**Performance**

**Report**

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Staffball Pty Ltd |
| Commission ID: | 700875 |
| Address: | Unit 1, 220 Varsity Parade, VARSITY LAKES, Queensland, 4227 |
| Activity type: | Quality Audit |
| Activity date: | 6 December 2024 to 11 December 2024 |
| Performance report date: | 24 January 2025 |

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.

# Services included in this assessment

Home Care Packages (**HCP**) included:  
Provider: 7068 Staffball Pty Limited  
Service: 26177 Just Better Care Gold Coast  
  
Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 7959 Staffball Pty Ltd as trustee for the Baker Family Trust trading as Just Better Care Gold Coast  
Service: 24781 Staffball Pty Ltd as trustee for the Baker Family Trust trading as Just Better Care Gold Coast - Car  
Service: 24780 Staffball Pty Ltd as trustee for the Baker Family Trust trading as Just Better Care Gold Coast - Com

**This performance report**

This performance report has been prepared by Peter Frangiosa, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the assessment team’s report for the Quality Audit report was informed by a site assessment, observations at service outlets, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 15 January 2025.

# Assessment summary for Home Care Packages (HCP)

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

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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

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

# Areas for improvement

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

Requirement 2(3)(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.

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.

# Standard 1

|  |  |  |  |
| --- | --- | --- | --- |
| Consumer dignity and choice | | HCP | CHSP |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant | 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 | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant | 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 | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant | Compliant |

Findings

Requirement 1(3)(d) - was found non-compliant for Service ID’s 26177, 24781, and 24780 following a Quality Audit undertaken from 6 December 2024 to 11 December 2024. The service did not demonstrate:

* Each consumer is supported to take risks to enable them to live the best life they can.

The Assessment Team was not satisfied the provider had supported consumers to take risks to enable them to live the best life they can, nor were they consistently informed of risks to make informed decisions. Staff interviewed were unable to demonstrate an understanding of the organisation’s dignity of risk policies and procedures. Clinical staff could not demonstrate that open discussions were being consistently held to inform and ensure consumers understood the risks involved in their decisions. The Assessment Team provided the following evidence to support their assessment:

* Documentation reviewed for a consumer revealed that the consumer had declined ongoing dietetic services and nutritional supplements.
  + Documented discussion around the risks involved with declining nutritional and dietetic interventions were not captured through progress notes or a dignity of risk form. Notations highlighted that the consumer experienced weight loss in the months following this decision.
  + Clinical staff interviewed in delivering this consumer’s care were not able to demonstrate that conversations were held with the consumer/representative around the risks involved with declining services.
* A clinician interviewed stated that dignity of risk training was provided to staff in July 2024 due to a lack of awareness of how to talk through risk with consumers and processes to be followed.
  + However, interviews with some staff that attended this training did not demonstrate an understanding of dignity of risk concepts or procedures, including how to talk through risks with consumers.
* Management interviewed and documents reviewed confirmed the services dignity of risk policy, procedures and form to support consumer choices while also ensuring consumers understand the implications of the risk.
  + However, management confirmed the dignity of risk form had only been completed once since its establishment and did not demonstrate that this procedure is implemented consistently for all consumers who have chosen to undergo risk.
* In response to the Assessment Teams feedback, management advised of the inclusion of dignity of risk improvement opportunities in their Continuous Improvement Plan (CIP). Improvement actions planned include refresher training, expanding the scope of training to all staff, and the addition of a dignity of risk agenda item in clinical meetings to enhance staff knowledge for the effective consultation with consumers.

The Provider provided the following in response to the Assessment Team’s report.

As per included documentation (Actions and Considerations Plan (CIP) 15.01.2025) identifying a series of considerations and actions, including.

* Acknowledgement of the need to enhance practices to better demonstrate how consumers are supported to take risks in a safe informed manner.
* Recognition of risk-related information should be communicated more effectively to consumers to support informed decision-making. Detailed further in CIP Standard 1 tab.
* Acknowledgement that consumers and their representatives feel their choices are respected; and recognition of the need to strengthen practices around risk-related consultations.
* Acknowledgement some staff were unable to demonstrate a comprehensive understanding of dignity of risk. Commitment to ensuring all staff are better trained and confident at applying these principles. A comprehensive training program is being implemented.
* Advisement of a comprehensive training program on dignity of risk is scheduled to be completed for all office and home care workers by February 2025. This will ensure staff have a thorough understanding of dignity of risk policies and procedures, as well as practical guidance on how to apply these in their work.

Additional measures to be included, as documented within CIP.

* Advisement of a home visit was conducted 8th January 2025 by Clinician and Franchise Manager to address the issues associated with identified consumer. During the visit, a comprehensive discussion was held regarding the risks associated with falls and refusal to use mobility aids. The dignity of risk form was completed.
* Comprehensive training program: Comprehensive dignity of risk training for both office based and home care workers by 28 February 2025 ensuring a consistent understanding and application.
* Clinical meeting: Dignity of risk agenda item added as a standing agenda item in the clinical meetings to foster discussion and reinforce its importance. Meeting held 20 December 2024.
* Ongoing monitoring: Regular team meetings, Internal audits conducted by the Quality and Compliance Coordinator, Business health checks, Annual refresher training, Article in the staff newsletter published
* Urgent home visits: Clinicians have commenced home visits with a focus on informing and educating consumers about their rights and risks involved, ensuring informed decision-making. In direct response to identified consumer, home visit was conducted 8 January 2025 by clinician and franchise manager with client to discuss dignity of risk.

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with the information provided.

The intent of this requirement is about consumers having the right to make decisions about things that affect their lives and to continue to make those decisions as they get older. Making decisions in everyday life involves risks. This requirement is about how the organisation respects a consumer’s wishes and preferences relating to the risks they choose to take.

I appreciate the provider’s acknowledgement regarding identified deficiencies and proposed timeframes in responding to them. Despite the full suite of proposed CIP actions having not been implemented or embedded yet, I am confident that immediate and tangible actions have already been actioned, including in direct response to consumers identified by the audit process. Once remaining proposed actions are embedded, results should identify themselves expediently.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 1(3)(d) in Standard 1 Consumer dignity and choice.

Remaining requirements in Standard 1 - Consumers and representatives stated consumers are treated with respect by staff. Staff described how they treat consumers with dignity and respect, including using culturally appropriate engagement. Documentation showed detailed recognition of consumers’ identity, culture and diversity, with each consumer’s background, social, cultural, language documented and considered. Staff interviewed stated that consumer’s identity and specific needs including cultural needs are documented in their care plans and are accessible to all staff providing care and services.

Staff confirmed they consider the consumer’s cultural background when providing care and services. Survey results confirmed consumers agree the service respects their religious or cultural beliefs.

Consumers and representatives confirmed the service supports consumers to exercise choice and independence, with staff ensuring the consumer is provided opportunities to decide on services and care provided. Staff described how they support consumers to make day-to-day choices. Management discussed how the service has ongoing discussion with consumers to support consumer choice and independence. Documentation showed the service captures details about whom the consumers wish to be involved in decisions.

Consumers and representatives confirmed consumers receive information about the care and services provide. Staff described strategies used to assist consumers with communication barriers, including using body language and written cues.

Consumers and representatives confirmed staff respect and protect the consumer’s privacy. Staff described how they maintain consumer privacy and confidentiality by not sharing information with others who are not authorised to receive it. Management described the process for sharing personal and sensitive information only with those who require the information. Documentation confirmed the service uses a privacy consent process prior to sharing information with others.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 1, Consumer dignity and choice (HCP and CHSP).

# Standard 2

|  |  |  |  |
| --- | --- | --- | --- |
| Ongoing assessment and planning with consumers | | HCP | 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 | 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 | 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 | 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 | 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. | Not Compliant | Not Compliant |

Findings

Requirement 2(3)(a) - was found non-compliant for Service ID’s 26177, 24781, and 24780 following a Quality Audit undertaken from 6 December 2024 to 11 December 2024. The service did not demonstrate:

* 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 was not satisfied the provider identified risks to each consumer’s health and well-being are appropriately assessed nor contribute to care planning for the minimisation of risk. The Assessment Team provided the following evidence to support their assessment:

Although not consistently used the provider has available a comprehensive assessment for the identification of risks to consumer’s health and well-being and a suite of validated clinical assessment tools such as a Falls risk for older people in the community (FROP-Com) and a Psychogeriatric Assessment Scale (PAS).

* One consumer file review identified a comprehensive assessment completed on 14 February 2024 identifying risks including, dementia, double incontinence, decreased mobility, high falls risk and risk of bruising and skin tears due to mobility and having dry and fragile skin, with a risk score of 4 on their FROP-COM.
  + No further validated falls risk assessments had been completed after the comprehensive assessment on 14 February 2024 which stated the consumer was a ‘high falls risk’.
  + Viewed Psychogeriatric Assessment Scale (PAS) was completed on 14 April 2023, with the consumers care plan noting their dementia diagnosis however did not note individualised strategies for staff to manage behaviours during service delivery.
* An additional consumer reviewed identified the following.
  + Care plan includes an oxygen management plan which states staff need an understanding of oxygen management, use of the device, monitoring oxygen levels, responding to respiratory distress and take prompt action if saturation changes.
  + Clinical staff confirmed one RN, and the consumer have been trained in the safe use of the oxygen device on return from Hospital in July 2024 from the oxygen supplier.
    - An oxygen risk assessment was completed on 25 July 2024 which stated staff need training on oxygen management.
    - Clinical staff confirmed staff visiting this consumer had not been provided training and acknowledged how this contributes to the risk and does not inform the delivery of safe services.
  + Electronic care file evidenced comprehensive assessment completed on 5 June 2024 which stated the consumer was incontinent, noted skin integrity concerns due to dermatitis and dry skin, stated no clinical considerations, stated no risks and no mitigation strategies.
    - The file did not include skin or continence assessments.
* Staff interviewed advised clinical staff complete initial and annual assessment and care planning for all HCP consumers.
* Clinical staff and management acknowledged assessments and care planning had not been completed for each consumer upon intake nor at the time of the Quality Audit. This included specific validated assessment tools and care plans to address and minimise individual consumer risks had not been completed for each consumer upon intake nor at the time of the Quality Audit.
* Provider interviews demonstrated CHSP consumer care plans are informed by My Aged Care (MAC) assessments and intake documentation with the consumer. However, staff interviews and documentation review evidenced a lack of internal assessment and planning to mitigate risks associated with consumer’s health and well-being during service delivery.
* One CHSP consumer review identified risks to their health and wellbeing including, falls risk, lives alone, multiple comorbidities causing pain and depression.
* Management and clinical staff interviewed confirmed a lack of internal assessment, and they do not create condition-based health care plans for CHSP consumer to address risk.

The Provider provided the following in response to the Assessment Team’s report.

As per included documentation (Actions and Considerations Plan (CIP) 15.01.2025) identifying a series of considerations and actions, including.

* Issuing a Consumer survey: Posted 23 December 2024 to capture consumer concerns.
* CIP updated: To reflect the need for more personalised care plans tailored to consumers specific needs.
* The provider has recently allocated split caseloads between case managers to ensure consumers have continuity of care via their allocated case manager.
* Recognition and use of the comprehensive assessment for identification of risks to consumers health and wellbeing and a suite of validated clinical assessment tools.
* Advising of the commitment to ensuring improving on demonstrating identified risks to each customers health and well-being. Given the feedback from the audit team regarding this, an urgent meeting was held with the clinical team on 16/12/2024.
* The Quality and Compliance coordinator provided training to the clinical team to utilise comprehensive assessments as the foundation for care plans, ensuring a more holistic approach to meeting customer needs. Introduction of a monitoring system to track the completion of comprehensive assessment and address gaps promptly.
* Advisement of an improvement project is in place to ensure CHSP health care plans are in place, including implementing a structured process to develop condition-based health care plans for all CHSP consumers.
* In response to the identified consumer with identified gaps in identification and services, 9 January 2025, the providers Registered Nurse attended a home visit to review identified gaps, the care plan was updated to include strategies to assist staff better manage the consumers dementia. The FROP was updated with care plan strategies to reduce the risk of falls. Incontinence assessment was completed. The representative present declined for the consumer to engage in a skin assessment. Given the level of risks, the clinician explained the risks involved and provided the representative with a fact sheet, in conjunction with completing a dignity of risk form. Additional measures included Braden Scale for pressure risk completed and Clinical register updated to reflect risks.
* In response to another consumer identified with identified gaps and services, the providers Registered Nurse attended the consumers residence 16th December 2024. Oxygen management plan reviewed with consumer and signed. Oxygen cylinder instructions made and distributed to their representative. Home Care Worker training and competency assessments are scheduled 31 January 2025. Continence assessment was completed. Braden scale for predicting pressure sore risk completed. Quality and Compliance Coordinator will conduct an internal audit of the consumers files once complete.
* In response to a CHSP consumer identified, a home visit was scheduled 22 January 2025 with representative, Team leader and Registered Nurse. The following were conducted. Diabetes health care plan to be completed (self-managed). Pain management form to be completed. Depression to be reviewed; Referred to beyond blue and GP / How is this managed. Discuss current supports – it was noted this consumer needs to increase in the new year. Improve isolation. Update assessments / care plan to ensure they are personalised and include strategies for home care workers, and completing FROP-COM.

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with the information provided.

The intent of this requirement is about making sure that assessment and planning are effective. These processes will support organisations to deliver safe and effective care and services.

Relevant risks to a consumer’s safety, health and well-being need to be assessed, discussed with the consumer, and included in planning a consumer’s care. This supports consumers to get the best possible care and services and makes sure their safety, health and well-being aren't compromised.

To assess, plan and deliver care and services that are safe and effective, members of the workforce need to have the relevant skills, qualifications and knowledge to assess individual consumers’ needs and to understand their needs, goals and preferences.

I acknowledge the providers response regarding identified deficiencies and proposed timeframes in responding to them. The service has responded to immediate deficiencies identified with sampled consumers. When viewed in conjunction with broader proposals within the CIP, I am confident that remaining proposed actions will be implemented.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 2(3)(a) in Standard 2, Ongoing assessment and planning with consumers.

Requirement 2(3)(e) - was found non-compliant for Service ID’s 26177, 24781, and 24780 following a Quality Audit undertaken from 6 December 2024 to 11 December 2024. The service did not demonstrate:

* Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer

The Assessment Team was not satisfied appropriate action is taken after an incident or change to consumers need goals or preferences is addressed by the Provider. Documentation reviewed evidenced where incidents or changes impacted consumer’s needs, goals and preferences care and services were not reassessed or reviewed. The Assessment Team provided the following evidence to support their assessment:

* One consumer electronic care file evidenced a FROP-COM completed on 13 January 2024.
  + Review of the incident register notes a fall occurred on 8 March 2024 resulting in bruising. The incident report notes a call to the representative to check in, no offer of a falls assessment, nor changes to service requirements and state ‘Client will be more careful’. Clinical staff confirmed they did not offer a falls risk assessment to the consumer post fall to reassess the consumers ability or needs.
  + The incident register noted a second fall occurred 28 August 2024, resulting in the consumer breaking their ribs. The report states the consumer declined additional services. Clinical staff confirmed no falls risk assessment was offered or completed.
  + The incident register noted a third fall on 12 November 2024 detailing fractured ribs. An RN attended an annual review and post fall review on 26 November 2024 stating the RN with submit a review for a higher package.
* Review of another consumers file evidenced a progress note from staff on 14 February 2024, reflected on the incident register noting a suspected pressure injury spanning from sacrum to the groin area. Clinical staff confirmed discussion with the representative on 14 February 2024 and determined it to be incontinence-associated dermatitis to be treated with barrier cream. Clinical staff confirmed neither a continence, skin nor wound assessment were conducted for the consumer after this incident.
  + A second progress note dated 23 February 2024, reflected on the incident register noted worsening of the sore and breaking of the skin. The incident register noted Clinical staff requested a photograph of the wound however did not receive it as staff had left the service. No further follow up was conducted until 01 March 2024 where clinical staff said they attended the consumer’s home for the purpose of upgrading to a higher package. Clinical staff said they offered to review the sore but stated the representative declined. The provider was unable to demonstrate this discussion had taken place.
* The incident register noted a consumer fainted and fell on 27 November 2024. This consumer advised they attended their GP who adjusted their medication. Review of their file said they had been waiting on an ACAT assessment since May 2024.
  + The incident register outcome states the case management and clinical team will monitor future reports by staff, and did not state any further internal assessments were completed.
  + Review of the consumers care plan reflected their medical history as a diabetic, history of heart attacks, stroke, high blood pressure and breathing difficulties however did not include strategies to minimise risk of falls during care delivery while they await a package upgrade.

The Provider provided the following in response to the Assessment Team’s report.

* An acknowledgement of gaps, with recognition of additional follow up required, including.
  + While incidents are reviewed, actioned and closed by clinicians, the provider recognises the need for a more consistent follow-up and assessment to close the loop.
  + Further commitment to continuous improvement on risk mitigation and strategies to reduce the likelihood of the incident reoccurring.
  + All office staff and home care workers will receive additional guidance on the importance of documenting changes and updating care plans accordingly. Audits of customer files will be conducted monthly to verify that changes in circumstances are consistently followed.
* Staff Training: The Franchise Manager and Quality and Compliance Coordinator reviewed the incident management process with clinicians to discuss audit findings and ensure follow up assessments are more consistently undertaken. Planned completion date 31 January 2025.
* Incident management Process Updates: A structured follow-up protocol is being developed and implemented to ensure that every incident is appropriately responded to; including reassessment and risk mitigation where necessary. Planned completion date 31 January 2025.
* Regular monitoring and supervision: A dedicated clinical resource has been tasked with the role of reviewing incidents weekly at a higher level. The clinical resource will investigate progress notes, assessments and make recommendations to mitigate the risk of another incident. Planned completion date 31 January 2025.
* Feedback Mechanism: Clinician will report to the Franchise Manager monthly reporting on barriers or challenges in completing follow-up assessments, allowing for improvements ongoing. Planned completion date 31 January 2025.

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with the information provided.

The intent of this requirement is ensuring organisations are regularly reviewing the care and services they provide to consumers. This is important to make sure that the care and services plans are up-to-date and meet the consumer’s current needs, goals and preferences, care and services the organisation provides meet the consumer’s needs safely and effectively, and care and services the organisation provides are updated to apply better practice when available.

All care and services plans are expected to include an agreed review date. How often a review is done depends on the needs of each consumer and on the nature and type of services the organisation is providing. However, in addition to the reviews that are scheduled, a consumer’s care and services plan should be reviewed when the consumer’s condition changes (for example, physical or mental health), situations change (for example, if the organisation’s arrangements for a service changes), and incidents or accidents happen (for example, if a consumer has fallen).

I acknowledge the providers response regarding identified deficiencies and proposed timeframes in responding to them. I appreciate the risk mitigation actions taken with consumers identified within the assessment report, however, also acknowledge that consumer deficiencies identified in this requirement have not been fully addressed, with many having a proposed timeframe of 31 January 2025. Please see my findings in Requirements 2(3)(a) regarding consumer actions.

However, at the time of my finding, the full suite of proposed CIP actions have not been implemented or embedded. Once established and embedded, results should identify themselves expediently.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 2(3)(e) in Standard 2, Ongoing assessment and planning with consumers.

Remaining requirements in Standard 2 Consumers and representatives confirmed assessment and care planning occurs. Care planning documentation showed assessment and planning considers risks to consumer health and well-being. The service uses validated tools to assess risks to guide the delivery of safe and effective care and services. Risks assessed include falls, pain, wounds and cognition. Staff confirmed they have access to care planning documentation to guide them on the care and services provided.

Consumers and representatives confirmed they receive assessment and care planning information and documentation, and staff know what they are doing. Staff confirmed they have access to care planning documentation to guide the care and services they provide for consumers. Documentation showed staff at the social support groups have access to clear directives in care plans to support consumers with their interests, likes, dislikes and medical conditions and HCP care plans have clear directives for staff.

Consumers and representatives confirmed assessment and planning outcomes are reflective of what is important to the consumer to meet their needs and goals. Staff demonstrated awareness of what is important to each consumer, including the consumer’s needs and preferences for care. Staff and management described how assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advanced care planning and end of life planning if the consumer wishes.

Management explained care planning documentation is updated regularly based on ongoing assessment and planning processes. Documentation showed clear directives for staff to support the consumer based on the consumer’s assessed needs and goals.

Consumers and representatives confirmed the service involves them, and others they wish involved, in the care planning and assessment process. Staff and management demonstrated how assessment and planning occurs in partnership with consumers, the service and other health care professionals where necessary. Documentation showed assessment and planning involves the consumer and others the consumer agrees to be involved, including other organisations, individuals and other providers.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all remaining Requirements in Standard 2, Ongoing assessment and planning (HCP & CHSP).

# Standard 3

|  |  |  |  |
| --- | --- | --- | --- |
| Personal care and clinical care | | HCP | 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. | Compliant | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant | Compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Not Compliant | Not Compliant |

Findings

Requirement 3(3)(b) - was found non-compliant for Service ID’s 26177, 24781, and 24780 following a Quality Audit undertaken from 6 December 2024 to 11 December 2024. The service did not demonstrate:

* Effective management of high impact or high prevalence risks associated with the care of each consumer.

The Assessment Team was not satisfied the provider could demonstrate risks associated with each consumer’s care, and services were managed effectively. Staff described how they identify and assess some high-impact and high-prevalence risks associated with consumers personal and clinical care. However, staff interviews and document review evidenced not all risks for each consumer had been identified, assessed nor managed effectively. The Assessment Team provided the following evidence to support their assessment:

* One consumers electronic care file was reviewed which identified the consumer lives alone has multiple comorbidities including chronic kidney disease and dementia.
  + Document review evidenced measures were not put in place to support this consumer to manage their medication safely resulting in multiple medication mistakes and worsened condition.
    - The incident register noted 2 medication incidents in March 2024. Clinical staff said at this stage the consumers family were supporting medication prompting via phone. No action was taken in response to incidents, the register noted an ongoing concern for medication incidents due to the consumers dementia and to monitor future incident reports.
    - Impacting factors to regular care resulted in medication prompting between 9 September 2024 and 18 September 2024. The provider put medication prompting services in for each weekday however due to budgeting constraints did not put in weekend medication prompting. Management and staff were unable to demonstrate any alternative strategies had been discussed with the consumer/representative to ensure the consumer was able to take her medication safely during this time. The incident register evidenced 2 missed medication incidents on each weekend the representative was away. No action was taken, stating the representative would be back soon for medication prompting on weekends.
    - The incident register showed an incident of missed medication on 14 October 2024 and subsequently 7 November 2024 resulting in an overdose of medication which contributed to kidney failure.
    - A comprehensive assessment completed on 06 November 2023 noting consumer weight loss, resulting in a referred to a Dietician by their GP with the initial assessment completed on 23 January 2024. A comprehensive assessment completed on 13 November 2024 noted further weight loss to 44kg. Clinical staff acknowledged the decline in weight as a risk. Clinical staff advised there was no further intervention as weight started to decline, stating they were already receiving supplement drinks and sandwich prompts.
* Staff advised they track risks associated with HCP consumers on the clinical register. Staff advised the register is incomplete as not all consumer risks had been logged at the time of the Quality Audit. Review of the register identified.
  + Entry for the above consumer noting medication risk but failing to identify nutrition or hydration.
  + A previous consumer identified in Requirement 2(3)(a) lists within their care plan various comorbidities including dementia, falls and hearing loss. The entry for this consumer on the clinical register demonstrated no risks were marked.
* Clinical meeting minutes did not include discission of the clinical register. Management confirmed at the time if the quality audit there was no process in place to manage the high-impact and high-prevalence risks associated with CHSP consumers.

The Provider provided the following in response to the Assessment Team’s report.

As per included documentation (Actions and Considerations Plan & Audit Findings CIP 15.01.2025) identifying a series of considerations and actions, including.

* Advisement of ticket lodged with the providers client management system provider to develop an improved system to manage consumers at risk via level. i.e. Low priority 1, Medium priority 2, High priority 3.
* Introduction of a training plan incorporating management of high risk, high prevalence risk consumers booked with all office staff 29th January 2025.
* Phone consult with representative of one consumer identified in assessment report as above. Key issues and mitigation strategies discussed, including raised high risk and possible residential care and provided codes. Strategy put in place to reduce medication errors.
  + Stakeholders meeting in person scheduled for February when representative returns from overseas to improve issues identified; weight loss, nutrition and hydration, deterioration, risk management, residential care, previous medication incidents.
* As discussed in Requirement 2(3)(e), RN is currently reviewing the incident process. Providing a report of incidents and recommendations for the Franchise Manager, QCC, Clinicians to review and implement. RN will review actions, follow-ups and documents completed to ensure appropriate measures are in place, and that consumers who deteriorate have appropriate assessment and follow-up from RN was received. First report from RN was received 14th January 2025.

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with the information provided.

The intent of this requirement is about ensuring organisations need to do all they can to manage risks related to the personal and clinical care of each consumer. This means following best practice guidance and applying measures to make sure the risk is as low as possible whilst supporting a consumer’s independence and self-determination to make their own choices, including to take some risks in life.

Effective management of risks is underpinned by clinical governance systems for safety and quality. This includes reviewing how personal and clinical care is delivered to apply new practices and responding appropriately and promptly to a consumer’s changing needs.

I appreciate the provider’s acknowledgement regarding identified deficiencies and proposed timeframes in responding to them. Despite the full suite of proposed CIP actions having not been implemented or embedded, responses with risk mitigation strategies to respond to consumers identified by the audit process have occurred. Once remaining proposed actions are embedded, results should identify themselves expediently.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement 3(3)(b) in Standard 3 Personal care and clinical care.

Requirement 3(3)(g) - was found non-compliant for Service ID’s 26177, 24781, and 24780 following a Quality Audit undertaken from 6 December 2024 to 11 December 2024. The service did not demonstrate:

* Minimisation of infection related risks through implementing standard and transmission-based precautions to prevent and control infection; and practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.

The Assessment Team was not satisfied the provider could demonstrate effective practices to promote appropriate antibiotic use and reduce the risks of consumers increasing resistance to antibiotics. Staff interviewed could not demonstrate steps taken in practice to reduce the risk of increasing resistance to antibiotics. Documentation review evidenced the provider did not have policies and processes in place to support appropriate use of antibiotics at the time of the Quality Audit. The Assessment Team provided the following evidence to support their assessment:

* One consumer file review identified evidence of a history of Urinary Tract Infection (UTI) and subsequently long-term use of antibiotics. File review and the incident register noted on multiple occasions staff were advised this consumer was taking antibiotics due to UTI’s. Clinical staff stated they advised them to increase water intake and stay hydrated. However, staff could not demonstrate strategies were discussed with them or their representative to minimise possible infection and the risks of ongoing use of antibiotics.
  + This consumers medication management plan dated 27 March 2024 was sighted on the consumer file which included a list of medications taken. The medication management plan template included a section to monitor, educate and plan for antimicrobial use. This section of the medication management plan was left blank.
* Documentation reviewed evidenced the provider had industry resources available in relation to antimicrobial stewardship. Clinical staff stated references to antimicrobial stewardship were embedded into the Infection control policy. However, review of infection control policies did not evidence guidance in relation to the monitoring or use of antibiotics.

The Provider provided the following in response to the Assessment Team’s report.

As per included documentation (Actions and Considerations Plan & Audit Findings (CIP) 15.01.2025) identifying a series of considerations and actions, including.

* Recognition of the importance of promoting appropriate antibiotic use to reduce resistance risks and has initiated the implementation of an antimicrobial stewardship (AMS) program. This program includes the development of policies and procedures and protocols to ensure antibiotics are prescribed appropriately based on clinical evidence. Collaboration with general practitioners and pharmacists to review antibiotic prescriptions and ensure compliance with best practices.
* Additionally, antimicrobial stewardship agenda item added to the clinical meeting to promote AMS to ensure consumers are educated and well. Examples must be discussed and reviewed at each team meeting.
* Staff training for clinicians in AMS documentation.
  + A planned completion date of 31 March 2025 is documented.

In coming to my finding, I have considered the information in the Assessment Team’s report, in conjunction with the information provided.

The intent of this requirement is about ensuring organisations are expected to assess the risk of, and take steps to prevent, detect and control the spread and severity of infections. To minimise the risk of transmission, severe illness, hospitalisation or even death, precautionary infection control measures should be prioritised, including standard and transmission-based precautions and facilitating timely access to relevant vaccinations

I appreciate the provider’s acknowledgement regarding identified deficiencies and proposed timeframes in responding to them. At this however, the proposed actions have not been implemented or embedded.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement 3(3)(g) in Standard 3 Personal care and clinical care.

Remaining requirements in Standard 3 Consumers and representatives confirmed consumers receive quality personal care. Staff were knowledgeable of each consumer’s unique needs and preferences. Management described how personal care is tailored to the needs of the consumer to optimise the consumer’s health and well-being. Documentation showed care directives clearly guide staff in how to provide personal care.

Staff described how they provide care for vulnerable and high need consumers and how they manage risks during service delivery. Management described how high-impact and high-prevalence risks are identified and how staff are provided with directives on how the support those consumers. Documentation showed strategies in place to guide staff in provision of care where high-impact or high-prevalence risks have been identified.

Consumers and representatives confirmed discussions about end-of-life planning are held. Staff and management described strategies for maximising consumer comfort when a consumer is nearing end of life. Documentation showed the service has procedures to prioritise services and onward referrals for consumers nearing end of life.

Consumers and representatives expressed confidence in staff being able to recognise and respond to a change in the consumer’s condition. Staff described how they would identify deterioration and how the service would adjust service delivery to meet the changed needs of the consumer. Management and staff have received training in recognising and responding to deterioration. The service uses a deterioration assessment tool which enables staff and management to identify, record and report signs and symptoms of deterioration.

Consumers and representatives expressed satisfaction that the consumer’s condition, needs and preferences are communicated within the service and with others where care is shared. Staff confirmed they have access to the consumer’s care directives through an application on their mobile device. Management discussed how information and recommendations to other health practitioners are received, reviewed and implemented and documented. Documentation showed the service communicates with others to ensure the provision of personal and clinical care for consumers.

Consumers and representatives expressed satisfaction the service will refer the consumer to other organisations and providers when required. Management demonstrated an understanding of referral networks and described internal and external referral processes used by the service. Documentation showed the service makes referrals to other organisations and providers where the need is identified.

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

# Standard 4

|  |  |  |  |
| --- | --- | --- | --- |
| Services and supports for daily living | | HCP | 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 | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant | 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 | 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 | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant | Not applicable |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant | Compliant |

Findings

Consumers and representatives confirmed the services and supports for daily living the consumers receive support the consumers to optimise their independence and well-being. Staff described how individualised and effective services and supports for daily living meet each consumer’s needs, goals and preferences. Management stated feedback from consumers on activities would be part of the service’s activities calendar. Documentation showed assessments and care plans identify services and supports for daily living which promote individual consumer’s independence and enhanced quality of life.

Consumers and representatives expressed satisfaction with the supports for daily living received by consumers. Staff described how they recognise and support consumers’ emotional, spiritual and psychological well-being and how services provided meet those needs. Management demonstrated an understanding of supporting consumers in their emotional, spiritual and psychological well-being. Documentation showed evidence of support strategies to meet individual consumer’s emotional, spiritual and psychological well-being.

Consumers and representatives confirmed consumers participate in activities of interest to them in their homes and in the community. Staff stated they access information about consumers on the mobile application to guide them on how to support the consumer in their personal relationships. Management described processes used by the service to meet the social and personal needs of consumers. Documentation showed services and supports for daily living support consumers to participate in the community, do things of interest to them and have social and personal relationships.

Consumers and representatives confirmed the consumer’s needs and preferences are communicated during the assessment process. Staff confirmed they have access to each consumer’s needs and preferences through a mobile application. Management advised consumer care plans are available to staff through a mobile application and to subcontracted services through a service request process. Documentation showed care plans include clear directives about the consumer’s condition, needs and preferences.

Consumers confirmed the food provided is satisfying and nutritious. Staff described how the service ensures appropriate meals are provided based on consumer needs and preferences, including allergies and likes and dislikes. Documentation showed the service has a documented emergency plan which identifies allergies, likes and dislikes of consumers and there are special directives for consumers with diabetes.

Consumers and representatives confirmed consumers have received equipment, which is safe, and suitable. Management described the assessment and ongoing processes to ensure equipment provided is suitable and safe for the consumer. Management stated equipment is checked at reassessment and will be serviced or replaced as necessary. Documentation showed equipment is selected for safety and suitability on the recommendations of allied health professionals.

Consumers and representatives confirmed the service supports consumers to access other services, including other lifestyle services where appropriate. Staff stated they will document concerns about consumers for management to review and make referrals where necessary. Management discussed processes used to refer consumers for additional care and higher-level packages. Documentation demonstrated the service refers consumers to organisations and providers for additional services and supports when necessary.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 4, Services and supports for daily living (HCP and CHSP).

# Standard 5

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

Findings

The Assessment Team did not assess Standard 5 as the provider does not provide services within a service environment.

# Standard 6

|  |  |  |  |
| --- | --- | --- | --- |
| Feedback and complaints | | HCP | CHSP |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant | 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 | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant | Compliant |

Findings

Consumers and representatives confirmed they are aware of how to provide feedback and raise complaints and feel safe to do so. Staff stated they seek feedback from consumers during service delivery and emphasise to consumers the importance of making feedback. Management stated the complaint procedure is explained to consumers. Documentation showed complaint mechanisms and procedures are included in consumer agreements and consumer information manuals.

Consumers and representatives confirmed they are aware other methods for raising and resolving complaints, including knowing how to contact the Commission. Documentation showed the service’s complaints procedure and consumer manuals offer consumers diverse internal and external feedback, complaints and advocacy options, in the consumer’s language of choice.

Consumers and representatives confirmed the service resolved issues or informal complaints they had made. Staff described processes for escalating complaints from consumers. Management described how the service responds to complaints and how it uses open disclosure when issues are identified. Documentation showed the service uses an open disclosure approach to resolve issues.

The service’s complaints policy states complaints will be addressed promptly, treated confidentially, and used as an opportunity for improvement. The service’s complaints register is used to trend complaints and improve service, with strategies implemented to avoid the same issues occurring again. Documentation showed complaints are actioned and finalised and, if necessary, improvements to services are implemented.

Based on the information summarised above, I find the provider, in relation to the service, compliant with all Requirements in Standard 6, Feedback and complaints (HCP and CHSP).

.

# Standard 7

|  |  |  |  |
| --- | --- | --- | --- |
| Human resources | | HCP | 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 | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant | 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 | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant | Compliant |

Findings

Consumers and representatives confirmed consumers feel respected. Staff described how they relate to consumers respectfully. Results from a survey conducted by the service showed consumers feel they are treated with integrity and respect.

Consumers stated staff are competent. Staff described the minimum qualifications required for their roles. Management described the service’s processes for determining staff competency, including for subcontracted staff. Documentation showed evidence of minimum qualifications and knowledge required for each role.

Staff confirmed they receive induction training and ongoing mandatory training. Management explained the service uses an online training system for staff. Documentation showed the service maintains up-to-date training and competency records for staff.

Support staff confirmed they undergo regular informal performance appraisal processes with management. Management confirmed support staff undergo regular informal performance appraisal processes with office staff undergoing formal annual appraisal processes. Management stated a review of performance appraisal processes will be undertaken. Documentation showed evidence of performance reviews being completed for office staff.

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

# Standard 8

|  |  |  |  |
| --- | --- | --- | --- |
| Organisational governance | | HCP | CHSP |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant | 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. | Compliant | Compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant | Compliant |

Findings

The service has established a consumer advisory body, with consumers invited to attend focus groups and engagement sessions. The service seeks feedback from consumers through an annual surveys, website portals and other contact mechanisms and through group sessions to understand the needs of consumers. Consumers are provided newsletters and correspondence to keep them informed of changes in Aged Care. Staff stated the service supports consumers to be engaged in service delivery and development.

Interviews with consumers, staff and management and documentation showed there are effective organisation wide governance systems in place to support information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints.

The organisation has a risk management framework inclusive of a risk register and risk management procedure. This ensures effective management of high-impact and high-prevalence risks, effective identification and response to abuse and neglect, support for consumers to live their best life and management and prevention of incidents through an incident management system.

The governing body remains informed via established leadership reporting pathways from the service level through the management structure, in order to satisfy itself that the Quality Standards are being met. The governing body meets and considers operational reports presented by management. Feedback, complaints, incidents and deterioration reporting are part of monitoring, with reporting on subcontractors to be incorporated into the monthly governing body reporting processes.

The organisation has an infection control plan and all staff have received infection control training and refresher training. Open disclosure is used when things go wrong.

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

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)