**Performance**

**Report**

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| Name: | The Benevolent Society |
| Commission ID: | 200229 |
| Address: | 2E Wentworth Park Road, GLEBE, New South Wales, 2037 |
| Activity type: | Quality Audit |
| Activity date: | 16 July 2024 to 19 July 2024 |
| Performance report date: | 10 September 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: 1675 The Benevolent Society  
Service: 27352 HCP Central West  
Service: 17545 HCP Eastern Suburbs  
Service: 17547 HCP Nepean & Western Sydney  
Service: 19341 HCP New England  
Service: 17550 HCP Northern Sydney  
Service: 17551 HCP South West Sydney  
Service: 17557 HCP Southern Sydney  
Service: 28341 The Benevolent Society - Home Support - ACT  
Service: 28340 The Benevolent Society - Home Support - Illawarra  
  
Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 7735 The Benevolent Society  
Service: 24738 The Benevolent Society - Care Relationships and Carer Support  
Service: 24737 The Benevolent Society - Community and Home Support

**This performance report**

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

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

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

# Material relied on

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

* the assessment team’s report for the Quality Audit report was informed by a site assessment, observations at service outlets, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 20th August 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 | **Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Not Applicable** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Compliant** |

# Assessment summary for Commonwealth Home Support Programme (CHSP)

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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 | **Compliant** |
| **Standard 4** Services and supports for daily living | **Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Compliant** |
| **Standard 7** Human resources | **Compliant** |
| **Standard 8** Organisational governance | **Compliant** |

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

# Areas for improvement

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 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 1(3)(d) was found non-compliant following a Quality Audit undertaken from 16 to 18 July 2024. The service did not demonstrate:

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

The Assessment Team was not satisfied each consumer is supported to take risks to enable them to live the best life they can. This could not be demonstrated in practice, across all services. The Assessment Team provided the following evidence to support their assessment:

* Consumers discussed their satisfaction with their ability to live their best life and the supports received. Staff and management described the process for identifying consumers exercising their dignity, documentation and supports available to consumers, however, the approved provider could not provide evidence across any and all services during the Quality Audit, such as completed dignity of risk assessments where risks had been identified and documented for individual consumers or documented conversations with consumers about decisions to exercise their dignity to take a risk.
* The Assessment Team reviewed a consumers care plan noting it was not descriptive of individual supports needed, neither were the individual choices the consumer wishes to make with their independence.
* Management acknowledged all services have not been using the dignity of risk form to support consumers making an informed choice, resulting in gaps of information captured. In addition, it was recognised by the approved provider’s executive team, consumers had not been supported to take risks to live their best life across all services.
* Management discussed the plan for continuous improvement and the inclusion of the dignity of risk form, recognising a broader scope was needed to train, monitor and verify the use of the form after the identification of consumers exercising their dignity, in addition to supporting staff to recognise and appropriately respond to consumers wanting to take risks.

The provider submitted information in response to the Assessment Team’s report, including:

* The providers model of care supports clients to exercise dignity of risk. By building strong relationships between consistent care staff and each client the staff support consumers to take risks where necessary and ensure the consumers know the consequences of risks before they take on support.
* The provider has developed and implemented a comprehensive formal dignity of risk procedure and form that has been completed for all consumers.
* The provider has recruited a Clinical nurse coordinator to provide specific assistance to care staff.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate and comprehensive response to address the gaps identified by the Assessment Team. I appreciate the provider’s acknowledgement regarding identified gaps and proposed timeframes and methods in responding to them.

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

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

Consumers and representatives said consumers are treated with respect and dignity and their diverse identity and culture is valued. Staff and management described how they treat consumers with dignity and respect. Documentation reviewed showed clearly documented consumers individual preferences with respect to their care and services.

Consumers and representatives said the care and services consumers receive are culturally safe. Staff demonstrated knowledge of individual consumers cultural identity and what is important to them. Management described the process utilised to capture consumers cultural needs and preferences. Documentation showed consistent consideration of consumers culture as it relates to culturally safe and effective care and services.

Consumers and representatives said they are supported and enabled to make decisions and establish relationships and connections that are important to them. Staff confirmed they support and encourage consumers to make decisions about their care. Staff outlined the process of respecting and documenting consumers choices and decisions. Documentation sighted clearly identified steps to follow to document and record consumers preferences of who is to be involved in their care and decisions they make in relation to their care and services.

Consumers and representatives said they are provided with written and verbal information that is timely, relevant and easy to understand. Staff described how they assist consumers to understand the information provided and offer additional supports. Documentation reviewed confirmed consumers receive relevant and timely information they understand.

Consumers and representatives said the services ensure their information is kept confidential and their privacy is respected. Staff demonstrated knowledge and described ways they ensure consumers information is kept confidential and how they respect their privacy. Management discussed the governance frameworks in place to ensure consumers confidentiality and privacy.

Based on the information above I find the provider, in relation to the service, compliant with all requirements in Standard 1 Consumer dignity and choice.

# 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. | 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

Requirements 2(3)(a) was found non-compliant following a Quality Audit undertaken from 16 to 18 July 2024. The service did not demonstrate:

* Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services.

The Assessment Team provided the below evidence to support their assessment:

* For some consumers, while risks have been identified, they have not been adequately assessed and strategies to manage them are not consistently documented.
* Where other health professionals were involved in the care of consumers, there was inconsistent evidence that outcomes of assessment and planning were shared with care staff, to ensure their understanding of risks to each consumer’s health and well-being.
* While the provider utilises a home safety checklist and staff complete an assessment considering consumer’s needs across various domains and referral options, there was no guidance in the policy and procedures to guide care managers in relation to when referrals to the clinical nurse or allied health professionals should be undertaken.
* Interviews with management, case managers and care staff identified that staff are aware of risks for each consumer. Whist the approved provider is identifying risk for many consumers, they did not demonstrate risk management strategies are consistently documented to support staff in providing adequate care and services.

The provider submitted information in response to the Assessment Team’s report, including:

* An Assessment, Review and Care Planning best practice guide has been endorsed to ensure a robust systemic practice across all programs. The best practice guide for assessment, reviews and care planning will enhance current practice and together with the adoption of our CRM provide greater consistency across aged care services. Care Managers have been provided information and training on the guide to improve practice consistency and support their ability to identify client care needs, risks, abilities and strategies.
* Care Managers have updated care plans to ensure that identified risks have been included.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate and comprehensive response to address the gaps identified by the Assessment Team. I appreciate the provider’s acknowledgement regarding identified gaps and proposed timeframes and methods in responding to them.

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

Requirement 2(3)(b) was found non-compliant following a Quality Audit undertaken from 16 to 18 July 2024. The service did not demonstrate:

* 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.

The Assessment Team provided the below evidence to support their assessment:

* Whilst care plans are developed based on the consumer/representative’s understanding of their needs, goals, and preferences, documentation reviewed did not consistently reflect all relevant information regarding each consumer’s current care needs, including risks to their health and well-being, and how these would be met at point of care. Whilst staff demonstrated an understanding of consumer’s current needs, documentation did not reflect this level of understanding.
* The service did not demonstrate that advance care planning or end of life planning discussions are occurring with each consumer within Service 24737.
* The Assessment Team provided feedback to management about care plans not identifying consumer’s current needs and preferences and whilst care staff demonstrated understanding of consumer current needs, documentation did not reflect this understanding. Management acknowledged this deficit and advised that the cause related to the roll out of the CRM and that assessment and care planning training would be reviewed for care managers to understand the new processes.

The provider submitted information in response to the Assessment Team’s report, including:

* Bi-Monthly Assessment, Review and Care Planning practice workshops will be held for staff to discuss practice, share knowledge and skills and identify any gaps across Aged Care Services. These workshops will provide everyone with an opportunity to evaluate the effectiveness of the processes to ensure consistency in practice and to identify opportunities for continuous improvement.
* The increased adoption of the CRM allows us to developed regular reporting on review date, care plan completion, type of clinical services in place for each client, dignity of risk, risk screening tool.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate and comprehensive response to address the gaps identified by the Assessment Team. I appreciate the provider’s acknowledgement regarding identified gaps and proposed timeframes and methods in responding to them.

Based on the evidence summarised above I find the provider, in relation to the service compliant with Requirement 2(3)(b) in Standard 2 On-going assessment and planning with consumers.

Requirement 2(3)(e) was found non-compliant following a Quality Audit undertaken from 16 to 18 July 2024. The service did not demonstrate:

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

The Assessment Team provided the below evidence to support their assessment:

* Evidence indicates the issues are systemic as the provider confirmed they do not currently have oversight of care plan reviews, however the CRM system, once fully implemented, will allow management to have oversight.
* The Assessment Team noted that care plans across some services, were not consistently reviewed, particularly when there was a change in a consumer’s condition.
* The Assessment Team advised management of the issues identified in care plan reviews. Management advised they will be hiring a new system analyst, who will be able to support the service in developing manners in which to better monitor care plan review dates within the new CRM.

The provider submitted information in response to the Assessment Team’s report, including:

* Advanced care planning and end of life planning are discussed at assessment with clients and recorded in care plans. The provider acknowledged feedback that advanced care planning has not consistently been discussed with clients receiving services within Service 24737. Care Managers working with clients under Service 24737 have been advised this is a part of standard practice.
* Client onboarding checklist updated to include Advanced Care Planning and End of Life Planning fact sheets. This will prompt care managers to have a conversation with consumers if they wish to do so and document the outcome.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate and comprehensive response to address the gaps identified by the Assessment Team. I appreciate the provider’s acknowledgement regarding identified gaps and proposed timeframes and methods in responding to them.

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

Requirements 2(3)(c), 2(3)(d).

Consumers and representatives confirmed the service involves them, and others they wish involved, in the care planning and assessment process. Staff described how they work in partnership with other who consumers wish to be involved in their care such as, organisations, individuals and service providers. Documentation reviewed confirmed that assessment and care planning is undertaken in collaboration with the consumer and others whom the consumer wishes to be involved in their care.

Consumers and representatives said the outcomes of their assessment and planning are communicated to them and they are provided with copies of the care and services plans they receive. Staff described the process they undertake to ensure consumers receive information such as care plans in the consumers preferred communication method. Documentation sighted showed the consumers signed care plans inclusive of copies they have been provided for their use and knowledge.

Based on the information above I find the provider, in relation to the service, compliant with all requirements in Standard 2 on-going assessment and planning with consumers.

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

Findings

Requirements 3(3)(b) was found non-compliant following a Quality Audit undertaken from 16 to 18 July 2024. The service did not demonstrate:

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

The Assessment Team provided the below evidence to support their assessment:

* In relation to the CRM, some care managers advised the Assessment Team they commenced using the new system in February 2024, however, other care managers from the same service said they were still using the older care plans. Care managers advised they are meant to list consumer risks as ‘alerts’ in the CRM, if a consumer’s care plan has been reviewed. However, in some cases, although a care plan had been updated in the CRM, the alerts had not been completed. Furthermore, care managers advised for some consumers rostering may update the alerts, although the new care plan had not been completed.
* Although management and staff were able to describe the high impact and high prevalence risks for their consumer cohort, as these risks are not consistently documented, it impacts the provider’s ability to effectively manage risk.
* The CNC demonstrated the organisation used a register to monitor consumers with clinical risks and these were discussed at regular meetings. They further advised that care managers escalate any concerns in relation to consumer’s clinical care needs.
* Whilst the service is identifying risks for many consumers, documentation demonstrates these risks are not being consistently documented, or care plans updated when consumer needs change, or effective strategies identified.

The provider submitted information in response to the Assessment Team’s report, including:

* Management is responsible for monitoring and tracking actions against any reported items and do this on a regular basis in leadership meetings. Matters of concern are escalated to the appropriate role and where applicable reported to the Aged Care Quality and Safety Commission. Executive Management and the Board have oversight of reported risks through various Committees.
* The Benevolent Society has a process for managing and escalating client risk in an emergency, including for brokerage agencies. This process is often a trigger for discussion and care plan review with the client.
* Risks are entered and monitored through the Client Overview section on the CRM. Emergency Plans are added to the Client Coordinator note on the CRM. Risks from the client overview section and Client Coordinator notes present on the CRM App for care staff visibility. Where these have not been embedded in the CRM in the past, we have provided care staff with copies of care plans and safe home visiting checklists via email.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate and comprehensive response to address the gaps identified by the Assessment Team. I appreciate the provider’s acknowledgement regarding identified gaps and proposed timeframes and methods in responding to them.

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

Requirement 3(3)(e) was found non-compliant following a Quality Audit undertaken from 16 to 18 July 2024. The service did not demonstrate:

* 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 below evidence to support their assessment:

* Evidence of clinical care assessments and reviews are noted and care managers and care staff demonstrated a good understanding of consumer care needs. However, the Assessment Team identified that whilst information is obtained from subcontracted clinical or allied health services, appropriate information is then not consistently made available for care staff.
* Most consumers and their representatives reported staff know consumer’s needs as they generally have the same care staff providing their services. Management and care managers discussed the means of communication within the service, which is dependent on whether the care plan is updated in the CRM, or under the former system.
* The Assessment Team evidenced that inconsistencies between care managers, in relation to when they commenced utilising the CRM leads to care staff not accessing the most up to date information about a consumer.
* The Assessment Team evidenced that while processes are in place to share information, due to there being inconsistencies between care managers and services, this limits the ability for care staff to ensure they have access to the most up to date information about consumers’ needs.

The provider submitted information in response to the Assessment Team’s report, including:

* Care Managers have undertaken a self-audit to ensure client information is up to date regarding client risks, needs and preferences. Leadership team oversees the completed the self-audit.
* Uptake and adoption of new CRM together with the assessment, review and care planning tool mentioned above will ensure consistency of practice across all programs including the identification, documentation and monitoring of client information.
* Identified risks will be monitored through the CRM. Staff and management have access to live dashboards and reports for monitoring and evaluation.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate and comprehensive response to address the gaps identified by the Assessment Team. I appreciate the provider’s acknowledgement regarding identified gaps and proposed timeframes and methods in responding to them.

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

Requirements 3(3)(a), 3(3)(c), 3(3)(d), 3(3)(f), 3(3)(g).

Consumers and representatives said they are satisfied with the personal and clinical care they are provided that is in line with their needs. Staff demonstrated knowledge of consumer’s needs, goals and preferences and were able to describe how the care provided to consumers Is safe and effective to the consumers needs. Management said they are confident that staff provide safe and effective clinical and personal care as various frameworks are in place to ensure deterioration and change in consumer circumstances is monitored, responded and addressed in a timely manner. Documentation showed clear, detailed assessments, care plans and progress notes relating to the consumer care that demonstrated it is safe, effective and customised to the needs and preferences of the consumer.

Consumers and representatives did not report specifically on palliative care; however, they described how the care and services provided to consumers maximise their quality of life and preserve their dignity. Each service demonstrated care delivery for consumers at end of life ensures their personal care needs are honoured, pain is managed, and the consumer’s dignity is maintained. The service does not directly provide consumers with palliative care, however, ensures consumers are referred to partners in the community who provide palliative care. Staff were able to demonstrate the steps taken to ensure care and services are reviewed and adjusted where a consumer is reaching their end of life. Documentation showed conversations are held with consumers in relation to advance care planning.

Consumers and representatives said they are confident staff providing care would recognise deterioration and take appropriate action. Staff demonstrated knowledge in relation to early identification and monitoring of changes in consumers health and well-being. Documentation confirmed appropriate action is taken in response to instances where deterioration is identified.

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

Consumers and representatives said they are confident staff providing care adhere to infection mitigation measures that minimise the transmission of infectious diseases. Staff demonstrated knowledge of how to minimise the transmission of infectious diseases. Documentation confirmed appropriate actions are taken to minimise the spread of infectious diseases.

Based on the information above I find the provider, in relation to the service, compliant with all requirements in Standard 3 Personal care 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 | Compliant |

Findings

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

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

Consumers and representatives expressed satisfaction with the supports for daily living received by consumers. Staff described how they recognise and support consumers’ emotional, spiritual and psychological well-being and how services provided meet those needs. Documentation confirmed consideration of the consumers emotional, spiritual and psychological well-being is captured during intake.

Consumers and representatives said the service and supports consumers receive for daily living supports consumers to participate in their community and interact with people and things of interest to them. Staff described how they support and encourage consumers to access the community, assisting consumers to do things of interest to them.

Consumers and representatives expressed they are satisfied the service has processes to support the continuity of their care. Consumers interviewed were confident information about their needs and preferences is communicated in the organisation and with others who they wish to be involved in their care. Staff described how information about the consumer’s condition, needs and preferences is communicated within the organisation and with others whom the consumers wish to be involved in the consumers’ care. Documentation confirmed information about the consumers care, needs and preferences is shared within the organisations and others involved in the consumers’ care.

Consumers and representatives interviewed said the service ensures timely and appropriate referrals are made to individuals or other providers of care and services where required. Staff demonstrated an understanding of referrals that can be made based on the consumers needs and preferences. Documentation sighted confirmed policies, procedures and processes are embedded in the service to guide staff on referrals ensuring they are timely and appropriate and based on the consumer’s needs.

Consumers confirmed the food provided is satisfying and nutritious. Staff described how the service ensures appropriate meals are provided based on consumer needs and preferences, including allergies and likes and dislikes. Documentation showed completed checklists for all consumers relating to food safety.

Consumers and representatives confirmed that the equipment they have is safe and suitable and maintained. Consumers interviewed advised they are satisfied with the equipment they use, where suitability was on the recommendations of allied health professionals or the consumers themselves. Staff advised they have access to various equipment options that they can support consumers with ensuring it safe and meets the consumers needs.

Based on the information above I find the provider, in relation to the service, compliant with all requirements in Standard 4, services and supports for daily living.

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

Findings

Requirements 5(3)(b) was found non-compliant following a Quality Audit undertaken from 16 to 18 July 2024. The service did not demonstrate:

* The service environment is clean, well maintained, comfortable and enables consumers to move freely, both indoors and outdoors.

The Assessment Team provided the below evidence to support their assessment:

* This Requirement has been assessed as not met in relation to Service: 24738 The Benevolent Society - Care Relationships and Carer Support and Service: 24737 The Benevolent Society - Community and Home Support. Evidence indicated that findings were at Rosemore Cottage respite services operated by the approved provider as management indicated consumer risks should be assessed, identified and managed consistently across each service.
* The approved provider did not demonstrate sufficient oversight and effective management of environmental risk to consumers at Rosemore Cottage.
* Management and care staff described the process to ensure the service is avoiding environmental risk, is safe and well maintained which is supported by various policies and procedures. However, management and staff for Rosemore Cottage did not demonstrate knowledge of strategies to promote free movement of consumers including, front door and side gate access. Property management advised they were not aware of these maintenance matters at Rosemore Cottage.
* Whilst at Rosemore Cottage the Assessment Team observed restricted access and trip hazards for consumers in back garden.
* All consumers interviewed at Greenwood Centre-day respite reported that the service is clean, well maintained and comfortable and they can go outside as they please.
* The Assessment Team observed Greenwood Centre-based day respite as clean, well maintained and consumers can move freely indoors and outdoors.

The provider submitted information in response to the Assessment Team’s report, including:

* When consumers attend Rosemore for their first service, we induct them on physical accesses of the property, including doors are locked and that consumers will ask staff on shift to unlock the door if they wish to enter and exit the property. Consumers at Rosemore Cottage receive screening at assessment stage, to ensure that they have low care needs and that they are able to consent to service with information given and explained to them.
* In consideration of front door locked from the egress of Rosemore poses a parameter of restraint, the provider has removed the restraint whilst putting in appropriate safety and security measure for the property. A new lock has been installed with deadlatched doorknob which allow free access from the inside of the property by turning the doorknob.
* In relation to the side gate, the provider has implemented a process to ensure all consumers are informed about the locked gate prior to receiving services, and the method used to allow free access to the gate.
* Ramp is secure now, completed 6 August with new brackets fitted.
* Pictorials – updated and embedded throughout the Cottage.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate and comprehensive response to address the gaps identified by the Assessment Team. I appreciate the provider’s acknowledgement regarding identified gaps and proposed timeframes and methods in responding to them.

Based on the evidence summarised above I find the provider, in relation to the service compliant with Requirement 5(3)(b) in Standard 5, Organisation’s service environment.

Requirements 5(3)(a), 5(3)(c).

Consumers confirmed they feel comfortable and welcome in the service environments. Staff described how they support consumers to interact and use the service environment to suit their needs. Management described how they know consumers feel welcome by assessing attendance and participation in activities. Consumers were observed participating in activities in the service environment.

Each service, Greenwood Centre-based day respite and Rosemore Cottage demonstrated that furniture, fittings and equipment are safe, clean well maintained and suitable for consumers to use. Both services provided open space for the consumers to maintain access to their mobility aids at an arm's reach. Staff and management described the processes for cleaning equipment and escalating issues with furniture. The service environment was observed to be clean and well-maintained.

Based on the information above I find the provider, in relation to the service, compliant with all requirements in Standard 5, Organisation’s service environment.

# 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. | Compliant | Compliant |

Findings

Requirements 6(3)(a), 6(3)(b), 6(3)(c), 6(3)(d)

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

Consumers and representatives confirmed they are aware other methods for raising and resolving complaints, including knowing how to contact the Commission. Management described how the service supports consumers to access advocates and other services and methods for raising and resolving complaints. Documentation showed the service’s complaints procedure offer consumers diverse internal and external feedback, complaints and advocacy options.

Consumers and representatives confirmed the service resolved issues or informal complaints they had made. Staff described processes for escalating complaints from consumers. Management described how the service responds to complaints and how it uses open disclosure when issues are identified. Documentation showed the service uses an open disclosure approach to resolve issues, even though the service does not have an open disclosure procedure.

The service’s complaints register is used to trend complaints and improve service, with strategies implemented to avoid the same issues occurring again. Documentation showed complaints are actioned and finalised and, if necessary, improvements to services are implemented.

Based on the information above I find the provider, in relation to the service, compliant with all requirements in Standard 6, feedback and complaints.

# 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

Requirement 7(3)(d) was found non-compliant following a Quality Audit undertaken from 16 to 18 July 2024. The service did not demonstrate:

* The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.

The Assessment Team provided the below evidence to support their assessment:

* In relation to workforce training, all staff received the same training across all services and was monitored through an electronic employee training management system. However, the workforce did not receive training on restrictive practices, resulting in a lack of awareness surrounding aspects of care related to this.
* The Assessment Team acknowledges the approved provider’s plan to attend and deliver training to internal workforce on restrictive practices. However, the lack of training on restrictive practices led to gaps in the workforce’s knowledge and understanding of restrictive practices. The workforce was not supported to recognise restrictive practices and, as such, failed to escalate these events to management.

The provider submitted information in response to the Assessment Team’s report, including:

* The provider has embedded and implemented a mandatory training module in relation to essential knowledge for restrictive practices. The training has now been delivered to all staff in Rosemore Cottage.
* Furthermore, Restrictive Practices Guide training was completed with all care managers on 19th August. Electronic learning module for Restrictive Practice is available for all staff as a mandatory training module.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate and comprehensive response to address the gaps identified by the Assessment Team. I appreciate the provider’s acknowledgement regarding identified gaps and proposed timeframes and methods in responding to them.

Based on the evidence summarised above I find the provider, in relation to the service compliant with Requirement 7(3)(d) in Standard 7, Human resources.

Requirements 7(3)(a), 7(3)(b), 7(3)(c), 7(3)(e)

Consumers and representatives said the services provides their services in a safely and timely manner. Staff advised there is enough staff and the right mix of staff to provide to plan and deliver care and services. Management demonstrated the process of ensuring workforce planning and availability met the consumers required hours of service.

Consumers and representatives said interactions with staff are kind, caring and respectful of their cultural diversities. Staff explained how they interact with consumers in a way that is kind, caring and respectful. Management described the training and orientation staff undertake to ensure the workforce supports values- based interactions with consumers. Documentation confirmed training and processes are in place to ensure staff deliver care in a kind, caring and respectful manner.

Consumers and representatives said the care and services they receive are delivered by a workforce that is competent, hold the appropriate qualifications and effectively performs their role. Staff were able to demonstrate that they are supported by organisational governance and on the job training to fulfill their roles. Documentation confirmed the service has systems to ensure staff have the right mix of skills, qualifications and knowledge to perform their role.

Consumers and representatives recalled the approved provider calling to occasionally inquire about services and staff. Consumers and representatives articulated they were comfortable providing feedback directly to management should there be any concerns. Staff confirmed methods of supervision and performance monitoring in place. The Assessment Team sighted evidence that feedback from consumers relating to subcontracted staff and internal workforce was sought and documented in electronic consumer files.

Based on the information above I find the provider, in relation to the service, compliant with all requirements in Standard 7, Human resources.

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

Findings

Requirements 8(3)(d) was found non-compliant following a Quality Audit undertaken from 16 to 18 July 2024. The service did not demonstrate:

* Effective risk management systems and practices, including but not limited to managing high impact, high prevalence risks, identifying and responding to abuse and neglect, supporting consumers to live the best life they can and managing and preventing incident including the use of an incident management system.

The Assessment Team provided the below evidence to support their assessment:

* The approved provider did not demonstrate sufficient oversight and effective management of high-impact or high-prevalent risks.
* Care staff demonstrated knowledge of consumer risks and mitigating strategies in place to minimise the impact of risks.
* Management described the development of a high-risk/complex care consumer register. However, this was not an embedded practice at the time of the assessment.
* Clinical risk assessments were not consistently completed where risks were identified such as using validated risk assessment tools. Care plans reviewed did not consistently include consideration of clinical risk assessments and outcomes, limiting the information available to care staff.
* The Assessment Team acknowledges the approved provider’s plans to improve oversight over high-risk and complex care consumers. However, at the time of the assessment, the approved provider did not demonstrate effective high-impact or high-prevalent risk management.

The provider submitted information in response to the Assessment Team’s report, including:

* All Care Managers discuss concerns and raise issues with the CNC during assessment, review and care planning. The CNC provides advice and recommendations for referral interventions for discussion with the client. Clients are then referred to external brokerage agencies for interventions and or pay for allied health services and seek reimbursement through their Home Care Package funds. When possible, the CNC can conduct face to face assessments in the wider Sydney area.
* The provider has addressed the gaps identified in relation to managing restrictive practices in Requirement 5(3)(b), strategies have been embedded to ensure management of risks is adequate.
* To identify and assess harm or distress of consumers, the provider has conducted a review of all incidents reported to their incident management system for Rosemore, for the past 24 months and consulted with their staff as part of the review. It is not to the provider’s awareness that harm, distress, change of behaviour or adverse sustained impact have been identified to Rosemore cottage consumers.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate and comprehensive response to address the gaps identified by the Assessment Team. I appreciate the provider’s acknowledgement regarding identified gaps and proposed timeframes and methods in responding to them.

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

Requirement 8(3)(e) was found non-compliant following a Quality Audit undertaken from 16 to 18 July 2024. The service did not demonstrate:

* Where clinical care is provided—a clinical governance framework, including but not limited to the following: antimicrobial stewardship, minimising the use of restraint and open disclosure.

The Assessment Team provided the below evidence to support their assessment:

* In relation to minimising the use of restraint, the approved provider did not demonstrate that the governing body had sufficient oversight of restrictive practices.
* Workforce training was not undertaken, resulting in the inability to articulate examples and identify restrictive practices.
* Management indicated consumers attending Rosemore cottage were low care. The approved provider was unable to adequately justify the need for the environment to influence consumer behaviour and restrict free movement with consumers having low care needs.
* The Assessment Team sighted the SIRS policy and procedure. This demonstrated that the approved provider assigned roles and responsibilities. Documentation showed a clear process for reporting and recording incidents and its linkage to continuous improvements and open disclosure. It provided appropriate guidance to staff regarding the incident management and escalation workflow.
* The Assessment Team acknowledges the approved provider’s plans to deliver training on restrictive practices. However, at the time of the assessment, the approved provider did not demonstrate adequate oversight over restrictive practices.
* Clinical governance oversight over restrictive practices would need to be reviewed, and monitoring systems would need to be implemented to enable the governing body to have sufficient oversight. The clinical governance framework would also need to be reviewed to ensure all elements of this Requirement are reflected.

The provider submitted information in response to the Assessment Team’s report, including:

* Corrective actions have been undertaken to address workforce training and support relating to risk assessments, care plans and clinical risk oversight.
* The systems and processes implemented will be regularly monitored and evaluated to ensure effectiveness and consistency in practice across all services. The Business Analyst is supporting the leadership team to implement more effective monitoring strategies in the CRM to easily identify, monitor, manage and report on client risks.
* The provider has implemented processes to manage risks and ensure consistent practice.
* The systems and processes implemented will be regularly monitored and evaluated to ensure effectiveness and consistency in practice across all services. The Business Analyst is supporting the leadership team to implement more effective monitoring strategies in the CRM to easily identify, monitor, manage and report on client risks.

In coming to my finding, I have considered the information in the Assessment Team’s report and the provider’s response which shows a proportionate and comprehensive response to address the gaps identified by the Assessment Team. I appreciate the provider’s acknowledgement regarding identified gaps and proposed timeframes and methods in responding to them.

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

Requirements 8(3)(a), 8(3)(b), 8(3)(c)

Consumers and their representatives are engaged in the development, delivery and evaluation of all care and services through annual surveys and the consumer advisory body. Staff stated the service is well run and that consumers are engaged in their care. Management described the different ways the organisation involves consumers in developing, delivering and managing care and services.

Management explained the governing body meets regularly and considers operational reports presented by management. Feedback, complaints, incidents and deterioration reporting are part of monitoring, incorporated into the monthly governing body reporting processes.

The service demonstrated that the governing body effectively oversaw information management, continuous improvement, financial governance, workforce governance, regulatory compliance, and feedback and complaints.

Based on the information above I find the provider, in relation to the service, compliant with all requirements 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)