**Performance**

**Report**

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| Name: | WeCare Disability and Social Work Services |
| Commission ID: | 701118 |
| Address: | 1-3 Patrick Street, AITKENVALE, Queensland, 4814 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 11 June 2024 to 12 June 2024 |
| Performance report date: | 31 July 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: 9563 WeCare Disability and Social Work Services Pty Ltd  
Service: 27680 We2Care

**This performance report**

This performance report for WeCare Disability and Social Work Services (**the service**) has been prepared by J. Bayldon, 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 Assessment contact (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others.
* the provider’s response to the assessment team’s report received 17 July 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 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Not 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)(c) – Ensure that the consultation with existing consumers process regarding changes to the home care agreement have been embedded to enable consumers to make decisions about the way care and services are delivered.
* Requirement 2(3)(d) – Ensure that the new care plan template is successfully embedded, and all consumer care plans are reviewed to include outcomes of assessment and planning to guide staff in the delivery of care and services to consumers.
* Requirement 2(3)(e) - Ensure that consumer care plans are reviewed and updated as circumstances change or when incidents occur.
* Requirement 3(3)(d) – Ensure that staff can recognise and respond to the deterioration of a consumer’s condition or capacity.
* Requirement 3(3)(e)– Ensure that information regarding a consumer’s condition, needs and preferences is documented and the service has processes in place for how this is communicated within the organisation.
* Requirement 6(3)(d) – Ensure that complaints and feedback are reviewed and analysed by the service effectively to improve the quality or care and services to consumers.
* Requirement 7(3)(d) – Ensure that staff are inducted, trained and equipped to deliver outcomes as required by these standards.
* Requirement 8(3)(c) – Ensure the organisation has effective organisation wide governance systems in relation to information management, continuous improvement, and feedback and complaints.

# Standard 1

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| Consumer dignity and choice | | HCP |
| 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. | Not Compliant |
| Requirement 1(3)(e) | Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice. | Compliant |

Findings

Requirement 1(3)(c)

Requirement 1(3)(c) was found non-compliant following a Quality Audit undertaken from 18 September 2023 to 22 September 2023 as the service was unable to demonstrate that it had successfully embedded a consultation process for consumers in relation to changes the service made in delivering care in 2-hour packages to consumers and prior to updating the home care agreement.

At the time of the Assessment Contact – Site, the Assessment Team found the following relevant information to my finding:

* Consumers interviewed were aware of the 2-hour minimum service, however they expressed concerns that this was the only option available to them.
* Management advised new consumers are informed they can receive services for less than 2 hours, however, they could not evidence that this had been discussed with existing consumers of the service.
* Care staff advised that they often would do additional work outside of consumers’ assessed needs where a consumer does not need the full 2 hours.

In response to the Assessment Team’s Report, the service provided the following information relevant to my finding:

* The service has sent out correspondence to consumers advising of options for consumers who require service delivery for less than 2 hours.
* The service will discuss the issue with existing consumers during upcoming care plan reviews in the next 90 days.
* Staff meeting Agenda for July & August to ensure staff understand that services delivered to consumers is within their assessed needs and staff are not to perform duties outside these needs.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and provider’s response. Whilst I acknowledge that the service is taking steps to rectify the gaps in consultation with consumers are the care and services they receive, I am not satisfied that at the time of the performance report decision that the service has ensured consumers (both existing and new) are aware of the service changes and service options available to them, particularly given existing consumer care plan reviews are happening over the next 90 days. Therefore, I find the provider in relation to the service, non-compliant with Requirement 1(3)(c) at the time of the performance report decision.

Requirement 1(3)(e)

Requirement 1(3)(e) was found non-compliant following a Quality Audit undertaken from 18 September 2023 to 22 September 2023 as the service was unable to demonstrate that information provided to consumers, namely monthly statements, were clear and easy to understand, enabling consumers to exercise choice. The decision maker acknowledged in their decision that the service had committed to several action items as part of its Continuous Improvement Plan, including the following:

* Supplying a new handbook for consumers
* Changes in process for onboarding consumers
* Providing advocacy information to consumers
* Updating budget tools and review of budget template system
* Training for staff on new onboarding process.
* Making amendments to the home care package clause withing the Home Care Agreement

At the time of the Assessment Contact – Site, the Assessment Team found the following information relevant to my finding:

* Staff interviewed all confirmed the budget template and budget tools have been updated and most consumers interviewed by the Assessment Team said they understand their budgets and statements. Management and staff were able to describe how they ensure consumers can understand their budgets and statements.
* The consumer onboarding process had been updated to ensure consumers receive consistent and correct information. Staff interviewed confirmed and could demonstrate an understanding of the new process to the Assessment Team.
* The Assessment Team reviewed the new onboarding pack and consumer handbook, which included information about advocacy groups and informed consumers regarding their rights and service delivery.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, and evidence in the Assessment Team’s report. Based on the information summarised above, I am satisfied that the service has taken significant steps in ensuring consumers are not only receiving information but are able to understand it so they can make informed choices about the care and services they receive. Therefore, I find the provider in relation to the service, compliant with Requirement 1(3)(e) at the time of the performance report decision.

# Standard 2

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| Ongoing assessment and planning with consumers | | HCP |
| 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. | Not 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 |

Findings

Requirement 2(3)(d)

Requirement 2(3)(d) was found non-compliant following a Quality Audit undertaken from 18 September 2023 to 22 September 2023 as the service was unable to demonstrate that outcomes of assessment and planning were documented of discussed with consumers and that had successfully embedded processes to ensure that consumers and staff have access to consumers’ care plans.

At the time of the Assessment Contact – Site, the Assessment Team found the following information relevant to my finding:

* The Assessment Team confirmed that information that is in a written format was not being consistently uploaded to the electronic care management system (ECMS).
* The Assessment Team reviewed consumer care plans which did not evidence that assessment outcomes (such as falls and incontinence risk assessments) for consumers are included in the electronic care plan to guide staff practices.
* Staff interviewed confirmed they have access to consumers’ care plans via the ECMS and review the plans when providing care and services to consumers, however these do not include the completed assessments and staff did not know where to upload wound care assessment and planning documentation.
* Management confirmed that many consumers in Townsville have not received a hard copy of their care plans, and this was confirmed by consumers who were interviewed by the Assessment Team.

In response to the Assessment Team’s Report, the service provided the following information relevant to my finding:

* A copy of a new care plan template that ensures completed assessments and outcomes can be captured and provided to consumers.
* Evidence of records that all consumers had been sent their care plans.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, evidence in the Assessment Team’s report and the provider’s response to the Assessment Team’s report. Whilst I am satisfied that the consumers have all now received a copy of their care plans which will guide staff in providing care and services, I am concerned that the new care plan template that includes outcomes of assessment and planning has not been imbedded in practice at the service and the service has not ensured that existing consumer care plans have been reviewed to ensure that outcomes of assessments and planning are including in consumers plans. Therefore, I find the provider in relation to the service, non-compliant with Requirement 2(3)(d) at the time of the performance report decision.

Requirement 2(3)(e)

Requirement 2(3)(e) was found non-compliant following a Quality Audit undertaken from 18 September 2023 to 22 September 2023 as the service was unable to demonstrate that the service was conducting reviews of care plans for consumers who have recently experienced deterioration to determine any changes to their assessed needs.

At the time of the Assessment Contact – Site, the Assessment Team found the following information relevant to my finding:

* The services PCI includes actions to have completed all consumer care plan reviews to ensure information and current and complete by 5 August 2024. At the time of the assessment, this had not been completed.
* Management was not able to describe an effective process for ensuring care plans are reviewed annually as per the service’s policies and procedures.
* Consumers interviewed could provide examples of falls that had occurred where there was no mobility or falls risk assessments or strategies to minimise risk of future occurrences in their care documentation. This was also evidenced for consumers with wounds.

In response to the Assessment Team’s Report, the service provided the following information relevant to my finding:

* The service provided a copy of an updated PCI which evidenced the following:
  + Under 2(3)(e) of the PCI:
    - the review of progress notes and ensuring changes are documented in assessments and care plan is ‘ongoing’ with no end date.
    - Education was provided to all care staff reminding them that care plans should be evaluated as changes occur and that the Service Delivery Manager will direct this process.
* The service stated, with no evidence provided, that it had introduced a care plan review template and reviewed the care plan review policy and procedure and they have created a spreadsheet to track and highlight upcoming care plan reviews.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, evidence in the Assessment Team’s report and the provider’s response to the Assessment Team’s report. Whilst I acknowledge that the service has provided staff with training in relation to ensuring consumers assessments and plans are updated as things change, I am concerned that the consumer care plans have not all been reviewed and updated regularly based on the services PCI that was evidenced in response to the Assessment Team’s Report. Therefore, I find the provider in relation to the service, non-compliant with Requirement 2(3)(e) at the time of the performance report decision.

# Standard 3

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| Personal care and clinical care | | HCP |
| 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. | Not 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. | Not Compliant |

Findings

Requirement 3(3)(d)

Requirement 3(3)(d) was found non-compliant following a Quality Audit undertaken from 18 September 2023 to 22 September 2023 as the service was unable to demonstrate that the deterioration of a consumer’s condition is consistently identified and responded to in a timely manner.

At the time of the Assessment Contact – Site, the Assessment Team found the following relevant information to my finding:

* The service had introduced a high-risk and high-prevalence register, which is reviewed at clinical governance meetings.
* Consumer files reviewed by the Assessment Team, following interviews with management and staff, failed to reflect examples about when consumer’s conditions had deteriorated and were recognised and responded to by the service.
* Management confirmed consumers identified at risk are discussed during weekly meetings to identify risk strategies. When the Assessment Team evaluated this with consumer examples from documentation, it was noted that this was not occurring for some consumers who were identified as being at risk.

In response to the Assessment Team’s Report, the service provided the following information relevant to my finding:

* The service provided a copy of the new Care Plan which will be modified to include an area to identify behaviours.
* The service stated in their response that a policy and procedure (which was evidenced) has been developed to assist staff with recognising and responding to deterioration. A review of this document indicates the policy was last updated in April 2022. A training calendar was provided by the service; however, it does not indicate when the training will occur.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, evidence in the Assessment Team’s report and the provider’s response to the Assessment Team’s report. Based on the information summarised above, I am concerned that the service is unable to effectively recognise and respond deterioration of a consumer’s capacity or condition. The service appears to have started to make some changes; however, it is clear from the evidence provided none of these changes have been implemented at the service level. Therefore, I find the provider in relation to the service, non-compliant with Requirement 3(3)(d) at the time of the performance report decision.

Requirement 3(3)(e)

Requirement 3(3)(e) was found non-compliant following a Quality Audit undertaken from 18 September 2023 to 22 September 2023 as the service was unable to demonstrate that information about the conditions, needs and preferences of consumers is documented and communicated within the organisation.

At the time of the Assessment Contact – Site, the Assessment Team found the following relevant information to my finding:

* A review of consumer care documentation demonstrated that the service is not consistently documenting information about consumers’ conditions, needs and preferences.
* Outcomes of care provided by external clinical care staff are not recorded in consumers care documentation when reviewed by the Assessment Team.
* The services PCI provided to the Assessment Team by the service did not include any actions to address this deficiency.

In response to the Assessment Team’s Report, the service provided the following information relevant to my finding:

* The service has revised their assessment tool to ensure comprehensive assessments of all needs for consumers.
* The service provided an updated PCI in relation to the deficiencies identified by the Assessment Team which included the following in relation to this requirement:
  + Monitor how the workforce manages information regarding information gaps for consumers and ensure follow ups occur with a planned completion date of 5 August.
  + Review each month consumer care plans to ensure there is evidence of updates reviews and communication alerts (planned completion listed as ‘ongoing’).

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, evidence in the Assessment Team’s report and the provider’s response to the Assessment Team’s report. Based on the information summarised above, the service will need more time to ensure that consumer care plans document the condition, needs and preferences of consumers, which the service has acknowledged in their PCI. I am also concerned that once this occurs, that the service will need to have processes in place to ensure that this information is communicated within the organisation effectively, which does not appear to have been addressed by the service. Therefore, I find the provider in relation to the service, non-compliant with Requirement 3(3)(e) at the time of the performance report decision.

# Standard 6

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| Feedback and complaints | | HCP |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant |

Findings

Requirement 6(3)(d) was found non-compliant following a Quality Audit undertaken from 18 September 2023 to 22 September 2023 as the service was unable to demonstrate how complaints are reviewed and used to improve the quality of care and services to consumers.

At the time of the Assessment Contact – Site, the Assessment Team found the following relevant information to my finding:

* The PCI provided by the service to the Assessment Team upon review evidenced that most action items in relation to this requirement remain in progress with the service, including those related to the following:
  + Implementation of staff training in relation to the complaints management process.
* The Assessment Team reviewed the complaints register from the last 6 months which evidenced that complaints are not being consistently recorded by the service, therefore are unable to be analysed to improve care and services.
* Consumers interviewed that provided the Assessment Team of examples of where they had provided feedback and complaints to the service, could not be traced to the complaints register or the consumers care documentation.
* Management said complaint trends are discussed during staff meetings to identify trends and strategies to improve the quality of care and services. However, staff interviewed said complaint trends and analysis are not discussed during staff meetings.
* Management have implemented weekly meetings to discuss feedback received and identify trends. The Assessment Team requested minutes for these meetings, however they were not provided.
* The weekly report management use to review complaints and feedback, contained only the number of complaints received. The report did not contain details of the complaint type or a description of the complaint to identify trends or areas for improvement.

In response to the Assessment Team’s Report, the service provided the following information relevant to my finding:

* Evidence that feedback and complaints have been added to the weekly management meeting agenda.
* Evidence of training calendar that shows training for staff on the feedback and complaints policy is scheduled for December 2024, despite the PCI provided by the service evidencing that planned completion of training in the management of feedback and complaints is 5 August 2024.
* Evidence of a spreadsheet that has information on complaints/feedback for trends, however the information does not drill down into specifics to identify improvements.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, evidence in the Assessment Team’s report and the provider’s response to the Assessment Team’s report. Based on the information summarised above, I am concerned that the service is not able to appropriately manage & review feedback and complaints to improve the quality of care and services to consumers. Therefore, I find the provider in relation to the service, non-compliant with Requirement 6(3)(d) at the time of the performance report decision.

# Standard 7

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| Human resources | | HCP |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Not Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirement 7(3)(d)

Requirement 7(3)(d) was found non-compliant following a Quality Audit undertaken from 18 September 2023 to 22 September 2023 due to the following deficiencies that the service has not had sufficient time to imbed improvements for:

* The service was unable to demonstrate staff had undertaken an induction process.
* Staff said they were required to assist consumers with little information provided by the service.
* There were no available position descriptions to guide staff practice.
* Staff were unable to demonstrate knowledge of the Aged Care Quality Standards including, but not limited to, an understanding of the Serious Incident Response Scheme (SIRS).
* The service’s monitoring processes to ensure staff were enrolled in and had completed training was ineffective.

At the time of the Assessment Contact – Site, the Assessment Team found the following relevant information to my finding:

* Management said they developed an induction program for new staff which includes a checklist to demonstrate staff have participated in the program. The Assessment Team requested a sample of completed checklists to evidence new staff have participated in program, however this was not provided.
* Staff interviewed who were new to the service in the past 6 months advised the Assessment Team they do not have access to the services learning management system and had not completed mandatory training sessions.

In response to the Assessment Team’s Report, the service provided the following information relevant to my finding:

* Evidence of spreadsheet showing staff that have completed an induction checklist and mandatory training. A review of this indicates that several staff, including recent staff, have not completed the induction program and staff have also not completed mandatory training.
* Evidence of mandatory training list included in the services policies and procedures, with the list including SIRS and Aged Care Quality Standards training.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, evidence in the Assessment Team’s report and the provider’s response to the Assessment Team’s report. Based on the information summarised above, it is evident that staff are not trained or equipped to deliver the outcomes required by these standards. Therefore, I find the provider in relation to the service, non-compliant with Requirement 7(3)(d) at the time of the performance report decision.

Requirement 7(3)(e)

Requirement 7(3)(e) was found non-compliant following a Quality Audit undertaken from 18 September 2023 to 22 September 2023 as the service was unable to demonstrate that is has a process to regularly assess, monitor, and review the performance of staff and could not provide evidence regular performance reviews of each staff member had occurred.

At the time of the Assessment Contact – Site, the Assessment Team found the following relevant information to my finding:

* Management was able to evidence a process which monitors staff performance.
* Evidence that a review of staff files had been completed in April and May 2024.
* Management and consumers were able to describe and provide examples how they seek/give regular feedback about staff who are delivering care and services.
* Staff interviewed who have been at the service for longer than a year, confirmed they had completed a performance appraisal with their manager.
* The Assessment Team reviewed staff files and a report provided by management which outlined that performance appraisals have been undertaken regularly by the service.

Based on the information summarised above, I am satisfied that the service is undertaking regular reviews and assessments of staff performance. Therefore, I find the provider in relation to the service, compliant with Requirement 7(3)(e) at the time of the performance report decision.

# Standard 8

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

Findings

Requirement 8(3)(a)

Requirement 8(3)(a) was found non-compliant following a Quality Audit undertaken from 18 September 2023 to 22 September 2023 due to the following deficiencies:

* The service was unable to provide evidence with demonstrates that feedback received was analysed or that improvements were implemented and evaluated for their effectiveness.
* Consumers who were invited to partake in a consumer advisory board have not been engaged by the service to provide input for the development, delivery or evaluation of care and services.
* The organisation has no framework to support the engagement of consumers in the delivery and evaluation of care and services.

At the time of the Assessment Contact – Site, the Assessment Team found the following relevant information to my finding:

* Consumers and representatives said the service seeks their feedback and their contribution is sought regarding the development of how care and services are delivered.
* Management provided evidence of communication with consumers and representatives, policies and procedures and consumer advisory board meeting minutes demonstrate engagement with consumers in the development, delivery, and evaluation of care and services.
* The consumer advisory board share meeting minutes with the service for consultation and improvement purposes.

Based on the information summarised above, I am satisfied that consumers are now engaged in the delivery and evaluation of care and services. Therefore, I find the provider in relation to the service, compliant with Requirement 8(3)(a) at the time of the performance report decision.

Requirement 8(3)(b)

Requirement 8(3)(b) was found non-compliant following a Quality Audit undertaken from 18 September 2023 to 22 September 2023 as the service was unable to evidence that the following improvements were fully implemented by the service to ensure the governing body is accountable for the delivery of safe and quality care and services:

* The establishment of a Quality Advisory Board.
* Training of staff in the Aged Care Quality Standards.
* Evidence that the service reports, trends or analyses indicators of performance against the Aged Care Quality Standards.

At the time of the Assessment Contact – Site, the Assessment Team found the following relevant information to my finding:

* Sufficient evidence that the service has commenced forming a governing body that has oversight over the delivery of care and services for consumers.
* Evidence that the service has reviewed and improved policies and procedures, holds regular management meetings and staff meetings where service delivery oversight is discussed.
* The service’s PCI refers to specific requirements that require development and planned actions to ensure the service’s ongoing accountability.

Based on the information summarised above, I am satisfied that the service has taken significant steps to ensure it has a governing body that is accountable for service delivery. Therefore, I find the provider in relation to the service, compliant with Requirement 8(3)(b) at the time of the performance report decision.

Requirement 8(3)(c)

Requirement 8(3)(c) was found non-compliant following a Quality Audit undertaken from 18 September 2023 to 22 September 2023 as the service was unable to evidence that it has effective organisation wide governance systems relating to information management, continuous improvement, workforce governance, feedback and complaints, and regulatory compliance.

At the time of the Assessment Contact – Site, the Assessment Team found the following relevant information to my finding:

* The Assessment Team evidenced that information provided to consumers to support them in making decisions is not consistently accurate. Information regarding consumers’ care needs and outcomes of assessment and planning are not consistently documented or communicated within the organisation.
* The service was unable to demonstrate that continuous improvement actions have not been monitored, evaluated, demonstrated or documented.
* Management was able to demonstrate how they train, support and develop the workforce to deliver safe and quality care and services, including the provision of position descriptions outlining role specific responsibilities and performance management.
* Management was not able to demonstrate how feedback and complaints are used to improve the quality of care and services to consumers.
* Management was unable to demonstrate effective systems and processes to meet the regulatory requirements for the HCP program.

In response to the Assessment Team’s Report, the service provided the following relevant information to my finding:

* Evidence of documentation and systems that have been implemented to ensure information to consumers is more consistent and accurate, however the evidence provided demonstrated this was not fully embedded at the service level.
* The service advised that the regional manager would review and evaluate previous improvement actions and the outcomes will be documented in the PCI, though this had not occurred at the time of the performance report decision.
* Evidence that management is now meeting the regulatory requirements of the HCP program.
* Documentation that evidences feedback and complaints are being recorded and trended, however no evidence or examples provided of how this is used to guide improvements to care and services to consumers.

In coming to my finding, I have considered the previous Performance Report, the Assessment Team’s assessment, evidence in the Assessment Team’s report and the provider’s response to the Assessment Team’s report. Based on the information summarised above, I find the provider in relation to the service, non-compliant with Requirement 8(3)(c) in relation to information management, continuous improvement, and feedback and complaints.

Requirement 8(3)(d)

Requirement 8(3)(d) was found non-compliant following a Quality Audit undertaken from 18 September 2023 to 22 September 2023 as the service was unable to demonstrate a clinical governance framework that is tailored to the organisation and improvements to the compliance and document control systems had not been fully implemented.

At the time of the Assessment Contact – Site, the Assessment Team found the following relevant information to my finding:

* Consumers/representatives expressed satisfaction the service enables consumers to make informed decisions regarding how care and services are delivered to support consumers to live their best life.
* Management evidenced improved risk management policies and procedures, including incident management and prevention.
* Staff demonstrated a shared understanding of the service’s incident management processes and were familiar with how to identify and respond to incidents of abuse and neglect.
* Management provided the Assessment Team with a risk management plan and supporting policies and procedures including risk management, high-impact or high-prevalence risks, identifying and responding to abuse and neglect of consumers, and managing and preventing incidents.

Based on the information summarised above, I am satisfied that the service has sufficiently addressed the deficiencies and has effective risk management systems and practices in place. Therefore, I find the provider in relation to the service, compliant with Requirement 8(3)(d) at the time of the performance report decision.

Requirement 8(3)(e)

Requirement 8(3)(e) was found non-compliant following a Quality Audit undertaken from 18 September 2023 to 22 September 2023 as the service was unable to demonstrate a clinical governance framework that is tailored to the organisation and a lack of awareness by staff and management in relation to the policies and procedures that form part of the framework.

At the time of the Assessment Contact – Site, the Assessment Team found the following relevant information to my finding:

* Management provided the Assessment Team with a clinical governance framework policy, which included policies and procedures specific to restrictive practice, antimicrobial stewardship and open disclosure.
* Monthly and quarterly clinical governance meetings are structured to provide improved clinical outcomes and address the Quality Standards as regular agenda items with the intention to provide clinical oversight across the service.

In the Assessment Team’s report, the Assessment Team recommended that the service had not met this requirement, however provided information that I have considered not relevant to my finding of compliance. Therefore, I find the provider in relation to the service, compliant with Requirement 8(3)(e) at the time of the performance report decision.

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