**Performance**

**Report**

**1800 951 822**

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| Name of service: | Western HomeCare Pty Ltd |
| Service address: | Shop 1/40 Glen Kyle Drive BUDERIM QLD 4556 |
| Commission ID: | 701075 |
| Home Service Provider: | Western Homecare Pty Ltd |
| Activity type: | Assessment Contact - Desk |
| Activity date: | 7 December 2022 |
| Performance report date: | 3 January 2023 |

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 Western HomeCare Pty Ltd (**the service**) has been prepared by M Abjorensen, 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.

# Services included in this assessment

**Home Care:**

* Hazel Home Care, 28134, Shop 1/40 Glen Kyle Drive, BUDERIM QLD 4556
* Coastal Home Care - Sunshine Coast, 27752, Shop 1/40 Glen Kyle Drive, BUDERIM QLD 4556

# Material relied on

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

* the assessment team’s report for the Assessment Contact - Desk; the Assessment Contact - Desk report was informed by, review of documents and interviews with staff, consumers/representatives and others

# Assessment summary for Home Care Packages (HCP)

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| Standard 1 Consumer dignity and choice | Not Applicable |
| **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 4** Services and supports for daily living | **Not Applicable** |
| **Standard 5** Organisation’s service environment | **Not Applicable** |
| **Standard 6** Feedback and complaints | **Not Applicable** |
| **Standard 7** Human resources | **Not Applicable** |
| **Standard 8** Organisational governance | **Not Applicable** |

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 | | HCP |
| 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 |
| 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. | Not Applicable |
| 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 |
| 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 Applicable |

Findings

The Assessment Team reported assessment and planning processes involve an initial assessment and the use of validated assessment tools for specific risks including clinical and cognitive conditions and how this may impact the delivery of services including the coordination of referrals to a registered nurse. Interviews with consumers and representatives evidenced how the service involves them in assessment process to support consumers to receive the care and services they need. Staff interviewed demonstrated a good understanding and knowledge of the consumers they care for and said they have access to up-to-date care plans and progress notes. The Assessment Team reviewed care planning documentation which evidenced the practice of staff undertaking assessments to consider specific risks impacting on individuals such as falls, nutrition and cognitive decline. Specific information about how the care and services are to be delivered are detailed in the care plan and in subsequent progress notes following each visit. Where key risks had been identified, strategies to manage the risks had been documented to guide staff in the delivery of care and services. For example:

* Information gathered during assessment and planning includes consumer health information, relevant diagnoses, past medical history, medications, any special instructions to access the property and who to contact if the consumer is not home for the visit.
* Care documentation for sampled consumers living with dementia contained assessments of needs to inform individualised behaviour support strategies to guide staff. Strategies varied, including the use of therapy dolls and prompting for medication and meals.
* Care documentation contained individualised strategies, and relevant referrals, to support sampled consumers living alone with medication assistance needs, support with diabetes management and falls prevention.

Through interviews conducted by the Assessment Team, consumers and representatives report the services they receive meets their needs, goals and preferences and described having daily input into how their services are delivered. Staff interviewed could describe how they undertake assessment and planning, taking into account the consumer’s needs, goals and preferences. Staff reported advanced care planning is discussed in line with the consumer’s preferences during the initial assessment and throughout the reassessment process based on the consumer’s wishes. Care plans reviewed were individualised, describing in sufficient detail the services the consumer receives, and evidenced discussions around advanced care planning with consumers. Examples include:

* One consumer described how staff support them to declutter their belongings, congruent with goals recorded in care documentation to support the consumer in maintaining an organised and safe home.
* A representative described the sampled consumer’s goal to attend a community breakfast at a local church, when they feel up to it. The Assessment Team reported care documentation reflected congruency with the goals described. Additionally, care documentation contained advanced care planning information, including hospital preferences and end of life wishes.

The Assessment Team reported the service maintains electronic care planning documentation that is accessible to staff. Consumers and representatives are provided with a copy of the plan that is kept in the consumer’s home for reference, and they also have the option of accessing their care plans via an application (app) on their tablet or mobile phone. Through interviews conducted by the Assessment Team, consumers and representatives described the services they receive and the frequency of service are explained to them on commencement and when changes occur. Staff reported having access to the care and services plan and reported service plans contain relevant information to provide services in line with the consumer’s preferences. Care planning documentation reviewed were reflective of consumer’s current needs and included sufficient information to guide staff. For example:

* One representative described how they reference the care plan to monitor the services being received. Care staff described how, prior to a scheduled visit, they access service plans through a mobile application to inform them of any changes or alerts.

# Standard 3

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| Personal care and clinical care | | HCP |
| 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 Applicable |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | 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. | Not Applicable |
| 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 Applicable |
| 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 Applicable |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Not Applicable |
| 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. | Not Applicable |

Findings

The Assessment Team collected evidenced and found service processes effectively identify, monitor and manage consumer risks. Risk assessments are undertaken for high impact or high prevalence risks to inform risk management strategies. Risks identified include falls, diabetes and medication management. Staff interviewed were able to describe risks for individual consumers. Through interviews with the Assessment Team, management described how weekly meetings are conducted to monitor and evaluate the needs of consumers identified as being vulnerable and high-risk. The meetings are attended by the service manager, care managers and registered nurses who review the changing condition and needs of consumers following incidents, while providing oversight of individual consumer’s clinical care. Outcomes from these meetings can result in changes to the provision of care, and referrals to specialists or hospital where required.

Information is reflected in care planning documentation, including the identification of risks, strategies and guidance for staff who provide services to consumers. A review of the service’s incident register and the weekly meeting minutes evidenced the regular review of recorded incidents, including incidents in relation to medication management. For example:

* A consumer living with insulin dependent type 2 diabetes self manages their blood glucose levels (BGLs). Care documentation includes diabetes management strategies to guide staff to minimise the risk of hypoglycaemia, including monitoring BGLs and actions to take if the recorded BGLs are out of the range specified by the medical practitioner.
* Following a medication incident, where a consumer was hospitalised after they missed their medication, the service conducted a clinical review of the consumer’s needs. Care documentation reflected the outcomes of the review, which included the installation of a medication box and daily medication monitoring visits. The representative reported an improvement in their family member’s health since the service has increased these services.

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)