**Performance**

**Report**

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| Name: | SA Disability Care Pty Ltd |
| Commission ID: | 600631 |
| Address: | 15 Weerena Rd, Salisbury, South Australia, 5108 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 11 March 2024 to 13 March 2024 |
| Performance report date: | 12 April 2024 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

# Service included in this assessment

Home Care Packages (**HCP**) included:  
Provider: 10037 SA Disability Care Pty Ltd  
Service: 28277 SA Disability Care Pty Ltd

**This performance report**

This performance report for SA Disability Care Pty Ltd (**the service**) has been prepared by P. Frangiosa, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Assessment contact (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the performance report dated 22 November 2023 in relation to the Quality Audit undertaken from 20 September 2023 to 22 September 2023.

The provider did not submit a response to the Quality Audit report.

# Assessment summary for Home Care Packages (HCP)

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

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

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Standard 2

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| Ongoing assessment and planning with consumers | | HCP |
| 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)(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. | Complaint |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

Requirements (3)(b), (3)(d) and (3)(e) were found non-compliant following a Quality Audit undertaken from 20 September 2023 to 22 September 2023, as the service did not demonstrate:

* Assessment and planning identified and addressed the consumer’s goals and preferences, including advanced care planning and end of life planning.
* Assessment and planning are effectively communicated to the consumer and documented in a care and services plan readily available to the consumer and where care and services are provided.
* 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.

The Assessment Team’s report for the Assessment contact undertaken on 11 March 2024 to 13 March 2024 includes evidence of actions taken by the service in response to the non-compliance. These actions include but are not limited to:

* Established processes in place to support consumers to identify their specific goals and preferences with the information outlined in the care plan.
* Ensuring a copy of the care plan is provided to all consumers and ensuring the care plans are uploaded to the electronic care management system to allow staff to access them via their mobile phone work app.
* The introduction of a comprehensive continuous improvement plan to address the identified deficits including ensuring care services are reviewed following an incident or change in consumers’ condition.

The Assessment Team was satisfied these improvements were effective and recommended Requirements (3)(b), (3)(d) and (3)(e) met. The Assessment Team provided the following evidence relevant to my finding:

* Staff interviewed and documentation reviewed showed information is collected through discussions with consumers, representatives and others involved in the consumer’s care. The care manager stated consumers are provided an opportunity during the initial assessment and at the time of the annual review, to identify their end-of-life preferences in an advanced care directive if they have not already done so.
* Review of care plan documentation confirmed alerts recorded in the electronic care management system, to advise staff of advanced care directives.
* All consumers interviewed advised they have been provided an opportunity to discuss with the care manager or coordinator their specific goals and preferences, including where appropriate advanced care directives.
* The care manager advised, and documentation confirmed the service discusses specific service needs and preferences, with information recorded reviewed against the measurable goals identified each time the care plan is reviewed. In addition, staff will provide feedback to the coordinator if the consumer shares with them changes to their goals or preferences.
* Organisational policies and procedures reviewed in relation to assessment and planning have been revised and implemented. Guidance includes the need for every assessment to be conducted in accordance with the complexity of needs, requirements, goals, special needs such as wound management or dietary requirements and the preferences of each consumer.
* A review of documentation indicated that care plans include detailed information about the services provided and outcomes of reassessments are clearly recorded and available to support workers.
* Management stated and documents confirmed the service’s process for reviewing care plans includes reviewing risks at least every 6 months, including triggers for a reassessment of care needs include hospital discharge, an incident, a change in circumstances and a change in health of the consumer.
* The care manager stated, and progress notes confirmed family members are contacted at the time consumer incidents occurred. General practitioners and allied health staff are informed of all clinical incidents for action and follow up as required.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 2 Ongoing assessment and planning with consumers.

# Standard 3

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| Personal care and clinical care | | HCP |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |

Findings

Requirements (3)(b) and (3)(e) were found non-compliant following a Quality Audit undertaken from 20 September 2023 to 22 September 2023, as the service did not demonstrate:

* Effective management of high impact or high prevalence risks associated with the care of each consumer and specifically risks associated with pressure ulcers, pain and falls.
* The identification of risks, and strategies to mitigate or reduce the risk to each consumer was not discussed with the consumer or their representative at the time of admission or during the ongoing review process.
* Information about the consumer’s condition, needs and preferences is not documented and communicated within the organisation, and with others where responsibility for care is shared.

The Assessment Team’s report for the Assessment contact undertaken on 11 March 2024 to 13 March 2024 includes evidence of actions taken by the service in response to the non-compliance. These actions include but are not limited to:

* The service employed a registered nurse as the care manager responsible for the monitoring and assessing of high-risk consumers.
* The introduction of specific validated assessment tools has been added to the comprehensive assessment process completed on admission to the service by the registered nurse.
* The adoption of Incident and clinical incident reports completed being collated, analysed and discussed at the monthly leadership team meetings and policies and procedures have been reviewed and revised to reflect current practice.

The Assessment Team was satisfied these improvements were effective and recommended Requirements (3)(b) and (3)(e) met. The Assessment Team provided the following evidence relevant to my finding:

* Management advised, and supporting documentation confirmed the organisation responds to high-impact or high-prevalence risks by reporting each incident and completing an analysis. Each incident that occurs is recorded and a review is undertaken, initially by the coordinator and the care manager to ensure what occurred is understood, the action needed, and any strategies and interventions that can be implemented to avoid a recurrence.
* Reassessment of consumers’ needs is undertaken as issues are identified. All incidents are then trended on a monthly basis and discussed at the monthly leadership team meeting.
* Documentation confirmed the service has introduced policies and procedures to guide staff in the management and monitoring of high prevalence, high impact risks to the consumers. All high impact and high prevalence clinical and personal risks for consumers are recorded in the care plans, assessment, and progress notes. Consumer clinical risks are trended, analysed, and discussed at the leadership meeting and strategies implemented to mitigate the risks.
* Staff interviewed and documentation reviews confirmed progress notes are recorded and information is shared with others to aid in care and service delivery. In addition, the support workers advised they can discuss specific identified preferences or strategies they use at the regular staff meetings.
* Documentation reviewed confirmed information regarding care and services provided by external support workers is communicated regularly through emails, phone calls and regular meetings that are documented with outcomes recorded in progress notes. Allied health staff are required to provide regular feedback to the coordinator or care manager as appropriate.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 3 Personal and clinical care.

# Standard 7

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| Human resources | | HCP |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

Requirements (3)(c) and (3)(d) was found non-compliant following a Quality Audit undertaken from 20 September 2023 to 22 September 2023, as the service did not demonstrate:

* The workforce was competent to effectively perform their role in relation to the management of consumers with pain, falls and wounds.
* The workforce was consistently recruited, trained, equipped and supported to deliver the outcomes required by these standards. Staff did not have training on elder abuse, cultural awareness, goal setting, assessment and planning, wound and falls management.

The Assessment Team’s report for the Assessment contact undertaken on 11 March 2024 to 13 March 2024 includes evidence of actions taken by the service in response to the non-compliance. These actions include but are not limited to:

* Provision of training to staff on elder abuse, cultural awareness, goal setting and assessment and planning. Clinical staff have completed complex wound care and falls management training.
* The employment of a dedicated aged care registered nurse, as care manager. The care manager had completed training in pain, falls and wound management and possessed the required knowledge and skills to perform the role effectively.

The Assessment Team was satisfied these improvements were effective and recommended Requirement (3)(c) and (3)(d) met. The Assessment Team provided the following evidence relevant to my finding:

* Consumers and representatives described in various ways how staff are competent in their roles. Staff and management described how recruitment processes ensure staff have adequate skills and qualifications.
* Staff interviewed, and evidence reviewed, identified qualifications and experience required to effectively perform their role.
* The care manager identified, and documents reviewed supported Care plans for new consumers in the initial assessment captured consumer’s needs, goals and preferences. The care manager advised she had reviewed all consumers care plans and had updated consumer’s needs, goals and preferences as required.
* The review of the 2024 training calendar identified forthcoming training in medication administration, restrictive practises, incident reporting, elder abuse and cultural awareness.
* Review of documentation showed the service had all relevant documentation for subcontractors and the training matrix recorded their certificates/training and when they were due for renewal.
* Review of job descriptions for support workers and the registered nurse which ensured staff had the appropriate competencies to perform their role. The service has an electronic care management system to record staff qualifications, competencies and police checks. The system generates an alert when staff including subcontractors when certificates/training were due for renewal.
* Management advised, and reviewed documentation evidenced certificate III in aged care, first aid, CPR and manual handling was mandatory for all support workers prior to delivering care and services to consumers. A review of the training matrix and support workers qualifications evidenced all support workers had completed the mandatory training.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 7 Human resources.

# Standard 8

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| Organisational governance | | HCP |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |

Findings

Requirement (3)(d) was found non-compliant following a Quality Audit undertaken from 20 September 2023 to 22 September 2023, as the service did not demonstrate:

* Effective risk management systems and practices. Specifically in relation to managing high-impact or high-prevalence risks associated with the care of consumers and managing and preventing incidents including the use of an incident management system.

The Assessment Team’s report for the Assessment contact undertaken on 11 March 2024 to 13 March 2024 includes evidence of actions taken by the service in response to the non-compliance. These actions include but are not limited to:

* Development of a comprehensive continuous improvement plan to address the identified deficits. The organisation has recorded all incidents that have occurred in the last six months.
* All incidents were assigned to a dedicated care manager in aged care who manages the incident and implements strategies to mitigate the risks to consumers.

The Assessment Team was satisfied these improvements were effective and recommended Requirement (3)(d) met. The Assessment Team provided the following evidence relevant to my finding:

* The introduction of processes to identify risk with consumers and demonstrated consumer risk assessments undertaken, and risks managed. Management demonstrated knowledge and understanding of individual consumer’s risks and vulnerabilities.
* The introduction and demonstrated use of validated assessment tools to assist with the identification of consumer risks.
* Training to staff in relation to elder abuse and neglect of consumers, responding to abuse and the Serious Incident Response Scheme (SIRS).
* Service engagement with consumers and use of a well-being approach to enable consumers to remain connected to their community.
* An expression of interest sent to consumers so they can decide what activities they would like to be involved in. Once all responses had been received the service created an activities calendar based on consumer feedback.
* Facilitated occupational therapist assessments for the provision of equipment to maintain or increase a consumer’s capacity to remain independent and reduce reliance on others.
* Management and staff could advise of steps in identifying, responding to, and reporting of incidents.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 8 Organisational governance.

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