Performance

Report

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| Name of service: | Performance report date: |
| Taiwan Care | 18 November 2022 |
| Commission ID: | Activity type: |
| 700934 | Quality Audit |
| Approved provider: | Activity date: |
| Queensland Taiwan Charity Fund Incorporation Pty Ltd | 6 October 2022 to 11 October 2022 |

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

**This performance report**

This performance report for Taiwan Care (**the service**) has been considered by J Zhou delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

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

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

# Services included in this assessment

# Home Care:

# Queensland Taiwan Charity Fund Incorporation Pty Ltd, 26521, 58 Padstow Road, EIGHT MILE PLAINS QLD 4113

# Material relied on

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

* the assessment team’s report for the Quality Audit, the Quality Audit report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives, and others
* the provider’s response to the assessment team’s report received 7 November 2022.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Non-compliant** |
| **Standard 3** Personal care and clinical care | **Non-compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 6** Feedback and complaints | **Non-compliant** |
| **Standard 7** Human resources | **Non-compliant** |
| **Standard 8** Organisational governance | **Non-compliant** |

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

# Areas for improvement

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

The provider to take active measures to ensure it is:

* Undertaking effective assessment and planning to inform the delivery of safe and effective services.
* Reflecting each consumer’s current needs, goals and preferences in assessment and planning.
* Demonstrating that advance care planning and end-of-life planning are discussed with each consumer.
* Effectively documenting, identifying, and managing high-impact or high-prevalence risks associated with the care of each consumer.
* Monitoring and recording complaints and feedback.
* Using feedback or complaints to inform improvements to care and services.
* Providing staff with the training and support to deliver the outcomes required by the Quality Standards.
* Demonstrating staff have the skills and knowledge to effectively perform their roles.
* Demonstrating the governing body asks for and receives the information it needs to maintain oversight of service delivery and ensure the Quality Standards are being met.
* Demonstrating an effective system for identifying and responding to risk.
* Demonstrating the governing body understands and sets priorities to improve the performance of the organisation against the Quality Standards.

# Standard 1

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| Consumer dignity and choice | | Compliant |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

## Findings

The service is providing dignified and respectful care to allow consumers to live the life they choose, recognising consumers’ individuality and their right to make their own decisions about the care and services they receive. Consumers appreciated having care staff attend to them who speak their preferred language, which is important to them. The Assessment Team found the service to be providing consumers with sufficient information, organised and presented in a way that was useable to the consumer to enable them to make informed choices about their care and funding information. Consumers reported meeting with the Case Manager when they commenced services with information being explained to them during an orientation.

Staff demonstrated an understanding of their responsibilities in relation to maintaining confidentiality. Management and staff demonstrated knowledge, awareness and understanding of consumer choices and preferences and described how tasks are undertaken in accordance with individual consumer-identified priorities. Management described when and how information was provided to the consumers.

Documentation evidenced the organisation has a consumer-centred approach to delivering services, most information provided was current and accurate and showed consumer involvement in decisions about the services they receive.

# Standard 2

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| Ongoing assessment and planning with consumers | | Non-compliant |
| 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. | Non-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. | Non-compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(d) | The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

## Findings

Consumers/representatives confirmed they do participate in the planning and review of services that they receive and they are provided with a copy of their care plan for reference. Care planning documentation revealed that consumer care and services are reviewed at least annually and more often when circumstances change, or when incidents impact the needs and preferences of the consumer. The Assessment Team observed evidence in consumer files that consumers/representatives are involved in the planning and review of services. Consumers/representatives reported that the service maintains good communication with the consumer and others with whom the consumer wishes to be involved in their care.

Staff conducting the assessment and planning reviews could describe the process, which involves a standardised list of questions they ask the consumer or their representative. Staff and management described how they work with other service providers, stakeholders, and organisations. The service stores consumer care and service plans on an organisational drive which is accessible to staff.

2(3)(a) non-compliance

However, the Assessment Team observed that sampled consumer care plans contained insufficient information about the risks posed by its consumers. The absence of risk based planning therefore impacts the service’s ability to deliver safe and effective care and services to all consumers. For instance, the Assessment Team reviewed care plans containing a list of services applicable to each consumer, but there were no further instructions to guide care staff on how to effectively deliver these services to each individual consumer. Consumers’ preferences concerning how they want to receive their services were also not captured.

Furthermore, information collected about consumers were brief and did not inform care workers about each person’s specific care needs such as strategies to manage the behaviours of consumers living with cognitive decline. For example, an HCP L4 consumer’s progress notes stated ‘behaviour issues’ were communicated to their representatives, but the care plan did not provide guidance regarding the management of these behaviours, or strategies that might assist staff when caring for this consumer. The Assessment Team found four consumers to be living with cognitive decline which is a risk factor, however, their care plans lacked instruction and strategies that informed staff on how to deliver safe and effective care and services bespoke to these consumers.

2(3)(b) non-compliance

The service was unable to demonstrate that advance care planning and end-of-life planning are discussed with each consumer. For example, the Assessment Team asked whether advance care planning had been discussed with a consumer who recently started to receive palliative care. The Case Manager was of the view that such conversation had occurred and evidence would be detailed in their care plan or progress notes. The Assessment Team could not corroborate the care manager’s views with relevant documentary evidence on this consumer. As such, I am not persuaded that advanced care planning had been discussed with the specific consumer or any other consumer and their representatives.

The service provided a written response to the Assessment team’s preliminary findings and proposed improvements to remedy the deficiencies. The improvements included:

* Care plan folders (to be kept both in the clients’ home and office for care staff to access) for each consumer including:
* Personal information about consumers backgrounds, individuality, preferences and what their interests might be (personal portfolio)
* Consumer’s preferences and individuality
* Instructions to guide care staff on how to deliver these services
* Strategies to manage the behaviour of consumers living with cognitive decline.
* Cognitive decline assessment and strategies in care plan.
* Advanced care plan discussions.

As I am yet to see evidence that these changes are embedded in the service to the extent that the issues are rectified, I find these Requirements are non-compliant.

# Standard 3

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| Personal care and clinical care | | Non-compliant |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-compliant |
| Requirement 3(3)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |
| Requirement 3(3)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

## Findings

Consumers/representatives reported that clinical and personal care received is safe, effective and optimises their health and well-being. They stated that the care workers are very professional, they are happy with the care they receive and that most of the time, they receive care and services from the same staff, who know their needs and preferences. Care staff sampled had good knowledge of each consumer’s needs, goals and preferences and were able to describe how the service ensures care is best practice and tailored to the consumer’s needs.

Staff and management described steps the service takes to ensure the comfort of consumers nearing the end of life is maximised and their dignity preserved. Management and staff advised that because care staff are seeing the consumers regularly, they are strongly encouraged to report any changes in their condition or function. When deterioration is identified, the service determines what additional support or referrals may be required.

Staff and management confirmed that where a need is identified, the service refers consumers to other organisations that may be involved in their care and services. Consumer files demonstrated that referrals are made to appropriate professionals, such as occupational therapists and physiotherapists, when the need arises. Staff and management described measures taken by the service to ensure the risk of consumers or staff contracting COVID-19 is minimised.

3(3)(b) non-compliance

The service advised the Assessment Team that it does not currently maintain an incident register that captures high risk incidents that may occur while care is being provided to its consumers.

The Assessment Team interviewed care staff and learned of a recent incident involving a consumer who choked. The care worker stated that the consumer choked on some food after eating too fast, resulting in the care worker having to assist the consumer in dislodging the food. The care worker stated that they reported the incident back to the service. When the Assessment Team asked the Case Manager whether this had been recorded, they were unfamiliar with the incident involving the specific consumer. Staff stated that the incident was recorded on the consumers file, however, time stamps within the consumer’s progress notes evidenced that details surrounding the incident were added after the Assessment Team had raised the incident with the service.

The service acknowledged that it currently does not have a method for detecting and managing high impact or high relevance risks to its consumers. As a result, I cannot confidently conclude that the management of such risks is being effectively managed.

In response to the Assessment team’s evidence, the provider has proposed:

* An incident register and a clinical governance framework to manage high-impact or high-prevalence risks.

I acknowledge that the provider has proposed how the service is to address this Requirement, however, as these changes will take some time to become embedded in the service, this Requirement is non-compliant.

# Standard 4

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

## Findings

Consumers/representatives reported that the services and supports consumers receive help them to maintain their quality of life and independence. They confirmed the organisation is flexible in the delivery of services, enables consumers to participate in the community, do things of interest to them and stated that activities in the community often involve going to the park, shopping, or going out for lunch. Consumers/representatives reported that consumers get the same staff most of the time, that those staff have a good knowledge of their needs and preferences and stated they were satisfied with the meals provided by the service. They also confirmed that the equipment located by the service is in good condition and did not report any issues or faults. Consumers/representatives are satisfied with the services provided by organisations the consumer has been referred to.

Staff demonstrated a good understanding of what is essential to individual consumers, could describe how services optimise their well-being, demonstrated an understanding of what is important to the consumers and provided examples of how the service supports the well-being of consumers when they may be feeling low. They advised that due to the service’s connections in the community, consumers are encouraged to attend the nearby Taiwanese Community Social Group, in cases where a consumer would like to attend the social group, the service provides transportation where possible. Staff advised that consumers request what meals they would like to eat, and if the staff member has the appropriate proficiency to prepare the meal, they will do so

Staff and management could describe the process for referrals to other organisations and individuals involved in the consumer’s care. Staff advised that if the organisation the consumer has been referred to does not speak Mandarin, a member of the Taiwan Care workforce who does speak that language will be present to assist the consumer in communicating. Whilst assessment and planning were found not to effectively capture the consumer’s needs and preferences (see Requirement 2(3)(a)), feedback from consumers/representatives indicates that this has not yet adversely impacted their services and supports for daily living. **Standard 5**

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| Organisation’s service environment | | Not applicable |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction, and function. | Not applicable |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Not applicable |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Not applicable |

## Findings

The organisation does not have a physical service environment and therefore this Standard is not applicable to this quality audit.

**Standard 6**

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

## Findings

Most consumers/representatives were aware of how to make a complaint or provide feedback and said they felt comfortable to do so. Most consumers/representative advised they would prefer to directly communicate with the service or via an application. On entry to the service, consumers/representatives are provided with an information pack and handbook which provide details on ways to make a complaint or provide feedback. This information is written in Mandarin, which is the primary language used by most consumers and representatives of the service.

Management and staff described ways they support consumers/representatives to provide feedback. The service provides information to consumers/representatives on internal and external complaints mechanisms and advocacy services. This information is provided in Mandarin, all staff employed at the service speak Mandarin and management have awareness of how to access translation services if required.

6(3)(c) non-compliance

However, I note that management confirmed to the Assessment Team that they do not have a complaints policy or information for staff on open disclosure. Furthermore, management advised they do not keep a record of feedback provided or the actions taken to resolve any concerns raised by consumers or representatives. While consumers/representatives sampled reported never having had to make a complaint or provide feedback, management confirmed there have been occasions when feedback was provided. For example, progress notes for a consumer indicated they had complained to managed about cleaning services, but no further actions or follow up were taken. When queried about this, management acknowledged most feedback received were about cleaners by way of acknowledging that this was an issue, but could not show the Assessment Team how they actioned this consumer’s complaint issue beyond this acknowledgement. Another consumer provided a list of suggestions and requests, including a change to their service times. Again, there was no evidence of any of the information being followed up with the consumer.

6(3)(d) non-compliance

Management reported to the Assessment Team they receive minimal complaints. Irrespective, there was no evidence found to demonstrate that management then took action to ensure complaints are analysed, to inform quality improvements to the consumer care and service experience. They advised that they do not maintain a register of complaints and said that any feedback is generally verbal and is not usually recorded. I am therefore unable to conclude that feedback and complaints are being effectively captured to identify trends within the service per this Requirement.

Management acknowledged they do not have a Plan for Continuous Improvement (PCI) and as a result complaint information is not being used to make improvements. Staff interviewed were unable to describe how feedback and complaints are used to improve care and services.

In response to the Assessment team’s evidence, the provider has proposed:

* Feedback /complaints register and open disclosure process to document and action on feedback/complaints.
* Complaints register review to identify trends and to review feedback/complaints.

I acknowledge that the provider has proposed how the service is to address these Requirements, however, as these changes will take some time to become embedded in the service, these Requirements are non-compliant.

**Standard 7**

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| Human resources | | Non-compliant |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Non-compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Non-compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Non-compliant |

## Findings

Consumers/representatives are satisfied with the workforce mix and felt the workforce provides services in accordance with their individual needs and preferences. Consumers reported staff generally arrived as scheduled and any delays are communicated. Consumers/representatives provided positive feedback in relation to their interactions with the workforce and said management and staff are kind, caring, respectful and helpful.

Staff say they have sufficient time to undertake services in a safe and efficient manner. Management reported they utilise the staff available to cover any periods of leave, including utilising office staff to transport consumers to appointments.

7(3)(c) non-compliance

However, the evidence showed the service could not demonstrate a process for ensuring that staff have the required competencies to perform their roles. Staff reported they had not been provided with a position description outlining their roles and responsibilities. The Assessment Team corroborated this with management who said that while that a list of tasks is available for the key roles, staff are generally not provided with this information.

The Assessment Team also made the finding that Management and staff do not have a shared understanding of the Quality Standards to effectively perform their role in managing care and services for consumers or a shared understanding of the requirements of the Home Care programs to ensure they are equipped to assist consumers to make decisions about the care and services they may access.

For instance, there is currently no system for monitoring requirements for the role, such as criminal history and driver’s licence checks. For example, while the service provided evidence that criminal history checks are undertaken for all members of the workforce, there is currently no system for monitoring expiry dates. The Assessment Team identified that six out of nine criminal history checks for members of the governing body, management and staff were out of date.

The Case Manager told the Assessment Team that the service has five mandatory training requirements, they are fire safety, infection control, incident reporting, work health and safety and elder abuse. There is no evidence to demonstrate these have been completed since 2020 and there is currently no process for monitoring completion of these mandatory trainings.

The service was unable to demonstrate how staff and brokered staff practices are monitored to determine that they are competent, capable and have the qualifications and knowledge to effectively perform their roles.

7(3)(d) non-compliance

The service was not able to demonstrate management and staff receive ongoing support, training, and supervision to enable them to carry out their roles.

The Case Manager reported that the service does not have a training calendar and there was no evidence to demonstrate management and staff had received training relevant to the Quality Standards, including but not limited to:

* Complaints management and open disclosure.
* Dignity of risk.
* Antimicrobial stewardship.
* Identifying abuse and neglect of consumers.
* Incident management.
* Restrictive practices.

Members of the workforce confirmed they have not received training at the service. For example, one staff member reported having had no orientation and has not been provided with any training since commencing with the service, another staff member confirmed they have received no training to support them caring for consumers living with dementia, two staff attended a webinar on the Aged Care Reforms which was not recorded and three staff reported that no training had been provided on the Quality Standards.

According to the Case Manager staff are ‘buddied’ with an experienced staff member when they commence, however, a sampled staff member advised the Assessment Team this was not their experience. Two staff said they are booked into training on the Serious Incident Response Scheme (SIRS), but management are unaware of how and where to access training on Commission’s website on this training or other resources.

7(3)(e) non-compliance

While consumers/representatives said they are satisfied with the staff providing their care and services, the service did not demonstrate an effective system is in place to regularly evaluate how staff are performing their role, including subcontracted staff through brokerage arrangements. The service did not demonstrate a system is in place to assess, monitor and review the performance of staff delivering services through brokered arrangements.

The Case Manager reported reviews of staff performance are not undertaken. They reported having informal updates with new staff members but acknowledged they do not discuss with staff any training needs they may have.

Management acknowledged they had not considered to rely on feedback from consumers/representatives to inform continuous improvement and that there is no system to regularly assess and monitor the performance of staff, relying only on feedback from consumers. Even then, there is no documentation to evidence feedback from consumers has facilitated monitoring of staff performance.

In response to the Assessment team’s evidence, the provider has proposed:

* To provide staff with ‘intro packs’, job descriptions, orientation responsibilities, and organise ‘buddy’ shifts.
* Mandatory training.
* System for monitoring requirements.
* police check every 3 years
* driver’s license
* CPR
* Brokered service feedback.
* Staff training schedule relevant to the Quality standards.
  + Complaints management and open disclosure.
  + Dignity of risk .
  + Antimicrobial stewardship.
  + Identifying abuse and neglect of consumers.
  + Incident management.
  + Restrictive practices.
  + Dementia training.
  + Clinical governance.
* Training records.
* Staff appraisal.
* Feedback from consumers regarding performance.
* Monitor services through brokered arrangements.

I acknowledge that the provider has proposed how the service is to address these Requirements, however, as these changes will take some time to become embedded in the service, these Requirement are non-compliant.**Standard 8**

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

## Findings

8(3)(a) non-compliance

The service does not have an organisation-wide approach to involve consumers in developing, delivering, and evaluating their care and services. While consumers/representatives can provide feedback, no surveys are undertaken and there is no evidence of consumers being asked for input about their experience and the quality of care and services they receive.

Management and staff could not describe how consumers are actively engaged in the development, delivery and evaluation of care and services beyond that associated with a review of their care and services plan. Management identified one consumer who had provided a list of suggestions for improving services, ranging from employing younger staff to not using brokered staff. There is no evidence to indicate management acknowledged receipt of the suggestions or that they followed up with the consumer.

Management could not provide examples of how the feedback from consumers is used to plan improvements at the service or how the organisation responds to information received from consumers through this process.

8(3)(b) non-compliance

There is no evidence the governing body asks for and receives the information needed from the service to provide oversight of service delivery or to satisfy itself that the Quality Standards are being met within the service. There was insufficient evidence provided to demonstrate that the governing body understands and sets priorities to improve the performance of the service against the Quality Standards based on discussions with the Chief Executive Officer (CEO), the Case Manager and office staff and an analysis of the information provided by management during the quality audit.

Management could not describe how the governing body maintains oversight of the quality of subcontracted services through brokerage agreements. The Case Manager was able to identify vulnerable consumers as those who live alone, those without family support and those with high clinical needs but there was no evidence the approved provider maintains oversight of their service delivery. Only two meeting minutes were on record with the item discussed January 2022 being a reduction in management fees and in March 2021, discussing the service’s website, fee changes, and the use of an external provider to write policies and procedures. The minutes did not demonstrate the governing body was provided with information on complaints, incidents, continuous improvement, or risk.

8(3)(c) non-compliance

The service did not demonstrate it has effective organisation wide governance systems in place for managing and governing all aspects of care and services in relation to information management, continuous improvement, workforce governance, regulatory requirements and feedback and complaints.

* Information management

Assessment and care planning information was not always documented, including where risk to consumers were identified. Information was incomplete and care plans did not consistently document strategies to guide staff practice in the delivery of care and services. Outdated terminology and information were evident within key documents, staff engagement letters were inconsistent, with some not outlining staff responsibilities around WHS and confidentiality.

Staff were unaware of whether there were policy and procedure documents, and meeting minutes are not consistently documented. This is discussed further in Standard 2.

* Continuous Improvement

Management were unable to speak to how continuous improvement activities are identified and the service does not maintain a PCI. While some feedback is provided by consumers/representatives this information is not recorded and there is no evidence the information is used to improve care and services. Management had not considered other avenues for identifying improvements such as incidents, audit results and legislative changes.

* Financial Governance

The service has financial governance systems and processes to manage the finances and resources required to deliver a safe and quality service. This includes providing consumers with monthly statements and having processes to identify and manage unspent funds.

* Workforce governance, including the assignment of clear responsibilities and accountabilities

The service did not demonstrate how they support, develop, and monitor the workforce to deliver safe and quality care and services. The service did not demonstrate management and staff had the required skills and knowledge of aged care programs or the requirements of the Quality Standards. Refer to Standard 7.

* Regulatory Compliance

Management said the organisation maintains up to date information on legislative guidelines through various methods, including for example from media releases and Australian Government websites.

The service did not demonstrate effective systems and processes in place to support the service to meet regulatory requirements in respect of the Home Care Package program. For example, criminal history checks are out of date, management had no knowledge of the new Code of Conduct to be introduced in December 2022 and no knowledge of the requirement, introduced in April 2021, for home service providers to have an Incident Management System (IMS).

Compliance with the Quality Standards was not demonstrated, as reflected in the Quality Standards recommended by the Assessment Team as not met.

* Feedback and Complaints

While feedback and complaints are minimal and usually received verbally, the service does not record, monitor, analyse and use feedback and complaint data to improve the quality of its care and services. Refer to Standard 6.

8(3)(d) non-compliance

The service did not demonstrate that there is an effective risk management framework and associated policies and procedures to guide staff practice in identifying and responding to risk.

The service was unable to demonstrate it has an effective IMS or adequately demonstrate assessment and planning processes included a consideration of high-impact or high-prevalence risks to inform the delivery of safe and effective care for each consumer. Refer to Standard 2.

Staff have not received training on incident management following the introduction of the IMS requirement in April 2021, however, staff said they would report any incidents involving consumers or staff to the office.

While records did not demonstrate staff have received training in the identification of abuse and neglect since 2020, management and staff understood their responsibilities in relation to reporting abuse and neglect and management were aware of the soon to be introduced SIRS. While the CEO provided a procedure on risk management, there is no evidence of staff being aware of their responsibilities around identifying and responding to risk or being provided training in risk management.

The service did not provide a risk register and the procedure provided described the risk register as ‘a log of all risks identified both clinical and non-clinical’ with no evidence provided to demonstrate risks are discussed at meetings of the Board or service level meetings.

8(3)(e) non-compliance

The organisation was not able to demonstrate it has an effective clinical governance framework in place to maintain and improve outcomes for consumers.

The Case Manager could not describe clinical governance and how it applies to their roles in a practical way. They reported the current consumers do not require any clinical care, they have provided consumers with wound care and medication assistance previously and there are current consumers receiving continuous oxygen and palliative care.

Management acknowledged in their self-assessment and during the Quality Audit, they did not have a clinical governance policy or framework and during interviews that they did not have policies in relation to restrictive practices, antimicrobial stewardship, or open disclosure. A review of training records identified, and management confirmed that staff have not received training in relation to clinical governance, antimicrobial stewardship, restrictive practices, or open disclosure and what it means for them in their role.

In response to the Assessment team’s evidence, the provider has proposed:

* Consumer meetings, surveys, and organisation response for PCI.
* Board meeting and report, meeting minutes and agenda re: complaints, incidents, continuous improvement, and risks.
* Review outdated information within key document update.
* Staff engagement update including responsibilities around WHS and confidentiality.
* Staff access to policy and procedure, care plan.
* Plan criminal check and follow up system.
* New code of conduct information.
* Incident management system information.
* Risk management framework.
* Staff training risk management, incident management.
* Risk register.
* SIRS training.
* Clinical framework.

I acknowledge that the provider has proposed how the service is to address the outstanding issues, however, as these changes will take some time to become embedded in the service, all Requirements under this Standard are non-compliant.

1. The preparation of the performance report is in accordance with section 57 of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-2)