Performance

Report

**1800 951 822**

Agedcarequality.gov.au

|  |  |
| --- | --- |
| Name: | Huon Eldercare |
| Commission ID: | 8805 |
| Address: | 3278 Huon Highway, FRANKLIN, Tasmania, 7113 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 6 March 2024 |
| Performance report date: | 11 April 2024 |
| Service included in this assessment: | Provider: 1069 Huon Regional Care  Service: 5081 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 N 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

|  |  |
| --- | --- |
| 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 6

|  |  |  |
| --- | --- | --- |
| 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 between on 6 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

|  |  |  |
| --- | --- | --- |
| 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 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)