**Performance**

**Report**

**1800 951 822**

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| Name of service: | Pearl Home Care Brisbane North |
| Service address: | 1277 Sandgate Road NUNDAH QLD 4012 |
| Commission ID: | 700965 |
| Home Service Provider: | Pearl Home Care Pty Ltd |
| Activity type: | Quality Audit |
| Activity date: | 2 August 2023 to 4 August 2023 |
| Performance report date: | 24 October 2023 |

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.

**This performance report**

This performance report for Pearl Home Care Brisbane North (**the service**) has been prepared by M Murray, 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.

# Services included in this assessment

**Home Care:**

* Home Care Assistance, 26338, 1277 Sandgate Road, NUNDAH QLD 4012

# Material relied on

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

* the assessment team’s report for the Quality Audit; 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 approved provider’s response to the assessment team’s report received 7 September 2023.

# Assessment summary for Home Care Packages (HCP)

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

* Ensure the information in care planning documents and the service’s mobile application is sufficient to inform a care worker of the strategies that have been developed to support the consumer balance their quality of life with any risks they wish to take.
* Ensure information provided by care staff about a consumer’s well-being is triaged and appropriately escalated to a clinical staff member for management.
* For all incidents that the service becomes aware of, demonstrate how service has considered any impact of the incident on the needs of the consumer going forward. Undertake relevant re-assessments, referrals to allied health practitioners and make required changes to the care being delivered and update care plans accordingly.
* Establish an effective incident management system.

# Standard 1

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| Consumer dignity and choice | | HCP |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | 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. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Consumers and representatives said consumers are treated with respect and dignity and that the staff are friendly and polite. Staff interviewed spoke respectfully about consumers and they demonstrated an awareness of the consumer’s personal experiences. Documentation reviewed evidenced the service has a consumer-centered approach to delivering services.

Management said cultural safety training is conducted during staff orientation to the service. Documentation evidenced information is collected on individual cultural backgrounds to inform care.

Consumers described how they are able to make choices about what services they receive and the timing of those services and felt their choices were respected by staff.

The service has a supported decision making and dignity of risk policy which acknowledges every consumer’s human right to make decisions about their own life and to have those decisions respected. When dignity of risk arises, the service has a risk acknowledgement form they complete with consumers, after providing them with information on the options available to them for balancing risk and wellbeing.

Consumers and representatives said they receive written information in a way that they can understand and that enables them to make informed choices. They receive a monthly statement which was described as easy to understand. Management said they visited each consumer in their home when the pricing structure changed to ensure each consumer had the opportunity to ask questions directly to management.

Consumers’ information is stored on an electronic database with multifactor authentication access. Staff demonstrated an understanding of their responsibilities in relation to maintaining confidentiality. Consumers are provided with information about the collection, use and disclosure of their personal information.

# Standard 2

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| Ongoing assessment and planning with consumers | | HCP |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Non-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. | Compliant |

Findings

Requirement 2(3)(a)

The Assessment Team reported that the service does not adequately consider risks when undertaking assessment and care planning.

The Assessment Team’s evidence that is relevant to this requirement is summarised below.

* The service does home risk assessments for all consumers and several validated assessments are completed by clinical staff on intake and review, including a Braden pressure skin assessment, self-medication assessment, falls risk for older people in the community tool, hygiene and toileting assessment, geriatric depression scale, cognitive assessment mini mental state examination and nutrition and hydration assessments. For some consumers, while key risks had been identified in the assessments, strategies to manage those risks had not been identified and/or documented to support safe and effective care.
* Care plans, although providing information on consumer service needs, did not contain sufficiently detailed information to guide staff practice in relation to mitigating risks.
* Care staff have access to a mobile phone application (App) which contains key information including a consumer profile, access to residency notes, identified risks and shift alerts. Care staff advised they usually use the App to access the most up to date consumer information. Care staff advised, prior to working with a consumer for the first time, they also review the consumer’s care support plan and care directive. It was noted by the Assessment Team that in many cases, although risks were identified in the validated assessments and listed in the care plan, they were not listed in the App.
* Three consumers’ care information when viewed in the App did not reflect the strategies outlined in the written care plans.
* Management advised the App should contain the key risks care staff need to be aware and acknowledged this information has not been entered. Management said care staff are provided with a handover verbally when they commence working with a new consumer and advised many consumers have the same care staff and are therefore aware of the associated risks of their care.

The approved provider’s evidence that is relevant to this requirement is summarised below.

* All the consumers' care plans and care directives will be reviewed and updated reflecting risk mitigation strategies, including management of oxygen therapy, falls prevention, wound management, and assistance with medication management.
* Risk minimization strategies are being reviewed to ensure safe care, and the strategies developed will be documented and implemented in partnership with consumers and representatives.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and the approved provider’s response.

I am satisfied that while relevant assessments are being undertaken as part of planning the consumer’s care and services, strategies to mitigate risk are not fully articulated in either the care planning document or the App used by staff.

While the staff are generally regular, information in care planning documents need to be sufficient to ensure a care worker with no history with a consumer can deliver care in line with strategies that have been endorsed by a suitably qualified staff member with responsibility for delegating care and who is accountable for the delivery of safe care.

Based on the information summarised above, I find the approved provider does not comply with this Requirement.

Other Requirements

Based on the Assessment Team’s evidence, which is summarised below, I am satisfied that the service complies with the other Requirements of this Standard.

Consumers and representatives said they were included in the assessment and planning process and the care meets consumers’ needs, goals, and preferences. Consumer feedback included that initial care planning focused on what was important to them.

Documentation evidenced consumer and representative involvement in the planning of services and the involvement of others involved in the care of the consumer.

Consumers are provided with information about Advance Care Planning and are asked about Enduring Powers of Attorneys and Advance Health Directives during their initial appointments.

Consumers confirmed they had received a copy of their care plan. Staff confirmed care plans are accessible in consumer’s homes.

The service demonstrated care and services are reviewed regularly including when consumer circumstances change. Consumers and representatives said staff regularly communicate with them about the service the consumer receives and makes changes to meet any changed needs. A review of care planning documentation demonstrated reviews occurred for all HCP consumers at least every 12 months. The registered nurse advised consumers are offered 6 monthly reviews, however, many decline. Management advised that the service completes ‘welfare checks’ every month for Level 3 and 4 HCP consumers to assess whether there has been any deterioration and whether other supports may be required. Staff undertaking reviews could describe the process and under what circumstances a review or reassessment may be required.

Documentation and consumer interviews evidenced reviews occur on time and staff seek to understand any changed needs of the consumer so that services can be adjusted accordingly.

# Standard 3

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| Personal care and clinical care | | HCP |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-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 reported that the service does not effectively manage high impact or high prevalence risks associated with the care of each consumer.

The Assessment Team’s evidence that is relevant to this Requirement is summarised below.

* Consumer A had a skin tear identified by a care staff member on 16 June 2023. On 19th June 2023, a further note outlines the skin tear was inflamed but the consumer reported it was not painful. On 23 June 2023 the care worker took the dressing off and put on a waterproof dressing and wrote an incident report. The same day care staff contacted the consumer’s representative who was aware of the wound and said they would involve the consumer’s doctor. On 30 July 2023 the care worker changed the dressing again and on 3 July 2023 it was confirmed the consumer had a further appointment with their GP that day.
* The Registered Nurse (RN) was not aware of the initial skin tear of 16 June 2023 was not aware of the type of dressing being used. The service’s view was that the representative was managing the wound and follow up by the service was not required.
* Management advised that after the care staff member contacted the office on 16 June 2023 they did contact the representative to discuss the wound, saying that during busy periods these conversations may not be documented.
* Consumer B had a blister on their shin on 21 July 2023 and the care worker reported this to the consumer’s representative. Care staff had a further conversation with the representative on 26 July 2023. On 28th July a second blister was noted on the consumer’s right ankle and the care staff worker changed one of the dressings for the consumer. During a regular welfare check the representative raised the issue of the blisters and the service encouraged the representative to seek the advice of the consumer’s GP. A further note on 2 August 2023 noted that the consumer had been referred to a dermatologist. The service did not undertake its own clinical review and skin integrity re-assessments were not undertaken.
* Consumer C’s main representative had taken a break and regular RN follow up was scheduled to occur, however the Assessment Team could not confirm this support had been provided. On 8 July 2023 the consumer reported feeling unwell to the care worker. This was escalated to the service, however, no follow up was evident. Two further incidents occurred for the consumer in July 2023, the first a fall and the second resulting in a ambulance transfer to hospital.
* Management advised that although dated notes were not written, Management had been in contact with the representatives of Consumer C from when they were first made aware of issues by care staff.

The approved provider’s evidence that is relevant to this requirement is summarised below.

* The mobile App will allow staff to enter information in a format that will trigger an alert to the office, and the registered nurse will follow up on the consumer’s health status within 24 hours of notification.
* Internal auditing has commenced.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and the approved provider’s response.

I am satisfied that suitably qualified staff members have not had proactive oversight of risks which impact the consumer’s health and well-being. Care staff have demonstrated they consistently record notes, however, this information is not being triaged and appropriately escalated to clinical care staff. While not all incidents occurred during the delivery of the service, the approved provider is responsible for considering how each incident might impact on the needs of the consumer going forward, undertaking relevant re-assessments, referrals to allied health practitioners and updating care plans accordingly.

Based on the information summarised above, I find the approved provider does not comply with this Requirement.

Requirement 3(3)(d)

The Assessment Team reported that changes in consumer’s mental health, cognitive or physical function is not consistently recognised and responded to in a timely manner

The Assessment Team’s evidence that is relevant to this requirement is summarised below.

* Care staff demonstrated how they have recognised deterioration in consumers; however, this is not consistently reported to Management to enable it to be responded to in a timely manner.
* Three consumer incidents were outlined (Consumers A,B and C) including a skin tear, and a blister being observed and one incident of a prior fall being reported by the consumer. During the course of a service being delivered, one of the three consumers noted in the Assessment Team’s report felt unwell and care staff called an ambulance.
* Management were alert to some incidents not being reported in June 2023 and July 2023 and undertook training in relation to risk, deterioration, and incident reporting.

The approved provider’s evidence that is relevant to this requirement is summarised below.

* The registered nurse was provided education by an external clinical consultant on assessment and care planning. Further education, mentoring and support are scheduled for Registered Nurses.
* An external Clinical Consulting Service will be providing guidance to clinical staff.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and the approved provider’s response. I have considered the evidence on the incident management system in my compliance finding in Standard 8(3)(d). I have considered the issue of care workers undertaking duties which are generally classified as clinical in Standard 7(3)(c),

I am satisfied care staff are escalating their concerns to the care team for further action. I am persuaded that while detailed notes are not recorded, the management team did consult with the representatives of all the consumers noted in the Assessment Team’s report in a reasonable timeframe. Representatives who were interviewed in relation to these incidents are satisfied with the care delivered.

I note that the skin tears and the fall outlined in the Assessment Team’s report did not occur during the provision of a service being delivered, but were noted by observant staff and/or self-reported by the consumer. I do not consider the skin tear or the blister meets the threshold of a change in a consumer’s mental health, cognitive or physical function. I have considered aspects of these incidents in my compliance finding in Standard 3(3)(b).

On the occasion when a staff member had knowledge of a previous fall by the consumer, and they reported being unwell again, I am satisfied that the staff member did recognise a deterioration in the consumer’s physical health and an ambulance was called, which I find an appropriate response.

Based on the information summarised above, I find the approved provider complies with this Requirement.

Other Requirements

Based on the Assessment Team’s evidence, which is summarised below, I am satisfied that the service complies with the other Requirements of this Standard.

Staff have a good knowledge of consumers’ needs, goals and preferences and could describe how the service ensures care is tailored to the consumer’s needs.

Various validated assessments are completed by clinical staff on joining the service and care and services align with consumers’ assessed needs.

The service liaises with palliative care teams from whom consumers are receiving services or refers consumers to appropriate services, as required. Management stated that although they have not needed to support a palliative care consumer in recent years, they have linked in with the Queensland Health palliative care team to ensure they understand the process when required.

Management said that care staff usually work with the same consumer and that management provide a verbal handover to care staff for the first service. There are processes to ensure information is communicated effectively within the organisation and with those who are involved in the consumer’s care.

Consumers and representatives said the delivery of care, including referral processes, are timely and appropriate. Consumers said they have access to their GP and other health professionals when they need it. A review of consumers’ care documentation demonstrated input form others such as GPs, hospital discharge staff, physiotherapists, and occupational therapists and evidenced their recommendations are acted on.

Consumers and representatives described staff practices to prevent the spread of infection including hand washing, the use of hand sanitiser and personal protection equipment. Staff described how they maintain appropriate infection control and minimise the risk of COVID-19. Management advised staff are trained in effective infection control practices within their areas of responsibility. Staff have completed COVID-19 training and are trained in donning and doffing personal protection equipment. The service has policies and procedures in place relating to infection prevention and control to guide staff practice.

# Standard 4

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| Services and supports for daily living | | HCP |
| 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. | Compliant |

Findings

Consumers receive services and supports of their choice such as gardening, domestic assistance, home maintenance and prepared meals through approved meal providers. Consumers and representatives described how staff support the consumer to be as independent as possible and to do the things they want to do. Staff demonstrated they understand what is important to consumers and how the services and supports they deliver, help to maintain the consumer’s independence.

Consumers described episodes of loneliness and how staff supported their well-being during these times. Staff have regular consumers and have a familiarity with their circumstances, providing support when the consumer is worried or upset.

Documentation evidenced the things consumers like to do to stay connected to the community. Consumers are satisfied that they can get support to go, for example, to social events, medical appointments and the local shops.

Information is appropriately shared. A staff member interviewed was visiting a consumer for the first time on the day of the audit. They reported they had received sufficient information about the consumer prior to the visit and said they would spend time getting to know the consumer during the initial visit.

Consumers said and a review of documents evidenced that timely referrals have been made, for gardening services, occupational therapy, personal alarms, mobility aids and home modifications.

Should the consumer wish to have meals provided as part of their HCP, the service is able to facilitate this through third party meal service providers. Consumers said they are able to select the meals they prefer and that they manage the delivery directly with the supplier. Consumers were aware that they could change meal providers should they wish to and were aware that part of the cost of the meals was excluded under their HCP.

Where equipment has been sourced for consumers to use in their homes, consumers reported that the equipment is suitable and meets their needs. Management advised the process for sourcing equipment, including consultation with the consumer and assessment by an occupational therapist. Staff said if they notice, or a consumer reports, any issues with equipment then maintenance is organised.

# Standard 5

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| Organisation’s service environment | | HCP |
| 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 |
| 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 |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Not applicable |

Findings

This Standard is not applicable as the approved provider does not provide a physical service environment where care and services are delivered.

# Standard 6

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| Feedback and complaints | | HCP |
| 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. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Consumers and representatives demonstrated their awareness of ways to make complaints, however most advised they prefer to communicate directly with the service. Consumers said they have access to an online complaints portal.

Staff and management reported all current consumers can communicate in English; however, they are aware of how to access information in other languages if required.

Consumers who have raised concerns reported satisfaction with the handling of their concerns. Staff and management demonstrated an understanding of the importance of utilising open disclosure throughout the complaints process and were able to describe the process in detail. The Assessment Team reviewed the feedback and complaints register, and while there are minimal numbers of complaints received, there was a clear process to record, monitor, respond and manage feedback and complaints.

Consumers outlined improvements to their care or service as a result of giving feedback. Management said no specific trends have been identified from their feedback data.

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# Standard 7

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| Human resources | | HCP |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| 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)(c)

The Assessment Team reported that care staff are working outside of the scope of their practice.

The Assessment Team’s evidence that is relevant to this Requirement is summarised below.

* A care staff worker applied a waterproof dressing to a wound.
* A care staff worker dispensed eye drops into both eyes of a consumer.

The approved provider’s evidence that is relevant to this requirement is summarised below.

* Recognition of the importance of staff working within their defined professional boundaries and scope of practice to maintain quality care and safety.
* Notes for the past month have been audited to understand any education gap and as per audit results, no other episodes of staff working outside of scope of practice have been identified.
* The care staff members that were identified as performing outside their scope have been supported to better understand the scope of their roles.
* Staff have received targeted training on regulatory requirements, incident reporting, risk management, assessment and care planning, roles and responsibilities and code of conduct.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and the approved provider’s response.

I note that relevant care staff members were not interviewed by the Assessment Team.

I am satisfied that the corrective actions outlined by the approved provider have mitigated, to as great an extent as possible, any risk of care staff working outside of their scope of practice moving forward.

Based on the information summarised above, I find the approved provider complies with this Requirement.

Other Requirements

Consumers are satisfied the workforce is sufficient to ensure they receive their services in accordance with their individual needs and preferences. Consumers reported they generally have the same staff, staff arrive when expected or if the staff member is going to be late, they are notified.

There were no unfilled shifts in the month preceding the audit.

Consumers and representatives provided positive feedback in relation to their interactions with the workforce, saying in various ways, staff are kind, caring, respectful and helpful. Consumers described feeling safe and comfortable with staff.

Management described the recruitment processes, noting that a clinical staff member is always on the panel for employing registered nurses to ensure they have appropriate experience and an understanding of the role.

Staff said they have received ‘on the job’ training and guidance and felt supported to undertake their duties safely and efficiently.

Management and staff have access to online training options include medication safety in the home; infection control; cleaning; hand hygiene; falls prevention; manual handling and caring for a consumer living with dementia.

Training needs are identified through consumer feedback, performance reviews and through documentation audits, topics are discussed with staff as they are identified.

Staff said they have participated in performance appraisals with management.

# 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. | 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 |
| 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. | Non-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 |

Findings

Requirement 8(3)(b)

The Assessment Team reported that the organisation’s governing body does not have oversight to risks occurring for consumers.

The Assessment Team’s evidence that is relevant to this Requirement is summarised below.

* The governing body is informed of details relating to each franchisee via the Chief Executive Officer (CEO) and management within the franchisor head office. The CEO advised the governing body meets monthly. The meeting agenda and meeting minutes demonstrate clinical governance, incidents, complaints, legal and financial matters are discussed at these meetings.
* The CEO and franchisor management discussed audit processes are conducted by the franchisor on each franchisee annually with the service last being audited in November 2022. The CEO stated these audits relate to policies, processes, human resource, and clinical matters with a plan to incorporate financial audits soon.
* The CEO described enhanced communication opportunities between the franchisor and franchisee and provided the Assessment Team with a monthly newsletter that is sent to all franchisees which highlights service changes, expectations of service and quality care and clinical governance. Bulletins and updates provided by the Aged Care Quality Commission and Department of Health alerts are also circulated.
* Despite the level of oversight currently in place, the Assessment Team identified deficiencies in the service’s incident reporting processes which included incidents identified through progress notes that were not reported or escalated in a timely manner.
* When incidents are not being reported at the service level, this information cannot be included in reports being presented to the board, limiting the board’s ability to effectively have oversight of the service’s risks.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report. I have considered the evidence in last two dot points in my finding of compliance in Standard 3(3)(d) and do not intend to consider the evidence again under this Requirement. I am satisfied in the absence of other evidence of deficits at a governance level, that the approved provider complies with this Requirement.

Based on the information summarised above, I find the approved provider complies with this Requirement.

Requirement 8(3)(c)

The Assessment Team reported that the organisation’s governing body does not actively pursue continuous improvements and does not have effective systems for workforce governance. Effective governance systems are evidence for information management; financial governance; regulatory compliance and feedback and complaints.

The Assessment Team’s evidence that is relevant to sub-Requirement (ii) is summarised below.

* Whilst the service collects information that could be used for service related improvements, management advised there no single continuous improvement process which collates information from a variety of sources such as complaints, feedback, surveys, audits, or incidents to inform service improvements.
* Management gave an example from the franchisor level of a large number of complaints across all franchisees from consumers/representatives not understanding their statements. This has led to the franchisor developing training for franchisee management to ensure they accurately understand the statement process to enable better communication with consumers.
* Management was unable to provide further examples of continuous improvement.

The Assessment Team’s evidence that is relevant to sub-Requirement (iv) is summarised below.

* The Assessment Team identified instances where care staff are operating outside their scope of practice.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report.

In relation to sub-Requirement (ii) the improvement to the consumer statement is satisfactory in my view to demonstrate the service actively pursues continuous improvement.

In relation to sub-Requirement (iv) I have considered this evidence in my finding on compliance in Standard 7(3)(c).

Based on the information summarised above, I find the approved provider complies with this Requirement.

Requirement 8(3)(d)

The Assessment Team reported that the organisation’s governing body does not have an effective incident management system.

The Assessment Team’s evidence that is relevant to this Requirement is summarised below.

* The Assessment Team reviewed dated progress notes for three consumers and identified specific entries where incidents were documented but not escalated, or where the note advises that management have been alerted to the incident but there is no corresponding incident form completed.
* Without this information being recorded as an incident, the Assessment Team determined the service, franchisor, and board does not have effective oversight of the risks within the service rendering the incident management system ineffective.

The approved provider’s evidence that is relevant to this Requirement is summarised below.

* The service has established an internal auditing system to ensure an effective system for managing and preventing incidents, including the effective use of an incident management system.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and the approved provider’s response. While I acknowledge the focus of the approved provider on their incident system, I consider that this action will take time to embed into day to day practice and monitoring will need to occur for some months to establish its effectiveness.

Based on the information summarised above, I find the approved provider does not comply with this Requirement as it has failed to comply with sub-Requirement (iv).

I am satisfied with the evidence of the Assessment Team that risk management systems and practices are in place for sub-Requirements (i); (ii) and (iii) and that the service complies with these sub-Requirements.

Other Requirements

Consumers advised they felt comfortable to contact the service if they had concerns relating to their care and services. Management reported consumers and staff have access to feedback forms in folders in the consumer’s home. A survey has been undertaken with consumers and examples of completed consumer surveys were evident.

The service has policies, procedures and an operations manual to guide clinical care.

The service has the staffing and capability to provide clinical care, and whilst the clinical governance framework is being developed and the clinical governance process strengthened, the service and franchisor has processes in place to ensure clinical staff are well supported.

Clinical staff could describe and provide examples of antimicrobial stewardship, restrictive practice, and open disclosure within home care and stated they felt supported by management in their role.

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)