Performance

Report

1800 951 822

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | TAC Home Care Packages |
| Commission ID: | 301066 |
| Address: | 198 Elizabeth Street, HOBART, Tasmania, 7000 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 11 September 2024 to 12 September 2024 |
| Performance report date: | 28 October 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.

# Services included in this assessment

Home Care Packages (**HCP**) included:  
Provider: 2004 Tasmanian Aboriginal Corporation  
Service: 27371 TAC Home Care Packages

**This performance report**

This performance report has been prepared by L. Malone, 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 Assessment contact (performance assessment) – site 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 24 October 2024

# Assessment summary for Home Care Packages (HCP)

|  |  |
| --- | --- |
| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all Requirements assessed |
| **Standard 3** Personal care and clinical care | **Not applicable as not all Requirements assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all Requirements assessed** |
| **Standard 7** Human resources | **Not applicable as not all Requirements assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all Requirements assessed** |

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

# Areas for improvement

There are no specific areas identified in which **improvements must be made to ensure compliance with the Quality Standards**. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Standard 2

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

Findings

Requirement 2(3)(a)

The service was previously found not compliant with this Requirement following a Quality Audit conducted from 22 September 2023 to 27 September 2023. The service has implemented improvement actions to address the issues found.

At the Assessment Contact conducted 11 to 12 September 2024 (referred to as the Assessment Contact in this report), consumers provided feedback to the Assessment Team that the service’s staff have a sound understanding of their health and medical conditions and offer care and services that keep them safe and connected. Improvement actions implemented since the finding of not compliant included introduction of a wellness and reablement assessment tool and processes to support multidisciplinary risk assessment and care planning. The service introduced a weekly meeting to discuss consumers who are living with risks to their wellbeing. These meetings are attended by HCP coordinators and the local medical centre staff who are involved in the consumer’s care, and care planning for at-risk consumers is supported by a multidisciplinary team.

.

The Assessment Team recommended this Requirement was Met. I have considered the available evidence, and I find this Requirement Compliant.

Requirement 2(3)(b)

The service was found not compliant with this Requirement following a Quality Audit from 22 September 2023 to 27 September 2023. The service has implemented improvement activities to address the issues found. Actions included the introduction of a wellness and reablement assessment described in Requirement 2(3)(a), and discussion of advance care planning with consumers. The assessment prompts coordinators to ask consumers what is important to them and how they would like their care to be delivered.

At the Assessment Contact, consumers stated their coordinators speak with them regularly and seek to understand their needs and preferences including advance care planning and end-of-life wishes. The Assessment Contact report demonstrates care coordinators understand consumer’s care in line with their goals and preferences and care planning documentation demonstrated regular communication and how supports planned for the consumer address their goals.

The Assessment Team recommended this Requirement was Met. I have considered the evidence in the Assessment Contact report, and I find this Requirement Compliant.

Requirement 2(3)(c)

The service was found not compliant with this Requirement following a Quality Audit from 22 September 2023 to 27 September 2023. The service has implemented improvement activities to improve partnerships with other organisations and programs involved in consumer care.

At the Assessment Contact, consumers provided positive feedback about the way the service involves other organisations and felt confident staff were informed of the other providers involved in their care. Staff described the implementation of weekly meetings attended by coordinators and medical centre staff as effective to support information sharing and care planning. The Assessment Team found documentation in care files and meeting minutes reflected of the systems and processes described by consumers and representatives.

The Assessment Team recommended this Requirement was Met. I have considered the evidence in the Assessment Contact report, and I find this Requirement Compliant.

Requirement 2(3)(e)

The service was found not compliant with this Requirement following a Quality Audit from 22 September 2023 to 27 September 2023. The service has implemented improvement actions to address the issues found including revision of the policy related to assessment, care planning and reviews, and the implementation of weekly meetings (previously mentioned).

At the Assessment Contact, consumers were satisfied their care and services are reviewed regularly, and changes are made to meet their needs as required. Staff described the schedule of reviews for consumers receiving HCP levels 1 to 4 with more frequent reviews for consumers with a higher level of need. Staff provided examples to the Assessment Team of what kind of a change in a consumer’s condition or circumstance would prompt a review of assessment and care planning such as hospitalisation, change in social situation or living circumstances, change in medical condition or clinical deterioration. Care documentation viewed by the Assessment Team provided evidence of regular reviews of the effectiveness of care and services.

The Assessment Team recommended this Requirement was Met. I have considered the evidence in the Assessment Contact report, and I find this Requirement Compliant.

# Standard 3

|  |  |  |
| --- | --- | --- |
| Personal care and clinical care | | HCP |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

Requirement 3(3)(b)

The service was found not compliant with this Requirement following a Quality Audit from 22 September 2023 to 27 September 2023. The service has implemented improvement activities to improve the management of high-impact, high-prevalence risks associated with the care of each consumer.

At the Assessment Contact, the Assessment Team found evidence of effective systems and processes to identify and respond to high-prevalence, high-impact risks to consumer’s wellbeing. Service coordinators described how they identify risks and monitor changes in consumers’ health and wellbeing and use regular communications at risk meetings and documentation of information to support effective risk management. A review of consumer care documentation demonstrated strategies such as equipment use and referral to appropriate health services to manage identified risks to the consumer.

The Assessment Team recommended this Requirement was Met. I have considered the available evidence, and I find this Requirement Compliant.

Requirement 3(3)(e)

The service was found not compliant with this Requirement following a Quality Audit from 22 September 2023 to 27 September 2023. The service has implemented improvement actions to address the issues found including improvements to documentation and communication of consumer conditions and needs within the organisation or with others where care is shared.

At the Assessment Contact, consumers provided feedback they felt confident the service was well-informed of their medical conditions, needs and preferences, and that information is shared appropriately with their consent. Care documentation was found to reflect consumer’s individual support needs and included information which demonstrated regular and ongoing communication with other providers who share care. The Assessment Team found the service had implemented weekly meetings to discuss at-risk consumers, and effective communication with the co-located Aboriginal Health Service.

The Assessment Team recommended this Requirement was Met. I have considered the available evidence, and I find this Requirement Compliant.

Requirement 3(3)(g)

The service was found not compliant with this Requirement following a Quality Audit from 22 September 2023 to 27 September 2023. The service has implemented improvement activities related to the promotion of antimicrobial stewardship.

Actions taken by the service as described in the Assessment Contact report include providing information in the consumer information welcome pack on antibiotic prescription, and reference to antimicrobial stewardship in the service’s clinical governance framework.

I am not presented with further evidence in relation to this Requirement. The Assessment Team recommended this Requirement was Met. I have considered the evidence available to me and I find Requirement 3(3)(g) Compliant.

# Standard 6

|  |  |  |
| --- | --- | --- |
| Feedback and complaints | | HCP |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Requirement 6(3)(c)

The service was found not compliant with this Requirement following a Quality Audit from 22 September 2023 to 27 September 2023. The service has planned improvement activities including the implementation of a feedback and complaints register, analysis of a 2023 consumer satisfaction survey, review of the service’s feedback policy and procedure to include open disclosure, and the delivery of open disclosure training for staff.

At the Assessment Contact 11 to 12 September 2024, the Assessment Team received feedback from some consumers had made a complaint and were not satisfied with the resolution, and the details of one consumer’s feedback is presented under this Requirement in the Assessment Contact report. I note the feedback includes the duration of delayed installation of home modifications but limited further detail about the consumer’s concern with the service’s processes of complaints management. Evidence in the Assessment Contact report includes that staff were aware of the issue and reported it as incomplete due to the lack of availability of appropriate tradespeople in the regional area to undertake the work. The Assessment Team found evidence in consumer’s documentation which demonstrated discussions to progress the issue had been occurring over a significant period.

The Assessment Team found that some staff were not familiar with the term open disclosure, but that management described it’s use routinely in complaints management. The service’s policy related to feedback and complaints sighted by the Assessment Team was not updated at the time of the Assessment Contact to include reference to open disclosure, and staff education in open disclosure had not been delivered.

The provider submitted a response to the Assessment Contact report, which includes statements that the service’s policy has been reviewed and updated to include reference to open disclosure, and relevant staff training has been delivered. The service acknowledges some staff’s prior unfamiliarity with the terminology and states information has been communicated in the service’s newsletter to increase understanding. The provider offers further information in relation to regional challenges in the availability of service providers but also states that contracts on these works have progressed at the time of my decision.

In considering the evidence, I acknowledge the issues described in the Assessment Contact report are not specifically related to the complaints management process, but of delays contributed to by external factors. However, the evidence in the Assessment Contact report convinces me at least one consumer was dissatisfied with communication. While I am not provided with supporting evidence of actions implemented since the Assessment Contact, I accept the provider’s statements and consider these actions relevant to address the issues as described in the Assessment Contact report, and I note that actions to improve communication with consumers are included.

The Assessment Team recommended this Requirement is Not Met. I have considered the evidence available to me in the Assessment Contact report and that submitted by the provider. While I cannot determine the level of the consumer satisfaction with the provider’s actions to date, I find evidence of actions to resolve complaints, the use of open disclosure, and that the provider has taken relevant actions. I find Requirement 6(3)(c) Compliant.

Requirement 6(3)(d)

The service was found not compliant with this Requirement following a Quality Audit from 22 September 2023 to 27 September 2023. The service has implemented improvement activities to address the issues found.

The Assessment Contact report provides evidence that 2 consumers provided feedback the service had not made improvements in response to their complaints. The Assessment Team state the service’s complaints register documented 2 complaints about communication and/or delayed access to allied health services and home modifications. Evidence presented in the Assessment Contact report describes documentation of actions in response to consumer complaints about home modification delays including arranging the required allied health assessment and communication with the consumer. The Assessment Team states the service did not demonstrate how feedback and complaints are reviewed to effectively identify trends, and that recurring concerns are not reported to the governing body, but further examples or evidence is not provided.

In their response, the provider acknowledges the delays in arrangements for service providers and that there are opportunities to improve communication. The provider describes actions implemented since the Assessment Contact including establishing more frequent, regular contact with consumers, progression on outstanding home modification contracts, and that improvements have been made in reporting feedback and complaints to the governing body. I am not provided with supporting evidence, but I accept the statements submitted by the provider.

The Assessment Team recommended Requirement 6(3)(d) is Not Met. The intent of this requirement is that feedback is captured and reviewed to identify opportunities to improve care and services for consumers. I have considered the evidence in the Assessment Contact report and that submitted by the provider and, at the time of my decision, I am satisfied relevant actions have been implemented by the service to review feedback and improve care and services in relation to the evidence described in the Assessment Contact report. I find Requirement 6(3)(d) Compliant.

# Standard 7

|  |  |  |
| --- | --- | --- |
| Human resources | | HCP |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirement 7(3)(a)

The service was found not compliant with this Requirement following a Quality Audit from 22 September 2023 to 27 September 2023. The service has implemented actions to improve workforce planning and deployment including the engagement of a human resources consultant with responsibilities for workforce planning and deployment, and external agencies to deliver required brokered care and services.

At the Assessment Contact, most feedback from consumers was positive in relation to the consistency of care and services and included that it had improved with the introduction of brokered staff. One example of consumer feedback related to a recent occasion of a cancelled service is noted in the Assessment Contact report. The Assessment Team found the service did not demonstrate documentation related to the management of unplanned leave and subcontractor registers at the time of the Assessment Contact. Evidence in the Assessment Contact report describes unplanned leave, or unfilled shifts are managed by regional coordinators and managers rather than managed centrally.

The Assessment Team recommended Requirement 7(3)(a) is Not Met. I have considered the evidence available to me and came to different view to the Assessment Team. The issues presented in the Assessment Contact report do not persuade me that deficiencies in planning and deploying the workforce, or unfilled shifts, are occurring, or that care and services are not safe and of quality. I am persuaded by consumer feedback of improvements and their reported satisfaction with the workforce number and mix. I am further persuaded by evidence in the approved provider’s response which describes the number and mix of the workforce and how the service utilises external brokerage arrangements to address workforce planning. I find Requirement 7(3)(a) Compliant.

Requirement 7(3)(d)

The service was found not compliant with this Requirement following a Quality Audit from 22 September 2023 to 27 September 2023. The service has implemented actions to address the issues including a mandatory training program and delivery of staff training.

At the Assessment Contact consumers provided feedback they are satisfied that staff at the service are well-trained or are knowledgeable in their roles. Some consumers provided feedback that further training in communication and HCP management is required. The Assessment Contact report provides evidence the service has a mandatory training calendar. Evidence includes feedback from staff describing relevant training they had participated in such as dementia specific training, first aid and manual handling and that documentation viewed by the Assessment Team provided evidence of staff participation in training delivered such as manual handling, food safety and first aid training. The Assessment Team found staff had not participated in some training courses and these examples are described and relevant to the Quality Standards. However, I have no further details related to the content or planned schedule of the mandatory training calendar. The Assessment Contact report presents reasoning that feedback received from staff and management demonstrates the mandatory calendar is not implemented but I do not find the evidence is sufficient to support that.

The Assessment Team recommended this Requirement as Not Met based on the service not demonstrating implementation of the mandatory training calendar. I have considered the evidence available to me and the intent of Requirement 7(3)(d), that is that the workforce is trained and enabled to deliver outcomes required by the Aged Care Quality Standards, and I have come to a different view to the Assessment Team. Staff provided feedback of relevant training, the service has a mandatory training program, and while specific training topics may not have been delivered or recalled by staff, I am not presented with evidence of deficits in staff knowledge or practice. I have considered evidence available to me and I find Requirement 7(3)(d) Compliant.

Requirement 7(3)(e)

The service was found not compliant with this Requirement following a Quality Audit from 22 September 2023 to 27 September 2023. The service planned actions to improve systems and processes related to workforce performance reviews including the introduction of a new electronic human resources system, and improvements to capture and reporting on performance review information within the electronic system.

At the Assessment Contact, the Assessment Team found while the new electronic human resources system had been introduced, it was not yet operational for the performance review process. Staff explained that other information is required to be integrated to the electronic system first, and staff require training on use of the new system. The Assessment team found all coordinators and management and most support staff had undertaken a performance review in the past 12 months which involved feedback on performance and discussion of learning goals and training opportunities.

The Assessment Team recommended this requirement as Not Met based on inconsistencies in staff practice in performance review scheduling frequency and the way the performance review information was stored. In their response the provider describes regular feedback with staff and acknowledges while performance reviews had stopped for some time they have now resumed. I have come to a different view to the Assessment Team and find the evidence describes reviews of workforce performance are occurring and improvements to the service’s electronic management system to integrate performance reviews are in progress. I find Requirement 7(3)(e) Compliant.

# Standard 8

|  |  |  |
| --- | --- | --- |
| Organisational governance | | HCP |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | 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 |
| 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 |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

Requirement 8(3)(a)

The service was found not compliant with this Requirement following a Quality Audit from 22 September 2023 to 27 September 2023. The service planned actions to increase consumer engagement in the development, delivery and evaluation of care and services including the resumption of the bi-monthly Quality Care Advisory Board (QCAB).

At the Assessment Contact, management, staff and consumers provided feedback to the Assessment Team that QCAB was established and met twice but the meetings had since ceased. One consumer who described previously participating on the QCAB said they had enquired about the meetings resuming but had not yet received a response.

In their response to the Assessment Team report the provider states that there are plans for the QCAB to resume. The service’s submitted PCI has a documented action to send out an expression of interest to the Elders to re-establish the QCAB with a planned completion date in the near future. The provider’s response also describes how the service ensures consumers have the opportunity to be engaged and describes how the service notified all consumers face-to-face via home visits after the Assessment Contact, when notification via mail would not have been possible. The provider also states in their response that the service has examined and shared the findings of the 2023/2024 consumer survey.

The Assessment Team recommended this Requirement as Not Met. While I am not presented with supporting evidence of actions implemented by the provider, I accept the provider’s statement, and I find evidence in the Assessment Contact report is addressed by the provider’s response.

At the time of my decision, I find evidence demonstrates relevant actions in progress to re-establish the QCAB are underway, and I encourage continuation of this for ongoing compliance with the Quality Standards. I find the evidence demonstrates how the service engages consumers in development, delivery and evaluation of care and services. I have come to different view to the Assessment Team, and I find Requirement 8(3)(a) Compliant.

Requirement 8(3)(b)

The service was found not compliant with this Requirement following a Quality Audit from 22 September 2023 to 27 September 2023. The service has implemented improvement such as the delivery of training for Board members in relation to their legislative obligations; changes to incident reporting processes, establishment of a QCAB, review of policies and procedures and to undertake future strategic planning.

At the Assessment Contact, the Assessment Team found the service had reviewed and updated several policies and procedures related to the safety and quality of care and services, including those relating to when a consumer is not available for a scheduled visits, falls prevention, and risk management. The Assessment Team also found that an organisation strategic plan is under development and consultation. The Assessment Team found QCAB meetings had ceased and upon review of sampled documentation including governing body meeting minutes from earlier in 2024, discussion of incidents and safety issues were not documented. The Assessment Team reasoned that based on this information the service did not demonstrate effective accountability of the governing body and recommended Requirement 8(3)(b) as Not Met.

The provider’s response acknowledges improvement opportunities in the reporting of feedback to the governing body but in response to the findings of the Assessment Team state the governing body receives frequent updates to ensure safe and quality care and service delivery. The provider also confirms that recruitment to a position described as vacant in the Assessment Team report has occurred and indicates the role will focus on quality and compliance.

In coming to my decision, I have considered evidence in the Assessment contact report and that submitted by the approved provider. I have considered the intent of this Requirement, and the provider’s obligations to ensuring accountability of safety and quality. While the QCAB is not yet resumed, relevant actions are in progress, and I am satisfied the provider will continue to progress the actions. While I agree it will take further time to establish and sustain the QCAB, I am presented with little evidence of deficits in quality, safety or inclusivity of care, or systems and processes which identify lack of accountability. I find Requirement 8(3)(b) Compliant.

Requirement 8(3)(c)

The service was found not compliant with this Requirement following a Quality Audit from 22 September 2023 to 27 September 2023. The service has implemented actions to address the issues found and improve organisation wide systems of governance.

The Assessment Contact report presents evidence of effective information management systems to document and share information. Internal and external staff described how information is accessible and enables the delivery of safe and quality care, and that changes to policies and procedures are effectively communicated through the organisation. The service did not provide a current plan for continuous improvement at the time of the Assessment Contact; however, one was submitted by the provider in their response to the Assessment Contact report.

The Assessment Team present statements that there was no evidence of reporting consumer feedback or incidents to the governing body, however, in relation to incident reporting this is not supported by evidence in the Assessment Contact report. I note the Assessment Team found evidence to support a recommendation of Met in Requirement 8(3)(d) which considers effective incident management, and the communication of feedback has been addressed in Requirement 6(3)(d). Evidence related to the QCAB presented under this Requirement has been addressed by the provider in their response and I have considered this in Requirement 8(3)(a).

The provider’s response describes undertaking service wide audits to ensure care and services are safe, describes weekly regional and state meetings focused on continuous improvement and program coordination, and fortnightly risk assessment meetings with health professional engagement. The provider states their commitment in their response to understanding and addressing the non-compliance, and the service’s PCI indicates some actions progressed since the Assessment Contact report.

I have considered the evidence available to me and I have come to a different view to the Assessment Team. I find Requirement 8(3)(c) Compliant.

Requirement 8(3)(d)

The service was found not compliant with this Requirement following a Quality Audit from 22 September 2023 to 27 September 2023. The service has implemented improvement activities to ensure effective systems and processes are in place to identify and manage high-impact or high-prevalence risks.

The Assessment Team found at the recent Assessment Contact that the service has introduced weekly meetings with Aboriginal Health Service clinical staff to discuss risks related to care and service delivery and ensure a holistic, multidisciplinary approach. This has been previously described in other Requirements. The Assessment Team also found the service had developed a risk management policy and procedure which details the roles and responsibilities of staff in the management of risk and developed tools to support risk assessment. Consumers provided feedback that staff consider medical and environmental risks to their health, and service coordinators described processes to monitor consumers who have risks associated with their care through risk registers, and weekly meetings which discuss risk.

The Assessment Team recommended this Requirement as Met. I have considered the evidence available to me and I find Requirement 8(3)(d) Compliant.

Requirement 8(3)(e)

The service was found not compliant with this Requirement following a Quality Audit from 22 September 2023 to 27 September 2023. The service has implemented actions to address the issues found.

The Assessment contact report states the service has a clinical governance framework and effective communication between the service and medical and other clinical providers. The evidence describes weekly meetings, and effective processes to capture and document clinical information, and utilise this information it in assessment and care planning.

The Assessment Team have not provided further evidence and recommend this Requirement as Met. I have considered the evidence available to me, and I find Requirement 8(3)(e) Compliant.

1. The preparation of the performance report is in accordance with section 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)