**Performance**

**Report**

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| Name: | Sydney Multicultural Community Services Inc |
| Commission ID: | 200645 |
| Address: | 3 General Bridges Crescent, DACEYVILLE, New South Wales, 2032 |
| Activity type: | Quality Audit |
| Activity date: | 9 January 2024 to 10 January 2024 |
| Performance report date: | 27 February 2024 |

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

# Service included in this assessment

Home Care Packages (**HCP**) included:  
Provider: 1172 Sydney Multicultural Community Services Incorporated  
Service: 17670 Multicultural Home Care Packages  
  
Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 7705 Sydney Multicultural Community Services Inc  
Service: 27914 Sydney Multicultural Community Services Inc - Care Relationships and Carer Support  
Service: 24439 Sydney Multicultural Community Services Inc - Community and Home Support

**This performance report**

This performance report for Sydney Multicultural Community Services Inc (**the service**) has been prepared by M Abjorensen, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

# Material relied on

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

* the Assessment team’s report for the Quality Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others; and,
* the provider’s response to the Assessment Team’s report received 8 February 2024 and 13 February 2024.

# Assessment summary for Home Care Packages (HCP)

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

# 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 Compliant** |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Not Compliant** |

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

# Areas for improvement

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

Standard 2 Requirement (3)(a)

* Implement assessment and planning processes that consider the risks to the health and wellbeing of HCP consumers, to inform care and service delivery

Standard 3 Requirement (3)(b)

* Ensure management of high impact and high prevalent risk associated with the care of each consumer occurs through tailored adjustments in care delivery in response to consumer changing needs and risks

Standard 5 Requirement (3)(b)

* Embed updated processes to ensure all areas of the service environment remain safe, clean and well maintained.

Standard 6 Requirement (3)(d)

* Ensure feedback and complaints are reviewed and used to improve the quality of care and services, enable trending and support reporting mechanisms within the organisation

Standard 8 Requirement (3)(b)

* Ensure the governing body is accountable of the quality of care and services delivered through current policies, procedures and mechanisms to ensure the board remains informed of incidents and feedback trends and regulatory requirements

Standard 8 Requirement (3)(c)

* Implement effective governance wide systems relating to continuous improvement and feedback and complaints systems

Standard 8 Requirement (3)(e)

* Establish and implement an effective clinical framework.

# Standard 1

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| --- | --- | --- | --- |
| 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 (3)(d)

The Assessment Team found the service demonstrated CHSP consumers are supported to take risks to enable them to live the best life they can. However, The Assessment Team was not satisfied HCP consumers are 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:

* While consumers/representatives were not able to provide circumstances where the service had promoted the taking of risk to enable consumers to live independently, feedback did not indicate the service prevents them from living the life they choose; and,
* Staff provided practical examples of how they support consumers to take risks, such as a preference against using mobility equipment. However, care documentation did not contain evidence of assessments, or discussions, around the risks associated with this; and,
* In response to Assessment Team feedback, staff and management committed to revision of care documentation, in consultation with consumers, to include dignity of risk discussion and documentation. Management advised they will make dignity of risk documentation accessible to service delivery staff.
* In response to the Assessment Team’s report, the provider’s response included the following: Explanation that inaccurate information was provided regarding a sampled consumer as records and case manager knowledge of the consumer did not align with the information provided or interviews conducted; and,
* Explanation, and evidence, that the service has provided additional training for staff regarding duty of care and dignity of risk processes

In coming to my finding, I have considered the information and evidence in the Assessment Team’s report and the provider’s response, which does not demonstrate a failure to support consumers in taking risks or living the life they choose.

I find the information and evidence identifies improvements relating to dignity of risk processes and documentation of relevant discussions, rather than issues in how the service respects a consumer’s wishes and preferences relating to the risks they choose to take . Furthermore, feedback from consumers throughout the report shows the service supports them to continue living the life they choose.

In addition to the corrective actions commenced during the Quality Audit to revise care documentation and the provider’s response shows proportionate actions have been taken to improve dignity of risk processes through staff training.

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

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

Consumers/representatives confirmed consumers feel accepted and valued and staff treat consumers well. Staff spoke respectfully about consumers and demonstrated an awareness of consumers’ individual identities. Documentation showed the service has a consumer-centred approach to delivering services.

Consumers confirmed staff understand their needs and preferences and know what to do to make sure they feel respected, valued and safe. Staff and management described how the service adapts the way care and services are offered to ensure they are culturally safe for each consumer. Documentation reviewed confirm cultural needs are taken into consideration during service delivery.

Consumers/representatives confirmed consumers are supported to make their own decisions about the services they receive, and decision making is in consultation with the consumer/representative. Staff displayed knowledge, awareness and understanding of consumer choices and preferences and described how each consumer is supported to make informed decisions about their care and services. Documentation evidenced consumer involvement in decisions about the services they receive, including details for those whom consumers would like involved in their care and services.

Consumers/representatives confirmed consumers receive information in a way they can understand that enables them to make informed choices. Management described when and how information is provided to consumers. Documentation confirmed information provided to consumers is current and accurate.

Consumers confirmed their privacy and confidentiality is respected. Staff and management demonstrated an understanding of their responsibilities in relation to maintaining consumer privacy and confidentiality. Privacy information provided to consumers was evidenced to include information about the collection, use and disclosure of consumer personal information.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirements (3)(a), (3)(b), (3)(c), (3)(e) and (3)(f) in Standard 1 Consumer dignity and choice, for both HCP and CHSP programs.

# Standard 2

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| --- | --- | --- | --- |
| 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. | Not 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. | Compliant | Compliant |

Findings

Requirement 2(3)(a)

The Assessment Team found the service demonstrated assessment and planning includes consideration of risks to CHSP consumers health and well-being and informs the delivery of safe and effective services. However, the Assessment Team was not satisfied HCP consumers had validated risk assessment tools used to rate level of risk, identify risk management strategies, or triggers for further clinical assessment. The Assessment Team provided the following evidence relevant to my finding:

* Three consumers identified as having falls risks did not have validated falls risk assessments completed; and,
* Management advised validated risk assessment tools were for residential care only; and,
* A consumer a form of physical restraint, where equipment was provided prior to commencement with the service, did not have assessments conducted to determine if continued use of equipment was the most appropriate strategy to maintain safety.
* In response to the Assessment Team’s report, the provider’s response included the following: Explanation, supported by evidence, that risk assessment tools (such as falls risk assessments) will be implemented; and,
* Explanation, supported by evidence, of corrective actions taken for a consumer with a physical restraint, including, a case conference, and documentation, to determine the appropriateness of the equipment in consultation with the family; and,
* Explanation appropriate assessment and planning tools will be used to assess and document the use of restrictive practices.

In coming to my finding, I have considered the information and evidence in the Assessment Team’s report and the provider’s response.

I acknowledge the service has advised appropriate risk assessment tools will be implemented moving forward and findings discussed with consumers/representatives and documented. However, I find these corrective actions remain in their infancy and further time is required to demonstrate the sustainable effectiveness of these actions.

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

In relation to CHSP, I find the provider, in relation to the service, compliant with Requirement (3)(a) in Standard 2 Ongoing assessment and planning with consumers.

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

Consumers/representatives confirmed the care and services meet the needs, goals and preferences of the consumer and advance care planning is discussed. Documentation reviewed confirm care needs were accurately recognised, preferences were listed, and goals were individualised. Furthermore, advanced care directive information was also captured in consumer files.

Consumers/representatives confirmed they are involved in assessment and care planning discussions that include choice and options available. Management described how they keep consumers and families involved in assessment and planning processes. Documentation showed consumers, those consumers wish to be involved and other organisations and individuals are included in care planning discussions.

Consumers/representatives confirmed receipt of hard copy care plans and that were easy to understand. Staff confirmed they have access to sufficient information included in care plans which enables them to deliver safe and effective care and services.

Consumers/representatives confirmed care plans are reviewed annually at a minimum but have occurred more frequently as required. Staff/management, and review of documentation, confirmed care planning review processes in place.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirements (3)(b), (3)(c), (3)(d) and (3)(e) in Standard 2 Ongoing assessment and planning with consumers, for both HCP and CHSP programs.

# Standard 3

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| --- | --- | --- | --- |
| 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 | Not Applicable |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant | 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. | Compliant | 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. | Compliant | 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. | Compliant | Not Applicable |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant | 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. | Compliant | Not Applicable |

Findings

Requirement 3(3)(a)

The Assessment Team was not satisfied consumers received safe and effective personal/clinical care services. The Assessment Team provided the following evidence relevant to my finding:

* Consumers/representatives described personal care as being tailored to consumer needs with regular staff delivering personal care, in accordance with their preferences; and,
* Staff were knowledgeable of consumer care needs and preferences and described being supported by coordinators, if they have any concerns; and,
* For a consumer who refuses wound care, the service advised the strategy was to ‘keep sending nurses’.

In response to the Assessment Team’s report, the provider’s response included the following:

* Evidence provided of numerous referrals/correspondence to consumer, general practitioner (GP), nursing contractors, social workers, palliative care specialists to manage continual refusal of wound care services for the one consumer identified by the Assessment Team; and,
* Explanation, and evidence of vital sign monitoring charts and reports received that are received from external providers and documented in consumer files.

In coming to my finding, I have considered the information and evidence in the Assessment Team’s report and the provider’s response.

I am satisfied with the provider’s response providing further evidence refuting the Assessment Team’s initial assessment. I acknowledge, the provider has to the best of its ability taken appropriate action to provide effective clinical care whilst respecting consumer choice.

In relation to vital sign monitoring charts, I find this relates to the sharing of information on consumer condition, needs and preferences and for this reason I have considered this under Requirement (3)(e) in this Standard.

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

Requirement 3(3)(b)

The Assessment Team was not satisfied the service demonstrated effective management of high-impact or high-prevalence risks associated with the care of each consumer. The Assessment Team provided the following evidence relevant to my finding:

* Three consumers identified to continually refuse personal/clinical care with no further behavioural support assessments conducted; and,
* Management was unaware of and had no procedures in place to identify and assess restrictive practices; and,
* There were no processes in place to easily monitor consumers with high impact or high prevalence risks.

In response to the Assessment Team’s report, the provider’s response included the following:

* Explanation that the workforce is equip with knowledge and referral networks to support consumers living with dementia
* Plan to implement behaviour support plans (BSP) to identify, assess and manage restrictive practices.

In coming to my finding, I have considered the information and evidence in the Assessment Team’s report and the provider’s response, which does not demonstrate effective management of high-impact or high-prevalence risks associated with the care of each consumer.

I have considered the intent of the Requirement which expects services to review how personal and clinical care is delivered to apply new practices and respond appropriately and promptly to a consumer’s changing needs. I find this has not occurred through the lack of tailored approaches for consumers who refuse personal/clinical care. I find that without the use of validated assessment tools the service does not demonstrate how risks are identified to find ways to reduce these risks.

I acknowledge the service has plans in place to manage and monitor restrictive practices, however, no evidence was provided to address how other high-impact, high-prevalence risks would be managed or monitored.

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

Requirement 3(3)(e)

The Assessment Team was not satisfied 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. The Assessment Team provided the following evidence relevant to my finding:

* Most consumers/representatives advised they felt on occasion there was a need to repeat information or direct newer staff; and,
* Management advised the hard copy consumer communication book is removed from the consumer’s home during care plan reviews, which the Assessment Team advised did not demonstrate effective management of communication within the organisation; and,
* Information and evidence under Requirement (3)(a) in this Standard, shows the service made improvements to ensure vital sign monitoring charts/reports are received and documented in consumer files.

In response to the Assessment Team’s report, the provider’s response included the following:

* Explanation to clarify that staff do not remove communication books during care plan reviews; and,
* Evidence provided demonstrating process in place for staff to report verbally concurrently with anything documented in the communication book; and,
* Explanation that processes have been established to transition paper based documents to the incoming electronic platform

In coming to my finding, I have considered the information and evidence in the Assessment Team’s report and the provider’s response, which does not demonstrate a failure to effectively communicate information about the consumer’s condition, needs and preferences.

While the information shows areas for improvement relating to documentation, evidence does not show communication regarding consumer needs, preferences and condition is ineffective. I find evidence throughout the report shows information is communicated within the organisation, and to external providers where required.

I am satisfied with the provider’s response providing further evidence refuting the Assessment Team’s initial assessment. In relation to some consumers/representatives having to occasionally repeat or direct newer staff, I do not find it proportionate to deem a failure in this Requirement based on this alone.

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

Requirements 3(3)(c), 3(3)(d), 3(3)(f), and 3(3)(g)

Management and documentation review confirm the needs, goals and preferences of consumers nearing the end of life are recognised, addressed, and their comfort maximised, and their dignity preserved.

Consumers/representatives confirmed they are confident staff can recognise any changes to consumers condition/deterioration and respond appropriately. Staff/management and review of documentation confirm actions taken in response to notification of consumer deterioration.

Consumers/representatives confirmed care delivery, including referral processes to relevant health professionals, is timely and appropriate. Management and documentation review confirm referral processes to appropriate individuals to ensure care and services meet consumer’s needs, goals and preferences.

Consumers/representatives confirmed staff practice appropriate infection control precautions to prevent the spread of infection. Staff confirm they have completed appropriate infection control training and are provided with an adequate supply of personal protective equipment (PPE). Documentation review confirm staff have completed training in antimicrobial stewardship.

Personal care and clinical care is provided to consumers under the CHSP program funding, as such, this standard is not applicable.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirements (3)(c), (3)(d), (3)(f), and (3)(g) in Standard 3 Personal and clinical care.

# Standard 4

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

Findings

Requirement 4(3)(g)

The Assessment Team was not satisfied where equipment provided using HCP funding is safe, suitable and well maintained. The Assessment Team provided the following evidence relevant to my finding:

* Two of 2 consumers who had occupational therapist (OT) assessed equipment purchased did not have any reference how cleaning or maintenance of equipment is monitored or rectified.

In response to the Assessment Team’s report, the provider’s response included the following:

* The provider corrected inaccuracies within the Assessment Team report relating to the equipment provided to a consumer by another care provider; and,
* Explanation, and evidence, that information relating to equipment provision, cleaning and maintenance has been included in care plans; and,
* Explanation that the service has implemented a register of equipment and maintenance schedules within the electronic care system.

In coming to my finding, I have considered the information and evidence in the Assessment Team’s report and the provider’s response which demonstrates equipment provided is safe, suitable, clean and well maintained.

I have considered, evidence did not show issues relating to equipment suitability, cleanliness or maintenance. Instead, allied health clinicians inform the suitability of equipment provided and consumers did not raise concerns in relation to how their equipment functions or is maintained.

I acknowledge the service has taken steps to address the Assessment Team’s findings and place weight on the fact no incidents/concerns were reported by consumers/representatives regarding safety, suitability, or cleanliness of purchased equipment at time of Quality Audit.

Requirement (3)(g) is not applicable for CHSP funded services, as the service does not provide equipment to consumers funded through the CHSP program.

Based on the totality of information summarised above, I find the provider, in relation to the service, compliant with Requirement (3)(g) in Standard 4 Services and supports for daily living.

Requirements 4(3)(a), 4(3)(b), 4(3)(c), 4(3)(d), 4(3)(e), and 4(3)(f)

Consumers/representatives confirmed consumers are supported by staff in optimising their independence, health, well-being, and quality of life. Staff/management, and documentation review confirm, an understanding of consumer's individual preferences and steps taken to support quality of life whilst managing potential risks.

Consumers/representatives confirmed staff support consumers emotional, psychological, and spiritual needs. Staff, and documentation reviewed confirm, consumer’s emotional, psychological, and spiritual needs are assessed and supported.

Consumers/representatives confirmed consumers are supported to stay connected with their loved ones, participate in the community and engage in activities that match their interests. Staff/management, and documentation review confirm, consumer’s background and social activity preference are integrated in services provided.

Consumers/representatives confirmed staff providing care and services to consumers have a thorough understanding of their needs and preferences. Staff (including external agencies) confirmed they can access relevant information regarding the consumer's care, needs and preferences. Documentation shows care planning documentation contains adequate information to guide staff in delivering care and services that align with consumers needs and preferences for daily living.

Consumers/representatives confirmed consumers are satisfied with the services provided by other organisations that they have been referred to. Staff/management confirmed and provided examples of the process for referrals to other organisations and individuals involved in services and supports for daily living.

Consumers expressed satisfaction with meals provided. Staff described the care planning process of identifying and documenting dietary intolerances/allergies and meal preferences. Documentation showed consumers are offered choice and a variety of meals tailored to their needs and preferences.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirements (3)(a), (3)(b), (3)(c), (3)(d), (3)(e) and (3)(f) in Standard 4 Services and supports for daily living, for both HCP and CHSP programs.

# Standard 5

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| 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. | Compliant | Compliant |
| 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 Compliant | Not Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant | Compliant |

Findings

Requirement 5(3)(b)

The Assessment Team was not satisfied the service environment (in particular the kitchen area) was clean and well maintained. The Assessment Team provided the following evidence relevant to my finding:

* Observations showed pest control spray located amongst kitchen equipment, dead insects on windowsills near working benches, unclean oven and fridge, outdated test and tag labels on hot water dispensers; and,
* A kitchen certification was not produced and management explained they are waiting on further information form the local authority following a recent refurbishment
* The maintenance schedule was not up to date
* The cleaning schedule does not specify the areas that require cleaning

In response to the Assessment Team’s report, the provider’s response included the following:

* Explanation, without supporting evidence, that action has been taken to ensure the kitchen/food preparation area is hygienic and in compliance with local council regulations; and,
* Explanation, without supporting evidence, that updates to electrical tagging have occurred; and,
* Explanation that corrective actions include the implementation of forms to track cleanliness and maintenance of kitchen area.

In coming to my finding, I have considered the information and evidence in the Assessment Team’s report and the provider’s response, which does not demonstrate the service environment is clean and well maintained.

I have considered the intent of the Requirement which expects organisations to make sure the service environment is safe, clean, well maintained and comfortable. I find this has not occurred due to observations showing an unclean kitchen environment and out of date maintenance tasks.

I acknowledge the service has taken steps to rectify issues identified by the Assessment Team. However, at the time of my finding, evidence was not provided to demonstrate the actions taken. In addition, I find these corrective actions remain in their infancy and further time is required to demonstrate the sustainable effectiveness of these actions.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement (3)(b) in Standard 5 Organisation’s service environment, for both HCP and CHSP programs.

Requirements 5(3)(a) and 5(3)(c)

Consumers and observations confirmed that the service environment is welcoming and easy to understand with a layout that facilitates independence.

Consumers and observations confirmed furniture, fittings and equipment are safe, clean, suitable for use and well-maintained. Staff/management and review of documentation confirm regular cleaning and maintenance of furniture, fittings and equipment.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirements (3)(a) and (3)(c) Standard 5 Organisation’s service environment, for both HCP and CHSP programs.

# Standard 6

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| --- | --- | --- | --- |
| 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. | Not Compliant | Not Compliant |

Findings

Requirement 6(3)(c)

The Assessment Team was not satisfied 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:

* Management advised issues raised are responded immediately, however, are not always recorded; and,
* While staff were not able to define open disclosure, they provided examples of how they implement the principles of open disclosure in practice; and,
* Information and evidence under Requirement (3)(d) in this Standard evidenced appropriate action was taken in response to a consumer’s complaint where the service explained, and provided translated policy information, to show the services requested are not within role scope of care staff.

In response to the Assessment Team’s report, the provider’s response included the following:

* Explanation that complaints are responded to verbally and result in immediate action
* Evidence of staff retraining on the concept of open disclosure completed 16 January 2024.

In coming to my finding, I have considered the information and evidence in the Assessment Team’s report and the provider’s response, which does not demonstrate a failure to take appropriate action in response to complaints or a failure to use an open disclosure practice.

While the Assessment Team identified deficits in relation to the capturing of feedback, I find this has an impact on the service’s ability to trend and make improvements based on feedback, rather than an impact on action taken in response to complaints. For this reason, I have considered this under Requirement (3)(d) in this Standard.

I place weight on staff/management ability to describe how open disclosure has been practiced and note there are actions of complaints resolved discussed and documented in management reports. Furthermore, evidence does not show consumers have concerns relating to how their feedback is addressed.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement (3)(c) in Standard 6 Feedback and complaints, for both HCP and CHSP programs.

Requirement 6(3)(d)

The Assessment Team was not satisfied 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:

* Feedback and complaints are not captured in a centralised complaints register, rather in individual consumer files; and,
* The service is unable to analyse and trend feedback data and instead relies on management knowledge of complaint trends to report to the Board; and,
* Evidence of improvements made relating to feedback was shown in staff meeting minutes, however, the complaint was not documented; and,
* Management showed a demonstration of the incoming central management system (CMS) that has the ability to record and analyse feedback and complaints data.

In response to the Assessment Team’s report, the provider’s response included the following:

* Explanation that moving forward all complaints and feedback will be recorded in the CMS to better identify trends reported to the Board.

In coming to my finding, I have considered the information and evidence in the Assessment Team’s report and the provider’s response, which does not demonstrate that feedback is reviewed and used to improve the quality of care and services.

I have considered that without evidence of the trends in complaints data, the service cannot demonstrate whether improvements to the quality of care and services are targeted to consumer feedback.

While the service has a plan in place to record all feedback and complaints in the CMS, I find the implementation of this system is still in its infancy and further time is required to demonstrate the effectiveness of this system to capture and review the feedback to improve the quality of care and services.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement (3)(d) in Standard 6 Feedback and complaint, for both HCP and CHSP programs.

Requirements 6(3)(a) and 6(3)(b)

Consumers confirmed they would have no hesitation in contacting the service if they had any issues. Management confirmed receipt of verbal suggestions and process of seeking feedback through regular contact/reviews and surveys conducted. Documentation provided to consumers/representatives contains information which details ways to make a complaint or provide feedback.

Consumers/representatives stated they were unsure if they had been provided information about advocacy services and other methods of making a complaint. However, management and documentation reviewed confirm system and processes are in place, such as the use of onsite social workers and provision of information packs (in preferred language) containing complaint and advocacy pathways available are provided.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirements (3)(a) and (3)(b) in Standard 6 Feedback and complaints, for both HCP and CHSP programs.

# Standard 7

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| 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/representatives confirmed consumers get quality care and services that are delivered as planned. Staff/management confirmed contingency plans are in place to fill unfilled shifts. Workforce planning include the use of external providers that match cultural needs and preferences of consumers.

Consumers/representatives confirmed staff are respectful, kind and caring. Staff described how they treat consumers respectfully and how they are aware of individual consumer’s preferences including cultural needs and background. Management confirmed cultural awareness training is provided to staff upon induction.

Consumers/representatives expressed satisfaction about staff competence. Management described staff qualifications, skills and knowledge required to effectively perform their roles. Management confirmed staff who do not possess relevant qualifications are not permitted to complete personal care services. Subcontractors for HCP services are managed through contract management processes.

Staff/management and review of documentation confirm staff are provided, and have completed, relevant training. Staff confirmed they are provided an induction booklet, induction training, and buddy shifts upon onboarding. Documentation reviewed confirm staff are provided access to online training.

Staff/management confirm performance appraisals are completed annually and monitoring of performance is ongoing. Documentation reviewed confirm all performance appraisals are up to date. Management discussed how feedback about staff is used to assess staff performance and identify upskilling/further training opportunities for staff.

Based on this evidence, I find the provider, in relation to the service, compliant with all Requirements in Standard 7 Human resources, for both HCP and CHSP programs.

# Standard 8

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| --- | --- | --- | --- |
| 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. | Not Compliant | Not Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Not Compliant | Not Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | 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. | Not Compliant | Not Applicable |

Findings

Requirement 8(3)(b)

The Assessment Team was not satisfied 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:

* Board meetings do not discuss aged care services unless there is a concern relating to work health and safety (WHS) or a change in consumer numbers for either CHSP or HCP programs; and,
* The Board does not regularly receive information relating to aged care services feedback and complaints nor incident data; and
* The Board has not met its governing board responsibilities that require existing approved providers to have from 1 December 2023 at least one member of the Board with experience in providing clinical care; and,
* Policies, ratified by the board, do not contain reference to current aged care regulatory requirements, such as the Serious Incident Response Scheme (SIRS); and,
* Clinical care qualifications were not provided by subcontracted clinical care staff due to privacy issues. Management advised legal advice will be sought to confirm validity of clinical subcontracting agreements.
* Information and evidence under Requirement (3)(d) in this Standard shows incident data and trends are not regularly reported to the board

In response to the Assessment Team’s report, the provider provided the following:

* Explanation that the incoming electronic management system will improve the information provided to the board, including relevant service data trends; and,
* Explanation that revised policies and procedures will occur following the implementation of the electronic management system.

In coming to my finding, I have considered the information and evidence in the Assessment Team’s report and the provider’s response, which does not demonstrate that the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.

I have considered the intent of the Requirement which expects the governing body of the organisation to oversee organisation’s strategic direction and policies for delivering care to meet the Quality Standards. I find this has not occurred through a failure to remain up to date on regulatory requirements relating to board structure, a failure to ensure external contractors hold the appropriate clinical qualifications through contractual procedures and a failure to oversee the quality of care and services delivered through information shared regarding the organisation’s aged care services. Furthermore, I have considered the provider’s response does not specify how it will meet governing body responsibilities of having at least one member with clinical experience.

I acknowledge the service has corrective plans in place to rectify some of these issues, however, at the time of my finding there is no evidence to demonstrate the effectiveness of these actions.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement (3)(b) in Standard 8 Organisational governance.

Requirement 8(3)(c)

The Assessment Team reported effective organisation wide governance systems were demonstrated for financial governance, workforce governance and regulatory compliance. However, the Assessment Team were not satisfied organisation wide governance systems were effective in relation to information management, continuous improvement, and feedback and complaints.. The Assessment Team provided the following evidence to support their assessment:

Information management

* Consumer information is in hardcopy communication books located in consumer homes and electronic copies accessible within the service The service is transitioning to a CMS where progress notes are entered by staff through a mobile application, and by management into consumer care planning documentation
* The organisation has established plans to train the workforce on the incoming system

Continuous improvement

* The Board does not consider continuous improvements based on regular information captured from feedback and complaints.

Financial governance

* The organisation oversees financial governance through quarterly financial reports to the board and annual audits conducted.

Workforce governance

* Staff were evidenced to have current position descriptions that included clear responsibilities and accountabilities; and,
* Relevant training is provided to staff members.

Regulatory compliance

* The organisation receives updates regarding regulatory and legislative changes through subscriptions to relevant industry or government notifications which are discussed at board meetings.

Feedback and complaints

* Feedback and complaints data / trends is not regularly captured or provided to the governing body.

In response to the Assessment Team’s report, the provider’s response included the following:

* Explanation that the incoming CMS will be used to capture and trend feedback and complaints.

In coming to my finding, I have considered the information and evidence in the Assessment Team’s report and the provider’s response, which does not demonstrate effective governance wide systems in relation to continuous improvement and feedback and complaints.

In relation to information management, I find the organisation demonstrated effective systems for this through processes to track transition from paper based documents to electronic, in addition to consumer and workforce feedback that they have access to the information required.

In relation to continuous improvement, the intent of the Requirement expects organisations to have a continuous improvement plan in place that works on improving the quality and safety of services provided based on experiences of consumers. I find the organisation has failed to demonstrate planned, or completed, actions to implement a continuous improvement plan with the exception of an incoming CMS.

In relation to complaints and feedback, I have considered the intent of the Requirement, which expects organisations to have a feedback and complaints system that actively look to improve results for consumers. I find this has not occurred as feedback data, and trends, is not captured or regularly shared with the governing body.

While I acknowledge the provider’s explanation that the incoming CMS will rectify deficits identified in relation to continuous improvement plans and feedback and complaints systems, there is not sufficient evidence to determine these systems are effective as the establishment or implementation of the systems has not yet occurred.

Based on the totality of information summarised above, I find the provider, in relation to the service, non-compliant with Requirement (3)(c) in Standard 8 Organisational governance.

Requirement 8(3)(d)

The Assessment Team was not satisfied the organisation’s has effective risk management system and practices in place. The Assessment Team provided the following evidence relevant to my finding:

* The organisation has a risk framework to identify risks
* The workforce receive training on risk management, incident management systems and elder abuse
* The organisation has established processes relating to consumer home risk assessments and committees to review incidents, near misses and injuries.
* Risk assessments were not always completed in relation to dignity of risk to inform risk management strategies
* Risk management policies and procedures, while established, are overdue for review according to the organisation’s review date. The policies did not include information relating to the serious incident response scheme (SIRS)
* The board does not regularly receive information relating to incidents

In response to the Assessment Team’s report, the provider’s response included the following:

* Evidence of dignity of risk process completed and documented for one consumer identified with a restrictive practice in place during Quality Audit; and,
* Explanation that the incoming CMS address out of date policies and procedures in line with current legislative and regulatory requirements.

In coming to my finding, I have considered the information and evidence in the Assessment Team’s report and the provider’s response, which does not demonstrate failures in an effective risk management system and practices.

The information shows deficits relating to policies which require review, mechanisms to ensure the board has visibility over incident data and practices in completing documentation relating to consumer dignity of risk processes. However, I have considered the expired policies and the board’s oversight over incident information under Requirement (3)(b) in this Standard, as these relate to the governing body’s oversight of the quality of care and services, rather than failures in risk management system and practices. Further, I have considered the information relating to individual consumer risk assessment under Requirement (3)(d) in standard 1 and I do not deem it applicable, or proportionate, to consider it again in relation to this Requirement.

Overall, I find the risk management system and practices are effective with improvement areas that will be addressed through corrective actions related to the incoming CMS.

Despite my finding, I encourage the provider to ensure risk management systems and practices are informed through contemporary policies and procedures to ensure the effectiveness is continuously assessed for sustainable effectiveness.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirement (3)(d) in Standard 8 Organisational governance.

Requirement 8(3)(e)

The Assessment Team was not satisfied there was an effective clinical governance framework in place. The Assessment Team provided the following evidence relevant to my finding:

* The Assessment Team did not sight evidence that of established clinical policies or procedures, or whether these are supplied to brokered external clinical providers; and,
* Staff had undertaken training in antimicrobial stewardship
* Reference to a consumer with equipment related to restrictive practices and open disclosure processes not documented in relation to complaints resolution

In response to the Assessment Team’s report, the provider’s response included the following:

* Explanation that the implementation of the CMS system will include a policy, procedure and compliance system to ensure policies reflect current regulatory requirements
* Evidence open disclosure practices are understood and practiced by staff/management
* Explanation and evidence of actions taken in relation to one consumer’s equipment provision and restrictive practices

In coming to my finding, I have considered the information and evidence in the Assessment Team’s report and the provider’s response, which does not demonstrate an effective clinical governance framework is in place.

I have considered information relating to a consumer’s equipment provision and restrictive practices in Standard 2 and Standard 3, and I do not deem it necessary, or proportionate, to consider again, in relation to this Requirement. Similarly, I do not find the reference to open disclosure in relation to the resolution of complaints to be relevant to this Requirement, as such, this has been considered in Standard 6.

I find the information and evidence does not demonstrate an effective clinical governance framework is yet established. I acknowledge the service has plans in place to improve its clinical governance framework, in particular ensuring there are relevant clinical policies and procedures provided and acknowledged by brokered external clinical providers. However, the development of current policies and procedures relates to the implementation of the CMS system that has not yet occurred. As such, further time is required to determine the effectiveness of an established clinical governance framework.

This Requirement is not applicable for CHSP subsidised services clinical care is not delivered.

Based on the information summarised above, I find the provider, in relation to the service, non-compliant with Requirement (3)(e) in Standard 8 Organisational governance.

Requirement (3)(a)

Consumers/representatives confirmed they have been provided opportunities to provide input as to how services are delivered to meet consumer’s diverse needs. Management, and review of documentation confirm, consumers are engaged to complete annual surveys to gauge consumer satisfaction and identify service improvements. Documentation shows consumers/representatives have been invited to join the established Consumer Advisory Body.

Based on the information summarised above, I find the provider, in relation to the service, compliant with Requirements (3)(a) in Standard 8 Organisational governance.

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)