**Performance**

**Report**

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| Name: | Sri Om Care |
| Commission ID: | 201359 |
| Address: | 39-41 Clower Avenue, ROUSE HILL, New South Wales, 2155 |
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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: 9327 Sri Om Foundation Limited  
Service: 27058 Sri Om Foundation Limited

**This performance report**

This performance report for Sri Om Care (**the service**) has been prepared by Gill Jones, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Quality Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 8 February 2024.

# 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 | **Not Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Not applicable** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

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

# Areas for improvement

Areas have been identified in which **improvements must be made to ensure compliance with the Quality Standards**. This is based on non-compliance with the Quality Standards as described in this performance report.

*Requirement 2(3)(a)*

Ensure assessment and planning processes including consideration of risks to the consumer’s health and well-being to inform the delivery of safe and effective care and services.

*Requirement 7(3)(d)*

Ensure staff are trained, recruited ,equipped and supported to perform their roles in order to deliver safe, quality care.

*Requirement 8(3)(b)*

Ensure the governing body promotes a culture of safe, inclusive and quality care and is accountable for the care delivered.

*Requirement 8(3)(c)*

Ensure effective organisation wide governance systems relating to information management, continuous improvement, workforce governance, regulatory compliance and feedback and complaints.

*Requirement 8(3)(d)*

Ensure effective risk management systems and practices including managing high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect of consumers, managing risk to support consumers to live the best life they can and managing and preventing incidents through the use of an 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

Overall consumers and representatives said they were treated with dignity and respect and their culture and diversity was valued. In interviewing care workers and other staff, it was evident they treated consumers with dignity and respect and responded to a consumer’s culture and diversity. A lack of documentation regarding the culture and diversity needs of consumers was identified by the Assessment Team, however, care workers were able to talk to the specific cultural and diversity needs of consumers and interviews with consumers and representatives indicated these needs were being met.

Consumers and representatives interviewed about cultural safety were satisfied the supports and services they are receiving are culturally safe. Care workers and care coordinators could speak to the specific cultural safety requirements of consumers. There was a lack of documentation in the care plan about supports being provided however, care workers could talk about the individualised culturally safe supports and services they provided and consumers and representatives verified these supports and services were being provided.

Overall consumers and representatives interviewed were satisfied they were supported to exercise choice and independence and develop and maintain relationships. Most consumers and representatives interviewed stated they had been included in an assessment when they commenced services and had been included in the development of a care plan. Care coordinators and care workers spoke of how they support consumers to make choices and be independent. Documentation was lacking as care plans do not always include the individual and specific supports and services consumers and representatives have been involved in deciding on.

Interviews with consumers and representatives did not identify consumers who had wanted to take risks to enable them to live the best life possible but staff demonstrated an understanding of the concept and are guided by a policy on dignity of risk.

Overall consumers and representatives were satisfied with the way information is provided to them and how communication occurs. All consumers and representatives interviewed about the home care agreement and monthly budget statement said both were easy to follow and they understood them. Case workers, care coordinators and managers provided examples of how they ensure information provided to consumers is accurate and timely and how they communicate in a way consumers can understand and exercise choice.

Through interviews with consumers, representative and care workers, it was evident that consumer’s privacy is respected, and personal information is kept confidential. Some anomalies were noted regarding the home care agreement and its alignment with the Privacy Act (1988) which management agreed to address by February 2024.

The Approved Provider provided a comprehensive continuous improvement plan in response to the Assessment Team’s report. This plan shows that management intend to provide staff training on person centred practices and review the policies which guide staff practice as well as address the lack of detail in care planning documentation by April 2024.

The Approved Provider also intends to develop a supported decision making policy to guide staff practices in relation to supporting consumers to take risks to live their best life. The risk management tool used to identify risks will be updated and staff training conducted regarding how to use both the updated tool and the new policy in supporting consumers to take risks by June 2024.

I have also considered the information in the Assessment Teams report and the Approved Provider’s response to the deficits identified in care documentation in making my decision in relation to compliance. I have also considered whether the lack of detail in consumer care documentation has impacted consumer’s care and I am satisfied that it has not because staff know the consumer’s needs and are delivering care in line with these. I will consider this issue further in Standard 8 in relation to information management and risk management.

I find six of the six requirements in Standard 1 compliant.

# 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. | Not Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

Consumers and representatives interviewed said they were satisfied with the assessment and planning process and that it met their needs. Information in the Assessment Teams report demonstrates that assessment and planning processes do not consider all health-related risks to the consumer to guide the delivery of safe and effective care. Whilst the service uses a range of risk screening tools, as appropriate, to assess and plan care based on the consumer’s need, validated assessment tools are not used to assess risks associated with the consumer’s clinical care needs, for example, falls risk. The service does not have policies and procedures to guide staff practices with regard to assessing risk to inform effective care planning, including making referrals for further clinical assessment. Without comprehensive assessments being completed using validated assessment tools where needed, I am not satisfied that all possible risks to the consumer’s health and well being have been identified to guide care workers in the delivery of safe and effective care.

Furthermore, assessments completed were not always fully comprehensive resulting in assessment and care planning documentation not fully reflecting risks identified with the consumer’s care. These assessments were not always being uploaded into the consumer’s electronic record. Risk management strategies observed in several care plans were generated by a systems alert using generic templates within the information system. Due to their generic nature these strategies were not individualised and informed by assessment of the consumer or any medical directives. In some instances the risk mitigation strategies contained within the consumer’s care documentation were incorrect posing a risk to the consumer if followed.

Whilst there was no immediate impact for consumers as a result of care planning information containing limited and/or inaccurate information I am not satisfied that assessment and planning processes and the care documentation developed post assessment is informing the delivery of safe and effective care and services.

The Approved Provider provided a comprehensive continuous improvement plan in response to the Assessment Team’s report. This plan shows that management intend to revise the assessment tools currently in use, and ensure all assessments completed are uploaded into each consumer’s records. Management intend also to undertake a review of the care plans cited by the Assessment Team where inaccurate information was noted and develop care planning policies and procedures that guide staff practices in effective assessment and planning. These activities are due to be conducted between March and May 2024. There is a significant amount of work to be completed by the Approved Provider and it will take time to embed the changes. I find Requirement 2(3)(a) not compliant.

Overall assessment and planning identifies and addresses the consumer’s current needs, goals, and preferences. Consumers confirmed their goals had been discussed with them and care provided met their goals, needs and preferences. Whilst care documentation did not contain individualised goals it contained goals related to using the home care package funding to meet the consumer’s needs. As previously identified in Standard 1, whilst care planning documents did not contain the cultural needs and preferences of consumers staff interviewed demonstrated they knew the needs of consumers. Whilst there was not strong evidence that advanced care planning was routinely being considered during assessment and planning processes consumers did not raise this as an issue for them. Management informed that they have recently drafted an advanced care planning policy which will be incorporated into care planning processes. In the comprehensive continuous improvement plan provided by the Approved Provider in response to the Assessment Team’s report, the Approved Provider provided a timeframe of April 2024 for incorporating the advanced care planning policy into care planning processes and stated they also intend to provide additional training for staff in initiating discussion of advanced care planning with consumers. The provider also intends to audit care plans to address the deficits identified.

I have also considered the information in the Assessment Teams report and the Approved Provider’s response to the deficits identified in care documentation in making my decision in relation to compliance. I have considered whether the lack of detail in consumer care documentation has impacted consumer’s care and I am satisfied that it has not. Consumers are satisfied because staff know their goals, needs and preferences and care is delivering care in line with these. There appeared to be no impact for consumers as a result of deficits identified in documenting their needs, goals and preferences and advanced care planning needs. I will consider this issue further in Standard 8 in relation to information management and risk management.

The service demonstrated assessment and planning is performed in partnership with the consumer and those they wish to be involved in their care, including family and friends, brokered allied health providers and medical practitioners. Consumers and representatives said they are very involved in planning their care, and care documentation reflected this involvement in progress notes. Involvement of external medical and allied health providers was also evident in assessment and planning documentation. As a quality improvement measure the Approved Provider stated that they will be reviewing their policies and procedures to ensure partnering with consumers is incorporated into care plans.

Consumers and representatives were satisfied assessment and planning information was explained to them and confirmed a copy of the care plan is available to them. Case managers confirmed that the outcomes of assessment and planning activity are discussed with consumers and a copy of the initial care plan provided to them with further updates provided as needs change. The level of detail in assessment and planning documentation is insufficient however, and, as previously outlined, this will be considered in Standard 8 in relation to information management and risk management.

Consumers and representatives interviewed said the service regularly communicates with them about their care and services, seeks feedback, and makes changes when circumstances or consumer needs change or if there has been an incident. Consumers confirmed the service formally reviews care plans and conducts annual reviews. This was confirmed by care staff and in documentation reviewed. In the continuous improvement plan submitted by the provider they intend to update their care planning policy to incorporate guidance in ensuring care plans are updated as needs change and reviews conducted routinely every six months from July 2024 to ensure care plans are current.

I find four out of the five requirements in Standard 2 compliant. I find Requirement 2(3)(a) Not Compliant.

# 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

Consumers and representatives interviewed confirmed personal care services were tailored to their needs, delivered safely, and optimised their health and well-being. Clinical care is currently not being provided to consumers. Documentation reviewed demonstrated that the consumer’s personal care requirements were not sufficiently detailed in their care plan but broad instructions were provided to care workers. This lack of detail did not seem to be impacting care provided to consumers. Care workers interviewed said they provide safe and appropriate personal care by following care alerts and task instructions in the mobile phone application, seeking feedback from the consumer, and tailoring care to their needs and wishes. Care workers complete notes at the end of each service and escalate any concerns. Care documentation showed evidence of management monitoring the health and wellbeing of consumers and care provided by reviewing worker feedback. In the plan for Continuous Improvement submitted by the Approved Provider they undertook to conduct staff training and introduce a proforma to improve staff practices in relation to documentation.

Falls, isolation, and nutrition were identified by management as the main high-impact or high-prevalence risks experienced by consumers. Consumers and representatives interviewed expressed confidence that risks associated with their care are managed well and they did not raise any concerns. As previously discussed in Standard 2 the service is not using validated assessment tools to assess for falls risk but alerts are in place to advice care workers when a falls risk is present, they have been trained in falls management and generic falls management strategies are in care planning documentation. However, the service does not use best practice guidelines and decision-making tools to manage high-impact or high-prevalence risks. There are no policies and procedures, clinical workflows or best practice guidelines to guide staff in assessing and managing high-impact or high-prevalence risks. The service does not routinely analyse and report on incident trends to proactively manage high-impact or high-prevalence risks. The service does not inform the workforce about best practice standards for managing high-impact or high-prevalence risks. Training is minimal and not planned. These issues will be considered in Std 8. In relation to this requirement, the Assessment Team did not identify any consumers whose care was not being managed appropriately in relation to managing high impact high prevalence risks therefore I am satisfied that this requirement is compliant.

In their response to the Assessment Teams report the approved provider intends to introduce a validated falls risk assessment tool and develop a falls risk Identification and management policy and introduce training for staff covering key risks including dementia, falls, restrictive practices. The provider also intends to develop and implement an effective risk management system which will enable the analysis of incident trends to enable the effective management of high impact, high prevalence risks to consumers.

The service does not currently or regularly manage the needs of consumers who are palliative or nearing end of life care. Generally, the service has not worked with local palliative care teams but will assist families in sourcing nursing services, if requested. The service has a palliative care policy dated January 2022 and palliative care procedures were observed in a draft Clinical Manual. In their response to the Assessment Teams report the approved provider intends to review their policies and procedures on palliative care against best practice, introduce staff training and develop a policy on end of life care.

Consumers and/or representatives interviewed expressed confidence that the service and all staff would quickly identify and respond to consumer deterioration or change. Care workers interviewed demonstrated knowledge of their responsibilities in reporting consumer deterioration or change to the case manager or manager immediately, calling emergency services if needed and completing an incident report as appropriate. Care documentation sampled demonstrated that changes in a consumer’s health or abilities are reported through care worker feedback, documented, and actioned.

Consumers and representatives interviewed expressed satisfaction that the consumers’ condition, needs, and preferences are well communicated across the service and with others, as necessary. Consumer care information is available for staff through an online information management system and daily meetings occur to discuss current consumer needs and health conditions, and any changes are communicated to care workers. Care workers confirmed they receive sufficient information to perform their roles adequately.

Consumers and representatives interviewed said they are satisfied that, when needed, the service assists them with timely referrals to appropriate individuals involved in their care. Case managers were able to demonstrate they have a small provider network of physiotherapists and podiatrists they refer to as well as to My Aged Care when a review of the home care package level was required. One referral was not timely due to staff oversight but otherwise all referrals were timely. In their response to the Assessment Teams report the approved provider intends to develop a referral pathway policy and referral pathways.

Consumers and representatives interviewed were satisfied with the measures taken by all staff to protect them from infection. Staff interviewed demonstrated their knowledge of infection control practices. The service does not have a policy on infection control but has one on antimicrobial stewardship. In their response to the Assessment Teams report the approved provider intends to develop policies and procedures on infection control and deliver staff training on this topic including antimicrobial stewardship.

I find seven of the seven requirements in Standard 3 compliant.

# 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

Overall consumers and representatives were satisfied the care and services being received were safe and effective for daily living. Care workers and care coordinators were aware of the services and supports for daily living consumers required, even though they were not well documented in the care plan. As in Standard 2, consumer goals and the services and supports consumers had agreed to being provided were largely generic. Staff indicated their lack of knowledge in how to record consumer goals in care documentation.

Overall consumers and representatives were satisfied the services and supports provided promoted emotional, spiritual, and psychological well-being. Whilst there were gaps in the documenting of these supports care workers could describe the services and supports they provided that promote emotional, spiritual, and psychological well-being.

Overall consumers and representatives were satisfied the services and supports provided for daily living assisted them/the consumer to be part of the community, develop relationships, and participate in activities they were interested in. Despite care documentation lacking detail, care workers and care coordinators could describe how they provided these supports and services.

Information about the consumer’s condition, needs and preferences was communicated verbally and through an app between managers, care coordinators and care workers. Whilst not always documented fully in care documentation care workers knew what daily living supports and services they were to provide. Given levels of consumer satisfaction there appears to be no impact to consumers from the deficits identified in care documentation.

In response to the Assessment Teams report the Approved Provider has undertaken to audit all care files to ensure gaps in documentation are addressed and provide training to staff on recording goals in care planning documentation.

The service has not needed to refer consumers to other organisations and providers of other care and services, other than for some allied health services as discussed in Standard 3. Consumers did not raise lack of referral this as an issue for them.

Meals are provided at the day centre which provides social support. The meals provided are varied and of a suitable quality and quantity.

Consumers have purchased equipment through their HCP but the service do not have a record of equipment owned and used by consumers and therefore do not have a record of maintenance and cleaning requirements. Instructions for care workers on cleaning and ensuring the suitability of equipment purchased are not included in the consumer’s care plan. Equipment, including hoists, is being used by staff to deliver care but there was a lack of clarity within service management about who’s responsibility it is to maintain the equipment. There have currently been no complaints by staff or consumers about equipment in use not being safe, clean, and well maintained however the lack of a maintenance plan could place the consumer at considerable risk.

In the response to the Assessment Teams report the approved provider has undertaken to develop a register of equipment purchased as part of the home care package and document details of how it is to be maintained in the consumer’s care plan by May 2024. I am satisfied that this will address the risk. I will consider this matter further in Standard 8 in relation to risk management.

I find seven of the seven requirements in Standard 4 compliant.

# 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 their representatives said they are encouraged and supported to complain and provide feedback at any time if they are not satisfied with the delivery of services. All consumers interviewed said they feel comfortable to provide feedback at any time to care workers, rostering staff or management. All staff said they are trained to encourage feedback and staff said they report complaints immediately to the office staff.

Consumers and their representatives were not always able to recall being informed about advocacy services to assist them when they first entered the service, but acknowledged a lot of information is given at this time. A consumer’s right to access an advocate and interpreter is explained at the initial visit by the case manager. A list of how to access advocacy support and interpreting services is also included in the client information kit provided to all consumers and their representatives.

Appropriate action is taken in response to complaints and an open disclosure approach is used when things go wrong. Consumers and representatives interviewed said they were satisfied with the action taken by the service in response to any feedback or complaint they made. Whilst the service implements an open disclosure approach in complaints management it does not have an open disclosure policy to guide staff practices.

All feedback and complaints are followed up personally by management and used to improve the quality of care and service. Feedback and complaints received are responded to and immediate actions implemented to improve the quality of care and services for consumers to their satisfaction. Very small numbers of complaints had been received in the last six months and management could talk about actions taken to improve the quality of care and services. However, systems are not in place to ensure feedback and complaints inform continuous improvement processes. Feedback provided by consumers in an annual survey for the day respite centres conducted in 2023 had not been collated or analysed nor feedback included in the continuous improvement plan. There is no formal collation, analysis or trending of feedback and complaints that is reported to the Board. Whilst the service has not been formally reporting feedback and complaints to the Board the vice president is aware of all complaints received and discusses them with board members. These issues will be discussed in Standard 8.

In response to the Assessment Teams report the approved provider stated they intend to develop an open disclosure policy. The approved provider also intends to develop mechanisms to analyse trends in incidents, feedback and complaints and report these to the Board as a standing agenda item.

I find four of the four requirements in Standard 6 complaint.

# 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. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

The workforce is planned and the number and mix of staff enables the delivery of safe and quality care. Staffing is planned utilising an electronic rostering and consumer information management system. This provides information to the rostering staff on worker availability and worker skills. This is then matched with the needs of the consumers such as gender and language and preferred workers are matched accordingly.

Consumers interviewed stated staff are kind and caring and respected their culture and diversity. The service has implemented a ‘Cultural Diversity Policy’ to ensure that all employees maintain work practices that are respectful and sensitive to the needs of people from diverse cultures. All staff at the service were observed by the Assessment Team to be very respectful of consumers at all times.

The workforce is competent and have the qualifications and/or knowledge to effectively perform their roles. Most consumers and representatives interviewed said they thought overall care workers have the knowledge to perform effectively.

Most consumers and representatives said they felt care workers are recruited, trained, equipped and supported to deliver the care required. The Assessment team however, found there was no system for the monitoring staff attendance at training and training was adhoc. Neither was there a system in place to ensure reference checks were obtained when recruiting and the banning list was not checked as part of the recruitment process to ensure the suitability of staff employed. Additionally, staff undertaking assessments were not necessarily equipped with the relevant knowledge to perform this role and did not have policies and procedures to guide their practice. All of which exposed consumers to risk.

Staff interviewed confirmed they had received a recent performance appraisal. Performance appraisals are attended regularly every 6 months. The performance appraisal process is used to identify any gaps in skill so that relevant training can be provided. All appraisals were up to date.

The Approved Provider responded to the Assessment Teams report by stating their intention to develop a policy on staff training, to develop an annual training calendar and systems to monitor staff attendance at training. The approved provider also undertook to conduct a comprehensive review of all recruitment and training policies and practices to ensure they adhere to the Standards and safeguard consumers. Furthermore, the recruitment of a Registered Nurse is planned to provide both support to staff and clinical oversight of consumer’s care. These measures are to be implemented by June 2024. I have taken the

I have considered the information in the Assessment Teams report and the Approved Provider’s response to the deficits identified in recruitment and training practices in making my decision in relation to compliance. There is a significant amount of work to be completed by the Approved Provider and it will take time to embed the changes.

I find four out of the five requirement in Standard 7 compliant. I find Requirement 7(3)(d) Not Compliant.

# Standard 8

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

Findings

The organisation has a new consumer advisory board that has been formed to support consumers provide input into the development, delivery and evaluation of care and services. In addition, the engagement of consumers in this tight knit community occurs regularly at cultural and spiritual functions where consumers can verbally and informally discuss service delivery issues with management. Consumer engagement also occurs between staff and consumers at the respite day centres consumers attend where consumers and their representatives provide verbal informal input into the social support activities to shape service provision.

The organisation could not demonstrate that their governing body promotes a culture of safe, inclusive, quality care and services. The Board could not demonstrate they had set priorities and the strategic direction for the service regarding the provision of safe, inclusive quality care for consumers. Additionally, the Board could not demonstrate their oversight of the quality of care being provided. There is no formal reporting structure in place to ensure the Board are kept informed and can monitor the performance of the service. The Board does not ask for information about how the organisation is meeting the Quality Standards and there is currently no collation of data provided with any analysis of trends to the Board. Recent Board minutes showed there is no discussion of what areas of improvement are required in both service provision and organisational wide governance systems.

The organisation does not have effective wide governance systems in place relating to information management, continuous improvement, workforce governance and regulatory compliance. As discussed previously in Standards 2 and 3 issues with information management were identified in relation to care documentation not being completed comprehensively, assessment documentation not being accessible in the consumer file and care outcomes not always documented in the consumer’s file. Information regarding the consumer’s care is held in multiple systems and information in the app used by staff does not get uploaded into the consumers file. Staff do not have a comprehensive set of policies and procedures to guide practice. There are no policies and procedures, clinical workflows or best practice guidelines to guide staff practices in both assessment and planning, the management of high risk high prevalence risks and infection control.

Whilst continuous improvement is a standing agenda item for Board meetings, management team meetings and staff meetings there was no information about continuous improvement included in any of the meeting minutes provided. As discussed previously in Standard 6 the organisation could not demonstrate how feedback and complaints feed into the continuous improvement cycle.

The organisation monitors their financial performance and monitors consumers who have large amounts of unspent funds.

In terms of workforce governance as discussed previously in Standard 7, recruitment practices were found to be lacking as reference checks and the relevant suitability checks were not being performed. There is no system for monitoring training attended by staff and some staff are not adequately equipped with the relevant training and support to perform their role.

There is no serious incident reporting scheme (SIRS) policy in place although staff have been provided with education on SIRS.

Whilst the Assessment Team found the organisation has rudimentary risk management systems and are introducing a quality care advisory board and a clinical risk framework this year, multiple risks identified by the Assessment Team had not previously been identified by the organisation. These risks related to organisational, workforce and consumer risk. Under the Quality Standards it is expected that organisations continually monitor risks to consumers and others and take action as required, however, a risk based approach was not evidenced by Sri Om. Risks identified included the following:

The Board does not have sufficient oversight of the organisation’s performance and is not using information available to improve its performance and how it delivers quality care and services. Staff are not necessarily trained adequately to perform their role with little clinical oversight provided by the organisation of the care being provided to consumers to ensure their needs are being met. Whilst an incident reporting system is in place to record and investigate consumer related incidents reported by care workers almost all incidents were actioned and closed by care coordinators, with minimal oversight by management recorded. Incident data is not being utilised to identify trends and drive continuous improvement to improve the quality of care provided. High risk equipment including hoists being used in the consumer’s home are not being adequately monitored to ensure they are safe and properly maintained as there is no system is in place.

As stated above, there are no policies and procedures, clinical workflows or best practice guidelines to guide staff practices in both assessment and planning, the management of high risk high prevalence risks and infection control. Validated tool are not being used during assessments. Care documentation is not comprehensively completed and stored adequately to ensure it is accessible.

Current recruitment practices are unsafe as the suitability of staff being recruited is not being adequately checked. Systems are not in place to monitor staff attendance at training and training provided is ad hoc. Whilst there is an elder abuse policy in place, staff have not been trained in it. Staff have been trained in SIRS but there is no reporting system in place.

It is recognised that the organisation is not currently providing clinical nursing care but it is providing allied health and podiatry through contacted organisations. The organisation has developed a clinical risk framework which will be operationalised later this year. It is noted that the organisation has a policy on antimicrobial stewardship and a policy on minimising restraint but staff have not been trained in these. There is no policy on open disclosure but staff were able to demonstrate they apply open disclosure in their practice.

The Approved Provider provided a response to the Assessment Teams report and has undertaken to establish a system for reporting to the Board with continuous improvement, feedback and complaints, incident management and compliance as standing agenda items. The organisations plan for continuous improvement will be updated to ensure it contains key items the organisation must address to meet the Quality Standards. The organisation will also review their strategic plan and priorities to ensure the provision of safe inclusive quality care and services. Regarding information management, all care plans will be reviewed and updated and care planning policies and procedures and other policies/tools to guide safe quality care developed and implemented. Issues regarding workforce governance relating to recruitment and training will be addressed. The organisation will also implement best practice guidelines to develop and implement an effective risk management system including reporting systems to enable trend analysis. The organisations plan for continuous improvement shows that these actions are planned to be completed between March and October 2024.

I have considered the information in the Assessment Teams report and the response by the Approved Provider in making my decision about compliance. There is a significant amount of work to be completed by the Approved Provider and it will take time to embed the changes.

I find two of the five requirement in Standard 8 compliant. I find Requirement 8(3)(b), Requirement 8(3)(c), and Requirement 8(3)(d) Not Compliant.

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