Performance

Report

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| Name: | Huon Eldercare |
| Commission ID: | 8002 |
| Address: | 3278 Huon Highway, FRANKLIN, Tasmania, 7113 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 5 March 2024 |
| Performance report date: | 11 April 2024 |
| Service included in this assessment: | Provider: 1069 Huon Regional Care  Service: 4975 Huon Eldercare |

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

**This performance report**

This performance report for Huon Eldercare (**the service**) has been prepared by Nicola Eastwood, 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 10 April 2024.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

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

# Areas for improvement

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

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | Compliant |
| Requirement 2(3)(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 |

Findings

Requirement’s 2(3)(b), 2(3)(c) and 2(3)(d) were previously found non-compliant following a Site Audit conducted between 25 September 2023 to 28 September 2023. At the time of the site audit, it was found that:

* not all behaviour support plans contained needs for behaviours requiring support, potential triggers or individualised interventions,
* consumers and representatives were not involved in the review or evaluation of consumer care,
* consumers and representatives were not provided with a copy of the consumer care plan, nor were they aware they could request a copy.

At the Assessment Contact conducted 5 March 2024 the service demonstrated assessments and care plans identify the current needs and preferences of consumers. Staff described how they discuss assessment and planning with consumers and representatives and the needs and preferences of consumers with changing behaviours. Consumer files reflected current information regarding identified behaviours, causes of the behaviours and individualised strategies to support consumers.

Staff explained the collaboration between consumers, representatives and other health professionals to ensure an ongoing partnership to meet consumer needs and preferences. Care planning documentation reflected communication between staff, consumers and representatives regarding consumer care and there was evidence of a three-monthly care plan review process in place.

The service demonstrated how the sharing of information is provided to consumers and representatives regarding assessment and planning outcomes and how care plans are offered and provided. Representatives confirmed they are notified about the changing needs of consumers and have information explained to them. A case conference approach has been introduced, with the service progressing through each consumer’s file to ensure the consumer and representative is involved in the process, a copy of the care plan is offered at the time of review.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with Requirements 2(3)(b), 2(3)(c) and 2(3)(d).

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |

Findings

Requirement 3(3)(a) was previously found non-compliant following a Site Audit conducted between 25 September 2023 to 28 September 2023. At the time of the site audit, it was found that consumers subject to chemical restrictive practice had been administered medications without informed consent being obtained.

At the Assessment Contact conducted on 5 March 2024 the service demonstrated that the psychotropic and restraint registers had been reviewed and updated with current information. registers identify the types of restrictive practice, the consumer diagnosis, the alternative used to the restrictive practice, informed consent information and review dates of the restrictive practice. Medication charts reflected prescribed psychotropic medication and the reasons for administration. Behaviour charts, assessments and support plans identified the type of restrictive practice used, causes of changing behaviours and individualised interventions for staff to use when approaching consumers care.

Consumers and representatives were satisfied with personal care delivery in particular gender sensitivity. The Assessment Team noted improvements to supporting medication management policies and access to staff according to consumer preference.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with Requirement 3(3)(a).

# Standard 6

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

Findings

Requirement’s 6(3)(c) and 6(3)(d) were previously found non-compliant following a Site Audit conducted between 25 September 2023 to 28 September 2023. At the time of the site audit, it was found that:

* consumers did not feel satisfied complaints were acknowledged and action taken, and
* the service was not taking action when complaints were made, and feedback was not being used to make improvements.

Since the Site Audit effective actions have been implemented, however the Assessment Team recommended ongoing area for improvement. With consideration to the available information and the Approved Provider response including supporting information and clarification of factual observations I have come to a different view and consider Requirements 6(3)(c) and 6(3)(d) compliant.

Requirement 6(3)(c):

At the Assessment Contact conducted on 5 March 2024 the feedback and complaints register reflected 18 outstanding complaints to be actioned outside of the service’s policy for conclusion within 15 days. In response to the Assessment Teams observations regarding the outstanding complaints, management identified a gap caused by recent staff changes and software settings. The software alerts were immediately updated and management forwarded an email to all staff regarding the identified gap. A further commitment to training regarding the internal complaints system was also provided.

The Approved Provider submitted a response (the response) with additional supporting evidence of practices related to complaints an open disclosure process. The response also demonstrates additional strategies implemented to support compliance with internal policies as well as training related to open disclosure. A reporting process has also been implemented with oversight by executive management to ensure progression to closure within relevant timeframes is adhered to. The response demonstrates adequate strategies are in place with additional actions to ensure complaints are addressed and actioned accordingly. I find this Requirement compliant.

Requirement 6(3)(d):

The Assessment Team noted that feedback was not consistently being recorded in the services Plan for Continuous Improvement, resulting in an inability to utilise feedback mechanisms to assess and implement improvements. Management acknowledged linking improvements to feedback had not previously occurred and would commence improving this practice.

The response also demonstrates communication to staff reminding them of obligations to document complaints and feedback. There have also been adjustments to handover documentation to include consideration to any feedback of complaints received and sample checks to clinical management software to ensure feedback and complaints are adequately captured. The response demonstrates adequate strategies are in place with additional actions to ensure complaints are addressed and actioned accordingly. I find this Requirement compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |
| Requirement 8(3)(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’s 8(3)(c) and 8(3)(e) were previously found non-compliant following a Site Audit conducted between 25 September 2023 to 28 September 2023. At the time of the site audit, it was found that governance systems related to feedback, complaints and open disclosure were ineffective. Since the Site Audit effective actions have been implemented related 8(3)(e), however the Assessment Team recommended ongoing area for improvement with Requirement 8(3)(c) specific to feedback and complaints. With consideration to the available information and the Approved Provider response including supporting information and clarification of factual observations I have come to a different view and consider Requirement 8(3)(c) is compliant. I agree with the Assessment Teams recommendation that 8(3)(e) is compliant.

Requirement 8(3)(c):

The Assessment Team noted improvements in areas of Regulatory compliance, privacy and restrictive practices. As indicated in Requirements 6(3)(c) and 6(3)(d) further improvement was required with acknowledging, actioning and utilising information gained from feedback and complaints processes to support improvement in practice.

The response submitted by the Approved Provider demonstrated actions have been implemented to ensure feedback and complaints will be recorded and actioned within designated complaints resolution timeframes. There was evidence of processes to support consideration to feedback and complaints in continuous improvement activities. The response demonstrates adequate strategies are in place with additional actions to ensure complaints are addressed and actioned accordingly. I find this Requirement compliant.

Requirement 8(3)(e):

Since the previous Site Audit effective actions have been implemented to improve the clinical governance framework as well as staff practice and training. A dedicated staff member monitors use of restrictive practices as well as review of relevant documentation to ensure all forms of chemical, mechanical, and environmental restraint include consent. There was evidence reflecting improvement in areas of open disclosure and revision of medication management policy and procedures.

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