**Performance**

**Report**

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| Name: | Valmar Support Services Ltd |
| Commission ID: | 201124 |
| Address: | 66 - 68 Russell Street, TUMUT, New South Wales, 2720 |
| Activity type: | Quality Audit |
| Activity date: | 5 February 2024 to 7 February 2024 |
| Performance report date: | 23 May 2024 |

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

**Service included in this assessment**

Home Care Packages (**HCP**) included:  
Provider: 9020 Valmar Support Services Limited  
Service: 26839 Valmar Support Services Ltd

Commonwealth Home Support Programme (**CHSP**) included:  
Provider: 7342 Valmar Support Services Ltd  
Service: 24012 Valmar Support Services Ltd - Care Relationships and Carer Support  
Service: 24011 Valmar Support Services Ltd - Community and Home Support

**This performance report**

This performance report for Valmar Support Services Ltd (**the service**) has been prepared by K. Jarvie, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

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

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

**Material relied on**

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

* the assessment team’s report for the Quality Audit report, which 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 18 March 2024.

**Assessment summary for Home Care Packages (HCP)**

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

**Assessment summary for Commonwealth Home Support Programme (CHSP)**

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

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

**Areas for improvement**

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

Requirement 1(3)(e)

* Ensure information provided to each consumer is current and accurate.

Requirement 2(3)(e)

* Ensure processes are in place to review care and services regularly for effectiveness and when circumstances change or when incidents impact on the needs, goals, and preferences of the consumer.

Requirement 3(3)(a)

* Ensure each consumer received safe and effective personal care which is best practice, including for medication management and possible restrictive practices.

Requirement 3(3)(b)

* Ensure effective management of high-impact or high-prevalence risks associated with the care of each consumer, particularly in relation to medication management and restrictive practices.

Requirement 6(3)(c)

* Ensure appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. This includes recording and responding to all complaints and feedback received.

Requirement 6(3)(d)

* Ensure feedback and complaints are reviewed and used to improve the quality of care and services. This includes recording and reviewing all complaints and feedback.

Requirement 8(3)(b)

* Ensure the organisation’s governing body is provided with relevant information to promote a culture of safe, inclusive, and quality care and services and the governing body is accountable for the delivery of this quality care and services.

Requirement 8(3)(c)

* Ensure effective organisation wide governance systems are in place relating to continuous improvement and feedback and complaints.

Requirement 8(3)(d)

* Ensure there are effective risk management systems and practices in place to manage high-impact or high prevalence risks.

**Standard 1**

|  |  |  |  |
| --- | --- | --- | --- |
| Consumer dignity and choice | | HCP | CHSP |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant | Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Not Compliant | Not Compliant |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant | Compliant |

**Findings**

Requirement 1(3)(a)

While most consumers provided positive feedback about staff treating them with dignity and respect, the assessment team assessed this Requirement as not met because staff and management could not describe how identity, culture and diversity is valued and documentation did not support staff to treat consumers with dignity and respect and to value each consumer’s dignity, culture, and diversity. The assessment team provided the following evidence relevant to my finding:

* Four of 5 consumers felt they were treated with dignity and respect within the service.
* One consumer said they felt disrespected when shifts are cancelled or when there is a lack of communication.
* Staff stated they deliver person centred care and involve the consumer in all elements of the service.
* Staff could not describe how they promote cultural awareness in their everyday practice.
* Staff and management could not demonstrate how they recognise, promote and value diversity.
* Although the quality improvement plan included a plan for cultural training for transport coordinators, the assessment team did not sight evidence of this training.
* The service does not have a diversity action plan or similar, to guide the workforce on strategies for inclusive care and services.

The provider’s response included explanation and evidence addressing the assessment team’s finding, including:

* Explanation management had identified a gap within this Requirement and had discussed this with the assessment team during the quality audit.
* Explanation the service has been reviewing and developing relevant policies in line with a schedule and the assessment team did not speak with the person responsible for review/creation of policies during the quality audit.
* Explanation culture and diversity considerations were identified as opportunities for improvement as part of a program in which the service is engaged.
* Evidence relevant mandatory training is being rolled out in line with a training schedule.
* Evidence the service recognises and respects each consumer’s individuality, with assessment processes identifying needs and goals to meet the consumer’s identity, culture, and diversity.
* Explanation the service is creating a diversity action plan and working with an external program to ensure the aged care diversity framework and action plans are embedded into planning practices.

In coming to my finding, I have considered information and evidence in the assessment team’s report and the provider’s response, which demonstrates the service treats consumers with dignity and respect, with their identity, culture and diversity valued.

I have considered the intent of this Requirement, which expects organisations to take the time to listen to and understand each consumer’s personal experience and to work with consumers in an inclusive and respectful way, using a consumer-focused approach. I find this did occur, as the service has detailed planning processes and documentation to help identify each consumer’s identity, culture, and diversity expectations.

I acknowledge the assessment team stated one consumer did not feel respected when shifts are cancelled or when there is a lack of communication. However, there was no evidence presented to indicate if the assessment team raised this feedback with management to identify if this is an ongoing issue or something which occurred in the past. I do not find it proportionate to decide non-compliance based on one statement without any supporting evidence. Although the assessment team stated staff could not describe how they promote cultural awareness in their everyday practice and staff and management could not demonstrate how they recognise, promote and value diversity, there was no evidence presented on the negative impact on consumers because of staff being unable to demonstrate this knowledge.

I have place weight on the provider’s response and evidence presented which shows the service treats consumers with dignity and respect, with their identity, culture and diversity valued. I acknowledge the service is working on improvements in policies and the development of a diversity plan and I encourage the service to continue this work.

In relation to HCP, I find the provider, in relation to the service, compliant with Requirement (3)(a) in Standard 1, Consumer dignity and choice.

In relation to CHSP, I find the provider, in relation to the service, compliant with Requirement (3)(a) in Standard 1, Consumer dignity and choice.

Requirement 1(3)(b)

The assessment team assessed this Requirement as not met as they were not satisfied consumers had been engaged in defining culturally safe care, not all staff had completed culturally safe care training and management did not have a plan to increase the staff training. The assessment team provided the following evidence relevant to my finding:

* Two consumers out of 7 felt the service knew about the consumer’s culture and background, with 2 consumers stating the service did not know and 3 consumers were unsure if the service knew about the consumer’s culture and background.
* One consumer described how the service provides personal care in line with her personal preference about with whom she feels safe.
* Staff provided examples of consumers with culturally specific considerations.
* Staff and management explained if a need for further cultural safety training was identified, it would be sought.
* Management explained the need for cultural safety training for staff had been identified as an improvement action, with staff enrolled in various training programs.
* Documentation showed 36% of staff had completed the training arranged by the service.

The provider’s response included explanation and evidence addressing the assessment team’s finding, including:

* Explanation management advised the assessment team during the quality audit that cultural safety training had been identified as an improvement action in a proactive approach and recognition that cultural safety training had not been delivered and was required for all staff.
* Explanation that evidence of staff induction and training was provided to the assessment team at the time of the quality audit. Through the response to the assessment team report, management identified issues in the reports being produced from the system, which were not including all completed training modules for all staff.
* Evidence of staff completion of training and staff training roster.
* Evidence of a training matrix to ensure staff compliance with mandatory training.
* Evidence the service is consulting with consumers to define cultural safety.

In coming to my finding, I have considered information and evidence in the assessment team’s report and the provider’s response, which demonstrates the service does provide care and services which are culturally safe.

I have considered the intent of this Requirement, which expects organisations to work with consumers and any other people they want to involve, so that their cultural preferences and needs can be understood. I find this did occur, as the service has identified and implemented processes to ensure all staff complete cultural safety training and the service is consulting with consumers to define cultural safety.

I acknowledge the assessment team stated not all consumers felt the service knows their culture and background. However, there was no evidence presented to show negative impact on any consumers in relation to this Requirement.

I have placed weight on the provider’s response and evidence presented which shows the service has processes and plans in place to ensure all staff receive relevant cultural safety training and the service is consulting with consumers on the definition of cultural safety.

In relation to HCP, I find the provider, in relation to the service, compliant with Requirement (3)(b) in Standard 1, Consumer dignity and choice.

In relation to CHSP, I find the provider, in relation to the service, compliant with Requirement (3)(b) in Standard 1, Consumer dignity and choice.

Requirement 1(3)(d)

The assessment team assessed this Requirement as not met, as consumers did not feel supported to take risks and the service had a lack of policy, procedure and training for staff to support consumers to take risks. The assessment team provided the following evidence relevant to my finding:

* Most consumers stated the service did not support them to do things they are not confident in doing, with one consumer stating they are supported to take risks.
* Staff described how they enable consumers to take risks. However, staff stated strategies for keeping consumers safe would not be documented.
* Management stated the service has open communication during assessment and support planning processes to identify and discuss risks and plan mitigation strategies which are documented. A profile is developed for each consumer to include risks and strategies to mitigate the risks. This is a new process and not all staff have access to this information. Management could not tell the assessment team how many of these profiles had been completed.
* Policies and procedures related to risk provided to the assessment team did not address processes to support consumers who decide to engage in risk and how to mitigate those risks.

The provider’s response included explanation and evidence addressing the assessment team’s finding, including:

* Explanation consumers don’t identify risks in the same context service providers identify risk.
* Explanation and evidence risk and mitigating strategies are identified and recorded in consumer support plans to guide staff.
* Explanation that the request by the assessment team for the number of profile summaries completed may have been directed to staff who did not know how to extract the information. The provider presented evidence of profile summaries are continuing to be completed for consumers.
* Explanation and evidence the service’s assessment tool is used to identify actual and potential risks, with those risks discussed with consumers and referrals made to external services if required.
* Explanation and evidence the support plan is created after the assessment, including safety and risk-taking goals, actions and strategies to mitigate the risks.

In coming to my finding, I have considered information and evidence in the assessment team’s report and the provider’s response, which demonstrates the service does support consumers to take risks to enable them to live the best life they can.

I have considered the intent of this Requirement, which expects organisations to show how they involve consumers and look for solutions that are the least restrictive of the consumer’s choice and independence when risk is involved. I find this did occur, as the service has assessment and planning processes in place to identify risk and develop mitigation strategies to support consumers to take risks.

I have place weight on the provider’s response and evidence presented which shows the service has processes in place to identify and assess risk and provide guidance to staff in how to manage those risks.

In relation to HCP, I find the provider, in relation to the service, compliant with Requirement (3)(d) in Standard 1, Consumer dignity and choice.

In relation to CHSP, I find the provider, in relation to the service, compliant with Requirement (3)(d) in Standard 1, Consumer dignity and choice.

Requirement 1(3)(e)

The assessment team assessed this Requirement as not met, as consumers indicated they are not provided with information which is current, accurate and timely and staff have not been provided with training to identify strategies to communicate with consumers with specific communication requirements. The assessment team provided the following evidence relevant to my finding:

* Three consumers stated they did not receive information from the service when and how requested or needed:

Consumer A stated they had been waiting for advice from the service about replacing equipment for over 2 weeks. Management advised the assessment team the equipment was not covered by the HCP funding but, the service has not advised the consumer.

Consumer B stated they had requested a telephone call the day before the support worker arrives but, this does not occur.

Consumer C stated they struggle to read due to advancing dementia. Staff stated they write things on the consumer’s calendar or display large signs to remind the consumer of upcoming appointments. The assessment team stated the service agreement is provided in a small font.

* Consumers confirmed they understand their budgets and invoices.
* Management stated for consumers who face challenges communicating their choices, the service engages family members or advocates where the consumer consents.
* Management stated the service was developing a guidance document for consumers about how to read budgets and invoices.
* Documentation showed the invoices provided to consumers are itemised and clear.
* Documentation showed orientation and training did not support staff to understand and identify strategies to communicate with consumers with specific communication requirements.
* Documentation showed results from a consumer survey references communication as an item for improvement. Management stated the service had not yet acted on the comments in the survey.

The provider’s response included explanation and evidence addressing the assessment team’s finding, including:

* Explanation and evidence the provider has processes in place to contact Consumer B prior to a support worker arriving but, Consumer B is unable to be reached.
* Explanation and evidence the service has included an item on the consumer body agenda about how the service can improve communication with consumers, to address communication gaps.
* Explanation Consumer C did not have a diagnosis of dementia when they commenced with the service. However, the coordinator read the documentation to the consumer (and their current advocate) at the time of signing the agreement.
* Explanation the service had previously identified it would assist consumers if the service provided a ‘how to understand your budget/statement’ document. This was in development and would now be in place and distributed as part of March invoicing.
* Explanation the service had identified that the consumer documentation requires updating, with improvements to include ensuring consumers receive information in a form they can understand.
* Explanation the service is sourcing further training to support staff in communicating with consumers with specific communication requirements.

In coming to my finding, I have considered information and evidence in the assessment team’s report and the provider’s response, which demonstrates deficits in providing current, accurate and timely information which is communicated clearly, easy to understand and enables consumers to exercise choice.

I have considered the intent of this Requirement, which expects organisations communicate clearly and supply helpful resources about the care and services. I find this did not occur, as the service did not demonstrate timely and clear information is provided to all consumers.

I acknowledge consumers confirmed they understand their budgets and invoices. However, feedback from consumers shows communication from the service is not occurring in a timely manner, particularly in response to a consumer’s specific query or request.

I have place weight on evidence presented which shows the service acknowledges its consumer documentation requires updating and consumers have provided negative feedback about communication from the service. I note the service is seeking additional training for staff to support them in communicating with consumers with specific communication requirements.

In relation to HCP, I find the provider, in relation to the service, non-compliant with Requirement (3)(e) in Standard 1, Consumer dignity and choice.

In relation to CHSP, I find the provider, in relation to the service, non-compliant with Requirement (3)(e) in Standard 1, Consumer dignity and choice.

Requirements 1(3)(c) and 1(3)(f)

Consumers confirmed they are supported to exercise choice and independence, with consumers providing examples of how the service had adjusted services based on consumer requests. Staff explained choice and independence is discussed with consumers during the initial assessment process. Management explained consumers are involved in care planning and they can choose what they would like to be part of their HCP or CHSP funding. Management also stated for consumers who face challenges communicating their choices, the service engages family members or advocates where the consumer consents.

Consumers stated they felt their privacy and personal information is respected. Staff described the processes used to ensure the service maintains consumer privacy and confidentiality. Management stated staff have completed privacy and confidentiality training.

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

**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. | Not Compliant | Not Compliant |

**Findings**

Requirement 2(3)(e)

While consumers and representatives confirmed consumers are regularly reviewed to ensure consumer needs and preferences are met, the assessment team assessed this Requirement as not met as the service did not demonstrate it had systems in place to monitor scheduled reviews. The assessment team provided the following evidence relevant to my finding:

* Consumers and representatives stated they would be supported to amend the consumer’s care and services if the consumer’s needs or preferences changed.
* Staff explained not all care plan reviews and/or reassessments were current and the system for capturing outstanding plans was dependent on one team.
* Documentation showed care plans were updated in a timely manner when there was an identified change in circumstances of a consumer.
* Documentation showed the service is expected to review consumers with CHSP funding or HCP level 1 or level 2 every 12 months and consumers on HCP level 3 or level 4 every 3 months. However, management was unable to provide information about the number of overdue care plans.

The provider’s response included explanation and evidence addressing the assessment team’s finding, including:

* Evidence of development and implementation of a new review and monitoring process for care planning.
* Explanation additional training is to be sourced to support staff in reviews.

In coming to my finding, I have considered information and evidence in the assessment team’s report and the provider’s response, which demonstrates deficits in care and service reviews. Although the service reviews care and services when a consumer’s circumstances change, the service does not have processes in place to regularly review care and services for effectiveness.

I have considered the intent of this Requirement, which expects organisations to regularly review the care and services they provide to consumers, with agreed review dates, depending on the needs of the consumer. I find this did not occur, as the service did not have processes in place to schedule, review and monitor consumer care plans in the event there was no request to change, or an incident/accident had occurred.

I acknowledge the service has an assessment and planning policy which details how often each consumer should be reviewed based on their care level. However, I have placed weight on the evidence implementation of this policy had not occurred, with the service not demonstrating processes to ensure all consumers are reviewed regularly.

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

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

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

Representatives confirmed the service assessed the consumer and considered risk to ensure safe and effective care and services are provided. Staff described how they incorporate assessment of risks when assessing consumer needs. Documentation showed care planning documentation was up to date for consumers whose needs have changed, and the assessments included consideration of risk.

Consumers and representatives confirmed the consumer was involved in the assessment and planning of care. Staff described how the service ensures the assessment and planning reflected the current needs of each consumer. Management and senior staff described how end of life planning conversations were held upon admission if the consumer wishes. Documentation showed current needs of consumers and advance care planning was recorded.

Consumers and representatives confirmed they are involved in assessment and planning processes. Staff described how the service refers consumers to other providers following an assessment when necessary. Management advised staff receive training in consumer capacity and decision making, with staff gathering as much information as possible from consumers and/or their representatives during initial and ongoing assessments. Documentation showed examples of referrals to other services where needed.

Consumers and representatives confirmed the service explains information about the consumer’s assessment and they have a copy of the consumer’s care plan. Management advised brokered services provide reports/recommendations and treatment/progress notes which are uploaded to the consumer’s file. Documentation showed assessment and planning resulted in individualised care plans for consumers, including needs, goals and preferences with individualised strategies to guide staff.

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

**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. | Not Compliant | Not Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Not Compliant | Not 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**

Requirement 3(3)(a)

The assessment team assessed this Requirement as not met, as the service did not demonstrate best practice understanding and implementation of restrictive practices and medication management. The assessment team provided the following evidence relevant to my finding:

* The service was unable to identify consumers who have equipment in place that could be considered a restrictive practice depending on a consumer’s changing conditions.
* The assessment team identified equipment, the use of which could be considered a restrictive practice, with no evidence of discussions with consumers on the risks involved in the use of this equipment or evidence of monitoring or review of the use of the equipment.
* The assessment team identified there were no policies or procedures to guide staff on restrictive practices.
* Staff did not demonstrate an understanding of restrictive practices in relation to their work.
* The service does not document the medications being administered during services.
* The assessment team identified there were no policies or procedures to support safe use of medications.
* Although management stated support workers providing medication administration have a minimum of certificate III in aged care or competency assessments, documentation and interviews with staff did not support this statement.
* Management stated some consumers are reluctant to share medical information.

The provider’s response included explanation and evidence addressing the assessment team’s finding, including:

* Explanation the service will use current resources to create a vulnerable consumer register and the service will include restrictive practices on this register.
* Explanation the service will include restrictive practices in its goals for inclusion in care plans.
* Explanation the service will review the assessment tool to include medication lists.
* Explanation staff will be provided with training on restrictive practices.
* Explanation and evidence of medication management process flow chart development and implementation.

In coming to my finding, I have considered information and evidence in the assessment team’s report and the provider’s response, which demonstrates a deficit in providing best practice care for consumers.

I have considered the intent of this Requirement, which expects organisations to refer to relevant national guidance about how to deliver safe and effective care and to implement this in their services, to ensure personal and clinical care is tailored and based on an assessment of a consumer’s needs, goals and preferences and the care optimises the consumer’s health and well-being. I find this did not occur, as the service did not demonstrate best practice approaches to medication management and restrictive practices.

I have place weight on the assessment team’s report which identified risks to consumers regarding medication management and use of equipment which could be considered a restrictive practice. I acknowledge the provider has implemented improvements to address the deficit. However, there was no evidence the improvements have been embedded and are effective.

In relation to HCP, I find the provider, in relation to the service, non-compliant with Requirement (3)(a) in Standard 3, Personal care and clinical care.

In relation to CHSP, I find the provider, in relation to the service, non-compliant with Requirement (3)(a) in Standard 3, Personal care and clinical care.

Requirement 3(3)(b)

Although the assessment team was satisfied high impact or high prevalence risks associated with the care of each individual consumer is effectively managed, the assessment team assessed this Requirement as not met, as the service did not demonstrate management of high impact or high prevalence risks at a system level. The assessment team provided the following evidence relevant to my finding:

* Documentation showed detailed instructions on tasks to complete and strategies for managing high impact or high prevalence risks for individual consumers.
* Staff identified falls as a key risk associated with the personal care of consumers and staff described strategies to manage consumer falls risks.
* Staff described, and documentation confirmed, the information available to staff at the point of care to guide them to support consumers with high impact or high prevalence risks.
* Management advised while individual risks to consumers were identified during assessment and planning, the service does not have a system in place to identify and manage high impact high or prevalence risks collectively and therefore is unable to review and monitor trends.
* Documentation showed not all incidents were recorded in the incident register.
* Workforce orientation, training and other records did not show how the service supports the workforce to manage high impact risks.
* Incident information, including falls and medication errors, is not collected or trended to analyse risk related incident information.
* The service was unable to identify consumers who have equipment in place that could be considered a restrictive practice depending on a consumer’s changing conditions.
* The assessment team identified equipment, the use of which could be considered a restrictive practice, with no evidence of discussions with consumers on the risks involved in the use of this equipment or evidence of monitoring or review of the use of the equipment.
* The assessment team identified there were no policies or procedures to guide staff on restrictive practices.
* Staff did not demonstrate an understanding of restrictive practices in relation to their work.
* The service does not document the medications being administered during services.
* The assessment team identified there were no policies or procedures to support safe use of medications.

The provider’s response included explanation and evidence addressing the assessment team’s finding, including:

* Explanation the service has 2 systems for reporting incidents, and this may have resulted in not all incidents recorded in the incident register.
* Explanation the service will use current resources to create a vulnerable consumer register.
* Explanation the service will include restrictive practices in its goals for inclusion in care plans.
* Explanation the service will review its assessment tool to include medication lists.
* Explanation staff will be provided with training on restrictive practices.
* Explanation and evidence of medication management process flow chart development and implementation.

In coming to my finding, I have considered information and evidence in the assessment team’s report and the provider’s response, which demonstrates the service is not effectively managing high impact or high prevalence risks associated with the care of each consumer.

I have considered the intent of this Requirement, which expects organisations to do all they can to manage risks related to the personal and clinical care of each consumer. I find this did not occur, as the service did not demonstrate best practice management of restrictive practices and medication management.

I have place weight on the assessment team’s report which identified a deficit in the management of medications and restrictive practices. The deficits in relation to organisational systems to manage risk at a system level is addressed in Requirement 8(3)(d) and therefore this information is not considered further here.

In relation to HCP, I find the provider, in relation to the service, non-compliant with Requirement (3)(b) in Standard 3, Personal care and clinical care.

In relation to CHSP, I find the provider, in relation to the service, non-compliant with Requirement (3)(b) in Standard 3, Personal care and clinical care.

Requirement 3(3)(e)

The assessment team assessed this Requirement as not met, as the service was seen to lack organisational processes to guide staff practice. The assessment team provided the following evidence relevant to my finding:

* Consumers and representatives stated the regular staff know the consumer’s personal care needs.
* Consumers and representatives were satisfied the consumer’s medical officer and pharmacist are giving correct medications and do not want to disclose the medication information to the service.
* Most support workers said they have access to all the information they need to guide them when providing care.
* Management stated staff will report medication misuse if identified when assisting consumers with medication.
* Management confirmed the information available to support workers at point of care and services.
* Documentation identified information and strategies to guide staff practice in relation to risks identified.
* Documentation identified an absence of information about medications being administered by staff to consumers. The assessment team considered the absence of knowing what medication are being administered is a risk of harm to consumers. Management stated the service manages the absence of medication documentation through regular contact with carers and those consumers who live alone.

The provider’s response included explanation and evidence addressing the assessment team’s finding, including:

* Evidence of a draft medication flow chart.
* Evidence of medication details in support plans.
* Evidence of safety and risk-taking information in support plans.

In coming to my finding, I have considered information and evidence in the assessment team’s report and the provider’s response, which demonstrates the service is ensuring 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.

I have considered the intent of this Requirement, which focuses on the communication processes that organisations are expected to have, so that their workforce has information about delivering safe and effective personal and clinical care and understanding the consumer’s condition, needs, goals, and preferences. I find this did occur, as the service provides relevant information at the point of care for support workers to understand the consumer’s condition, needs, goals, and preferences.

I have place weight on the provider’s evidence addressing information available to support workers. The evidence presented by the assessment team has been considered in Requirements 3(3)(a) and 3(3)(b), and therefore is not considered further in relation to this Requirement.

In relation to HCP, I find the provider, in relation to the service, compliant with Requirement (3)(e) in Standard 3, Personal care and clinical care.

In relation to CHSP, I find the provider, in relation to the service, compliant with Requirement (3)(e) in Standard 3, Personal care and clinical care.

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

Management described how the service has used palliative care support teams when consumers have been assessed as needing this support and the service collaborates with a nationally recognised palliative care support service. Staff confirmed palliative care was a component of their certificate III in aged care. Documentation showed the service works with a palliative care support service which also provides training for staff.

Consumers and representatives stated staff identify and report any changes to a consumer’s condition. Staff described how they identify signs of deterioration, their understanding of their role and the service’s processes for communicating and escalating any concerns. Management described the service’s reporting process for consumer deterioration, and advised staff are provided with relevant training to support them. Documentation showed evidence of staff being trained in recognising deterioration.

Consumers and representatives confirmed the consumer is referred to other organisations and services when needed. Management advised assessment and planning processes enable the service to decide which specialist providers are needed. The service has a network of allied health, hearing, dental and dementia specific services to meet consumer needs.

Consumers and representatives confirmed staff practice good hand hygiene. Staff described practical steps they take to reduce the risk of infection and confirmed they have access to personal protective equipment relevant to their roles.

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

**Standard 4**

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

**Findings**

Consumers confirmed they receive services and supports for daily living that are important to their health and well-being and the services and supports help their feeling of independence. Staff demonstrated understanding of what is important to consumers and how the services and supports they deliver assist consumers in their daily living. Management described procedures to support the workforce to deliver services according to the consumer’s preferences. Documentation showed assessment and planning captures information about the consumer’s capabilities and limitations, with strategies on how to achieve the consumer’s needs and goals.

Consumers and representatives confirmed staff provide emotional support by listening to the consumer and designing activities to meet the consumer’s needs. Staff demonstrated an understanding of what is important to the consumer and how the delivery of flexible service promotes the well-being of the consumer. Documentation showed the service includes psychological assessments in the assessment and planning process.

Consumers and representatives confirmed consumers are supported to take part in community and social activities and are encouraged to follow their interests. Staff provided examples of services and supports they deliver to assist consumers to stay connected with the community and to do the things the consumer enjoys. Staff stated information captured in the psychological assessments helps to identify social isolation and those consumers with little or no formal supports which is then used by staff to prompt engagement in relevant services and supports. Documentation evidenced discussions for inclusion and participation in regular social groups for consumers as well as individual consumer interests.

Consumers and representatives said consumers are informed about consenting to information about the consumer being shared with others. Staff described how the organisation keeps them informed of each consumer’s needs, preferences, and changes to the consumer’s condition. Documentation showed evidence of consumer conditions, needs and preferences communicated with those responsible for care.

Consumers and representatives confirmed consumers can access additional supports from other organisations and the service will refer the consumer to other organisations when needed. Management advised with delays in consumers being assessed for HCP upgrades, the service refers consumers to other organisations/government agencies for extra funding or supports. Documentation showed evidence of referrals to other organisations and support services.

Consumers confirmed the meals they receive meet their needs and preferences, expressing satisfaction with variety, quality and quantity of food provided. Staff described how they meet individual consumer dietary needs and preferences and the processes in place to ensure food safety requirements are met. Documentation showed dietary requirements, medication contraindications, consumer preferences and allergies, religious and cultural considerations are captured and referred to when delivering food and drinks to consumers. Consumers can choose from fresh meals and/or a contracted food supplier of frozen meals. The service ensures kitchen staff have current food safety qualifications and ensures staff receive training on food safety essentials, nutrition, and meal planning.

Consumers and representatives expressed satisfaction with the equipment provided for consumers. Staff said they inspect equipment regularly and report issues immediately when identified. Management advised equipment provided for consumers is assessed for suitability and safety by an appropriate allied health professional. Management described the processes for purchasing, servicing, maintaining, and replacing equipment, including vehicles. Documentation showed allied health professionals assess equipment for suitability and safety prior to the equipment purchase. The vehicle maintenance register showed all vehicles are regularly serviced and cleaned.

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

**Standard 5**

|  |  |  |  |
| --- | --- | --- | --- |
| Organisation’s service environment | | HCP | CHSP |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant | Compliant |

**Findings**

Consumers stated they enjoy attending the social support group, they feel welcome, and attendance has enhanced their sense of belonging. The service environment was observed to be welcoming with easy access for consumers with all levels of physical capability.

Consumers confirmed the service environment is always clean and well maintained. Staff described how maintenance issues are attended to promptly and how staff take responsibility for cleanliness and safety. Consumers were observed moving freely within the indoor and outdoor spaces. The service environment was observed to be clean and well maintained.

Management described the processes used to ensure equipment is maintained, including the use of an annual maintenance schedule and a maintenance register. Documentation showed no outstanding maintenance issues, and the service maintains a cleaning schedule and food safety processes. Observations showed the service kitchen was clean, with no maintenance issues and all fire safety equipment had been serviced regularly.

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

**Standard 6**

|  |  |  |  |
| --- | --- | --- | --- |
| Feedback and complaints | | HCP | CHSP |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Not Compliant | Not Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant | Not Compliant |

**Findings**

Requirement 6(3)(a)

The assessment team assessed this Requirement as not met, as 3 of 5 consumers were unsure how to make a complaint or provide feedback. The assessment team provided the following evidence relevant to my finding:

* Three of 5 consumers stated they were unsure how to make a complaint or provide feedback to the service. All consumers interviewed stated they had not needed to provide feedback or a complaint. Three of 4 consumers stated they felt safe to make complaints and provide feedback.
* Staff described multiple ways consumers are encouraged and supported to provide feedback and complaints, including completing a feedback leaflet in the service agreement, calling the service, or submitting a complaint through the website.
* Management stated other ways for consumers to provide feedback or complaints include through the consumer advisory board (although this has not held its first meeting yet) and an annual consumer survey (with management intending to conduct the survey more frequently).
* The service had not received any complaints over the previous 6 months.
* Staff explained the complaints process, including if things can be addressed quickly, they are actioned upon receipt, and this may be documented in the consumer’s care notes. Serious complaints are escalated to management, and these may be escalated to the feedback and complaints team who manage serious complaints/misconducts.

The provider’s response included explanation and evidence addressing the assessment team’s finding, including:

* Explanation feedback is logged in one of the service’s electronic systems and there were no formal complaints lodged during the 6-month period included in the quality audit.
* Explanation the service will implement a process to lodge minor complaints and service issues to allow service specific collection, collation, monitoring, and assessment to identify trends and provide continual improvement.
* Evidence the consumer handbook contains information about complaint processes.

In coming to my finding, I have considered information and evidence in the assessment team’s report and the provider’s response, which demonstrates consumers are encouraged and supported to provide feedback and make complaints.

I have considered the intent of this Requirement, which expects organisations demonstrate they encourage and support consumers and their representatives to provide feedback or complain about the services they receive. I find this did occur, as the service provides information about how to raise an issue or complaint in the service agreement provided to all consumers and in the consumer handbook, or via consumer surveys.

I have place weight on the information provided to consumers about how to raise complaints. I acknowledge there were no complaints lodged by the service in the 6 months prior to the quality audit and that some complaints may have been addressed informally and noted in consumer care notes instead of on a central complaint register.

In relation to HCP, I find the provider, in relation to the service, compliant with Requirement (3)(a) in Standard 6, Feedback and complaints.

In relation to CHSP, I find the provider, in relation to the service, compliant with Requirement (3)(a) in Standard 6, Feedback and complaints.

Requirement 6(3)(b)

The assessment team assessed this Requirement as not met, as the service could not demonstrate that consumers are made aware of advocates, language services and other methods for raising complaints. The assessment team provided the following evidence relevant to my finding:

* Three of 4 consumers stated they felt safe to make complaints and provide feedback. However, consumers were unsure how to access advocates.
* Staff explained they would use an advocacy service if needed. However, staff and management did not know how or which language services to use if needed.
* Staff could not describe a situation where they have engaged the consumer with an advocate to communicate a complaint. Staff explained advocacy details are included in the service agreement.
* The assessment team found the service agreement did not include the details of advocacy services.
* The service has an advocacy policy. However, it does not detail how to identify if a consumer requires an advocate. It does mention the use of the advocacy service staff stated they would use.
* Management stated the service received 2 complaints from the Commission in the past 12 months which indicates consumers are aware of how to make complaints to the Commission.

The provider’s response included explanation and evidence addressing the assessment team’s finding, including:

* Explanation and evidence the consumer handbook outlines advocacy and culturally and linguistic diversity links. The handbook is provided to every consumer at initial assessment. The sections in the handbook are all discussed with the consumer during assessment. The handbook is being reviewed and updated to ensure it aligns with the quality standards.
* Explanation discussion about advocacy, language services and methods for raising and resolving complaints will be held at the next case worker meeting.
* Explanation the client diversity and inclusion policy and procedure include reference to interpreter services. The service has not previously identified a requirement for a stand-alone interpreter policy. The current policy can be extended to ensure compliance in relation to identification for the need of and access to interpreters.

In coming to my finding, I have considered information and evidence in the assessment team’s report and the provider’s response, which demonstrates consumers are made aware of and have access to advocates, language services and other methods for resolving complaints.

I have considered the intent of this Requirement, which expects all consumers can easily make a complaint, whatever their culture, language, or ability. I find this did occur, as the service provides information about advocacy, language services and other methods for raising complaints in the consumer handbook which is provided to all consumers. As 2 consumers had lodged complaints through the Commission during the past 12 months, it is evident the information provided has supported consumers to raise complaints through various methods.

I have place weight on the information provided to consumers in the consumer handbook and the existence of complaints raised directly with the Commission.

In relation to HCP, I find the provider, in relation to the service, compliant with Requirement (3)(b) in Standard 6, Feedback and complaints.

In relation to CHSP, I find the provider, in relation to the service, compliant with Requirement (3)(b) in Standard 6, Feedback and complaints.

Requirement 6(3)(c)

The assessment team assessed this Requirement as not met, as the service could not demonstrate appropriate action is taken in response to complaints and feedback, with the current process not following best practice and complaints not recorded in a central register. The assessment team provided the following evidence relevant to my finding:

* Three staff were not familiar with the term open disclosure, although 2 staff were able to describe elements of open disclosure.
* One staff member stated they do not handle complaints or receive training about complaint handling. If a consumer has a complaint, the staff member will tell their coordinator.
* Feedback and complaints were not recorded in a centralised system and the service did not demonstrate a clear complaints management process.
* The service did not demonstrate it has an open disclosure policy and the assessment team could not find evidence the service seeks feedback on the complaints process.

The provider’s response included explanation and evidence addressing the assessment team’s finding, including:

* Explanation there were no complaints lodged in the electronic system relevant to the service in the past 6 months.
* Explanation the service has an established feedback and complaints team which meets fortnightly to assess, allocated and manage feedback lodged through the electronic system.
* Explanation training relating to lodging complaints was provided to staff both through face-to-face and at induction training.
* Explanation steps have commenced to identify gaps in training and miscommunication that led to comments by staff during the audit. Specific training will be tailored and delivered to address these gaps.
* Explanation the service will implement a process to lodge minor complaints/service issues to allow service specific collection, collation, monitoring, and assessment to identify trends and provide continual improvement.
* Explanation discussions have commenced in the service relating to additional information to be included in the current complaints and issues of concern policy and procedure to include open disclosure.
* Explanation an incident resulting in harm to a consumer would currently meet the threshold to be lodged within the electronic system and to be assessed by the feedback and complaints team.
* Evidence of complaints and open disclosure training provided to staff.

In coming to my finding, I have considered information and evidence in the assessment team’s report and the provider’s response, which demonstrates there is a deficit in taking appropriate action in response to complaints, with an open disclosure process not evident.

I have considered the intent of this Requirement, which expects organisations have a best practice system for managing and resolving complaints for consumers, including the use of open disclosure. I find this did not occur, as, although the service has an established feedback and complaints team, the service did not demonstrate all complaints and feedback are addressed consistently and open disclosure was not understood by staff.

I acknowledge the service has included complaints and open disclosure training for staff. However, the evidence presented showed staff did not understand open disclosure. I have place weight on staff not demonstrating an understanding of open disclosure and the service not recording all complaints and feedback received consistently.

In relation to HCP, I find the provider, in relation to the service, non-compliant with Requirement (3)(c) in Standard 6, Feedback and complaints.

In relation to CHSP, I find the provider, in relation to the service, non-compliant with Requirement (3)(c) in Standard 6, Feedback and complaints.

Requirement 6(3)(d)

The assessment team assessed this Requirement as not met, as the service could not demonstrate that complaints and feedback are reviewed and used for quality improvement of the service. The assessment team provided the following evidence relevant to my finding:

* Staff explained they receive frequent complaints about lawn mowing services being cancelled. However, these complaints were not recorded for the assessment team to review. Staff could not describe what had been done to address these complaints and were not aware of any improvements to the service because of these complaints.
* The continuous improvement log did not include any items related to consumer feedback or complaints.
* As the service does not collect all feedback and complaints, there was a lack of evidence the service monitors feedback and complaints.
* Report to the governing body included references to complaints but, it was unclear if these related to consumers of the HCP and CHSP services or of another service managed by the provider. No trends were identified and there was no mention of feedback and complaints leading to quality improvement.

The provider’s response included explanation and evidence addressing the assessment team’s finding, including:

* Explanation the question about how feedback and complaints led to improving the quality of care and services was not asked of the person who manages the service’s complaints. Examples could have been provided if the relevant person had been asked.
* Explanation complainant confidentiality and privacy are paramount in the complaints process. Therefore, staff may be unaware that process and quality improvements were implemented because of efforts to protect the complainant’s identity.
* Explanation the governing body is provided with complaints on hand and the status of these complaints. This is a high-level redacted report. The governing body is not provided with specific details to the sensitivity and the ongoing nature of some complaints. The rules of procedural fairness and natural justice are afforded to all involved in the complaint process. The governing body is informed of serious matters involving law enforcement and other oversight bodies that are under investigation and provided with further details upon request.
* Explanation the feedback and complaints process implemented by the service received a best practice rating from the organisation’s most recent disability audit.
* Explanation repeated non-compliance or concerns managed at the service level may be appropriate for referral to the feedback and complaints team or performance managed at the service level.

In coming to my finding, I have considered information and evidence in the assessment team’s report and the provider’s response, which demonstrates there is no evidence the service is not reviewing and using feedback and complaints to improve the quality of care and services.

I have considered the intent of this Requirement, which expects organisations have a best practice system to manage feedback and complaints. Organisations should use this system to improve how they deliver care and services. I find this did not occur, as the service does not register all complaints for further review and analysis. I acknowledge the service responds to complaints and feedback as they are received. However, the service is not recording these complaints for identification of further improvements based on trends and analysis of all complaints.

I have place weight on the service acknowledging not all complaints and feedback are recorded in the central complaints register. This practice does not provide for ongoing trending and analysis of complaints and feedback.

In relation to HCP, I find the provider, in relation to the service, non-compliant with Requirement (3)(d) in Standard 6, Feedback and complaints.

In relation to CHSP, I find the provider, in relation to the service, non-compliant with Requirement (3)(d) 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)(a)

The assessment team assessed this Requirement as not met, as the service did not demonstrate the workforce is planned at all times. The assessment team provided the following evidence relevant to my finding:

* Consumers explained staff turn up on time but, it can depend on the staff member as to how long they take to complete the service.
* Staff felt they were rushed in their work or they do not have enough time to complete their role.
* Coordinators stated they must work 2 hours each day in care worker shifts which has an impact on consumers not receiving responses from coordinators.
* Although management stated there were no unfilled shifts for the month prior to the quality audit, the assessment team identified 7 missed services in January 2024 where the service was unable to fill the shifts due to staffing shortages.
* The CEO stated the service is actively recruiting staff in the area, as it has a rapid growth since 2016. However, the person responsible for recruitment stated the service is not currently recruiting staff in the area.

The provider’s response included explanation and evidence addressing the assessment team’s finding, including:

* Evidence of request to recruit form.
* Explanation that with new services commencing and continual growth, appropriate recruitment requests were made in a timely proactive manner.
* Explanation the recruiting question was asked at service level and not at human resources level.
* Explanation the majority of the service’s aged care workforce are casuals and are only offered permanency after a year.
* Explanation that at the time of the quality audit, there were no open advertised positions for the service’s aged care workforce.

In coming to my finding, I have considered information and evidence in the assessment team’s report and the provider’s response, which does not demonstrate a deficit in workforce planning.

I have considered the intent of this Requirement, which expects organisations have a system to work out workforce numbers and the range and skills they need to meet consumers’ needs and always deliver safe and quality care and services. I find this did occur, as the service does identify and allocate staff numbers based on consumer needs. The service has processes in place to recruit staff as needed.

I have place weight on consumers stating staff arrive when they expect them to arrive. I acknowledge coordinators undertake care worker shifts regularly and this may impact on consumer’s access to the coordinators. However, there was no evidence consumers were negatively impacted by this practice.

In relation to HCP, I find the provider, in relation to the service, compliant with Requirement (3)(a) in Standard 7, Human resources.

In relation to CHSP, I find the provider, in relation to the service, compliant with Requirement (3)(a) in Standard 7, Human resources.

Requirement 7(3)(b)

Consumers and representatives stated they felt staff were kind, gentle and caring when providing services. Staff explained how they confirm how consumers which to be addressed during their first contact with the consumer. Coordinators explained and demonstrated if a consumer has a problem with a care worker, the care worker will be removed from providing services for that consumer. Management explained they undertake non-skills-based competency checks of care workers.

In relation to HCP, I find the provider, in relation to the service, compliant with Requirement (3)(b) in Standard 7, Human resources.

In relation to CHSP, I find the provider, in relation to the service, compliant with Requirement (3)(b) in Standard 7, Human resources.

Requirement 7(3)(c)

The assessment team assessed this Requirement as not met, as the service did not have oversight of staff qualifications and did not assess skills-based competencies of staff. The assessment team provided the following evidence relevant to my finding:

* Consumers felt confident staff were competent in their roles.
* Staff and management felt staff were competent in their roles based on training, qualifications, and orientation processes.
* Staff felt they were trained and competent to do their roles through performance reviews, mandatory training, buddy shifts and online training.
* Management stated all new staff are required to have a qualification or completing a qualification at the commencement of their employment. Management was unable to identify how many staff have qualifications, explaining the personnel system is not fit for purpose and they do not have oversight of this information and is not presented to the governing body. However, management did provide a list of care workers and their qualifications.
* The service does not have a plan for existing staff to gain qualifications.

The provider’s response included explanation and evidence addressing the assessment team’s finding, including:

* Explanation staff qualifications and training records are maintained by the service.
* Explanation the service maintains records of all staff qualifications and 2 reports were provided to the assessment team during the quality audit, listing staff qualifications.
* Explanation the service does have a plan for existing staff to gain qualifications, with an ongoing partnership with a local training organisation to address upskilling of staff.
* Evidence of a staff training matrix.

I have considered the intent of this Requirement, which expects organisations make sure the workforce has the skills, qualifications, and knowledge they need for their role to provide care and services. I find this did occur, as the service has a staff training matrix and processes in place to ensure staff are appropriately qualified and competent to perform their roles.

I have place weight on the evidence and explanation presented by the provider and the assessment team stating the service provided a list of care workers and their qualifications.

In relation to HCP, I find the provider, in relation to the service, compliant with Requirement (3)(c) in Standard 7, Human resources.

In relation to CHSP, I find the provider, in relation to the service, compliant with Requirement (3)(c) in Standard 7, Human resources.

Requirement 7(3)(d)

The assessment team assessed this Requirement as not met, as the assessment team identified gaps in records of mandatory training. The assessment team provided the following evidence relevant to my finding:

* Documentation showed several staff had not completed manual handling training, induction training and health essentials training.
* Management explained they do not produce reports of training compliance and the system is ‘not fit for purpose’ which makes it challenging to have oversight of it.
* Documentation showed driver’s licences and first aid certificate records had expired. Management stated staff had valid driver’s licences and first aid certificates. However, they may not have been recorded in the system.
* The assessment team identified low compliance of staff completing training modules prior to commencing work with consumers.

The provider’s response included explanation and evidence addressing the assessment team’s finding, including:

* Acknowledgement in relation to the gaps in training.
* Explanation manual handling training is offered to staff who support consumers with this requirement. The process for identifying and engaging relevant staff and booking them into training has commenced.
* Explanation induction training is conducted face-to-face. Options to offer induction on various days to address staff suitability issues are in process. The service is scoping options around the feasibility of introducing online training for components of induction, including the ability to test knowledge. This will be possible using the service’s online training system.
* Explanation service specific induction is completed before staff commence their first shift. This induction takes on average 3 days and includes completion of all mandatory training.
* Explanation there was a miscommunication around compliance with the online training completion. The Quality Standards training is covered at induction. Staff complete training and sign off the induction checklist. This is not recorded in the personnel system. This is separate from training completed online.
* Explanation comments relating to compliance with driver’s licence and first aid certificates is confusing. The driver’s licences were not expired. Rather the updated details had not be loaded into the system.
* Evidence of staff training matrix, mandatory training information, service specific induction information and performance reviews.

In coming to my finding, I have considered information and evidence in the assessment team’s report and the provider’s response, which demonstrates the service does recruit, train, equip and support staff to deliver the outcomes required by the Quality Standards.

I have considered the intent of this Requirement, which expects workforce induction prepares members of the workforce for their role and they receive ongoing support, training, professional development, supervision and feedback they need to carry out their role and responsibilities. I find this did occur, as the service has processes in place to ensure all staff complete induction training and have access to ongoing training.

I have place weight on the training records and evidence of processes to ensure staff complete required training and staff undergo ongoing reviews.

In relation to HCP, I find the provider, in relation to the service, compliant with Requirement (3)(d) in Standard 7, Human resources.

In relation to CHSP, I find the provider, in relation to the service, compliant with Requirement (3)(d) in Standard 7, Human resources.

Requirement 7(3)(e)

The assessment team assessed this Requirement as not met, consumers had not been consulted on staff performance, not all staff had an annual performance review and the service had not made plans to address the missing performance reviews. The assessment team provided the following evidence relevant to my finding:

* Most consumers stated they had not been asked to provide feedback on the staff and their performance.
* Staff could not describe how their performance is monitored and how any areas for further training and support are identified.
* Management could not provide an example of training needs identified from performance reviews.
* Not all performance reviews were completed in the past 12 months, with one staff member on leave at the time of the scheduled review and one staff member transferred from one role to another role and was missed in transition.

The provider’s response included explanation and evidence addressing the assessment team’s finding, including:

* Explanation the comment about management not providing an example of training needs identified from performance reviews conflicts with the service’s current process. At the time of performance appraisals, coordinators and managers are given a list of staff training. This is discussed and gaps identified.
* Explanation training needs are identified through regular communication between service coordinators, staff, and management. Feedback from the service’s staff survey is also used to determine organisational training needs and these are updated on the training calendar. Both the training calendar and staff survey identifying training was provided to the assessment team at the time of the quality audit.
* Evidence the service has a training calendar, conducts staff surveys to identify training needs and completed performance reviews with staff.

In coming to my finding, I have considered information and evidence in the assessment team’s report and the provider’s response, which demonstrates the service regularly assesses, monitors, and reviews the performance of each member of the workforce.

I have considered the intent of this Requirement, which expects organisations have an appropriate person regularly evaluate how staff are performing their roles and identify, plan for, and support any training and development needed. I find this did occur, as the service does have processes in place to conduct regular performance reviews and identify training needs.

I have place weight on the service’s evidence of a training calendar, performance review processes and staff surveys identifying additional training requirements.

In relation to HCP, I find the provider, in relation to the service, compliant with Requirement (3)(e) in Standard 7, Human resources.

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

**Findings**

Requirement 8(3)(a)

The assessment team assessed this Requirement as not met, as the service did not demonstrate it engages consumers in the development and delivery of care and services. The assessment team provided the following evidence relevant to my finding:

* Consumers stated they had not been asked to provide feedback into the service.
* Staff and management were unable to explain how consumer feedback has improved how the service delivers its care and services.
* Documentation showed the service had sent a letter offering participation in the service’s consumer advisory body, with 6 consumers expressing an interest. This body is yet to meet.
* The service conducted a consumer survey in 2023 and management explained the areas identified for improvement based on the survey have not been addressed as the service has not had time to interpret the data and act upon it.
* Documentation showed governing body reports did not represent a consumer voice or input.

The provider’s response included explanation and evidence addressing the assessment team’s finding, including:

* Explanation the consumer survey was conducted in December 2023 and closed at the end of January 2024, less than a week before the quality audit.
* Explanation the consumer advisory body offer was introduced 1 December 2023 and along with the consumer survey, the service expects to provide extensive feedback from consumers to the governing body.
* Explanation the consumer advisory body was to meet in February 2024 but, due to the Quality Audit, it was pushed back to March 2024.
* Evidence of consumer survey results.

In coming to my finding, I have considered information and evidence in the assessment team’s report and the provider’s response, which demonstrates there the service is engaging consumers in the development, delivery and evaluation of care and services.

I have considered the intent of this Requirement, which expects organisations have an organisation wide approach to involve consumers in developing, delivering, and evaluating their care and services. I find this did occur, as the service has processes to conduct regular consumer surveys and has implemented a consumer advisory body to ensure consumers can provide feedback directly to the service and the governing body. I acknowledge the consumer advisory body is newly created and it will take time to have an impact on delivery and evaluation of care and services. I also acknowledge the most recent consumer survey had closed a week prior to the quality audit. It is not appropriate to expect outcomes to be implemented in such a short period of time.

I have place weight on the service implementing a consumer advisory body and conducting regular consumer surveys. Feedback and complaints could be better reviewed and analysed to provide another means of engaging consumers. However, the service has received limited feedback and complaints from consumers for the service to review and analyse.

In relation to HCP, I find the provider, in relation to the service, compliant with Requirement (3)(a) in Standard 8, Organisational governance.

In relation to CHSP, I find the provider, in relation to the service, compliant with Requirement (3)(a) in Standard 8, Organisational governance.

Requirement 8(3)(b)

The assessment team assessed this Requirement as not met, as the service could not demonstrate the governing body has sufficient oversight of the delivery of care and services. The assessment team provided the following evidence relevant to my finding:

* Although the governing body has responsibility to oversee the organisation’s strategic direction for delivering care, the governing body is not provided with adequate information to monitor and make decisions on the quality of safe and effective care and services.
* Management confirmed the governing body does not receive information about clinical care nor clinical data to monitor whether care and services are being delivered safely, effectively and in line with best practice.

The provider’s response included explanation and evidence addressing the assessment team’s finding, including:

* Explanation the chief executive officer, manager of human resources and manager customer relations and systems attended a 2-day training program in clinical governance leadership in mid-2023. This was completed because it was recognised the organisation lacked the capacity to adequately report to the governing body on quality and safety of care and services being provided.
* Explanation an expert consultant was appointed to review the organisation’s clinical governance activities and help develop a framework.
* Explanation between July and October 2023, the executive and governing body members attended the governing for reform program conducted by the Commission. During these sessions, the plans and timeframes for the development of the framework were discussed and the facilitators agreed with the intended outcomes and timeframes.
* Acknowledgement this is an area which needs improvement, and it will be addressed as a priority.

In coming to my finding, I have considered information and evidence in the assessment team’s report and the provider’s response, which demonstrates there is a deficit for this Requirement.

I have considered the intent of this Requirement, which expects the governing body is responsible for promoting a culture of safe, inclusive, and quality, care and services in the organisation. I find this did not occur, as the service is not providing information to the governing body to consider in relation to the care and services provided by the service.

I have place weight on the service acknowledging this is an area which needs improvement. I acknowledge the organisation is in the process of developing a framework and improving how the governing body is provided with relevant information and ensured the governing body members and executive attended workshops about governing for reform. However, improvements have not been implemented and there are further actions to be taken.

In relation to HCP, I find the provider, in relation to the service, non-compliant with Requirement (3)(b) in Standard 8, Organisational governance.

In relation to CHSP, I find the provider, in relation to the service, non-compliant with Requirement (3)(b) in Standard 8, Organisational governance.

Requirement 8(3)(c)

The assessment team assessed this Requirement as not met, as the service could not demonstrate effective organisation wide governance systems in relation to continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints. The assessment team provided the following evidence relevant to my finding:

* Management demonstrated suitable information management systems and processes.
* Management was unable to demonstrate that monitoring and reviewing of complaints and incidents occurred to continuously improve the delivery of care and services. Management explained continuous improvement is identified through audits, emails from the Commission, using tools from the Commission, attending Commission webinars and issues raised at staff meetings. There was no evidence how the governing body has oversight of the service’s continuous improvement.
* Although management demonstrated appropriate financial management systems and processes, they acknowledged the service does not look at/track consumers with unspent funds. Documentation did not show evidence of discussions with consumers about high unspent funds. Unspent funds details/information is not provided to the governing body for consideration.
* The service did not demonstrate effective organisation wide workforce governance systems. The service did not demonstrate the workforce is planned to enable the number and mix of members of the workforce to deliver quality care and services. Workforce governance is not in place regarding the clear assignment, responsibilities and accountabilities when delivering some care and services.
* The service did not demonstrate how the organisation ensures regulatory compliance in the aged care sector. Reports to the governing body had minimal information on aged care regulatory compliance and those items were not followed through or there was no aged care related information. The chief executive officer stated the governing body subscribes to the Commission newsletter and have attended the most recent aged care conference. Although beyond these arrangements, there is nothing formal the governing body does to keep up to date with regulatory compliance.
* Although the service demonstrated effective feedback and complaints processes when formal complaints are recorded, the service was unable to demonstrate that all feedback and complaints are recorded, monitored and incidents were reviewed to improve the delivery of care and services.

The provider’s response included explanation and evidence addressing the assessment team’s finding, including:

* Explanation lack of documented conversation with consumers about unspent funds is not an indication that the funds will be spent on other activities not related to the consumer’s needs. Explanation statements are issued monthly, and liabilities are reconciled at the same time.
* Explanation about workforce governance addressed under Requirements 7(3)(a) and 7(3)(c).
* Explanation the governing body has set the establishment of a compliance register as a priority for the current year and acknowledgement that reporting on compliance matters is an area that needs improvement. However, the chief executive officer did not state the governing body subscribes to the Commission newsletter and have attended the most recent aged care conference. The chief executive officer explained the governing body members attended 5 sessions totalling 11 hours with facilitators appointed by the Commission under the governing for reform programme. The chief executive officer and 3 senior staff members attended the conference, the governing body did not. Explanation the organisation has adopted robust terms of reference of the quality advisory body and consumer advisory body, drafts of which were provided to the assessment team.

In coming to my finding, I have considered information and evidence in the assessment team’s report and the provider’s response, which demonstrates there are deficits in relation to organisation wide governance systems relating to continuous improvement and feedback and complaints. I find the organisation has effective organisation wide governance systems in relation to information management, financial governance, regulatory compliance, and workforce governance.

I have considered the intent of this Requirement, which is about how organisations apply and control authority below the level of the governing body. I find this did not occur for continuous improvement and feedback and complaints. There are deficits in systems to ensure continuous improvement processes improve the quality of care and services. There are also deficits in how the service receives and records feedback and complaint, leading to missed opportunities to identify possible improvements in care and services.

I have place weight on the service acknowledging not all complaints and feedback are recorded in the central complaints register. This practice does not provide for ongoing trending and analysis of complaints and feedback and therefore identification of opportunities for improvement.

In relation to HCP, I find the provider, in relation to the service, non-compliant with Requirement (3)(c) in Standard 8, Organisational governance.

In relation to CHSP, I find the provider, in relation to the service, non-compliant with Requirement (3)(c) in Standard 8, Organisational governance.

Requirement 8(3)(d)

The assessment team assessed this Requirement as not met, as the service could not demonstrate effective risk management systems and practices were in place. The assessment team provided the following evidence relevant to my finding:

* Management stated the service does not have a vulnerable consumer register and felt this was not required as they know their consumers.
* Management could not provide strategic policies or procedures to identify, monitor and evaluate the care of consumers with high risks.
* Management did not provide sufficient information to show the service has systems for identifying, minimising and managing risks to the safety and well-being of its consumers.
* Documentation showed the service’s incident reporting procedure and policy was not always followed as not all incidents were recorded and serious incidents had not been reported.
* The fact sheets used by the service about the serious incident response scheme related to residential services not home care services and did not include all categories of serious incidents.
* The service did not demonstrate all staff had received training in identifying abuse and neglect and serious incidents.

The provider’s response included explanation and evidence addressing the assessment team’s finding, including:

* Explanation the assessment team identified an incident as being reportable when it was not.
* Explanation the serious incident fact sheets have been provided to all staff and are relevant to home care services. Serious incident reporting has been addressed in staff meetings.

In coming to my finding, I have considered information and evidence in the assessment team’s report and the provider’s response, which demonstrates the service does not have effective risk management systems and processes in place at an organisational level.

I have considered the intent of this Requirement, which expects organisations to have systems and processes that help them identify and assess risks to the health, safety, and well-being of consumers. I find this did not occur, as the service does not maintain details of high-impact, or high-prevalence risks associated with the care of consumers.

I have place weight on the service not maintaining a vulnerable consumer register, nor any policy, procedures for the identification, monitoring, or strategic evaluation of risks. This does not provide for ongoing trending and analysis of risks and identification of strategies to prevent incidents.

In relation to HCP, I find the provider, in relation to the service, non-compliant with Requirement (3)(d) in Standard 8, Organisational governance.

In relation to CHSP, I find the provider, in relation to the service, non-compliant with Requirement (3)(d) in Standard 8, Organisational governance.

Requirement 8(3)(e)

Requirement 8(3)(e) was not assessed as the service does not provide clinical care for consumers. This Requirement is not applicable for the service, for both HCP and CHSP.

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