and identity, management explained:
  + Most consumers are of Anglo-Saxon origin and culture and identity recognition require little promotion.
  + Consumers may not identify as LGBTQI, indicating that the services’ processes may not always support this identification.
  + As part of the services’ 2024 Diversity plan however, management explained they plan to make the service environment more inclusive and value diversity.
* While consumers and representatives were satisfied consumers felt respected by the service, on occasions some consumers felt unimportant in the way they were communicated to when disruptions to services occurred. Two named consumers provided feedback in relation to services cancelled or delayed related to either unplanned leave or the consumer unable to reach the service by telephone to request transport home, after attempting to contact the service a number of times.
* In response to the consumer feedback management explained they checked the services’ voice message system and did not have any messages. Management explained there were no current or recent complaints about staff issues related to disrespectful conduct.
* Staff explained they respect consumers’ wishes to remain at home and they treat consumers how staff would wish to be treated.

The provider’s response includes the following actions to remedy the issues of valuing identity, culture, diversity, and treating each consumer with dignity and respect, and additional information:

* The service respects and appreciates the diversity of all of their consumers. The service believes the remark in relation “consumers may not identify as LGBTQI” may have been taken out of context and apologised for the misunderstanding.
* There has been an increase in consumers from Culturally and Linguistically Diverse (CALD) backgrounds accessing the service.
* The service is committed to diversity and provided names of local organisations they approached to partner with and increase their understanding of diversity and inclusion including LGBT and CALD backgrounds.
* An example of the current ‘About Me’ document provided is part of the service admission process and helps inform the service about consumer preferences, needs, culture and religion. The service will update this form to include diversity.
* The care assessment tool referring to the section that assesses diverse needs was provided.
* The services’ consumer handbook for CHSP consumers referring to the section titled ‘culturally appropriate services and communication’ was provided.
* Information in relation to the two named consumers and how the service responded. An explanation was provided of how the service did investigate at the time the unresponsive telephone calls and transport delay that occurred, and an apology was provided to the consumer. A communication breakdown with staff occurred and they have been provided with education since.
* A memorandum to staff to inform any changes of transport arrangements are to be communicated centrally so all options to meet consumer requests can be considered.
* In relation to the cancelling of services, the service reviewed their processes to replace staff leave by using agency staff and showed evidence of a register of local agencies to contact when internal staff are unable to replace a shift.
* Recruitment commenced for new ‘leave relief’ positions, and the service is working closely with the Human Resources (HR) staff to find ways to promote a healthy workplace culture.
* The service acknowledged their communication with consumers has not been consistent when cancelling services. The service has reviewed their processes and provided a memorandum to staff relating to contacting consumers when services are cancelled, will now be managed centrally. The service has commenced consultation with consumers and staff and will update the consumer handbook, so consumers are aware of this process.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the provider’s response, which demonstrates that not all consumers are treated with dignity and respect, or their identity, culture and diversity are always valued or considered.

I have considered the intent of this Requirement, which expects organisations to treat each consumer with dignity and respect and value their identity, culture and diversity. I find this did not occur as consumer and management feedback did not completely demonstrate this.

I acknowledge the provider in their response has provided evidence of actions taken with consumers at the time, and actions to address the deficiencies identified, some of these immediately and some due to be completed in 2024. Therefore, there is no evidence these actions have been effectively implemented or embedded at the time of my decision.

I find the provider, in relation to the service, non-compliant with Requirement 1(3)(a) in Standard 1 Consumer Dignity and Choice.

Requirement 1(3)(e)

The Assessment Team assessed this requirement as Not Met:

Overall consumers were not consistently provided with current or accurate communication to enable consumers to exercise choice.

* Consumers and representatives expressed that communication of service delivery times is not always satisfactory. Consumers who receive personal care or domestic services expressed they are not always aware when staff will be arriving to commence the service delivery and only some staff will contact consumers prior to commencing. Inconsistent staff attended to consumer services.
* While staff explained consumers are able to have a preference for staff to deliver their services, two named consumers provided examples of having many different staff attending to their services with the same staff member rarely attending, and waiting for long periods some days for staff to arrive. The care files of these named consumers had their preferred staff to deliver their services documented, however this did not occur in practice.
* Management explained their expectation that staff will contact consumers the day prior to commencing their shift and provide a time of arrival. They were not aware of the communication issues. On receiving the feedback, management will now implement a procedure relating to service delivery including the expectation to contact consumers.
* Three complaints registered in the feedback and complaints register related to the automated telephone call system when consumers are using transport services.
* Management explained in response to the automated telephone call system complaints, these consumers have been removed from the system and a staff member now contacts them instead.
* Consumers and representatives were satisfied however, that they understood the monthly consumer statements and the social calendars were helpful in order for consumer to inform the service which events they wish to attend.

The provider’s response includes the following actions to remedy the issues of consumers not consistently provided with current or accurate communication to exercise choice, and additional information:

* The management team is currently undergoing a transition of online management systems and developing and implementing a transition plan, including reviewing of the current master rosters from consumers and staff to enable consumers to exercise choice, preference and receive regular communication.
* Developed procedures to ensure scheduling functions and communication requirements are being followed consistently. Staff will receive training of these procedures to embed into practice.
* Consumers will receive communication relating to scheduling changes and communication improvements to exercise choice.
* The current mode of communication includes newsletters, the services’ website and a social media page.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the provider’s response, which demonstrates that not all consumers are consistently provided with current or accurate communication to enable consumers to exercise choice.

I have considered the intent of this Requirement, which expects organisations will provide current, accurate and timely information to each consumer that is communicated in a way that is clear, easy to understand to enable them to exercise choice. I find this did not occur as consumer and management feedback did not always demonstrate this.

I acknowledge the provider in their response has provided evidence of actions taken with consumers at the time, and actions to address the deficiencies identified, some of these immediately, and some due to be completed in 2024. Therefore, there is no evidence these actions have been effectively implemented or embedded at the time of my decision.

I find the provider, in relation to the service, non-compliant with Requirement 1(3)(e) in Standard 1 Consumer Dignity and Choice.

Requirements 1(3)(b), 1(3)(c), 1(3)(d) and 1(3)(f):

Consumers and representatives felt the service knows consumer backgrounds and what is important to them when providing services. Staff described how they may need to adapt how they work with individual consumers and provided examples of why they consider this important to consumers. Staff explained they participated in cultural safety training as part of their mandatory training during their induction. Management provided examples of culturally safe care to individual consumers and explained they have developed a relationship with a local First Nations organisation.

Consumers and representatives confirmed they are able to involve people who they wish to such as those within the service or their representatives. Staff explained how they provide support to consumers by offering and accommodating other people they wish to be involved. Staff encourage advocacy support services to consumers who do not know anyone who they wish to be their representative. The Assessment Team observed signed charter of rights documents in care planning files and in the consumer handbook, along with advocacy information, which was also on display in the services’ office.

Consumers and representatives described feeling risk adverse and did not feel the service encouraged consumers to take risks and do things they otherwise may not do. The service however demonstrated there are resources and skills available to provide the support to consumers. Management described the dignity of risk, and risk decision tools the service used to inform consumers of the services’ duty of care and encourage the consideration of mitigation strategies to manage the risk collaboratively. Staff described why they encourage and support consumers to do things that enable them to live their best life such as maximising their independence and safety with their personal care and attending events with compromised health conditions. The Assessment Team observed the risk tools management described, however no examples of CHSP consumers were provided.

Consumers and representatives felt the service and staff respect consumer privacy. Staff explained how they are guided by the services’ policy on privacy and confidentiality. Forms and information received are scanned into the online consumer file system and paper copies then disposed of. Computer access is password protected and the level of access to information is dependent on the role of the staff member. The Assessment Team observed information about privacy and confidentiality rights of the consumer and the services’ responsibility in both the consumer handbook and the staff employee handbook.

# Standard 2

|  |  |  |
| --- | --- | --- |
| Ongoing assessment and planning with consumers | | CHSP |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Not Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | 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. | Not Compliant |

Findings

Requirement 2(3)(a)

The Assessment Team assessed this requirement as Not Met:

Consumer risks and mitigating strategies were always not included in individual consumer care plans that inform staff to the delivery of safe and effective care.

* The Assessment Team observed consumer files and found the service performs consumer assessment and planning, and risks are identified. These consumers and representatives were satisfied with the care and services they receive and described how these services support them to remain living independently in their homes.
* Staff described the risks and needs of individual consumers when delivering care and services and had access to consumer care plans at the point of care. However, while staff delivering care to two named consumers, they were able to describe mitigation strategies in relation to risks of falls. These strategies however were not documented in individual care plans and coordinating staff were not aware.

The provider’s response includes the following actions to remedy the issues of individual consumer risk or mitigation strategies included in consumer care plans to guide staff, and additional information:

* The services’ process to assess consumer risks and mitigation strategies and maintain information in consumer care plans that is current was not followed.
* Commenced reviewing care plan information and found there are gaps in information and were rectified as they were discovered. The review of care plans is to be completed by March 2024 with staff education to be arranged.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the provider’s response, which demonstrates that care planning and risk mitigation strategies were not always included in consumer care plans to guide staff in the delivery of care and services.

I have considered the intent of this Requirement, which expects organisations include the consideration of risk to consumer health and well-being to inform the delivery of safe and effective care. I find this did not occur as consumer care plan documentation did not always demonstrate this.

I acknowledge the provider in their response has provided actions to address the deficiencies identified, due to be completed in 2024. Therefore, there is no evidence these actions have been effectively implemented or embedded at the time of my decision.

I find the provider, in relation to the service, non-compliant with Requirement 2(3)(a) in Standard 2 Ongoing Assessment and Planning with Consumers.

Requirement 2(3)(e)

The Assessment Team assessed this requirement as Not Met:

Not all consumer care plans in the service have had a review within the previous 12 months.

* Management identified a significant amount of care plans in the service not reviewed and explained this was due to staffing issues.
* The services’ assessment, care planning and review procedure guides staff to review care planning within 12 months minimum or when there is a change in consumer condition or a request from a consumer or representative.
* Management provided an action plan that was added this in the Plan for Continuous Improvement (PCI). The action plan included;
  + All consumers with outstanding reviews to be contacted and schedule a review by the end of December 2023,
  + All reviews to be completed by the end of March 2024 and,
  + A review of staffing requirements to be undertaken.
* Consumers and representatives however, felt confident they could contact the service if consumer needs, goals or preferences changed and will receive assistance. An example was provided by a representative to how the service has offered additional consumer assistance following contact with the service when to a change in the consumers’ needs occurred.

The provider did not respond specifically to this requirement.

In coming to my finding, I have considered the Assessment Team’s assessment and evidence in the Assessment Team’s report, which demonstrates that care and services are not reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

I have considered the intent of this Requirement, which expects organisations to monitor and review consumer care planning regularly and when a consumer situation changes. I find this did not occur as documentation did not demonstrate this.

I acknowledge the provider provided actions to address the deficiencies identified during the Quality Audit, due to be completed in 2024. Therefore, there is no evidence these actions have been effectively implemented or embedded at the time of my decision.

I find the provider, in relation to the service, non-compliant with Requirement 2(3)(e) in Standard 2 Ongoing Assessment and Planning with Consumers.

Requirements 2(3)(b), 2(3)(c) and 2(3)(d):

Consumers and representatives were satisfied with the current care and services consumers received and were confident staff will support and adapt their care with future changes to their needs. Some consumers confirmed coordinating staff have engaged in conversations relating to end of life. Staff delivering care explained they have enough consumer information to deliver the required care and are able seek further information if required from coordinating staff. Consumer documentation demonstrated care planning discussions have occurred with consumers. The consumer handbook has advanced care planning information and a procedure.

Consumers and representatives confirmed they are involved in making decisions relating to care and services when care planning with consumers, including others consumers wish to be involved. Management explained they encourage consumers to include others when participating in assessment, planning and reviews. Consent is obtained from consumers prior to this occurring and the Assessment Team observed consents in consumer files. The service has an assessment, care planning and review procedure to guide partnerships with the involvement of people such as the consumer, representatives, advocates and others involved in their care.

Most consumers and representative confirmed consumers have been provided with a copy their care plan located in the folder of their ‘home file’ following a review of care services assessment. Recent examples were provided of coordinating staff visiting consumers and representatives, conducting a review of services and leaving a copy of the consumer care plan. Staff described the information available in care planning documentation is able to be accessed either through a mobile application at the point of care, or a copy found in consumer home folders that all consumers are provided with.

# Standard 3

|  |  |  |
| --- | --- | --- |
| Personal care and clinical care | | CHSP |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | 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 |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | 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 |

Findings

Requirement 3(3)(b)

The Assessment Team assessed this requirement as Not Met:

Mitigating strategies related to identified high impact and high prevalence risks were not always transferred to individual consumer care plans to inform staff to the delivery of safe care and services.

* The service has a risk management framework policy which guides staff what type of risks are identified as high-impact or high prevalence and management, including the use of the high-risk consumer register.
* Consumers identified as high risk through assessment and review process are included in the services’ risk register to monitor. Management explained they meet regularly with coordination staff to review strategies and risk minimisation interventions of individual consumer.
* Consumers and representatives were satisfied consumers identified with high impact or high prevalence risks are supported and managed by staff.
* Staff described strategies they use to mitigate identified high impact and high prevalence risks while delivering care to consumers providing examples of assisted transfers and falls risks.
* Training records confirmed staff have completed training related to the management of falls risks and behaviours related to dementia.

The provider’s response includes the following action:

* A memorandum to staff reminding them to escalate any changes to consumer health condition, deterioration such as mobility or behaviours.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the provider’s response, which demonstrates overall the management of high-impact or high-prevalence risk associated with the care of each consumer, however the associated risk mitigation strategies were not always transferred to individual consumer care plans to inform staff of the delivery of safe care and services.

I have considered the intent of this Requirement, which expects organisations to effectively manage high-impact or high-prevalence risk associated with the care of each consumer. I find while consumer risks and mitigation strategies were not always documented in consumer care plans, staff were able to describe consumer risk and mitigation strategies, and management met with coordination staff regularly to discuss and monitor consumer risks.

I acknowledge the provider in their response has provided actions to reinforce staff awareness of high-impact or high-prevalence risks and the review of consumer care plan to contain risks and mitigation strategies to address the deficiencies identified. Therefore, my decision is weighted based on the total evidence.

I find the provider, in relation to the service, compliant with Requirement 3(3)(b) in Standard 3 Personal and Clinical Care.

Requirements 3(3)(a), 3(3)(c), 3(3)(d), 3(3)(e), 3(3)(f) and 3(3)(g):

Clinical care is not provided to consumers receiving funding under the CHSP.

Consumer and representatives were satisfied with personal care provided by staff although staff members are not always the same who regularly deliver the care to the same consumers. Management explained they ensure consumers receive care that is best practice through the recruitment of staff who have the relevant skills, experience and qualifications, and with regular training and competency assessments by a clinical educator occurring. While there were no restrictive practices identified by management in in the service, staff described the different types of restrictive practice and if identified any, the process to manage these. There are policies and procedures to guide staff to deliver care such as falls prevention and management, behaviours and restrictive practices.

Staff explained they follow consumer care plans and be guided by the coordination staff to ensure appropriate care is delivered is to consumers when they are coming the end of their life. Management explained they refer to palliative care services and the consumers’ general practitioner when a consumer requires end of their life interventions. The services’ policy for advanced care planning guides staff in relation to best practices and cultural considerations.

Consumers and representatives were confident staff recognise a sudden change in their health and respond appropriately. Staff described how they recognise deterioration and respond such as reporting to management, providing examples. Staff explained the incident reporting required to complete following responding to a deterioration incident. Staff are provided with information in the form of a prompt card to guide staff of early warning signs of deterioration and prompts to respond. The service has a policy to guide staff through responding to deterioration.

Consumers and representatives were satisfied consumers do not need to repeat instructions to staff, and were confident staff know what they are doing and are competent. They described the consumer folders located in their home that have a copy of their care plan which staff can access. Staff explained they have access to information to enable them to deliver safe care and document consumer care delivery each time. Any changes are communicated to coordination staff. The service is transitioning to a new online consumer management system where staff document care delivery entries into a mobile application instead of in the consumer folder in their home. Staff explained during the transitional period they are documenting entries in both systems to ensure information is current.

Staff explained how they inform the coordination staff when they identify a new need in care and services and provided examples where an external service was provided to consumers. Management described how they refer to other service providers when identified consumer needs are outside the scope the service is able to provide. The Assessment Team observed referral documentation and examples of referrals made to other providers including correspondence.

Consumers and representatives confirmed they have observed staff practice hand hygiene and wear gloves when providing personal care while most staff wear other Personal Protective Equipment (PPE) such as masks. Staff described their infection, prevention and control practices such as using hand sanitiser, wearing PPE as required, monitoring their own health and regular Rapid Antigen Tests (RAT). Staff receive regular infection control training. The service has infection control policies and procedures to guide staff, including an outbreak management plan, standard and transmission-based precautions, risk assessments, donning of PPE, hand hygiene and antimicrobial stewardship.

# Standard 4

|  |  |  |
| --- | --- | --- |
| Services and supports for daily living | | CHSP |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Not Applicable |

Findings

Consumers and representatives felt services provided to consumers support them to maintain their independence and a quality of life. Staff described what is important to consumers and provided examples of services and activities that maintain consumer well-being. Care planning documentation demonstrated services delivered aligned with consumer goals and preferences.

Consumers and representatives were confident staff know consumers well and will recognise if their mood changes and well-being. An example was provided where staff engaged with the consumer allowing them to express their concerns. Staff described how they have recognised a change in a consumers’ well-being and provided support to them. Staff will inform coordinating staff if they have concerns for a consumers’ well-being. Care documentation entries demonstrated staff acknowledge changes in consumers’ family and social situations that could or have impacted on their well-being.

Consumers and representatives felt consumers are supported to participate in social and personal relationships, within their community and are encouraged to follow their interests describing the variety of activity groups they prefer. Staff provided examples and described how services delivered support consumers to do things they enjoy and to remain connected with their community. Care plan documentation demonstrated consumer information including their backgrounds and preferences for social activities, and consumer contribution discussions and feedback of the services they receive. The Assessment Team observed the service schedule with a variety of group activities offered and consumers engaged in activities in an inclusive environment.

Consumers and representatives felt staff know consumers’ needs and preference and did not need to direct staff what to do. Staff explained that care plans and progress note entries guide staff to deliver care services and coordinating staff provide support to staff who deliver services when there has been a change in a consumers’ condition. Coordinating staff described the needs of individual consumers such as dietary requirements. Care planning documentation demonstrated effective communication within the service and with other organisations and providers who support consumer lifestyle needs.

Consumers and representatives confirmed they are aware consumers are able to access additional supports, and additional supports from other organisations. They confirmed staff have provided information to consumers and representative of services available. Staff described how they refer to different services as requested. Information in the consumer handbook confirmed appropriate information about services available is provided to consumers.

Consumers and representatives were satisfied with the quality and quantity of the meals provided through the services’ Meals on Wheels (MOW) service they provide. Coordination staff confirmed the consumer assessment process prior to providing the meal service to consumers such as dietary and cultural requirements, allergies and clinical needs. The Assessment team observed the MOW service area to in working order such as cleanliness and regulation checking.

The service does not provide equipment under CHSP to consumers. Therefore, this requirement 4(3)(g) is Not Assessed.

# Standard 5

|  |  |  |
| --- | --- | --- |
| Organisation’s service environment | | CHSP |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

Consumers and representatives felt welcomed when they attend the service and were satisfied the community room they use is fit for purpose. The Assessment Team observed staff engaging with consumers and consumers engaging with each other in a positive manner. The service was accessible with entry and exit signs clearly displayed and a bathroom accessible in close proximity to the community room.

Consumers and representatives were satisfied the service was clean, well maintained and all areas were accessible. Management demonstrated schedules and maintenance records related to cleaning and fire safety equipment. Staff described how they communicate with maintenance staff to follow up and addresses any maintenance issues as required. The Assessment Team observed the service to be safe, clean and well-maintained including safety signs clearly displayed in all areas and consumers able to move about freely.

Consumers and representatives confirmed the equipment was clean, safe and suitable for the activities undertaken. The Assessment Team observed an exercise class with enough equipment for the number of consumers participating in this activity.

# Standard 6

|  |  |  |
| --- | --- | --- |
| Feedback and complaints | | CHSP |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | 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 Assessment Team assessed this requirement as Not Met:

Consumers and representatives who have provided feedback or made a complaint were not satisfied they had been addressed.

* Only one of 4 complaints made in the complaints and feedback register contained documented evidence of collaboration with a consumer and open disclosure practiced.
* Staff explained when a consumer makes a complaint about their services, staff take action if able to and document in the consumer file, however not all complaints are documented if it can be actioned immediately.
* Consumers are also encouraged to complete a feedback form or telephone the service and staff will apologise if they are involved with or handling the complaint.
* Management explained when a consumer complains it is promptly addressed. However, they acknowledge that documentation could improve.

The provider’s response includes the following actions to remedy the issues of appropriate action not always taken in response to complaints or open disclosure practiced when things go wrong, and additional information:

* Commenced providing staff with education on trending feedback and use this to inform practice.
* They are aware of the opportunity to improve resulting from feedback and are working with their teams to ensure all complaints and feedback received are followed up and any learning is used to inform the care or service provided.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the provider’s response, which demonstrates that appropriate action in response to complaints and an open disclosure process is used when things go wrong does not always occur.

I have considered the intent of this Requirement, which expects organisations take appropriate actions in response to complaints and, when things go wrong open disclosure is practiced. I find this did not always occur as management and staff responses, and documentation did not demonstrate this.

I acknowledge the provider in their response has provided actions to address the deficiencies identified. However, there is no evidence these actions have been effectively implemented or embedded at the time of my decision.

I find the provider, in relation to the service, non-compliant with Requirement 6(3)(c) in Standard 6 Feedback and Complaints.

Requirement 6(3)(d)

The Assessment Team assessed this requirement as Not Met:

The service overall was unable to demonstrate how complaints and feedback lead to improvements for consumers, or of care and services.

* Consumers and representatives were not satisfied changes were made as a result of their feedback.
* The services’ Plan for Continuous Improvement (PCI) contained one item in the previous 12 months as a result of consumer feedback related to issues with communication and telephone system with a planned completion date of May 2023. Management described this example of how they use feedback to improve the services as mentioned in requirement 1(3)(e). No other examples were provided.

The provider’s response includes the following actions to remedy the issues of no regular care plan reviews or when consumer situations change, and additional information:

* Staff are being upskilled feedback to ensure feedback is captured and used to inform practice where necessary.
* The establishment of the Consumer Advisory Committee and the Quality Advisory Committee and will be reported to the Board quarterly.

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

I have considered the intent of this Requirement, which expects organisations will review feedback and complaints to inform improvement in service and care delivered. I find this did not always occur as consumer and management responses, and documentation did not demonstrate this.

I acknowledge the provider in their response has provided actions to address the deficiencies identified. However, there is no evidence these actions have been effectively implemented or embedded at the time of my decision.

I find the provider, in relation to the service, non-compliant with Requirement 6(3)(d) in Standard 6 Feedback and Complaints.

Requirements 6(3)(a) and 6(3)(b):

Consumers and representatives described ways they are able to provide feedback to the service such as telephoning the service or raising issues with staff. Staff described the process of consumers signing staff out of their shift on the mobile application if consumers are satisfied with staff’s delivery of services. Management described additional ways consumers can provide feedback such as through the services’ website, monthly surveys of a small portion of consumers randomly and a social media page. The Assessment Team observed feedback forms located within the service and a collection box. The consumer handbook also provides information on how to provide feedback.

Consumers and representatives confirmed they felt safe to make a complaint or provide feedback. Staff explained the consumer handbook and the service newsletter provide information on how to access advocacy and language services, and how to make a complaint to the Aged Care Quality and Safety Commission (The Commission). An example was provided of how an advocacy service supported a consumer who was illiterate. Management described engaging in interpreting services to assist consumers with language interpreting or a hearing impairment.

# Standard 7

|  |  |  |
| --- | --- | --- |
| Human resources | | CHSP |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Not Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirement 7(3)(a)

The Assessment Team assessed this requirement as Not Met:

The service was unable to demonstrate the numbers and skill mix of staff to deliver safe and quality care and services.

* Consumers were not satisfied with services cancelled related to staff leave, not knowing when staff will arrive to deliver their services or the inconsistent staff who deliver their services. One named consumer experiences pain when they do not receive the domestic assistance required to complete the laundry task they commence, when staff do not turn up.
* The service was unable to provide accurate data of unfilled shifts in the previous month.
* Management explained the service considers personal care services as high risk and prioritises these services when unplanned leave occurs. Unplanned leave is frequent, and staff have high annual leave hours that were not taken during the COVID-19 pandemic period.

The provider’s response includes the following actions to remedy the issues of a planned workforce to enable the numbers and skill mix of staff to deliver safe and quality care and services, and additional information:

* Commenced monitoring data of unfilled staffing shifts. This will be shared with the Board for monitoring and risk management.
* Management is reviewing unplanned leave usage and will consider options in relation to this.
* Developing a procedure for service cancellations to standardise the process.
* Communicated with staff the expectations when a scheduled service is cancelled.
* The service does not intend to increase service capacity until sufficiency of the workforce improves. Retention and recruitment strategies have commenced.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the provider’s response, which demonstrates that the workforce is planned to enable, however the number and mix of members of the workforce deployed does not always enable, the delivery and management of safe and quality care and services.

I have considered the intent of this Requirement, which expects organisations provided the staff to enable the delivery and management of safe and quality services and care. I find this did not occur as consumer and management feedback, monitoring of staff, and inconsistent processes did not demonstrate this.

I acknowledge the provider in their response has provided actions to address the deficiencies identified. However, these actions will require time to address and be effectively implemented or embedded at the time of my decision.

I find the provider, in relation to the service, non-compliant with Requirement 7(3)(a) in Standard 7 Human Resources.

Requirements 7(3)(b), 7(3)(c), 7(3)(d) and 7(3)(e):

Consumers and representatives felt staff were kind, gentle and caring when delivering services. Coordinator staff explained they try to match consumers with staff of similar culture and identity. The Assessment Team observed telephone calls between the receptionist and consumers being informative and kind.

Consumers and representatives were satisfied staff were competent and had the appropriate qualifications to perform their roles effectively. Staff they felt they were competent and well trained to perform their roles described the training and reviews they participate in such as mandatory face to face and online training, and performance reviews. Management explained the supervision checking that staff receive from the coordinating staff or Registered Nurse (RN) and provided evidence of recent competencies completed. The Assessment Team observed appropriate qualifications and matching position descriptions within staff personnel files.

Management demonstrated the workforce is recruited, trained and equipped to support the services delivered to consumers. They described how they are able to identify staff training needs through audits and updates from the Commission and examples of training arranged as a result. The Assessment Team observed documentation of staff recruitment, their mandatory training and support provided through a ‘buddy shift’ arrangement following induction.

While consumers and representatives could not recall being requested to provide feedback on staff performance, consumers did provide feedback on staff performance through the feedback and complaints system documentation. Staff described the informal feedback they receive from coordinating staff, and coordinating staff explained they seek feedback from consumers in relation to the performance of new staff if time permits. Management described the informal staff monitoring process and staff performance management process when underperformance occurs. The Assessment Team observed staff performance reviews completed in the previous 12 months.

# Standard 8

|  |  |  |
| --- | --- | --- |
| Organisational governance | | CHSP |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Not 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 Applicable |

Findings

Requirement 8(3)(a)

The Assessment Team assessed this requirement as Not Met:

Consumers and representatives were not satisfied consumers were engaged in the development, delivery or evaluation of care and services, including after providing feedback and making complaints.

* Management were unable to demonstrate they use feedback and complaints to improve the delivery of care and services.
* Staff and management were unable to confirm if consumers were involved in events such as the smoking ceremony during the National Aborigines and Islanders’ Day Observance Committee (NAIDOC) week.
* The service has commenced a consumer advisory board due to commence their first meeting in January 2024.

The provider’s response includes the following actions to remedy the issues of consumers not engaged in the development, delivery and evaluation of care and services and are supported in that engagement, and additional information:

* Engaged an external advisor to review their processes and improve the service capability with consumer engagement.
* Trending feedback and complaints and include this in the Board report.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the provider’s response, which demonstrates that consumers were not engaged in the development, delivery or evaluation of care and services, including after providing feedback and making complaints.

I have considered the intent of this Requirement, which expects organisations to engage and support consumers in the development, delivery and evaluation of care and services. I find this did not occur as consumer, staff and management feedback and feedback and complaints documentation did not demonstrate this.

I acknowledge the provider in their response has provided actions to address the deficiencies identified, due to be completed in 2024. Therefore, there is no evidence these actions have been effectively implemented or embedded at the time of my decision.

I find the provider, in relation to the service, non-compliant with Requirement 8(3)(a) in Standard 8 Organisational Governance.

Requirement 8(3)(b)

The Assessment Team assessed this requirement as Not Met:

The governing board do not receive information to promote a culture of safe, inclusive and quality care and services.

* The Assessment team observed documentation related to minutes of meetings, and the notes of various management roles. However, this information did not inform how the governing body ensures services are being delivered safely, effectively, are inclusive and of quality and accountable.
* Consumer file documentation were not always clear whether a service had been cancelled due to consumer choice or availability of staff.
* Management explained they are not collecting data of CHSP consumers or how many services have been cancelled due to staff leave.
* Management acknowledged they will need to undertake education for staff and develop a policy to support the collection of data of CHSP consumers to present to the Board.

The provider’s response includes the following actions to remedy the issues of no regular care plan reviews or when consumer situations change, and additional information:

* Commenced data collection and retrieval of services cancelled to trend and share with the Board.
* Data collection on consumers admitted to hospital and who experience falls, will be analysed and reported for improvement purposes.
* A review the service cancellation process including what actions to take following cancellation.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the provider’s response, which demonstrates that the organisational governing body did not always promote a culture of safe, inclusive and quality care and services or was accountable for their activity.

I have considered the intent of this Requirement, which expects organisations to promote and be accountable for a culture of safe, inclusive and quality services and care. I find this did not occur as data collection documentation, the analysis and trending related to incidents, services provided, feedback and complaints and manager reports provided to the Board did not demonstrate this.

I acknowledge the provider in their response has provided actions to address the deficiencies identified. However, there is no evidence these actions have been effectively implemented or embedded at the time of my decision.

I find the provider, in relation to the service, non-compliant with Requirement 8(3)(b) in Standard 8 Organisational Governance.

Requirement 8(3)(c)

The Assessment Team assessed this requirement as Not Met:

Continuous improvement

The service did not demonstrate effective organisation wide governance systems in relation to continuous improvement. Incident data overall was not trended. While improvement initiatives were identified with dates to be completed included in the Plan for Continuous Improvement (PCI), only one of these items was related to consumer feedback and another one action only was included related to an incident.

Feedback and complaints

The service did not demonstrate CHSP consumer complaints were escalated to the Board. The service did not always acknowledge, document, report, investigate all complaints, or always practice open disclosure. The service was unable to demonstrate overall how complaints and feedback provided transcribed into service improvements. A Board member interviewed was not aware of any CHSP consumer complaints nor were there any records of discussion in Board meeting minutes observed by the Assessment Team.

The provider’s response includes the following actions to remedy the issues of effective organisational governance systems related to continuous improvement and feedback and complaints:

* The establishment of the Consumer Advisory Committee and the Quality Care Advisory Committee and these will be included in the Board report.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the provider’s response, which demonstrates that continuous improvement and feedback and complaints governance systems were not always effective.

I have considered the intent of this Requirement, which expects organisations to ensure effective organisational governance systems related to continuous improvement. I find this did not occur as documentation related to continuous improvement and feedback and complaints did not demonstrate this.

I acknowledge the provider in their response has provided actions to address the deficiencies identified, due to be completed in 2024. Therefore, there is no evidence these actions have been effectively implemented or embedded at the time of my decision.

I find the provider, in relation to the service, non-compliant with Requirement 8(3)(c) in Standard 8 Organisational Governance.

The other organisational wide governance systems were assessed as effective:

Information management

Management and staff confirmed information was stored on a password protected online system. The service is currently transitioning to an online care system and has both systems operating during the transition period. The Assessment team observed consumer information privacy was managed appropriately.

Financial governance

Information in relation to CHSP consumers was not included in the CEO monthly reporting. Other management reporting included staff costs and Human Resources (HR) risks with mitigation strategies. A care manager report included the number of services cancelled against budgeted targets and in one particular month an analysis of this occurred. Some board members have backgrounds in accounting or finance.

Workforce governance

Annual performance reviews were completed with outstanding reviews reported to the Board. Support staff who deliver services undertake ‘buddy shifts’ with their induction. All staff in the organisation are required to complete mandatory training. The Assessment Team observed current position descriptions for each role including their responsibilities, the organisational chart and monthly HR reports.

Regulatory complaisance

Management and staff were aware of the Aged Care Code of Conduct, and this was included in the staff handbook. The service subscribes to various groups to ensure they are informed of any sector changes and a manager is responsible for the oversight of informing staff of changes. The Assessment Team observed records of qualifications, staff drivers’ licences and vaccinations. The service demonstrated that the Serious Incident Reporting Scheme (SIRS) is embedded and there is a policy to guide staff with their mandatory reporting obligations.

Requirement 8(3)(d)

The Assessment Team assessed this requirement as Not Met:

The service was unable to provide sufficient evidence to demonstrate effective risk management systems and practices.

* The service has a risk management framework which included high impact or high prevalence risks, neglect and abuse.
* The service did not demonstrate however, effective risk management systems and practices in high impact or high prevalence risks or mitigating strategies that were included in individual consumer care plans.
* Nor did the service demonstrate that the incident management system was analysed and trended to identify improvement opportunities for CHSP consumers.
* The policy for incident management guide staff to the various types of incidents.
* Staff demonstrated their knowledge and understanding of abuse and neglect and management demonstrated abuse and neglect was included in induction training.

The provider’s response includes the following actions to remedy the issues of effective risk management systems and practices not demonstrated, and additional information:

* Complaints and incidents will be trended to inform practice and included in reporting to the Board.
* The new online care system has reporting capabilities such as trends of incidents.
* Upskilling of staff to ensure they are aware of this requirement.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the provider’s response, which demonstrates that effective risk management systems and practices including high-impact or high-prevalence risks associated with the care of consumers did not effective.

I have considered the intent of this Requirement, which expects organisations to effectively manage risks including high-impact or high-prevalence risks. I find this did not occur as incident trending and analysis did not demonstrate this.

I acknowledge the provider in their response has provided actions to address the deficiencies identified. However, there is no evidence these actions have been effectively implemented or embedded at the time of my decision.

I find the provider, in relation to the service, non-compliant with Requirement 8(3)(d) in Standard 8 Organisational Governance.

Requirement 8(3)(e)

No clinical or personal care is provided under the CHSP services delivered. Therefore, this requirement 8(3)(e) is Not Assessed.

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)