**Performance**

**Report**

**1800 951 822**

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| Name of service: | * + - Senior Helpers Northern Tasmania |
| Service address: | * + - 63-65 Cameron Street LAUNCESTON TAS 7250 |
| Commission ID: | * + - 301022 |
| Home Service Provider: | * + - Mosel Williams Care Pty Ltd |
| Activity type: | * + - Quality Audit |
| Activity date: | * + - 16 June 2023 to 21 June 2023 |
| Performance report date: | * + - 15 August 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 Senior Helpers Northern Tasmania (the service) has been prepared by M Cooper, 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:

* Seniors Helpers Northern Tasmania, 26932, 63-65 Cameron Street, LAUNCESTON TAS 7250

# 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 Provider’s response to the Assessment Team’s report received 18 July 2023; and
* the Performance Report dated 10 January 2023 for the Quality Audit undertaken from 6 December 2022 to 9 December 2022.

# 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 | Compliant |
| **Standard 4** Services and supports for daily living | Compliant |
| **Standard 5** Organisation’s service environment | Not applicable as not all requirements have been assessed |
| **Standard 6** Feedback and complaints | Compliant |
| **Standard 7** Human resources | Non-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.

Requirement 2(3)(b)

* Ensure care plans are individualised and reflective of consumers’ current needs, goals and preferences, including in relation to end of life care.
* Ensure all staff are trained and procedures are in place the facilitate consistency in care planning and care planning documentation across all franchisees and service outlets.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to assessment and planning.

Requirement 7(3)(d)

* Ensure that all franchise operators consistency apply any policy or procedure in relation to the recruitment and training of staff.
* Ensure that all mandatory training and training required by staff to deliver the outcomes required by these standards.

Requirement 8(3)(b)

* Ensure the governing body is aware of and accountable for the delivery of care and services, review communication and reporting processes from the Service to the governing body and vice versa.

Requirement 8(3)(c)

* Revise and re-enforce all policies and procedures to ensure that there is an effective organisation wide governance system in place that is accepted and implemented by all franchises.

Requirement 8(3)(d)

* Revise and re-enforce all policies and procedures to ensure that all franchises have implemented effective risk management systems and practices.

# 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**

Requirements 1(3)(d) and 1(3)(e) were found non-compliant following a Quality Review undertaken from 6 December 2022 to 9 December 2022. The Assessment Team’s report for the Quality Review undertaken from 16 June 2023 to 21 June 2023 included some evidence of actions taken by the Provider in relation to the non-compliance and found them to be effectively implemented and embedded. The Assessment Team found the service demonstrated each consumer is supported to take risks and is provided information in a manner which enables them to exercise choice.

Requirement 1(3)(f)

Consumers and their representatives felt that the staff are respectful of consumers’ privacy when providing care and services, however, a staff member advised that although assessment and planning documents are loaded into an electronic database, paper copies of those documents are stored in a filing cabinet which cannot be locked as there is no key. The Provider’s ‘Retention and Disposal of file electronic records procedure’ specifies that all records containing private and confidential information about consumers will be kept in locked cabinets.

In its response to the Assessment Team report, the Provider has stated that it has already rectified the deficits by transferring confidential documents to a locked cupboard whilst securing a locksmith to replace the lock on the original filing cabinet. The Provider’s response includes a plan for continuous improvement (PCI), which includes completion dates for the work.

Having regards to the Assessment Team’s report, comments from the Approved Provider at the time of the audit, the Approved Provider’s written response, the Approved Provider’s obligations under the Aged Care Act and the Aged Care Quality Standards I have reasonable grounds to form the view that the Approved Provider has complied with this Requirement.

The intent of the Requirement expects organisations to make sure communication, behaviour and interaction of the workforce and others does not compromise a consumer’s privacy. I note that since receiving the Assessment Team report, the Provider has acted quickly to secure the documentation pertaining to its clients in the Tasmanian service. When I review the circumstances of the alleged deficit, I have no information to indicate whether the unlocked cabinet was in a public area accessible by any staff member or it was in an office space accessible only by administrative staff. That said I'm of the opinion that the Provider has taken sufficient actions to correct this non-compliance and find ongoing risk to be minimal.

Requirements 1(3)(a), 1(3)(b), 1(3)(c), 1(3)(d) and 1(3)(e)

Consumers and their representatives said they were being consulted and collaborated with to ensure consumers exercise choice and control the services they want. Consumers and their representative said consumers were being treated with respect and valued as individuals by the Provider, with staff describing how they ensure each consumer is treated with dignity whilst respecting their identity.

Consumers confirmed they are listened to by the Provider in relation to what is important to them. Staff also demonstrated an understanding of how to deliver services in relation to the consumer’s needs, goals and preferences to ensure a culturally safe service. The Provider also stated that there is a culturally safe training module available for staff online. However, this is only available to Tasmanian staff.

Consumers felt that the Provider supported their decisions, choices and independence, and provided examples of how this occurs. Staff could also describe how they support consumers and their representatives to exercise choice and make decisions about the consumer’s care. This was also supported by statements from management and the Provider’s policy on assessment and care planning.

Consumers and representatives confirmed the Provider supports them to live their best life by encouraging them to keep independent and be active. Staff could describe how they help consumers to take risks to maintain their independence and to do things that are important to them. Management also explained how they ensure consumers are informed of risks and the possible consequences in making decisions about their care. This procedure is included in the assessment and review process, being a new process that wasn't previously in place. Consumers also receive a risk assessment and acknowledgment form as well.

Consumers and their representatives confirmed they received monthly statements from the Provider detailing how consumers’ budget is spent and noted an improvement in information provided. In addition to this a consumer’s representative commented that they started receiving newsletters from the provider in February 2023, which included different pages of information from other relevant organisations. Management advised that to assist consumers in understanding their budget and monthly statements copies of those documents are provided in the care plan folder with an explanation to assist them in understanding the budget form. If they receive feedback that the actions to date have not been effective in assisting the consumer in understanding the budget a case manager will contact the consumer to explain the statement.

Based on the information summarised above, I find the Provider, in relation to the Service, compliant with all Requirements in Standard 1.

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. | 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. | Non-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**

All Requirements in Standard 2 were found non-compliant following a Quality Review undertaken from 6 December 2022 to 9 December 2022. The Assessment Team’s report for the Quality Review undertaken from 16 June 2023 to 21 June 2023 did not include evidence of actions taken by the Provider in relation to the non-compliance. However, the Assessment Team found improvements were effectively implemented and embedded, and the Provider demonstrated assessment and planning processes to be overall effective in relation to Requirements 2(3)(a), 2(3)(c), 2(3)(d) and 2(3)(e). The Assessment Team was not satisfied improvements were effective in ensuring consumers’ current needs, goals and preferences were identified and addressed, including in relation to advance care and end of life planning, and subsequently assessed Requirement 2(3)(b) as not met.

Requirement 2(3)(b)

The Provider was not able to demonstrate that assessment of planning identifies and addresses consumers’ current needs, goals and preferences. The Provider could not demonstrate that its assessment planning process included advance care planning and end of life planning if the consumer so desired. Staff were able to demonstrate that they knew their customers well. However, care planning documentation showed assessment processes are not consistently and effectively considering consumers current requirements.

* Care planning documentation was not consistent across all the Provider’s sites, with care planning templates differing between Queensland and Tasmania.
* Care planning documentation did not contain information specific to consumers’ needs, goals and preferences, but more generic statements, such as consumer wants ‘to remain in home and maintain as much independence as possible’, and consumer ‘to eat nutritious meals to assist my diabetes and help with wound healing’.
* Advance care planning information is provided to the consumers in their information pack but there is no evidence of advanced care planning completion in the consumers care plans or documentation. The Provider acknowledged feedback from the Assessment Team stating it would be an improvement moving forward for them.

As part of its response to the Assessment Team report the Provider supply a copy of their PCI, which includes planned actions on how deficits would be addressed. These include, but are not limited to, reviewing care and service plans and distributing them to franchise operators, and training for staff and franchise operators. The PCI also states that care and service plan templates have been revised and awaiting circulation to franchise operators, and training has been completed for staff.

Having regards to the Assessment Team’s report, comments from the Approved Provider at the time of the audit, the Approved Provider’s written response, the Approved Provider’s obligations under the Aged Care Act and the Aged Care Quality Standards I have reasonable grounds to form the view that the Approved Provider has not complied with this Requirement.

This Requirement expects organisations do everything they reasonably can to plan care and services that centre on the consumer’s needs and goals and reflect their personal preferences. I find this did not occur, as sampled care plans did not include sufficient detail to guide staff in providing personalised care, including in relation to advance care and end of life care. The Provider acknowledged areas for improvement in assessment and planning processes.

Based on the information summarised above, I find the Provider, in relation to the Service, non-compliant with Requirement 2(3)(b).

Requirements 2(3)(a), 2(3)(c), 2(3)(d) and 2(3)(e)

Consumers and their representatives confirm they are involved in the assessment process and have a say in what care services consumers’ need. The Provider undertakes a range of assessments when a consumer commences services and these are reviewed periodically or when there are changes in the consumer’s circumstances. Sampled care plans showed assessments have been undertaken to identify risks and inform the delivery of care, including in relation to diabetes management, wound care and falls. Staff demonstrated a good understanding and knowledge of the consumers and demonstrated detailed knowledge around strategies to support the consumers’ needs and mitigate risks.

Consumers and their representatives confirmed that they participate in the planning and review of the services consumers’ receive, with coordinators describing how they work in partnership with the consumer, representatives and other organisations such as general practitioners and allied health professionals. Staff also iterated the importance of communicating regularly with consumers regarding any changes to their needs.

Staff have access to consumers’ care plans and another relevant documents via the Provider’s electronic database, with copies of the plans kept in the consumer’s home. Consumers said their services and frequency of those services are explained to them when they start with the Provider or when change is to occur. Staff said consumers care and services plans have all the information they need to provide services in line with consumers’ preferences.

Consumers and their representatives said that staff regularly communicate with them about the services consumers receive and before making any changes to meet their current needs. Consumer care plans showed reviews were being made on a regular basis or when circumstances changed. Coordinators also explained that care plans were reviewed every 3 to 6 months, or as required, in response to a change or identified risk. Staff gave examples of where they had contacted the coordinator due to concerns about a consumer.

Based on the information summarised above, I find the Provider, in relation to the Service, compliant with Requirements (3)(a), 2(3)(c), 2(3)(d) and 2(3)(e).

# 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. | 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**

Requirements 3(3)(a), 3(3)(b), 3(3)(d), 3(3)(e) and 3(3)(f) were found non-compliant following a Quality Review undertaken from 6 December 2022 to 9 December 2022. The Assessment Team’s report for the Quality Review undertaken from 16 June 2023 to 21 June 2023 did not include evidence of actions taken by the Provider in relation to the non-compliance. However, the Assessment Team found improvements were effectively implemented and embedded, and the Provider demonstrated each consumer receives safe and effective care that meets their needs, goals and preferences and optimises their health and well-being.

Consumers and their representatives reported that the clinical care consumers receive is tailored to their needs and the service is flexible in the delivery of that care. Staff providing personal and or clinical care had a good understanding of each consumer's needs relating to the delivery of that care. Consumers and their representatives also stated that the staff knew what they were doing and consumers felt safe and supported. Care planning documentation provided enough detail for consumers current personal and clinical care needs for staff to deliver both services safely.

The Provider has processes in place to identify and monitor risks such as falls, wound care, diabetes management and cognitive decline with the view of minimising risks. Staff could describe documentation, including identification of all risks who they provide services to on a regular basis.

While consumers and their representatives did not specifically talk about end of life care, they described how the care and services maximises consumers’ quality of life and dignity. Coordinators describe the way current services are adjusted for consumers nearing end of life, including conversations with representatives, doctors and other medical professionals. Care documentation along with the staff interviews demonstrated that the provider has appropriate processes in place to identify support consumers nearing end of life.

Care documentation showed the Provider has processes in place to support staff to identify and notify others of changes in a consumer’s condition. Consumers and their representatives also confirm that this is the case. Where consumers have experienced deterioration or a change in their condition it was confirmed that this was reported and followed up with appropriate referrals arranged as required.

Consumers and their representatives report that staff know consumers’ needs as they are generally the same staff member providing the care services. Staff confirmed there is a care plan in the consumers home that they can refer to if needed. Staff also said they use an application on their phone to review care plans and record progress notes. Staff could describe the processes for referring consumers to other organisations who provide care services and care planning documentation demonstrates that referrals are being made to allied health professionals when appropriate and in a timely manner. Consumers and representatives said they are satisfied with the level of services delivered by others involved in consumers’ care.

Consumers and their representatives have stated that they have been kept up to date by the Provider in relation to COVID-19 and any impact that this had on the services consumers’ receive. Staff also demonstrated that they understand practical ways to minimise the transmission of infection and provided examples, including following the infection control policy, screening process prior to undertaking service with the consumer, practising regular hygiene and wearing personal protective equipment.

Based on the information summarised above, I find the Provider, in relation to the Service, compliant with all Requirements in Standard 3.

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

**Findings**

Requirements 4(3)(a), 4(3)(d) and 4(3)(e) were found non-compliant following a Quality Review undertaken from 6 December 2022 to 9 December 2022. The Assessment Team’s report for the Quality Review undertaken from 16 June 2023 to 21 June 2023 included some evidence of actions taken by the Provider in relation to the non-compliance. The Assessment Team found improvements were effectively implemented and embedded, and the Provider demonstrated safe and effective services and supports for daily living are provided that optimises consumers’ independence, health, well-being and quality of life.

Consumers and their representatives confirmed that the Provider was providing them with effective services and supports to allow consumers to remain in their home whilst maintaining independence and quality of life. Care staff could also describe the individual needs, goals and preferences for the consumers they care for. Management said they review services and supports provided to consumers every six months, to ensure consumers’ independence and quality of life is optimised. Management also stated that it was the role of the newly appointed Lifestyle Concierge for Tasmania to contact consumers monthly by way of phone call or by visiting them. Where an incident occurs involving a consumer, the Provider will undertake a review of the services to ensure they are still fit for purpose.

The Provider demonstrated that care and services for spiritual and emotional support were being provided to consumers to complement their daily living. Consumers and their representatives felt care staff would recognise if consumers were feeling low. A representative for one consumer provided an example of when a carer recognised their parent was very anxious and phoned them to let them know. This approach to providing emotional, spiritual and psychological well-being to consumers is reflected in the consumer’s care planning documentation.

Consumers and their representatives stated that they are being given the opportunity to build and maintain relationships, to pursue activities of interest to them and participate in their community. One consumer provided an example of how staff take them for a walk to feed the birds and that they attend bus trips. Care staff were able to describe how they provide social support, including taking consumers out shopping or to appointments. Care planning documentation contained information on important people and relationships in consumers’ lives as well as the consumers individual interests and preferred activities.

Consumers and their representatives stated that staff have a good knowledge of consumers’ care and service needs. They also felt staff are well informed, as this information does not need to be repeated to new staff. One consumer said when staff attend their home, they always check to ensure they’ve had their medicine and the support worker then cross checks that those days as they are marked out. One representative said all information about the consumers’ care and service needs are in a folder and staff will ring if they’re unsure.

Care staff stated they were satisfied with the information they receive in order to identify consumers’ conditions, needs or preferences. Where responsibility for consumers’ care is shared, the Provider explained that franchise partners are logging incidents through their system which was demonstrated to the Assessment Team. Brokered partners who are not part of the franchise group receive consumers care plans electronically.

Consumers and their representatives acknowledge the Provider is supportive in connecting consumers with other services and supports. The Provider stated that it has quite a few clients that go to respite centres. Care planning documentation showed referrals to other organisations occur for consumers to support their social connections and well-being. The referrals cover a range of lifestyle areas, including massage, home modifications, equipment and safety products, meal delivery and gardening.

The Provider demonstrated that where it provided equipment to consumers, it was safe, suitable, clean and well maintained. This was confirmed by consumers and their representatives. The Provider described how consumers equipment needs are assessed based on reviews or discussion with consumers and occupational therapists.

Based on the information summarised above, I find the Provider, in relation to the Service, compliant with all Requirements in Standard 4.

# 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**

The Quality Standard for Home Care Packages service was not assessed as the Provider does not provide a service environment and therefore Standard 5 is not applicable.

# 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**

Requirements 6(3)(a), 6(3)(c) and 6(3)(d) were found non-compliant following a Quality Review undertaken from 6 December 2022 to 9 December 2022. The Assessment Team’s report for the Quality Review undertaken from 16 June 2023 to 21 June 2023 included some evidence of actions taken by the Provider in relation to the non-compliance. The Assessment Team found improvements were effectively implemented and embedded, and the Provider demonstrated they regularly seek input from consumers, carers, the workforce and others, and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

All consumers and their representatives said they feel supported and understand how to give feedback and make a complaint. They said they have the relevant contact information to make a complaint, the service seeks feedback via surveys, and feedback is encouraged. They also said they felt comfortable in raising any complaints or providing feedback, and that staff are approachable. The Provider also demonstrated that it supported consumers to make complaints and provide feedback about their care and services. Information in the relation to feedback and complaints is listed in the care plan folder and the HCP programme client handbook which is provided to each client by every franchise office nationally.

The Provider was able to demonstrate consumers are made aware of and have access to advocates and language services for raising and resolving complaints. While consumers and their representatives could not recall whether they received information on their right to access advocacy services and other methods of raising complaints, the Provider stated and documentation showed consumers are informed about internal and external complaints and advocacy services in the HCP programme client handbook.

Three consumers and representatives were satisfied their complaints had been satisfactorily resolved. While staff were unable to describe the concept of open disclosure, they demonstrated it was practiced through their examples of actions taken in response to a complaint. The Provider stated and documentation showed franchise partners feed complaints information into their complaint system. A complaints register is maintained, which showed complaints are logged, prioritised, time lined, escalated (if appropriate) and actioned in a timely manner.

Consumers and their representatives said the Provider seeks feedback to see if they can improve services, with service improvement suggestions being sought through consumer surveys and verbally during care planning meetings. The Provider explained that from its complaint data analysis, trends in relation to finances/statements and communication on shift changes with consumers were noted. Changes were implemented to address the identified issues. Further to this the governing body convene monthly and review reports on complaints management.

Based on the information summarised above, I find the Provider, in relation to the Service, compliant with all Requirements in Standard 6.

# 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. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

**Findings**

Requirements 7(3)(c), 7(3)(d) and 7(3)(e) were found non-compliant following a Quality Review undertaken from 6 December 2022 to 9 December 2022. The Assessment Team’s report for the Quality Review undertaken from 16 June 2023 to 21 June 2023 included some evidence of actions taken by the Provider in relation to the non-compliance. The Assessment Team found improvements were effectively implemented and embedded, and the Provider demonstrated human resource processes to be overall effective in relation to Requirements 7(3)(c) and 7(3)(e). The Assessment Team was not satisfied improvements were effective in ensuring the workforce is recruited, trained, equipped and supported to deliver these Standards, and subsequently assessed Requirement 7(3)(d) as not met.

Requirement 7(3)(d)

The Provider was unable to demonstrate that its workforce is consistently recruited, trained, equipped and supported to deliver all the outcomes required by these Standards. Although the Provider has implemented considerable infrastructure and appointed new staff with the view of working towards consistent practices in the induction and training of new staff, gaps had been identified in the delivery of this strategy. The Provider gave details of a national ‘train the trainer’ program being rolled out to franchisees and senior staff across the organisation.

However, when reviewing the Provider’s training matrix it was identified that a significant number of staff are not completing the mandatory training in timely manner. Several staff commented about the lack of induction and training when commencing in their own positions along with a lack of clarity around the expectations of their specific role. While there are procedures in place for the induction of new support staff, these were found not to be applied consistency for all new appointments, with some support workers delivering services to consumers before they had completed the appropriate induction and training.

As part of its response to the Assessment Team report, the Provider supplied a copy of its PCI, which details actions taken to address the identified deficits. These include, but are not limited to, identifying relevant staff and removing them from the roster until they have completed mandatory training, supporting staff in understanding expectations of their roles, and providing staff education, training and orientation.

Having regards to the Assessment Team’s report and the Provider’s written response, I have reasonable grounds to form the view that the Provider has not complied with this Requirement.

I have considered the intent of this Requirement, which expects providers to support the workforce in their day-to-day practice to protect against risk and improve the care outcomes for consumers. It also expects the organisation to ensure workforce induction prepares members of the workforce for their role and ongoing support is provided by way of supervision, training and professional development. I find this did not occur, as staff had not consistently completed mandatory training or induction.

I acknowledge actions taken by the Provider to address deficits identified by the Assessment Team, however, there was no evidence demonstrating these actions are effectively embedded into organisational processes.

Based on the information summarised above, I find the Provider, in relation to the Service, non-compliant with Requirement 7(3)(d).

Requirements 7(3)(a), 7(3)(b), 7(3)(c) and 7(3)(e)

Consumers and their representatives stated that they receive a regular schedule of services and that this is met at all times. If a regular care worker is not available, the Provider will advise the consumer in advance and offer the opportunity to reschedule or continue with their replacement carer. Management stated that there had been no unfilled shifts across the service in the last month and this was generally the case. Management also said strategies are in place to ensure continuity of care if unexpected absences occur.

Consumers and their representatives provided predominantly positive feedback in relation to workforce interaction. Information and evidence in the Assessment Team’s report under Requirement 1(3)(a) includes examples from consumers of how staff are kind, caring and respectful. Staff members could demonstrate a strong understanding of requirement to treat all consumers respectfully and equally.

The Provider stated that it had appointed several key staff members which included a new clinical specialist Registered Nurse and a new Case Manager with significant experience in age care. The Provider asserts that feedback from consumers, their representatives and support workers was very positive in relation to these new appointments. In particular the appointment of a specialist Quality Manager to oversee the wider organisational governance and to work with franchisees across the country. Support workers could demonstrate they had successfully completed first aid training and describe the processes for identifying and reporting of vulnerable consumers, changes in conditions, incident management, and other matters that required escalation. Examples of positive outcomes for consumers, as evidenced in the Assessment Team’s report under Standards 1, 2, 3 and 4, supports that the workforce is competent and has the qualifications and knowledge to effectively perform their role.

The Provider demonstrated that they had processes in place to ensure the regular assessment, monitoring and review of staff performance. An examination of records held by the Provider confirmed that each support worker had an up-to-date performance review and that these are scheduled annually. The Provider asserted that it took a holistic approach to reviewing staff performance, where consumer feedback and incident reporting along with observed shifts and staff training needs are all combined to identify the areas for staff development.

Based on the information summarised above, I find the Provider, in relation to the Service, compliant with Requirements 7(3)(a), 7(3)(b), 7(3)(c) and 7(3)(e).

# 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. | Non-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. | Non-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**

All Requirements in Standard 8 were found non-compliant following a Quality Review undertaken from 6 December 2022 to 9 December 2022. The Assessment Team’s report for the Quality Review undertaken from 16 June 2023 to 21 June 2023 included some evidence of actions taken by the Provider in relation to the non-compliance. The Assessment Team was satisfied improvements were effectively implemented and embedded, and the Provider demonstrated organisational governance processes to be overall effective in relation to Requirements 8(3)(a), 8(3)(b) and 8(3)(e). The Assessment Team was not satisfied improvements were effective in ensuring organisation wide governance and risk management systems were effective, and subsequently assessed Requirement 8(3)(b) as not met.

Requirement 8(3)(b)

The Assessment Team was satisfied the organisation’s governing body promotes a culture of safe, inclusive and quality care and his encounter is accountable for the delivery of those services. However, information and evidence in the Assessment Team’s report under Standard 8, contradicts this assessment. This information and evidence are as follows:

* Under Requirement 8(3)(c), management said all franchise operators are not consistently reporting feedback outcomes to the governing body. Sampled reports to the governing body showed some franchise operators are reporting zero feedback on monthly reports, which is inconsistent with other data across the organisation.
* Under Requirement 8(3)(d), management said there is minimal feedback about allegations of abuse or neglect of consumers being provided by franchise operators, making it difficult to be certain that there are none. Furthermore, reports to the governing body showed a number of franchise operators are not consistently reporting risks to consumers.

As part of its response to the Assessment Team report, the Provider supplied a copy of its PCI, which details actions taken and/or planned to address the identified deficits. These include, but are not limited to, strengthening monitoring of franchise operators and reporting on their performance, and updating care and service plans.

Having regards to the Assessment Team’s report and the Provider’s written response, I have reasonable grounds to form the view that the Provider has not complied with this Requirement.

I have considered that reporting processes from the franchise operators to the governing body are not sufficient to ensure the governing body is aware of and accountable for the delivery of care and services. Franchise operators are not consistently reporting on feedback and complaints, allegations of abuse and/or neglect, and risks to consumers, all of which does not enable the governing body to be aware of trends and ensure consumers are receiving safe and effective care and services.

Based on the information summarised above, I find the Provider, in relation to the Service, non-compliant with Requirement 8(3)(b).

Requirement 8(3)(c)

While the Assessment Team was satisfied the service demonstrated an effective organisation wide governance system in relation to financial governance, they were not satisfied the organisation’s governance systems were effective in relation to information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints. The Assessment Team provided the following evidence relevant to my finding:

* Information management
  + Consumers reported that they are receiving a regular schedule of services that are to be provided.
  + Sampled care plans contained up-to-date and relevant information, which also included updated case notes all of which are available at the point of service.
  + Information and evidence in the Assessment Team’s report under Standards 3 and 4 demonstrates care plans are available to those responsible for consumers’ care and staff have access to policies, procedures and guidance material via the organisation’s intranet page.
* Continuous improvement
  + The Provider maintains a continuous improvement plan.
  + The board of directors convene monthly to review the organisation’s plan for continuous improvement.
* Financial governance
  + Consumers confirmed that statements and invoices are received regularly and are easy to follow and understand.
  + The Provider manages accounts for the whole organisation.
  + Minutes of board meetings show regular oversight of all financial matters.
* Workforce governance, including the assignment of clear responsibilities and accountabilities
  + The Provider has undertaken a review of all induction training and performance mechanisms, however, it had not been able to affectively deliver these strategies in a consistent manner at this point in time.
  + Several staff members reported gaps in induction processes and training records show that not all training is being undertaken by all staff in a timely manner. Other staff members reported a lack of clarity around administered roles and where responsibilities lie within the organisation.
* Regulatory compliance
  + The Provider maintains current information regarding legislative guidelines and changes, which is shared across the organisation and it was able to demonstrate that training is provided to all its franchises in relation to regulatory compliance, with training including the Aged Care Code of Conduct, the Age Care Quality Standards, the Serious Incident Response Scheme, and mandatory requirements for the screening of new staff members.
  + The Provider was not able to demonstrate that all regulatory guidelines and requirements are being practised consistently across the entire organisation.
* Feedback and complaints
  + The Provider has implemented a feedback and complaints infrastructure and when complaints are received, appropriate action is taken in a timely manner to address those complaints. The Provider maintains an up-to-date open disclosure policy and provides training on this subject for staff. Consumers confirmed that they are encouraged to provide feedback and given information on how to do this including to external organisations.
  + Management raised concerns that not all franchises are consistently reporting feedback and outcomes to the governing body. The feedback and complaints report indicates some franchises are consistently reporting zero feedback on monthly reports, which is inconsistent with other data across the organisation.

As part of its response to the Assessment Team report, the Provider supplied a copy of its PCI, which details actions taken and/or planned to address the identified deficits. These include, but are not limited to, simplifying communication reports, restructuring key performance indicators for franchise operators and applying penalties for failure to rectify issues, regular reporting of franchise operators, supporting staff in understanding expectations of their roles, and providing staff education, training and orientation.

Having regards to the Assessment Team’s report and the Provider’s written response, I have reasonable grounds to form the view that the Provider has not complied with this Requirement.

I have considered there is no evidence demonstrating governance systems relating to information management are ineffective. While the Assessment Team noted a lack of evidence demonstrating good information management practices were not consistent across the organisation, there was no evidence to support this assertion. I have placed weight on evidence in Standards 3 and 4 showing care plans are available to those responsible for consumers’ care and staff have access to policies, procedures and guidance material via the organisation’s intranet page.

In relation to continuous improvement, I have considered the organisation has some governance structures in place, such as a PCI and processes for reporting to the governing body. I have also considered the significant improvements implemented in response to the finding of non-compliance following the Quality Review undertaken from 6 December 2022 to 9 December 2022. However, the PCI included in the Provider’s response shows improvements only in response to deficits identified by the Assessment Team, rather than those that have been self-identified. As a result, I am not satisfied that robust continuous improvement systems have been effectively embedded.

I have considered the organisation’s workforce governance systems were ineffective in ensuring the organisation supports and develops its workforce to deliver safe and quality care and services. While induction and training supports are in place, the Provider did not monitor attendance and ensure it was consistently undertaken.

I have considered the intent of the Requirement in relation to regulatory compliance, which requires organisations to ensure systems and processes are in place to understand and comply with all relevant legislation, regulatory requirements, professional standards and guidelines. Evidence in the Assessment Team’s report shows the organisation maintains information on regulatory guidelines and disseminates to franchise operators. While the Assessment Team asserted the Provider could not demonstrate regulatory obligations are consistently practiced across the organisation, there was no evidence to support this assertion.

In relation to feedback and complaints, I have considered that while the organisation has processes to record, action, analyse and trend complaints, not all franchise operators are consistently logging complaints. As a result, the organisation is unable to effectively demonstrate a best practice feedback and complaints system is in place.

Based on the information summarised above, I find the Provider, in relation to the Service, non-compliant with Requirement 8(3)(c).

Requirement 8(3)(d)

While the Assessment Team was not satisfied the service demonstrated effective risk management systems and practices in relation to managing high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers, supporting consumers to live the best life they can, and managing and preventing incidents, the Assessment Team provided the following evidence relevant to my finding:

* Managing high impact or high prevalence risks associated with the care of consumers
  + Management and staff were able to describe dignity of risk and are engaging appropriate risk assessment tools when undertaking consume assessments
  + Reports for the board from across the organisation indicates that a number of franchisees and not consistently reporting consumer risks.
* Identifying and responding to abuse and neglected consumers
  + Training has been undertaken across all levels of staff in relation to the identification and appropriate practice in responding to abuse and neglect.
  + Staff provided an example of a situation where potential abuse of a consumer was identified. Staff said and documentation showed, the alleged abuse was reported to local police and an investigation was undertaken.
  + The organisation has appointed a Lead Lifestyle Concierge to work directly with vulnerable consumers and maintain oversight of their care and services.
  + While management stated that there are no current allegations of abuse or neglect involving consumers within its group, however, due to the minimal feedback being provided by some franchises within the group it is difficult to determine if this is an accurate depiction of the prevalence of this type of situation.
* Supporting consumers to live the best life they can
  + The Approved Provider has revised and improved its risk management procedures to include a dignity of risk process for all consumers to identify any risk they wish to engage in and allow the Provider to support them in making an informed decision about this risk.
  + Updated care planning documents and procedures has enhanced the capability of staff to assist consumers to live their best life. However, it has been determined that consumer goals and preferences are not consistently being identified and addressed and therefore allowing consumers gain maximum benefit to live the best life.
* Managing preventing incidents including the use of an incident management system
  + The Provider was able to demonstrate that it has made significant improvements to its incident management systems and procedures. However, whilst the governing body has visibility and can ensure appropriate management of those instances that are reported evidence from the reports indicates that not all instances are being captured or reported from all service sites.

As part of its response to the Assessment Team report, the Provider supplied a copy of its PCI, which details actions taken and/or planned to address the identified deficits. These include, but are not limited to, strengthening monitoring of franchise operators and reporting on their performance, and updating care and service plans.

Having regards to the Assessment Team’s report and the Provider’s written response, I have reasonable grounds to form the view that the Provider has not complied with this Requirement.

I have considered the intent of the Requirement which expects organisations to have systems and processes that help them identify risks to the health, safety and well-being of consumers, identify and evaluate incidents and near-misses, protect and safeguard vulnerable consumers, and reduce the impact of risks to consumers. While the Provider demonstrated some improvement in risk management systems and processes, these improvements have not been effectively embedded across the organisation, as franchise operators are not consistently reporting consumer risks or logging incidents.

Based on the information summarised above, I find the Provider, in relation to the Service, non-compliant with Requirement 8(3)(d).

Requirement 8(3)(a) and 8(3)(e)

The Provider was able to demonstrate that it engages and supports consumers in the development, delivery and evaluation of care and services. This Requirement has been enhanced by the recent establishment of several subcommittees which feed into the Office of the Provider and includes a consumer advisory and reference committee. When fully staffed the committee will be made up of clinical staff, industry experts and consumers of the service and will provide direct input to the board to give insight into issues and the lived experiences of consumers. The Provider also supplies feedback forms to consumers as well as information in relation to how to provide feedback to this service and to external organisations such as the Aged Care Quality and Safety Commission.

Through its clinical governance committee which includes the Provider’s Registered Nurse and senior management, the Provider was able to demonstrate that it has a suitable clinical governance framework for the provision of safe and appropriate clinical care to its consumer base. The committee reviews all clinical matters and takes anything that requires escalation to the board for consideration and recommendation. The Provider supplies all appropriate care staff with clinical guidebooks to detail many common clinical care activities to guide the staff at the point of care, and has a suite of clinical governance policies and guidelines in place. Clinical staff were able to quickly direct the Assessment Team to where these policy documents are held and were able to talk to how these translate into practice.

Based on the information summarised above, I find the Provider, in relation to the Service, compliant with Requirements 8(3)(a) and 8(3)(e).

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