**Performance**

**Report**

**1800 951 822**

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| Name of service: | St John Ambulance, Transport Access Project |
| Service address: | 157 Granite Street GEEBUNG QLD 4034 |
| Commission ID: | 700057 |
| Home Service Provider: | St John Ambulance Australia (Queensland) |
| Activity type: | Quality Audit |
| Activity date: | 4 July 2023 to 7 July 2023 |
| Performance report date: | 9 October 2023 |

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

**This performance report**

This performance report for St John Ambulance, Transport Access Project (**the service**) has been prepared by F.Nguyen, 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

**CHSP:**

* Community and Home Support, 23940, 157 Granite Street, GEEBUNG QLD 4034

# 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 21 August 2023 and 3 October 2023.

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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

Improve processes for appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

* *Requirement 6(3)(d)*

Improve processes to ensure that feedback and complaints are reviewed and used to improve the quality of care and services.

* *Requirement 7(3)(d)*

Improve processes for the workforce to be recruited, trained, equipped and supported to deliver the outcomes required by these standards.

* *Requirement 8(3)(a)*

Improve processes for consumers to be engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

* *Requirement 8(3)(b)*

Improve processes for the organisation’s governing body to promote a culture of safe, inclusive and quality care and services and is accountable for their delivery.

* *Requirement 8(3)(c)*

Improve processes in regard to effective organisation wide governance systems relating to the following:

(ii) continuous improvement

(iv) workforce governance, including the assignment of clear responsibilities and accountabilities

(vi) feedback and complaints

* *Requirement 8(3)(d)*

Improve processes for oversight in regard to effective risk management systems and practices, including but not limited to the following:

(i) managing high impact or high prevalence risks associated with the care of consumers

(ii) identifying and responding to abuse and neglect of consumers

(iii) supporting consumers to live the best life they can

(iv) managing and preventing incidents, including the use of an incident management system.

# Standard 1

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| Consumer dignity and choice | | CHSP |
| 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

Requirement 1(3)(a)

The Assessment Team recommended Requirement 1(3)(a) not met, as they were not satisfied that processes and procedures to ensure consumer culture, and diversity is identified and subsequently valued and respected. The Assessment Team provided the following evidence relevant to my finding:

* Consumer A and B both identify as Culturally and Linguistically Diverse (CALD) but the service does not have processes and procedures to identify how his cultural needs and preferences can be supported by staff.
* The service was unable to identify consumers who may identify as a member of the LGBTQI cohort. The service does not have systems, processes, or procedures to enquire, subsequently document and support consumers who may identify with the LGBTQI cohort. Management said the service attempts to match consumers with a preferred gender staff member or volunteer, although is only able to accommodate the “best fitting staff member at the time”.
* The service does not have processes and procedures to identify consumer preferred name. The service policies do not reflect the identification and subsequent support for consumers who identify as having cultural and/or diversity needs and preferences.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Updated Culture and Diversity questions included on new Intake Assessment Form, Unplanned Review Form, Planned Review Form.
* Preferences option included on Intake Assessment Form, Unplanned Review Form, Planned Review Form.
* Staff members engaged to conduct planned and unplanned reviews.
* A script is being created to support transparent conversations.
* Culture and Diversity Assessment tool being developed.
* Training schedule being developed to include Culture & Diversity.
* Culture and Diversity to be included on induction.
* Culture And Diversity preferences to be included on Taxi spreadsheet.
* Create and implement Aged Care Diversity Framework.
* Create and implement a Diversity Council.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does demonstrate that each consumer is treated with dignity and respect, with their identity, culture and diversity valued. Based on the above evidence, the Decision Maker finds Requirement 1(3)(a) compliant.

Requirement 1(3)(b)

The Assessment Team recommended Requirement 1(3)(b) not met, as they were not satisfied that care and services are culturally safe. The Assessment Team provided the following evidence relevant to my finding:

* While consumers interviewed from cultural and diverse backgrounds said the service respects their identity, the service was unable to demonstrate it has processes and procedures to ensure the care and services delivered are culturally safe.
* The service, through the MAC assessment identifies basic consumer cultural and diversity information, for example, if they identify with the Aboriginal and Torres Strait Islander cohorts, although their needs and preferences regarding their care and services is not further explored to enable the delivery of culturally safe services by staff.
* The service does not undertake a comprehensive initial assessment, preferring to use the MAC assessment to determine consumer cultural and diverse identity. The service does not have an internal assessment tool to further explore support for consumers who identify with various cultures and/or diverse cohorts.
* The service does not develop a consumer support/care plan and was therefore unable to demonstrate information is available to staff on how they can support individual consumers cultural and diversity needs and preferences.
* The service does not conduct routine reviews or re-assessments of consumers and was therefore unable to demonstrate culture and/or diversity is re-visited to determine any changes.
* The service has a range of policies, although they do not reflect the gathering and documentation of consumer culture and diversity. The service sub-contracts taxi services to one external provider. Information regarding consumer culture and/or diversity is not provided to them, and they are therefore unable to respond to individual consumer needs and preferences. Staff said the service does not have access to an interpreter service, preferring to rely on consumer’s representative to provide interpretation where required.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Updated Culture and Diversity questions included on new Intake Assessment Form, Unplanned Review Form, Planned Review Form.
* Further explanations/ supports can be provided on Intake Assessment Form, Unplanned Review Form, Planned Review Form.
* Staff member engaged to conduct planned and unplanned reviews.
* Culture and Diversity Assessment tool being developed.
* Training schedule being developed to include Culture & Diversity.
* Culture and Diversity to be included on induction.
* Culture And Diversity preferences to be included on Taxi spreadsheet.
* Create and implement Aged Care Diversity Framework.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does demonstrate that care and services are culturally safe. Based on the above evidence, the Decision Maker finds Requirement 1(3)(b) compliant.

Requirement 1(3)(d)

The Assessment Team recommended Requirement 1(3)(d) not met, as they were not satisfied that each consumer is supported to take risks to enable them to live the best life they can. The Assessment Team provided the following evidence relevant to my finding:

* The service does not have processes and procedures to enable consumers to be supported to take risks to enable them to live the best life they can.
* The service does not have oversight of consumers who may be at risk. The service does not conduct comprehensive initial and on-going assessments to inform the provision of consumer care and services.
* The service does not have processes and procedures to identify consumer risks during their initial entry to the service and on an on-going basis. Consumers do not participate in a comprehensive initial assessment, reviews, re-assessment or when the consumer circumstances change, and therefore risks are not routinely identified.
* The service does not seek further information or have addendum risk assessment tool/s to identify and subsequently support consumers who may be at risk.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Staff member engaged to conduct planned and unplanned reviews.
* Risk questions included on new Intake Assessment Form, Unplanned Review Form, Planned Review Form.
* Vulnerable and at-Risk Register created and implemented.
* Risk Register Assessment Tool created and implemented for identification.
* Advocacy Procedure created and implemented.
* Create Risk Alert field on Salesforce that can be seen by all staff.
* Consumer risk alerts to be included on Taxi spreadsheet.
* Training schedule being developed.
* Culture and Diversity to be included on induction.
* Create and implement Client Rights Policy.
* Advocacy Resource folder created on intranet for all staff.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does demonstrate that each consumer is supported to take risks to enable them to live the best life they can. Based on the above evidence, the Decision Maker finds Requirement 1(3)(d) compliant.

Requirement 1(3)(c)(e)(f)

Consumers/representatives interviewed said consumers are supported to make decisions regarding their own care and services, with the involvement of significant others, where applicable. Consumers are able to communicate their wishes with the service and maintain relationships, where applicable. The service has processes and procedures to ensure each consumer is supported to exercise choice and independence. Staff discuss, during the initial intake with consumers/representatives, the services available and also encourage consumer representatives to identify and support consumers in making decisions about their care and services.

Consumers/representatives said they receive communication from the service in a timely manner and in a way they can understand. The service was able to demonstrate that information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, and easy to understand. Consumers participate in an initial discussion with service staff and information provided includes the types of care and services available. This is supported by an information pack including a handbook and a copy of the outing activities calendar of events booklet, which includes the mobility level required to participate.

Consumers/representatives said consumer privacy is respected by staff delivering care and services. The service was able to demonstrate consumers privacy is respected and their personal information is kept confidential. The Consumer agreement includes consumer consent to share information. The service has privacy and permission to share consumer information forms, which were observed by the Assessment Team to be routinely completed. The service operates secure password protected electronic documentation systems and has both internal and external systems support.

# Standard 2

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| Ongoing assessment and planning with consumers | | CHSP |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

Requirement 2(3)(a)

The Assessment Team recommended Requirement 2(3)(a) not met, as they were not satisfied that 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.

The Assessment Team provided the following evidence relevant to my finding:

* The intake team monitors MAC referrals and access the MAC support plan for information relevant to the consumer including medical conditions and any identified risks. However, the Assessment Team identified not all risks identified in the MAC support plan have been detailed in the care planning system. There were no specific strategies to guide staff when delivery services to consumers with high risks.
* Coordinators advised consumers who have the alert, ‘elderly and infirmed and needing assistance’ ticked in their care planning information is a prompt for staff to assist the consumer when mobilising. However, there are no specific strategies to guide staff practice when delivering services to identified consumers. Whilst home risk assessments are completed for in-home social support visits these are not completed for accompanied activity services.
* Management acknowledged the deficiencies in the assessment planning process with inconsistencies in risk to consumers being detailed, and no strategies to guide staff practice in delivering services to high-risk consumers. Management advised they are reviewing assessment planning processes and policies, and this is detailed on the PCI.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Staff member engaged to conduct planned and unplanned reviews.
* Risk questions included on new Intake Assessment Form, Unplanned Review Form, Planned Review Form.
* Risk Register Assessment Tool created and implemented for identification.
* Care plans to be printed for all 'at Risk' consumers on social trips.
* Implement a 12-month training schedule for all staff and volunteers relevant to the Standards.
* Consumer risk alerts to be included on Taxi spreadsheet.
* Include on-going concerns on Home Risk Assessments.
* Create Home Risk Assessments forms for Accompanied Activities and implement.
* Create Risk Alert field on Salesforce that can be seen by all staff.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does demonstrate that care and services are culturally safe. Based on the above evidence, the Decision Maker finds Requirement 2(3)(a) compliant.

Requirement 2(3)(b)

The Assessment Team recommended Requirement 2(3)(b) not met, as they were not satisfied that assessment and planning identifies and addresses the consumer’s current needs, goals and preferences.

The Assessment Team provided the following evidence relevant to my finding:

* The Assessment Team observed care planning documents did not capture each consumer’s current goals and inconsistently detailed their current preferences and needs. Consumers/representatives said services generally meet their current needs, goals and preferences. However, consumers/representatives said they unaware of all the services available to them. The service has not discussed their goals for receiving the services. Interviews with staff demonstrated they know the consumers well and can discuss their needs and preferences based on memory.
* Management said advance care directive (ACD) information is not asked of consumers and is not recorded in the system or care planning information.
  + Management acknowledged the deficiencies and advised they had already made changes in the care planning system to prompt staff to ask this question and record details at the initial assessment and re-assessments.
  + Management advised staff would follow up existing consumers to detail this information.
  + Management and staff advised there were no consumers receiving services who were under palliative care.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Goals, needs and preferences included on Intake Assessment Form, Unplanned Review Form, Planned Review Form.
* ACD and enduring power of attorney (EPOA) included on included on Intake Assessment Form, Unplanned Review Form, Planned Review Form.
* Staff member engaged to conduct planned and unplanned reviews.
* Welfare Form created and implemented to capture wellness concerns from staff / volunteers about consumers.
* Create ACD and EPOA Alert field on Salesforce that can be seen by all staff.
* Training for intake team to support identification of goals.
* Training for intake team to support ACD and EPOA conversations.
* Create and implement End of Life Process.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does demonstrate that assessment and planning identifies and addresses the consumer’s current needs, goals and preferences. Based on the above evidence, the Decision Maker finds Requirement 2(3)(b) compliant.

Requirement 2(3)(d)

The Assessment Team recommended Requirement 2(3)(d) not met, as they were not satisfied that 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.

The Assessment Team provided the following evidence relevant to my finding:

* The Assessment Team observed care planning documents did not capture each consumer’s current goals and inconsistently detailed their current preferences and needs. Consumers/representatives said services generally meet their current needs, goals and preferences. However, consumers/representatives said they unaware of all the services available to them. The service has not discussed their goals for receiving the services. Interviews with staff demonstrated they know the consumers well and can discuss their needs and preferences based on memory.
* Management advised they do not provide a copy of the care planning documentation to the consumer or representative. Consumer/representatives advised they have discussed services and received a letter detailing which service/s they were receiving and were satisfied with the communication from the service. The letter that is sent to the consumer does not detail service days or times or if there are any specific preferences for service delivery.
* The initial assessment of the consumer’s needs and preferences does not include discussion on their goals or how service delivery will support their well-being. There are inconsistencies in the information for consumers to identify risks and strategies are not detailed to guide staff practice when delivering services this is further discussed in Standard 2 Requirement (3)(a).
* Management acknowledged under the standards they are required to provide a copy of care planning information to the consumer/representative have put this in the PCI. Management advised they will update consumer files to include the required information and provide a copy of care planning information to the consumer/representative.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Goals, needs and preferences included on Intake Assessment Form, Unplanned Review Form, Planned Review Form.
* Copy of care plan added to the consumer’s Welcome Pack information sent to consumers.
* Staff member engaged to conduct planned and unplanned reviews.
* Scheduled 12 Month review of Client Handbook.
* Service days and times added to Client Handbook.
* Letter to be sent to consumers regarding Customer Experience Role.
* Copy of care plan to be sent to consumers after planned or unplanned review.
* Create Community Services Impact Report.
* Quarterly consumer data review to ensure up-to-date information.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does demonstrate that 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. Based on the above evidence, the Decision Maker finds Requirement 2(3)(d) compliant.

Requirement 2(3)(e)

The Assessment Team recommended Requirement 2(3)(e) not met, as they were not satisfied that care and services are reviewed for effectiveness when circumstances change or when incidents impact on the needs, goals or preferences of the consumer.

The Assessment Team provided the following evidence relevant to my finding:

* The service does not conduct a formal review or reassessment of each consumer’s needs and preferences at least every 12 months. Each consumer’s needs and preferences were not regularly reviewed to identify a change in circumstances or following an incident.
* Management and volunteers were able to describe instances when there had been incidents involving the consumer, including falls, admission to hospital or non-response to a scheduled visit. However, this information and the follow up action taken was not consistently documented including a review to identify any changes in needs.
* Management advised assessment and planning policies and procedures are being reviewed however there are no guidelines for formal reviews to be undertaken. Management advised information is updated when changes are advised by the consumer or representative. The consumer/representative contacts the service to arrange transport times fortnightly or if they if their preference have changed.
* Management said the service does not actively conduct regular reviews of each consumer’s needs and preferences. They advised a process will be implemented for consumer reviews, a forward plan will be developed to conduct consumer reviews with priority given to those consumers identified as vulnerable or where potential risk is indicated. Management advised that all information known about the consumer, their level of vulnerability and the MAC Support Plan information will be considered in prioritising reviews.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Staff member engaged to conduct planned and unplanned reviews.
* Planned Review form and process created for a 12 monthly review.
* Welfare Form created and implemented to capture wellness concerns from staff / volunteers about consumers.
* Risk Assessment tool created and implemented to guide staff.
* Scheduled 12 Month review of Client Handbook.
* Tool created for identifying change in consumer welfare - STOP and WATCH poster.
* Process to be created for planned reviews.
* Process to be created for unplanned reviews.
* Process to be created for Risk Assessment tool.
* Quarterly consumer data review to ensure up-to-date information.
* Training for all staff regarding any changes identified in consumers.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does demonstrate that care and services are reviewed for effectiveness when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. Based on the above evidence, the Decision Maker finds Requirement 2(3)(e) compliant.

Requirement 2(3)(c)

The service demonstrated consumers are involved in assessment and planning of their services along with others who the consumer wishes to involve. The service communicates with the consumers or representative depending on their preference to discuss any additional services they may require. Management said they contact the consumer’s representatives if they notice any changes in condition of the consumer while delivering services. Consumers/representatives advised they are involved in the initial assessment and planning process and in making decisions on the services they receive.

# Standard 3

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| Personal care and clinical care | | CHSP |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Not applicable |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not applicable |
| 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. | Not applicable |
| 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. | Not applicable |
| 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. | Not applicable |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Not applicable |
| 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. | Not applicable |

Findings

All individual requirements within Standard 3 are not applicable, therefore Standard 3 is not applicable, and as a result was not assessed during the Quality Audit.

# Standard 4

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| Services and supports for daily living | | CHSP |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

Requirement 4(3)(d)

The Assessment Team recommended Requirement 4(3)(d) not met, as they were not satisfied that consumer’s condition, needs and preferences are effectively documented and communicated within the organisation to staff and volunteers delivering services.

The Assessment Team provided the following evidence relevant to my finding:

* Whilst staff were able to describe individual consumer’s specific condition, needs and preference this was not documented in care planning information and has not been made available to consumers/representatives where services are delivered, refer to Standard 2 Requirement (3)(d). Consumers/representatives said they are satisfied information about their needs and preferences is shared within the service and with others involved in their care. The service has consumers sign a consent form in relation to information sharing on intake. Staff and volunteers advise they receive verbal information on the needs and preferences of consumers and receive updates verbally or via a telephone App they use.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Welfare Form created and implemented to capture wellness concerns from staff / volunteers about consumers.
* Team Leader meetings to discuss Vulnerable & At-Risk Clients created and implemented.
* Major consumer concerns discussed at regular drivers meeting / added to agenda.
* Create ACD and EPOA Alert field on Salesforce that can be seen by all staff.
* Create Risk Alert field on Salesforce that can be seen by all staff.
* Process to be created for unplanned reviews.
* Care plans to be printed for all 'at Risk' consumers on social trips.
* Consumer risk alerts to be included on Taxi spreadsheet.
* Create and implement a process for deceased / palliative care consumers.
* Feedback, Risk, Serious Incident Response Scheme (SIRS) and other information to be included on Board Reports and Board Agenda.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does demonstrate that consumer’s condition, needs and preferences are effectively documented and communicated within the organisation to staff and volunteers delivering services. Based on the above evidence, the Decision Maker finds Requirement 4(3)(d) compliant.

Requirement 4(3)(a)(b)(c)(e)(g)

The service demonstrated that each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences. Consumers/representatives reported the services and supports consumers receive help them to maintain their quality of life and independence. Whilst care planning documentation does not consistently detail risks for consumers staff and volunteers were able to describe the specific needs and preferences of individual consumers. Support workers demonstrated a clear understanding of what is important to individual consumers and could describe how they help the consumer to do as much as they can for themselves if this is their preference.

Consumers/representatives said their services and supports for daily living promote the emotional, spiritual and psychological well-being of consumers. Staff demonstrated an understanding of what is important to the consumer and provided examples of how the well-being of consumers is supported. Staff said if a consumer is feeling down, they take the time to have a conversation with them and listen. Staff report any concerns about a consumer’s emotional or psychological well-being to management, who will follow up with the consumer/representative to discuss additional supports.

The service demonstrated services and supports for daily living assist consumers to take part in the community, interact with others and do things of interest to them. Consumers said they are provided with opportunities for social interaction and social connection through the supports they receive. Consumers/representatives spoke positively about the group social outings and in home social support consumers receive. Support workers provided examples of being flexible in providing social support based on what the consumer’s preference is for the day. Management advised the service organises regular group outings for consumers to different venues throughout the year and information is provided in pamphlets detailing specific mobility requirements for outings.

The service demonstrated timely and appropriate referrals to individuals, other organisations and providers of other care and services through MAC. Consumers/representatives said they are satisfied with the services provided by organisations the consumer has been referred. Staff and management could describe the process for referrals to other organisations and individuals involved in the consumer’s care. Staff advised if they identify an additional need for a consumer, they will contact the coordinator, depending on the nature of the need, conducts a review of the consumer’s care and services. Following the review, referrals are made to other services where required through MAC. Management advised of internal and external services used to ensure consumers/representatives access the broad range of supports needed, such as the Aged Care Volunteers Visitor Scheme (ACVVS), Carers Gateway and social group activities run by the service.

The service demonstrated transport provide is safe and suitable and meets consumer needs including buses and cars. The service has two buses which are used to take consumers to group social support and on social outings. Consumer’s mobility needs are assessed for social outings and specific cars are used to transport consumers in wheelchairs when required. Staff were able to explain the process should unsafe mobility equipment be used by consumers when they were taken for accompanied visits and/or when they are taken on outings. Staff demonstrated how they monitor the safety of the vehicles. Review of documentation identified cleaning, maintenance regimes for all vehicles and protocols for accidents when they occur.

# Standard 5

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| Organisation’s service environment | | CHSP |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | 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

All individual requirements within Standard 5 are not applicable, therefore Standard 5 is not applicable, and as a result was not assessed during the Quality Audit.

# Standard 6

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| Feedback and complaints | | CHSP |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Non-compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Non-compliant |

Findings

Requirement 6(3)(a)

The Assessment Team recommended Requirement 6(3)(a) not met, as they were not satisfied that the service is actively encouraging and supporting consumers/representatives to provide feedback and make complaints.

The Assessment Team provided the following evidence relevant to my finding:

* Consumers/representatives said the service does not routinely seek their feedback regarding care and services. Consumers/representatives said they are not made aware of internal feedback and complaints processes during the initial entry to the service.
* The service does not routinely seek consumer or representative feedback. While management said the Chief Executive Officer (CEO) sent a letter to all consumers, advising them of the introduction of two new transport services in May 2023, this letter was confined to feedback regarding the introduction of shopping related transport services, and did not include seeking their feedback regarding all the services provided.
* The service does not have systems, processes or procedures for consumers/representatives to make complaints, in a confidential manner. The service does not provide consumers or representatives with access to confidential complaint management processes, preferring to rely on staff and volunteers to provide verbal feedback, either one to one or at driver and staff meetings. The Assessment Team reviewed staff meeting minutes and was unable to identify discussion regarding consumer complaints.
* While the service operates a complaint register the Assessment Team noted it is not complete of all the complaints made by consumers. The service does not have a general consumer feedback or complaint form or processes to manage the same. While the service has a ‘taxi service complaint form’ and process, staff acknowledged they do not routinely complete this on behalf of consumers or their representatives.
* While the service has a complaint policy it does not include guidelines for staff regarding entering information into the complaint management register, or tracking, monitoring, and responding. The service does not, as a matter of practice, routinely liaise with the sub-contracted taxi service. A review of the service complaints register and feedback from consumers noted three complaints directed at the sub-contracted taxi service, although there was no evidence of action taken by the service to inform the sub-contracted provider of matters; or associated feedback from them regarding the action they have taken.
* The service Community transport worker guide does not include instructions on complaint handling and/or management, does not have a complaint management policy and does not collect or review complaint data, statistics, and information to maintain an oversight of issues or concerns.
* Staff said consumers/representatives have the opportunity to provide feedback and make a complaint, although this is not always documented. Staff confirmed they have not participated in complaints management training. A volunteer said they have provided feedback to management regarding consumer concerns, although they were unaware if matters have been fixed. They went on to say they have not participated in complaint management training and were not aware of external complaint services to support consumers.

In response to this feedback management acknowledged opportunities to undertake improvements in complaint management and said:

* The service has an on-line enquiry function located in their web site, which accommodates the opportunity to make a complaint, although acknowledged that this is cumbersome for some to access.
* The service has plans to establish consumer group (forum) by October 2023. The aim being to ‘co-design the proposed support at home program’.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Feedback brochure created and implemented - added to cars and welcome packs.
* Feedback process created and implemented.
* Internal Feedback form updated and distributed.
* Feedback register updated and staff member responsible for upkeep.
* Stop & Watch poster created internally to encourage staff participation.
* Feedback / concerns added to drivers meeting agenda.
* Monthly Team Leader feedback meeting / agenda created and implemented.
* Advocacy Procedure created and implemented.
* Staff member engaged to conduct planned and unplanned reviews including providing advocacy advise.
* Feedback and complaint mandatory training for staff and volunteers.
* Open disclosure policy to be created and implemented.
* Add external feedback options in ‘Quarterly Chatter’.
* Create and implement a consumer feedback survey.
* Add external feedback options to website.
* Commence Consumer Focus Group.
* Create and implement a complaints management policy.
* Create and Implement communication strategy.
* Client Advocacy and Support Person form created and implemented.
* Update Feedback Process.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does demonstrate that the service is actively encouraging and supporting consumers/representatives to provide feedback and make complaints. Based on the above evidence, the Decision Maker finds Requirement 6(3)(a) compliant.

Requirement 6(3)(b)

The Assessment Team recommended Requirement 6(3)(b) not met, as they were not satisfied that consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.

The Assessment Team provided the following evidence relevant to my finding:

* Consumers/representatives said they were unaware of external support agencies to support them in raising feedback or complaints. The service was unable to demonstrate it is providing consumers/representatives with information to enable them to access external services to assist with raising and resolving potential concerns or complaints, in a confidential manner.
* The service does not have access to advocacy services to support consumers. The Assessment Team reviewed the consumer handbook and noted while there is reference to the Aged Care Quality and Safety Commission complaint service, the handbook does not reflect access to advocacy services.
* The service does not have ready access to information to aid staff in referring consumers or representatives to advocacy services.
* The service does not have access to an external interpreter service to support consumers. The service does not have information to guide consumers or their representative on the use of interpreter services. Management said the service employs a range of staff, from different cultures that can support consumers, if required. Staff said they would use the consumer representative to interpret, if required, although both approaches do not accommodate consumer confidentiality of information.
* In response to this feedback management acknowledged there were opportunities for the service to identify and promote advocacy and language services for consumers.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Staff member engaged to conduct planned and unplanned reviews including providing advocacy advise.
* Feedback brochure created and implemented - added to cars and welcome packs for consumers.
* Advocacy Procedure created and implemented.
* Client Advocacy and Support Person form created.
* Aged Care Advocacy services flyer added into Welcome Care pack.
* Client Handbook updated to reflect complaints and advocacy process.
* Interpreter Services added to Client Handbook.
* Interpreter Services added to intake, planned and unplanned review forms.
* Create and Implement communication strategy.
* Client Advocacy and Support Person form created and implemented.
* Update Feedback Process.
* Feedback and complaint mandatory training for staff and volunteers
* Advocacy training to be implemented.
* Interpreter Services process to be implemented.
* Advocacy policy and process to be created and implemented.
* Interpreter Services process to be implemented.
* Create service and support flyers in other languages.
* Advocacy resources added to intranet to support staff and volunteers.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does demonstrate that consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. Based on the above evidence, the Decision Maker finds Requirement 6(3)(b) compliant.

Requirement 6(3)(c)

The Assessment Team recommended Requirement 6(3)(c) not met, as they were not satisfied that appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.

The Assessment Team provided the following evidence relevant to my finding:

* Not all consumers' said matters are attended to in a timely manner and an open disclosure approach is not undertaken by the service when things go wrong. The service was unable to demonstrate processes and procedures to take action in response to feedback or complaints, including open disclosure.
* The service was unable to demonstrate the processes and procedures adopted when a complaint is received regarding the sub-contracted taxi service.
* The service was unable to demonstrate an open disclosure approach to consumer complaints.
* The service does not have an open disclosure policy to guide staff in the actions to be taken when things go wrong.
* While staff demonstrated an understanding of the need to apologise when things go wrong, they have not participated in complaint management or open disclosure training and were unsure of what to do in the event of a complaint.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Monthly Team Leader feedback meeting / agenda created and implemented.
* Feedback register updated and staff member responsible for upkeep.
* Identified staff to ensure feedback is followed up with consumers.
* Regular operations meetings booked with Black and White Taxis to include complaint updates.
* Feedback process created and implemented.
* Open disclosure policy to be created and implemented.
* Open disclosure mandatory training for all staff and volunteers.
* Feedback and complaint mandatory training for staff and volunteers.
* Create and implement a complaints management policy.
* Update Feedback Process.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does not demonstrate that appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. Based on the above evidence, the Decision Maker finds Requirement 6(3)(c) non-compliant.

Requirement 6(3)(d)

The Assessment Team recommended Requirement 6(3)(d) not met, as they were not satisfied that feedback and complaints are reviewed and used to improve the quality of care and services.

The Assessment Team provided the following evidence relevant to my finding:

* Consumers/representatives said they were unaware if their feedback results in improvements to the quality of care and services. The service was unable to demonstrate consumer feedback and complaints are reviewed and used to improve the quality of care and services.
* The Assessment Team review of documentation confirmed the complaints and feedback register is not routinely populated or regularly reviewed. The service was unable to demonstrate information is shared with other management, staff, and consumers.
* Management provided the Assessment Team with an example of an improvement as a result of consumer feedback, although they were unable to provide evidence of the actions taken to achieve the initiative or the promotion of the improvement to service stakeholders. For example:
* As a result of a consumer suggestion management said the service has extended its transport service delivery time/s. Transport services now commence at 6am, to allow for early hospital admissions, to 8pm in the evening. In addition, consumers will also have access to transport on Saturdays and Sundays. Management said an expression of interest to work outside traditional business hours has been distributed to staff. Management said they expect this initiative to be implemented in August 2023.
* Feedback and complaints regarding the sub-contracted taxi service are not routinely reviewed, tracked, and monitored to aid in improvements to consumer services.
* The service does not have a complaint policy or staff guidelines to support complaint management.
* Staff were unable to recall a recent improvement as a result of feedback or complaints.
* In response to this feedback management said:
* The service is aware of some complaint related matters and the service has commenced preparing forms, processes and procedures to address the complaint related issues, although this information was not evident in the complaint register or the PCI.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Feedback register updated and staff member responsible for upkeep.
* Innovation and Strategy team to use feedback register to future service endeavours.
* Regular operations meetings booked with Black and White Taxis to include complaint updates.
* Feedback brochure created and implemented - added to cars and welcome packs.
* Feedback process created and implemented.
* Add feedback and impact updates in ‘Quarterly Chatter’
* Communicate internally and externally consumer survey results.
* Add Feedback, Risk, SIRS and other concerns and information on Board Reports
* Create Community Services Impact Report.
* Update Feedback Process.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does not demonstrate that feedback and complaints are reviewed and used to sufficiently improve the quality of care and services. Based on the above evidence, the Decision Maker finds Requirement 6(3)(d) non-compliant.

# Standard 7

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

Requirement 7(3)(b)

The Assessment Team recommended Requirement 7(3)(b) not met, as they were not satisfied that workforce interactions with consumers are kind and consumer’s identity, culture and diversity is respected.

The Assessment Team provided the following evidence relevant to my finding:

* Overall, consumers/representatives provided feedback that staff and volunteers are kind, caring and respectful of them as individuals. However, consumers/representatives, staff, volunteers and management provided examples of sub-contracted taxi staff not treating consumers with care and kindness, and described how they were not always flexible and adaptive to consumers individual and unique needs and abilities.
* A review of the service complaints register and feedback from consumers noted three complaints directed at the sub-contracted taxi staff.
* Staff gave examples of instances where they had been advised that sub-contracted taxi staff had not engaged in conversation with consumers or acknowledged their presence in the vehicle.
* Multiple staff and management provided examples where sub-contracted taxi staff had arrived at destinations and did not get out of the car to assist consumers with mobility equipment leaving consumers to disembark the vehicle unaided, having to retrieve their own mobility aid from the boot of the car.
* Management said they had concerns about the lack of consistent care provided by sub-contracted services and while they said they follow up on complaints from consumers with the sub-contracted service, they could not provide examples of how they monitor that sub-contracted staff interact with consumers in a kind and caring way.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Draft memorandum of understanding (MOU) for Black and White taxis created for discussion.
* Reducing taxi usage for consumers by implementing more services - e.g. shuttle services, multi-trips etc.
* Regular operations meetings booked with Black and White Taxis to include complaint updates.
* Feedback register updated and staff member responsible for upkeep.
* Provide training video for Black and White Taxi staff members.
* Change third party provider to more aligned service provider.
* Provide text messaging advice to consumers if a taxi is being used.
* Provide text messaging option for consumer feedback.
* Consumer risk alerts to be included on Taxi spreadsheet.
* Implement a 12-month training schedule for all staff and volunteers relevant to the Aged Care Quality Standards.
* Identify and place alert for consumers who must never be sent to taxi.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does not demonstrate deficiencies in relation to this Requirement.

I have considered that the deficiency is in relation to the lack of oversight under Requirement 8(3)(b).

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does demonstrate that workforce interactions with consumers are kind and consumer’s identity, culture and diversity is respected. Based on the above evidence, the Decision Maker finds Requirement 7(3)(b) compliant.

Requirement 7(3)(c)

The Assessment Team recommended Requirement 7(3)(c) not met, as they were not satisfied that the workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles.

The Assessment Team provided the following evidence relevant to my finding:

* While consumers/representatives said they have confidence in the workforce, and staff and volunteers described how they work within their scope; the service did not demonstrate all members of the workforce have the qualifications and knowledge they need for their role in the management and delivery of services to aged care consumers.
* the service could not demonstrate a process for ensuring staff have the required competencies to perform their role.
* While there are processes to monitor staff and volunteer criminal history checks, vaccination records and drivers’ licences, vehicle registration and insurance, the MOU signed July 2021 has not been renewed and does not outline the requirement for sub-contracted taxi staff to complete criminal history checks. The service did not provide evidence that there is a process to monitor criminal history checks of sub-contracted taxi staff.
* The service was unable to demonstrate how they ensure staff who provide services to consumers through sub-contracted arrangements, are competent and have the qualifications and knowledge to effectively perform their roles. Management advised they do not monitor the education, training and competencies of staff from sub-contracted services and do not monitor the performance of sub-contracted staff to ensure safe and quality care is delivered to the consumer.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Team Member Access to training, products and services procedure.
* Regular operations meetings booked with Black and White Taxis to review operations.
* MOU for Black and White includes requirement for monitoring and reviewing services.
* Engage Fleet coach to commence competency transportation training.
* Implement a 12-month training schedule for all staff and volunteers relevant to the Aged Care Quality Standards.
* Ensure all staff and volunteers have completed the Dementia Friend training.
* Commence mandatory Alis training for all staff and volunteers.
* Review and update on-boarding process for staff and volunteers.
* Open disclosure mandatory training for all staff and volunteers.
* Commence SIRS training for all staff and volunteers.
* Create Training & Professional Development Process.
* Create process for volunteer performance monitoring inline with existing staff process.
* Training Matrix completed for all team members.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does not demonstrate deficiencies in relation to this Requirement.

I have considered that the deficiency is in relation to the lack of oversight under Requirement 8(3)(b).

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does demonstrate that the workforce is competent, and the members of the workforce have the qualifications and knowledge to effectively perform their roles. Based on the above evidence, the Decision Maker finds Requirement 7(3)(c) compliant.

Requirement 7(3)(d)

The Assessment Team recommended Requirement 7(3)(d) not met, as they were not satisfied that the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

The Assessment Team provided the following evidence relevant to my finding:

* The service did not demonstrate that the workforce receives ongoing support, training and professional development they need to carry out their roles and responsibilities in delivering and managing care and services for aged care consumers.
* Feedback from staff and management, and a review of training records showed training to meet the needs of consumers are not always identified and provided to ensure staff have the required skills and knowledge to provide safe and quality care. Management confirmed that training has not been provided in areas relevant to the delivery of services to aged care consumers. For example, a coordinator said there is a lack of training for staff and management and said that while manual handling training is provided by internal staff, they believe staff would benefit from receiving competency-based training from an external provider. The coordinator said they receive requests for training from staff, particularly in manual handling of wheelchairs and dementia awareness.
* While there was evidence the service supported staff and volunteers to undertake first aid training and cardiopulmonary resuscitation (CPR), fire safety and evacuation training and mental health training and optional elder abuse, there was no evidence management, staff or volunteers had received the following training relevant to the Standards, including but not limited to:
  + Complaints management, open disclosure and advocacy
  + Cultural/diversity
  + Dignity of Risk
  + SIRS
  + Management and prevention of incidents
  + Training in the Quality Standards
* Staff and volunteers described the recruitment and orientation process at the service, including buddy shifts for volunteers when they first commence. However, there was no evidence of a system in place for how training and recruitment processes are monitored for effectiveness and how additional training requirements are identified and delivered.
* Feedback was provided to management who acknowledged the deficiencies brought forward by the Assessment Team. Information was provided to management about the training and resources available through the Commission, available to management, volunteers, sub-contracted services and the governing body.)

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Team Member Access to training, products and services procedure.
* Regular operations meetings booked with Black and White Taxis to review operations.
* MOU for Black and White includes requirement for monitoring and reviewing services.
* Engage Fleet coach to commence competency transportation training.
* Implement a 12-month training schedule for all staff and volunteers relevant to the Aged Care Quality Standards.
* Ensure all staff and volunteers have completed the Dementia Friend training.
* Commence mandatory Alis training for all staff and volunteers.
* Review and update on-boarding process for staff and volunteers.
* Open disclosure mandatory training for all staff and volunteers.
* Commence SIRS training for all staff and volunteers.
* Create Training & Professional Development Process.
* Create process for volunteer performance monitoring in line with existing staff process.
* Training Matrix completed for all team members.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does not demonstrate that the workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. Based on the above evidence, the Decision Maker finds Requirement 7(3)(d) non-compliant.

Requirement 7(3)(e)

The Assessment Team recommended Requirement 7(3)(e) not met, as they were not satisfied that regular assessment, monitoring and review of the performance of each member of the workforce.

The Assessment Team provided the following evidence relevant to my finding:

* While consumers/representatives said they are satisfied the workforce providing their care and services perform their roles well, the service did not demonstrate an effective system in place to regularly evaluate how staff are performing their role, including volunteers and subcontracted staff through brokerage arrangements.
* The performance of management and staff is monitored quarterly through a performance appraisal process. Sampled staff advised they had completed a performance appraisal with their supervisor within the previous 12 months. Management said they discuss any performance concerns with individuals when they are identified.
* However, the service was unable to demonstrate that regular assessment, monitoring and review of the performance of volunteers and sub-contracted staff occurs. Management advised that the service does not currently assess the performance of volunteers.
* Management advised they are currently reviewing their systems and processes and would action identified gaps as part of their continuous improvement process.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* The service was able to provide that there are processes for regular assessment, monitoring and review of the performance of the volunteer workforce. This was evidenced by the Decision Maker via documentation provided by the service.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does not demonstrate deficiencies in relation to this Requirement.

I have considered that the deficiency is in relation to the lack of oversight under Requirement 8(3)(b).

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does demonstrate that regular assessment, monitoring and review of the performance of each member of the workforce. Based on the above evidence, the Decision Maker finds Requirement 7(3)(e) compliant.

Requirement 7(3)(a)

The service has systems and processes for planning the number and mix of workforce required, managing staff vacancies and unfilled shifts. The service’s internal team comprises of permanent, casual and volunteer staff. The service engages a sub-contracted taxi service to support its own workforce and to meet the varied needs of consumers. Management said they feel there are enough staff, volunteers and contracted staff available to meet the needs of consumers and staff said there is more than enough time to complete their work effectively. Consumers/representatives confirmed staff always turn up when they expect them and if they are going to be late, they are notified. Consumers advised their frequency of service delivery is provided in line with their wishes, needs and preferences.

# Standard 8

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

Findings

Requirement 8(3)(a)

The Assessment Team recommended Requirement 8(3)(a) not met, as they were not satisfied that consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.

The Assessment Team provided the following evidence relevant to my finding:

* Consumers/representatives were unable to describe their involvement in the development, delivery and evaluation of care and services. The service was unable to demonstrate it has processes and procedures to support the engagement of consumers/representatives in the development, delivery, and evaluation of care and services.
* While consumers/representatives are encouraged to provide feedback regarding their care and services, this is not always documented and therefore actioned.
* The service does not seek consumer or representative feedback via a survey or any other planned feedback approaches.
* Feedback is not reviewed by senior management and the Board and therefore the information gathered is not considered for future planning for the service, and the wider organisation, where applicable.
* In response to this feedback management said:
* The service is in the process of establishing a consumer forum. It is expected to be implemented in October 2023. Management said the aim of the forum is to ‘co-design the proposed support at home program’.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* The service provided documentation to the Decision Maker of improvements made to care and services from feedback provided by a consumer, however, this was found to be insufficient evidence that improvements to care and services have been from consumer feedback.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does not demonstrate that consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. Based on the above evidence, the Decision Maker finds Requirement 8(3)(a) non-compliant.

Requirement 8(3)(b)

The Assessment Team recommended Requirement 8(3)(b) not met, as they were not satisfied that the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

The Assessment Team provided the following evidence relevant to my finding:

* There is insufficient evidence to demonstrate the management committee is provided with enough evidence to ensure safe and effective care of their consumers. The management committee does not receive the information it needs to identify risks to consumers to ensure the delivery of safe and effective care to meet the Standards. For example:
* Reporting processes are in place from the general manager to the Board to meet the governing body’s responsibilities and to maintain oversight of care and services delivered. However, these are not effective as evidenced throughout this report.
* There was insufficient evidence that feedback and complaints are used to improve the quality of services. Management acknowledged they do not trend, analyse or report complaints or incident data.
* There is no process in place for identifying the training needs of workforce relevant to the Standards.
* The MOU is out of date and the existing agreement does not outline the requirement for sub-contracted taxi staff to complete criminal history checks, or determine the qualifications and training required.
* The CEO said they were doubtful that the Board had an awareness of SIRS or the Quality Standards.
* While information is provided to the Board through reports, the Board does not always receive the information it needs to identify risks to aged care consumers and drive improvements to ensure the delivery of safe and effective care and services. Please refer to the deficiencies considered under Requirements 8(3)(c) and 8(3)(d).
* Deficiencies were also evidenced in examples from:
  + Requirement 7(3)(b)(c)(e).

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Leadership to complete the Communities Operations Review Document.
* MOU for Black and White taxis created for discussion at monthly meeting.
* Add Feedback, Risk, SIRS and other concerns and information on Board Communities Operations Review Report.
* Create Training & Professional Development Process.
* Implement a 12-month training schedule for all staff and volunteers relevant to the Standards.
* Create and implement a complaints management policy.
* Commence SIRS training for all staff and volunteers.
* Commence Fundamentals of Governing for Reform training for all Leaders, Executive and Board members.
* Create Serious Incident Response Scheme (SIRS) Policy and procedure.
* Identified responsible training officer to ensure mandatory training compliance.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does not demonstrate that the organisation’s governing body promotes and has an embedded culture of safe, inclusive and quality care and services and is accountable for their delivery. Based on the above evidence, the Decision Maker finds Requirement 8(3)(b) non-compliant.

Requirement 8(3)(c)

The Assessment Team recommended Requirement 8(3)(c) not met, as they were not satisfied that effective organisation wide governance systems, in particular information management, regulatory compliance, continuous improvement and feedback and complaints.

The Assessment Team provided the following evidence relevant to my finding:

Information management

The service was unable to demonstrate oversight of consumer information including care and services.

* The consumer list, provided to the Assessment Team on two separate occasions was not accurate or was incomplete of information. For example, the service was unable to identify if consumers identify as CALD, diverse, supported by a Public Guardian or vulnerable. Some consumers have recently joined the service, and were not on the consumer list, whereas some consumers have left the service, or passed away and remain on the list. Not all consumers have contact numbers or representative details to facilitate contact. Some consumers identified on the consumer list as Aboriginal, although at interview said they were not.
* The service was unable to access information in a timely manner. For example, management said as a result of a turnover of senior staff they were unable to access the service 2022 complaint register.

In response to this feedback management said:

* The service has experienced some difficulties with the accuracy of consumer information, particularly during the data migration process of moving from one system to another.
* They acknowledged there are inconsistencies with the information in the electronic care planning system and communication processes between different service coordinators.

Continuous improvement

The service was unable to demonstrate continuous improvement oversight by the governing body.

* While the service has a PCI, it is not reviewed or updated on a routine basis. In addition, initiatives identified from consumer feedback and complaints, staff suggestions and changes to legislative requirements were not evident in the plan.
* The service does not maintain oversight of the PCI and it therefore does not fully reflect the actions taken, or that monitoring and outcomes of improvements are completed in a timely manner. The service governing body does not review improvements or conversely provide top-down initiates to support the service to meet its broader organisational objectives.

Financial governance

The service was unable to demonstrate financial governance oversight by the governing body.

* The service is supported by internal organisation finance personnel. The organisation operates a monthly finance and risk sub-committee. The Assessment Team reviewed the Board meeting minutes and noted discussions regarding the service financial viability. Both management and staff said the service has sufficient supplies and equipment to support consumers.

Workforce governance

The service was unable to demonstrate workforce governance oversight by the governing body.

* The service is supported by internal organisation people and culture personnel, who are responsible for supporting recruitment, learning and development, and work health and safety. All staff have an up-to-date position description, which clearly outlines staff roles and responsibilities.
* The Board maintains oversight of the workforce including developing strategies to recruit and retain volunteers. In addition, the Board recently approved the appointment of two new staff members to support the ‘on-boarding’ of consumers to the service.

Regulatory compliance

The service was unable to demonstrate regulatory compliance oversight by the Governing body.

* Organisational discussions regarding regulatory compliance matters were not evident in Board meeting minutes.
* Staff are required to read a disclaimer and where applicable complete a statutory declaration. The current statutory declaration used by the service reflects ‘staff having lived in a country other than Australia for over 6 months, over the age of 18’. This refers to the provisions, as outlined in the Act of 1957. Staff have not participated in SIRS training.
* The service and taxi sub-contractor MOU was noted to be out of date, it was signed on 21 July 2021. The MOU states ‘it is valid for 12 months from the date of signing’.
* In addition, the MOU does not reflect contemporary practices, such as the sub-contractors need to demonstrate to SJAQ that they have processes and procedures to ensure drivers have up to date police certification and prudential requirements including driver’s license, insurance/s, or car road worthiness; as well as evidence of a discussion/training regarding the SIRS.

Feedback and complaints

The service was unable to demonstrate feedback and complaint oversight by the Governing body.

* The service does not collect consumer feedback and complaint information, data, or statistics. Matters such as feedback and complaints were not evident in Board meeting minutes.
* The Chief Executive Officer said they had been in the role for 4 weeks. They acknowledged there are opportunities for improvements regarding Board oversight. Including sub-contractor agreements, organisation risk framework, reviewing support for staff and risks associated with a partial volunteer workforce. The CEO said they were doubtful that the Board had an awareness of SIRS or the Quality Standards.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* New Intake process created and implemented.
* New Planned and Unplanned Review process commenced.
* New Welfare Event Form created to support review process.
* Staff member engaged to conduct reviews to ensure current CALD, diverse and other data is up to date.
* Monthly Feedback Meeting booked.
* Monthly PCI Meeting booked.
* Nominated staff member responsible for Plan for Continuous Improvement register.
* Innovation and Strategy team use PCI register to future service endeavours.
* Nominated staff member responsible for Compliance & Document Control.
* Created new overseas statutory declaration wording.
* Draft MOU for Black and White taxis created for discussion at monthly meeting.
* Monthly Meeting Calendar created for whole team.
* Review current shared folder data to ensure historical information is available.
* Gain readable historic data from Carelink system.
* Regulatory compliance information to be included on Board Reports and Board Agenda.
* Gain correct contemporary overseas statutory declaration from appropriate staff and volunteers.
* Commence SIRS training for all staff and volunteers.
* Feedback, Risk, SIRS and other information to be included on Board Reports and Board Agenda.
* Commence Fundamentals of Governing for Reform training for all Leaders, Executive and Board members.
* Create Serious Incident Response Scheme (SIRS) Policy and procedure.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does not demonstrate effective and embedded organisation wide governance systems, in particular information management, regulatory compliance, continuous improvement and feedback and complaints. Based on the above evidence, the Decision Maker finds Requirement 8(3)(c) non-compliant.

Requirement 8(3)(d)

The Assessment Team recommended Requirement 8(3)(d) not met, as they were not satisfied that effective risk management systems and practices, including managing high-impact or high-prevalence risks associated with the care of consumers, and responding to abuse and neglect of consumers, supporting consumers to live the best life they can, managing and preventing incidents, including the use of an incident management system.

The Assessment Team provided the following evidence relevant to my finding:

* The Board does not monitor incidents, analyse this information or use this information to inform risk management. The organisation did not demonstrate they support staff, volunteers and sub-contracted services in understanding their roles and responsibilities in meeting this requirement. For example:
* There is no process to identify, manage and mitigate high impact high prevalent risks associated with the care of the current consumer cohort. For example:
  + Key risks associated with consumers were not adequately identified, addressed or monitored nor documented through assessment and care planning processes, for example falls risk.
  + Home safety assessments to identify environmental hazards and potential risk to the consumer are not consistently conducted.
  + There are no systems and processes in place to consider individual risks for consumers regarding emergency planning for disasters.
  + Consumer cohort risk data is not captured for reporting to the Board to ensure informed decision-making regarding risk management strategies of vulnerable consumers.
* While incidents are noted on the consumer’s electronic record and managed by the coordinator, incident reports are not consistently completed. The service maintains an incident register, however not all incidents involving consumers are documented in the register. Management advised if there is an identified change in condition of a consumer a ‘consumer welfare event’ form is completed by staff however this is not recorded as an incident. For example:
* Management do not trend and analyse incidents to ensure strategies are developed and implemented to prevent recurrence and ensure risks to individual consumer’s health and wellbeing are mitigated, managed and/or eliminated. Review of example Board meeting minutes established consumer incidents are not a standing agenda item for discussion.
* There was no evidence of training to support the service’s staff and volunteers to identify, manage and respond to risks associated with the care of consumers. Management provided evidence of elder abuse training information being shared with staff and management, however this training was not mandatory for all staff to complete. Management and staff did not have an understanding of their responsibilities in relation to reporting abuse and neglect through the SIRS.

In response to this feedback management said:

* Management advised they will be creating a vulnerable consumer list to identify risk to all consumers receiving services and this has been detailed on their PCI.
* Management advised they would review IMS and develop incident reporting to the Board and this is detailed on their PCI.

The provider acknowledges the Assessment Team’s findings, however, maintains that expectations of this Requirement are met. The provider’s response includes additional information and evidence to clarify aspects of the Assessment Team’s report and demonstrate actions have been taken and/or planned to address identified deficits. This includes, but is not limited to:

* Vulnerable and at-Risk Register created and implemented.
* Risk Register Assessment Tool created and implemented for identification.
* New Intake process created and implemented.
* New Planned and Unplanned Review process commenced.
* Updated Incident Register.
* Current Whistle-blower Policy.
* Updated Incident Register.
* Feedback, Risk, SIRS, Incidents and other information to be included on Board Reports and Board Agenda.
* Commence monthly reports for the Risk Committee.
* Create and implement Home Assessment Review process.
* Create and implement Disaster Management Plan.
* Vulnerable Risk register to be shared with Risk Committee.
* Provide training to all staff and volunteers on Incident Procedures.
* Implement a 12-month training schedule for all staff and volunteers relevant to the Standards.
* Create and Implement communication strategy.
* Create and implement a Reablement and Wellness framework.

In coming to my finding, I have considered information and evidence in the Assessment Team’s report and provider’s response, which does not demonstrate effective and embedded risk management systems and practices, including managing high-impact or high-prevalence risks associated with the care of consumers, and responding to abuse and neglect of consumers, supporting consumers to live the best life they can, managing and preventing incidents, including the use of an incident management system. Based on the above evidence, the Decision Maker finds Requirement 8(3)(d) non-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)