ACH Group Residential Care - Highercombe

Performance Report

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Hope Valley SA 5090
Phone number: 08 8397 1600

**Commission ID:** 6289

**Provider name:** Aged Care & Housing Group Inc

**Site Audit date:** 15 December 2021 to 17 December 2021

**Date of Performance Report:** 23 February 2022

# Performance report prepared by

Alice Redden, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Non- compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Non-compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Non-compliant |
| **Standard 4 Services and supports for daily living** | **Non-compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Non-compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Non-compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Non-compliant |
| Requirement 6(3)(d) | Non-compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | Compliant |

# Detailed assessment

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 Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Site Audit; the Site Audit 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 Site Audit report received 14 January 2022.

# STANDARD 1 NON-COMPLIANT Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

The Quality Standard is assessed as Non-compliant as one of the six specific Requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirement (3)(d) in this Standard as not met. The Assessment Team found that although the service supports consumers to take risks that support their quality of life, they did not always complete risk assessments for consumers leaving the service independently and those using tricycles in the facility. Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirement (3)(d) in this Standard to be Non-compliant. I have provided reasons for my finding in the respective Requirement below.

In relation to the remaining Requirements in this Standard, the service is Compliant.

The Assessment Team found all consumers interviewed consider they are treated with dignity and respect and that staff make them feel valued and included. Consumer and representatives considered consumer individual choices and needs are recognised by staff and their individual cultures and identities are respected. The service supports consumers to make informed choices about their care and services, and provide accessible information about daily activities, meals, meetings, visiting staff and events happening in the service. Consumers are supported to make daily living and lifestyle choices and are supported in their decision-making through assessments of clinical and non-clinical needs.

The service demonstrated they provide care and services that are culturally- informed and safe. Most staff were familiar with consumers’ cultural backgrounds and were able to describe how those backgrounds influence the care they provide. Cultural days from a range of countries are celebrated at the service and the Assessment Team’s observations indicated the service seeks out and captures information about religious, spiritual, cultural and language needs. The service has policies and procedures that guide staff how to provide culturally safe care.

The service demonstrated they support consumers to decide how their care is delivered, who is involved in their care and to express their decisions about their care. Consumers described how they are supported to maintain their relationships, supported choose how they spend their days and the activities they participate in. Staff interviews, and other observations made by the Assessment Team, indicated that consumers’ independent choices and preferences are recorded and catered for by the service and that consumers are supported to maintain relationships of choice with people outside of the service.

Consumers and representatives confirmed consumer privacy and personal information is protected. Staff demonstrated practical ways they respect consumer privacy and dignity in their provision of personal care and services. The organisation’s policies emphasise privacy and confidentiality.

## Assessment of Standard 1 Requirements*.*

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Compliant

*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.*

### Requirement 1(3)(d) Non-compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

The Assessment Team found the service supports consumers to take risks they want to take to enhance their quality of life but could not demonstrate how consumers are supported to mitigate the specific risks entailed those activities. Relevant summarised evidence included:

* Consumer feedback and care documentation review showed that Consumer A, and other unspecified consumers who leave the service independently did not have risks assessment completed for that activity. Staff interviews showed that potential risks and strategies to mitigate those risks had not been discussed with consumers and management was not able to locate risk assessments completed by a previous manager.
* Consumer feedback and care documentation review demonstrated some consumers at the service use tricycles, however the service could not demonstrate strategies they have in place to identify and manage the risks associated with that. Consumer B, for example, indicated he enjoyed using the tricycle however care planning documentation showed that there had been no risk assessment in relation to getting on and off the tricycles for him.

When the above deficiencies were put to Management during the Site Audit, a complete risk assessment for Consumer A leaving the service independently was completed. Management also developed an action plan to complete functional assessments, including a referral to a physiotherapist, for all consumers using tricycles in the service.

In response to the Site Audit Report, the Approved Provider put forth the following relevant (summarised) arguments:

* The risk assessment management plan for Consumer A had been completed by a previous manager but were unable to be located. Numerous documents had gone missing following the staff changeover.
* In addition to completing a risk assessment for Consumer A during the Site Audit, the Action Plan developed by management also specified that a functional assessment and risk assessment for those consumers would be completed.
* Management also completed risk management plans for all consumers who leave the service during the Site Audit period.
* During the Site Audit, management also advised the Assessment Team that the tricycle riding is not an independent activity and consumers are fully supervised by a staff member.
* The service’s allied health team undertook a body of research work investigating tricycle riding and this included consideration of the safety of the activity.
* Management also added training and education in clinical risk management for high prevalence, high risk consumers into the service’s Plan for Continuous Improvement.

I acknowledge the Approved Provider’s responses and service management’s swift action to address the deficiencies identified by the Assessment Team during the Site Audit. However, I find that at the time of Site Audit, the service was unable to produce individualised risk assessment documents to demonstrate that consumers were supported to make informed risk-taking decisions in relation to tricycle riding and leaving the service independently. I note the Approved Provider’s assertion that assessments in relation to leaving the service unaccompanied had been completed by a previous manager but could not be located. However, the Approved Provider’s later written response did not contain any evidence to substantiate that risk assessments had been completed prior to the Site Audit. Additionally, the failure to find risk assessments prepared by previous managers raises concerns about the service’s ability to support consumers to continuously mitigate known risks even during periods of staff transition.

For the reasons detailed above, I find ACH Group Residential Care, in relation to Highercombe, to be Non-compliant with Standard 1 Requirement (3)(d).

### Requirement 1(3)(e) Compliant

*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.*

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

# STANDARD 2 COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Quality Standard is assessed as Compliant as five of the five specific requirements have been assessed as Compliant.

Consumers and their representatives interviewed were satisfied with assessment and planning processes at the service and confirmed they feel involved in the care planning process.

Routine and targeted assessments are used at the service to determine consumer needs, preferences and risks and are completed by registered staff, in consultation with consumers and their representatives, medical officers and allied health professionals. Documentation review demonstrated that specific risks related to consumer health and well-being are considered in assessment and planning processes at the service.

Consumers and their representatives reported they are involved in care planning discussions and there is ongoing partnership with the service in planning and assessment. Care plans sampled showed regular consultation with consumers and their representatives and that care plan reviews occur in accordance with the 6-monthly review schedule, as well as when there are changes in consumer condition or when incidents occur.

Care planning documentation reviewed was comprehensive and reflected consumers’ individual goals, needs and preferences for care and service delivery. Staff were knowledgeable about the needs, goals and preferences of sampled consumers and could describe what was important to them. Sampled care plans showed that when consumers had expressed a wish to do so, advance care and end of life planning was completed.

Care planning documentation review, consumer representative feedback and staff feedback demonstrated that external health professionals are involved in care planning and the service is supported by an onsite physiotherapist during weekdays. Other allied health professionals are accessed on a referral basis, with all referrals approved by the service’s clinical nurse.

Staff described their understanding of their incident reporting and escalation responsibilities. Documentation review confirmed the service has a clinical monitoring system and report to the governing body on clinical indicators each month. Management advised they monitor progress notes and clinical incidents to identify when follow-up, reassessment or referrals may be warranted for any given consumer.

Consumers and representatives confirmed the outcomes of assessment and planning are clearly communicated to them and were aware how to access their care plans and what is in them. Care planning documentation is available to clinical staff via the Electronic Care Management System (ECMS) and care staff have access to consumer care plans through the paper system. Staff at the service are guided by policies and procedures relating to palliative care, advance care planning and care plan review.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

*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.*

### Requirement 2(3)(b) Compliant

*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.*

### Requirement 2(3)(c) Compliant

*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.*

### Requirement 2(3)(d) Compliant

*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.*

### Requirement 2(3)(e) Compliant

*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.*

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The Quality Standard is assessed as Non-compliant as two of the seven specific Requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirements (3)(a) and (3)(g) in this Standard as Non-compliant. Based the Assessment Team’s report and the Approved Provider’s response, I find Requirements (3)(a) and (3)(g) in this Standard to be Non-compliant. I have provided reasons for my finding in the respective Requirements below.

In relation to the remaining Requirements in this Standard, the service is compliant.

Consumers interviewed considered the risks associated with their care were effectively managed and staff were well-informed as to the specific risks associated with sampled consumers’ care. Staff could identify the risk mitigation steps they take in relation to those consumers and safety measures the service has in place. Clinical monitoring occurs, and indicators are reported on monthly, though monitoring reports for the two months preceding the Site Audit were not complete.

Care planning documentation and consumer feedback demonstrated that the needs, goals and preferences of consumers nearing the end of life were recognised and addressed, whilst staff demonstrated how their care delivery changes for consumers nearing the end of their lives. Consumers and representatives considered the service recognises and responds to deterioration or changes in consumer condition and that stated they were kept informed changes.

The Assessment Team found the service documents and communicates information about consumer’s condition, needs and preferences within the organisation and information is made available to others involved in care. Most consumers considered that staff know them and their care preferences, while care planning documentation contained adequate information tailored to the individual consumer, to facilitate shared care.

Consumers confirmed they have access to other health professionals they need, including allied health professionals, medical officers and specialists. Staff are guided by the organisation’s referral policies and procedures and explained how they are informed of changes to the care of consumers that are made by external practitioners. The service has an onsite physiotherapist and occupational therapist, with other allied health professionals and specialists attending the service both regularly, and as needed.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-compliant

*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.*

The Assessment Team found pain management at the service to now be effective, after an Assessment Contact in August 2021 found the service to be Non-compliant with this Requirement. The Assessment Team also found the service currently provides effective management of skin integrity.

However, the Assessment Team found the service did not ensure each consumer receives safe and effective clinical and personal care that is best practice, tailored to their needs and which optimises their health and wellbeing. The Team detailed deficiencies in the identification and monitoring of restrictive practices at the service. Relevant summarised evidence included:

* Several consumers with wandering tendencies wore wandering alarm pendants however the service did not identify the pendants as a form of restrictive practice. Additionally, they could not demonstrate that consent had been provided for the pendants or if restraint authorisation forms had been completed.
* The service operates a dual information management system, with a paper-based system for care staff and an ECMS for clinical and visiting health staff. Clinical assessments and tasks are recorded in the ECMS whereas monitoring and behaviour, sleep and incontinence charting occurs on paper. Consumer care planning documentation is distributed across both systems. While some consumer care plans evidenced that consumers receive personal and clinical care in line with best practice, other care plans did not demonstrate this. For example:
	+ Consumer C has type 2 diabetes and on the ECMS, it was stipulated that their Blood Glucose Level (BGL) monitoring is to occur three times daily. Several recordings were missing from the ECMS but were recorded accurately on the consumer’s medication chart. Consumer A’s diabetes management plan did not contain instructions for staff if readings were returned outside of the specified clinical parameters, but there were instructions on the medication chart. When this evidence was put to Management, they advised they would include this in the post audit Action Plan.
	+ The Diabetes Management Plan and the medication chart for Consumer D, who is also a type 2 diabetic, did not contain staff instructions on steps to take if readings were outside of the specified clinical parameters.
* Consumers raised the following concerns with the Assessment Team:
	+ Consumer E reported that at night time, they regularly wait for lengthy periods for pain relief. Call bell data corroborated this, showing 42 call bell responses to be over the ten-minute target in the month preceding the Site Audit.
	+ Consumer F reported some staff were unaware of their preferences and how to support them in personal care.
	+ Consumer G’s representative reported that care staff were not applying the consumer’s topical medical lotions.
* Some staff were unable to describe specific individually-tailored strategies they would use to minimise behaviours in sampled consumers.
* During the entry interview, management could not advise how many consumers were subject to chemical restrains at the service. A list of consumers who take psychotropic medications was later provided but it did not specify how many of those consumers were considered to be subject to chemical restraint.
* The Service has documented policies and procedures relating to minimising the use of restraints and has a stated commitment to providing the least restrictive environment possible, with restraints used only as a last resort. However, sampled consumer planning documentation showed that:
	+ Consumer H, who is prescribed clonazepam for anxiety on a PRN basis, was administered the medication on occasion in August and October 2021. There were no recorded non-pharmacological interventions used prior to the consumer being administered clonazepam and the Assessment Team found no documented informed consent from Consumer H’s representative, who confirmed they had not been notified of the occurrences.
	+ Consumer I is prescribed oxazepam on a PRN basis, however the consumer’s medication chart did not state what the maximum dosage is, when it is to be given or what it is for. The Assessment Team identified an occasion on 10 November 2021 when a 7.5mg dose of oxazepam was administered with the non-pharmacological alternative strategy recorded as ‘given a drink.’ There was no recorded consent. When this was put to management, they produced a safety risk authorisation form signed by Consumer I’s representative in August 2021, stating they did not wish to be contacted when chemical restraint is used. However, the authorisation form stated that oxazepam use had been ceased but the medication chart stated it was restarted on 15 October. An updated safety risk authorisation form dated 28 October 2021 did not specify what had been discussed with the representative, including whether side effects of the medication had been discussed and consented to.
	+ The Behaviour Support plans for Consumers H and I were not in line with current legislation, because of the lack of documentation concerning how and when staff are using the interventions and the behaviours of concern that had led to consumers needing intervention. When this was put to management, they added training on behaviour support plans to the post-audit Action Plan.
* Management advised the Assessment Team there were no secluded consumers and none subject to physical, mechanical or environmental restraints. However, the Assessment Team reported they observed eight consumers wearing wandering pendants to address tendencies to abscond. Management was not able to provide the Assessment Team with a requested list of consumers with pendants, and no restraint authorisation forms or consent for the pendants was evidenced in reviewed care planning documentation. After this deficiency was put to management during the Site Audit, they:
	+ Advised a well-known advocacy service had informed them that wandering pendants are not considered restrictive practice.
	+ Supplied consent from the representative of one consumer to have that person’s pendant removed as it was no longer required.

Based on the evidence (summarised above), the Assessment Team recommended the service was Non-compliant with this Requirement. In their response, the Approved Provider disagreed with the Assessment Team’s findings and put forth the following arguments:

* In relation to Consumer C, the service confirmed that nursing instructions were not contained in the diabetes management plan and explained the clinical leadership group at the service had decided to notate on the diabetes management plan to ‘refer to medication chart for nursing instructions,’ to avoid the risk of transcription errors in having staff re-write the GP’s instructions.
* In relation to Consumer D, the Approved Provider demonstrated that the consumer’s diabetes management plan contains instructions to report to the medical officer if the BGL readings fall outside the stated clinical parameters.
* The Approved Provider’s response did not address the negative consumer and representative feedback relating to Consumers E, F and G.
* The response also did not directly address evidence that some staff could not describe individualised strategies for minimising concerning behaviour in sampled consumers.
* The Approved Provider did not put forth any direct response to the Assessment Team’s finding that Consumer H had been subject to chemical restraint without first trialling use of non-pharmacological strategies, that there was no informed consent provided for the restraints used in August and October 2021, that the representative had not been informed of the restraints being used and that the behaviour support plan was not compliant with legislation.
* In relation to Consumer I, the Approved Provider supplied what appeared to be an extract of the consumer’s progress notes from three dates, which evidenced that:
	+ The consumer’s representative had discussed the risks of use of psychotropics with the medical officer on 15 October 2021. During the consultation, oxazepam was prescribed for ‘severe agitation’ and a maximum dosage of 7.5mg recorded.
	+ In July (year not specified) a risk assessment by an RN occurred and the risks of use of psychotropics were discussed with the representative and the consumer. The note also specified that a 3 monthly review by the medical officer would occur. There was also listed instructions for staff to monitor for listed side effects and that staff were to follow the care plan to ensure ‘human needs’ are addressed in a timely manner.
	+ On 10 November 202, an RN recorded that Consumer H had been severely agitated, attempting to enter other consumer’s rooms and wandering in the middle of the night. The note stated the consumer had refused an offered drink, after which 7.5mg of oxazepam was administered with no effect.
* The Approved Provider put forth several arguments in relation to the Assessment’s Teams concerns around wandering pendants. They argued that:
	+ The device does not physically restrict a wearer from moving about or ambulating, or from moving about the site freely. They advised it sets off an alarm when the consumer goes near a door and that the intent of the bracelet is to give consumers the freedom to move as they choose and “support them in their risky activities of choice.” They noted the pendant can be removed independently by consumers.
	+ They argued the pendants are a safety strategy similar to sensor mats and the intention underpinning the pendants is it alert staff that the consumer “may be at risk of harm [enabling] staff to assist appropriately.” The Approved Provider also argued that “the customers who are wearing the bracelets are not actively seeking to leave the site but due to cognitive impairment [are] at risk of getting lost if leaving the site unattended.”
	+ They advised that there are now only two consumers with the pendant and that both have completed consent forms in place, which were put in place during the Site Audit. They confirmed that a third consumer stopped using a pendant as it was no longer required. The Approved Provider asserted that the other consumers identified by the Assessment Team as also wearing wandering pendants were in fact wearing call bell pendants.
	+ The provider reiterated that the well-known advocacy network does not consider wandering alerts to be a form of restraint.

Having regard to the Assessment Team’s findings, and the arguments and evidence put forth by the Approved Provider in their response, I find the service is Non-compliant with this Requirement because:

* The Approved Provider’s response did not address any consumer/representative feedback which raised concerns around timeliness of pain relief at night time and slow call bell response times, staff lack of familiarity with consumer needs and preferences and staff failures to apply medical lotions.
* The evidence put forth by the Assessment Team demonstrated that non-pharmacological interventions used prior to the use of chemical restraints were not recorded in relation to Consumer H and appropriate alternative non-pharmacological strategies were not identified in the plans for Consumer H and Consumer I. I also accept the Behaviour Support Plans for those consumers were not compliant with legislation in that respect and that the Behaviour Support Plan for Consumer H did not document how or when chemical restraints were used, nor did it specify what behaviour the restraints were used in response to.
* The service did not demonstrate there was consent to the use of clonazepam for Consumer H, on occasions in August and October 2021.
* Whilst the service’s pain management was found to be effective by the Assessment Team, there was consumer feedback which indicated at least one consumer waits for lengthy periods of time for pain control during night times. This was not addressed by the Approved Provider in their response.

I have accepted the Approved Provider’s arguments and evidence that:

* nursing instructions for Consumers C and D were recorded in care planning documentation accessible to clinical staff.
* Consumer I’s representative gave consent for the use of oxazepam on the date mentioned by the Assessment Team.
* Three consumers not eight were wearing wandering bracelets during the site audit. Consent forms have since been completed for two and the third no longer requires the bracelet. There was no evidence the wandering bracelets resulted in the consumers being prevented from free movement within and outside the service.

However, while the Approved Provider provided an adequate response in relation to the above evidence, the majority of evidence of non-compliance provided by the Assessment Team was not addressed in the response supplied to the Commission. As a result, I find that the weight of evidence demonstrated the service does not always provide safe and effective personal and /or clinical care that is tailored to individual consumer needs and which optimises their health and wellbeing.

For the reasons detailed above, I find ACH Group Residential Care, in relation to Highercombe, to be Non-compliant with Standard 3 Requirement (3)(a).

### Requirement 3(3)(b) Compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

### Requirement 3(3)(c) Compliant

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

### Requirement 3(3)(d) Compliant

*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.*

### Requirement 3(3)(e) Compliant

*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.*

### Requirement 3(3)(f) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 3(3)(g) Non-compliant

*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.*

The Assessment Team found that antimicrobial stewardship practices at the service were effective but identified deficiencies in the service’s COVID-19 infection control practices and as a result, recommended Non-compliance with this Requirement. Relevant summarised evidence included:

* Some staff were observed by the Assessment Team to be using PPE incorrectly and disregarding COVID 19 check-in and isolation precautions.
* Multiple hand sanitising stations were observed to not be working or to be empty. This was addressed by Management during the Site Audit period.
* Two visiting staff members were reportedly observed being permitted to enter the site without completing check-in procedures. This specific claim was adequately addressed by the Approved Provider in their later written response. However, when this was put to on-site management during the Site Audit, the Assessment Team was advised that staff go through the service entrance into the nurse’s station where they complete the QR check-in and temperature recording. The Assessment Team put to management that this practice meant that consumers and staff members already inside the service could be exposed to unscreened staff members walking to the nurse’s station. In response to this feedback, management advised that they had changed the staff screening process and emailed a staff memo requiring all staff to now enter at the staff entrance, and only enter after completing QR code check in, temperature checks and screening questions.
* The service’s IPC lead is not a dedicated lead for the facility, but an ACH-Group IPC lead. The IPC was not on site during the audit and the Assessment Team was advised they had taken over from a previous IPC lead in November and had been working from home since then.
* Staff temperature checks from September 2021 were not signed off by another staff member. When informed of this, the IPC lead was not aware that this was practice at the site.

Based on the evidence (summarised above), the Assessment Team recommended that the service was Non-compliant with this Requirement. In their response, the Approved Provider disagreed with the Assessment Team’s findings and put forth the following arguments:

* That observations made by the Assessment Team of staff and visiting staff reportedly disregarding check-in, PPE and isolation precautions had been misinterpreted, in two instances, and mistaken in another. The provider supplied evidence to support these arguments.
* In addition, the Approved Provider outlined that donning and doffing training and PPE usage training is included in staff orientation to the site, while “senior clinical staff and infection prevention and control lead provide oversight of infection control practices on site and educate and correct where required.”
* An audit of hand sanitiser dispensers was carried out upon receiving feedback from the Assessment Team. It showed that all units had adequate sanitiser, but some units had blockages requiring extra pumps to release the liquid. Evidence of the audit was supplied to the Commission, which demonstrated that at the time of the audit, one unit (at the foyer lift) was empty, four had blockages and one had the sanitiser bag positioned incorrectly and was not functional. There was a total of six none functional sanitising units out of a total 27 on the ground floor and 15 on the first floor.
* The provider argued that they have a long-established practice at the site of staff checking their own temperate and completing their own screening checks, whilst visitors to the site are checked by staff. However, the response did not address the concern that the IPC lead for the service was unaware this was a practice at the site.

Having regard to the Assessment Team’s findings, and the arguments and evidence put forth by the Approved Provider in their response, I find the service is Non-compliant with this Requirement because:

* Although the Assessment Team’s evidence that visiting staff to the service had not complied with check-in requirements was addressed in the response from the Approved Provider, the manager’s feedback about this to the Assessment Team on the first day of the audit raised concerns. Management advised that established practice at the service was for unscreened staff to walk from the site entrance to the nurse’s station, where they would complete check in procedures and screening. This suggests that prior to the Site Audit, screening and check-in procedures at the service were inadequate, as consumers and staff could potentially be exposed to unscreened staff and their air-borne droplets as they walked to the nursing station.
* At the time of Site Audit, the service did not demonstrate they had effective systems in place to identify and address problems with the hand sanitiser units in the service.
* The service did not demonstrate it had a service-specific, onsite IPC Lead who actively observes and monitors infection prevention and control practices on site. It is not clear that an off-site IPC lead, shared with other services, would be readily available to lead improvements and identify deficiencies in practice on a day-to-day basis, as is required of Commonwealth-funded aged care providers;
* The PPE usage training and the mask audit referred to in the response occurred after the time of Site Audit.
* The service failed to demonstrate there is sufficient oversight of staff check-in procedures as staff self-measure and record their own temperatures.

For the reasons detailed above, I find ACH Group Residential Care, in relation to Highercombe, to be Non-compliant with Standard 3 Requirement (3)(g).

# STANDARD 4 NON-COMPLIANTServices and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

The Quality Standard is assessed as Non-compliant as one of the seven specific requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirement (3)(f) in this Standard as Non-compliant due to consumer dissatisfaction with the quality and variety of meals provided at the service. Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirement (3)(f) in this Standard to be Non-compliant. I have provided reasons for my finding in the respective Requirement below.

In relation to the remaining Requirements in this Standard, the service is compliant.

Consumers interviewed confirmed they are supported to do activities that they enjoy and are interested in. Consumers described individual and group activities they enjoy pursuing at the service, including bingo, gardening, quizzes and using the gym. Sampled assessment and care planning documentation reviewed accurately recorded consumer preferences and the people important to them, and this information aligned with staff understanding of consumer preferences, likes and dislikes.

Consumer feedback confirmed that the service caters for the emotional, spiritual and psychological needs of consumers, by respecting privacy, providing emotional support and conversation to consumers as needed, meeting religious needs and supporting consumers to maintain their important relationships external to the service. Consumer care planning documentation includes information about consumer beliefs, social supports and emotional well-being strategies. Consumers confirmed they can talk to staff or access other supports when they are feeling down and need emotional support, whilst lifestyle staff outlined how they address psychological wellbeing, emotional and social needs by matching individual consumers to volunteers and supporting consumers with the use of technology to maintain connections outside the service.

The service demonstrated they provide effective daily living supports to connect consumers to the community inside and outside the service, to have social and personal relationships of their choice and do things which interest them. Consumer’s described visiting the community with friends and family on a regular basis, while reviewed care planning documentation outlined activities of interest and important relationships of sampled consumers. The service has a visiting library service and ties with local multicultural groups, volunteers and the University of the Third Age. Care planning documentation demonstrated the service makes appropriate and timely referrals to external care providers and services.

The service has effective preventative and reactive maintenance systems and staff and consumer feedback as well as Assessment Team observations demonstrated the service to be clean, adequately equipped and well maintained.

## Assessment of Standard 4 Requirements*.*

### Requirement 4(3)(a) Compliant

*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.*

### Requirement 4(3)(b) Compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

### Requirement 4(3)(c) Compliant

*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.*

### Requirement 4(3)(d) Compliant

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 4(3)(e) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 4(3)(f) Non-compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

The Assessment Team found most consumers and representatives sampled were dissatisfied with the quality and variety of food they receive at the service. Of seventeen sampled consumers, nine expressed different reasons for being unsatisfied with the meals provided, including that meals:

* Lack in variety.
* Are mostly Western in nature.
* Are not cooked on site.
* Feature meat which is “always tough…”
* Taste bland
* Lack vitamins and is “horrible”
* Are not of good quality and
* Had not changed, despite previous complaints from one consumer.

Care planning documentation showed that consumer dietary requirements and preferences for sampled consumers had been recorded however one consumer, Consumer J advised the Assessment Team that staff do not cut up his food unless he asks them to. Consumer J stated that when his meals are cut up, the pieces are still too large for him to eat.

The Assessment Team also noted that in May 2021, the service had been found non-compliant in four areas during a Food Safety Audit conducted by the local council.

In their response to the Site Audit report, the Approved Provider did not provide any direct acknowledgement of the poor consumer feedback or the identified issues relating to poor taste, quality and lack of variety in the meals. The service referred to their Post Site Audit Action Plan which specified the following actions to address deficiencies:

* A review to determine who is responsible for serving food at the service and
* A consumer food focus group.

Based on the Assessment Team’s evidence (summarised above) and the Approved Provider’s limited response, I find that at the time of site audit, the service did provide meals of suitable quality and variety. As a result, I find ACH Group Residential Care, in relation to Highercombe, to be Non-compliant with Standard 4 Requirement (3)(f).

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

The Quality Standard is assessed as Compliant as three of the three specific Requirements have been assessed as Compliant.

Sampled consumers and representatives confirmed they feel safe and at home in the service and reported that the service is a nice place to live. Consumers were observed using the multiple communal lounges and indoor dining areas to socialise, participate in lifestyle activities and share in conversations with visitors and other consumers. Suites were observed to be personalised and management confirmed consumers are encouraged to make their home “their own.”

The Assessment Team observed a homely environment, enhanced by the multiple lounge areas and fish tank. Consumers were observed moving about the service. There are various lifestyle features, including gardens, a café, a library space and a pool table, to support consumer belonging, well-being and lifestyle.

The service’s environment is signposted to assist consumers and visitors in navigating the service and the physical layout and design is suited to the use of mobility aids. Consumers have access to outdoors areas that contain seating and has shaded areas. Outdoor pathways were well maintained and were observed being traversed by consumers who use mobility aids and wheelchairs.

Consumers confirmed the site is kept clean, they have access to the equipment needed to support them in their daily living and staff confirmed that equipment is sufficient to meet consumer needs. Cleaning staff described their cleaning schedule and consumer representative feedback confirmed the service is kept clean.

There is an established reactive maintenance system in place at the service, with maintenance staff monitoring maintenance request forms on a daily basis. External contractors are engaged to complete major scheduled preventative maintenance tasks and also address reactive maintenance requests submitted by staff. Documentation review evidenced that regular maintenance occurs at the site and that maintenance tasks are mostly completed in a timely manner. The call bell system was observed to be operating effectively.

## Assessment of Standard 5 Requirements*.*

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 NON-COMPLIANTFeedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

The Quality Standard is assessed as Non-compliant as two of the four specific requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirements (3)(c) and (3)(d) in this Standard as Non-compliant because consumer/representative feedback provided to the Assessment Team, and the results of a consumer satisfaction survey conducted during 2021, showed significant dissatisfaction with how complaints are handled at the service. The Assessment Team’s review of the complaints and feedback register demonstrated the service did not routinely respond to complaints in a timely manner. Based the Assessment Team’s report and the Approved Provider’s response, I find Requirements (3)(c) and (3)(d) in this Standard to be Non-compliant. I have provided reasons for my finding in the respective Requirements below.

In relation to the remaining requirements in this Standard, the service is Compliant.

The Assessment Team found that consumers, representatives and others are encouraged to submit feedback and complaints and sampled consumers and representatives felt comfortable to do so. Care and registered staff outlined how they work to resolve complaints and provide emotional support when consumers do complain, while management described the ways the service elicits feedback through consumer meetings, surveys and feedback forms.

The service provides consumers information about how to access external complaints and advocacy services, while staff and consumers were aware of external avenues for consumers to raise concerns. Culturally and Linguistically Diverse consumers are supported with bilingual staff members and volunteers and information as well as the organisational feedback forms which are available in other consumer languages.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

### Requirement 6(3)(c) Non-compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

The Assessment Team found that although open disclosure processes are consistently followed and there is an organisational feedback and complaints system, the service could not demonstrate complaints were responded to and resolved in a timely manner. Relevant (summarised) evidence put forth by the Assessment Team included:

* Four consumers and representatives sampled advised that:
	+ They’d previously complained about the food at a consumer meeting and there had been no changes made.
	+ A representative advised they had previously complained about their family member being left sitting on the toilet waiting for assistance and the complaint had not been responded to. The feedback register noted the complaint was lodged in early September 2021 and was still listed as “open” at the time of Site Audit.
	+ Another representative indicated they had previously complained about quality of care to their family member, and although care had improved for a few weeks afterwards, the problems had then reappeared. The representative said there was a ‘disconnect’ between management and actions of care staff on the floor of the service. When this feedback was put to management, they demonstrated an open disclosure form had been completed and a meeting with the family had occurred which resulted in an Action Plan being developed to address the issue. However, the feedback register listed the complaint as “open” at the time of Site Audit.
	+ Another representative reported their family had complained to the CEO directly about the quality of personal care being received by their family member and that a short and immediate response was received, however it took some time to meet with management of the service. When they met with management, they were advised a daily oral and dental hygiene checklist would be implemented but the representative advised they had seen the checklists were incomplete during their visits. When this feedback was put to management of the service, they produced completed checklists for the four days preceding the Site Audit. The feedback register noted the complaint was still listed as “open” at the time of Site Audit.
* Staff feedback showed that
	+ Staff were familiar with the open disclosure procedure, that includes an apology and an incident investigation however management confirmed there were numerous unaddressed complaints in the feedback and complaints register, which predated the current Site Manager’s tenure at the service. Complaints resolution is to be the focus of the new Site Manager.
* The Assessment Team’s review of service documentation showed that:
	+ A consumer survey conducted during the period of accreditation showed that just over half of consumers agreed or strongly agreed that the service responds appropriately to complaints.
	+ The service was unable to provide on request detailed information about complaints and feedback trends for the service. The service eventually supplied lists of feedback to the Assessment Team as follows:
		- A list of all complaints, compliments and suggestions from 1 June 2021 to the date of Site Audit. It contained 66 feedback records with 26 listed as unresolved or “open.”
		- A list of some feedback for August-October 2021, which contained 13 feedback records. Three were listed as unresolved.
	+ In response to the lists received (described above) the Assessment Team requested further detail on complaints still “open.” A third list was supplied to the Assessment team, which contained 40 pieces of feedback that were still open. The feedback ranged in dates from mid-February 2021 to October 2021. The Assessment Team was advised by the ACH Group’s feedback review lead that:
		- The list included feedback results from a food quality survey and a mid-year consumer survey that should be considered an “administrative close.” The lead advised that 23 needed to be closed “administratively” after contacting the consumer and acknowledging their feedback.
		- The lead also advised that nine complaints have no recorded actions or progress, four were compliments to be closed “administratively” and four were complaints from surveys needing action and resolution.
		- The lead advised they would no longer enter complaints from surveys into the complaints database as they were difficult to follow-up and because they were more “query” than complaint. However, when the Assessment Team followed up and interviewed those consumers, they found the “queries” were specific concerns that the consumers/ representatives still held. These concerns ranged in nature, from food quality to concerns about the quality of care being delivered.
* In their response to the Site Audit report, the Approved Provider did not provide any direct acknowledgement of the Assessment Team’s findings, or the specific concerns raised by consumers and reflected in the complaints and feedback data for the service. The Approved Provider’s response referred to their Post Site Audit Action Plan which specified the following actions to address deficiencies:
	+ Completion of outstanding feedback.
	+ Future feedback be logged to within one business day of receiving and “open communication with customers and representatives.”
	+ Improvements to be entered onto the service’s Continuous Improvement log in future.

Based on the Assessment Team’s evidence (summarised above) and the Approved Provider’s response, I find that at the time of Site Audit, the service did not ensure appropriate action was taken in response to complaints raised at the service. As a result, I find ACH Group Residential Care, in relation to Highercombe, to be Non-compliant with Standard 6 Requirement (3)(c).

### Requirement 6(3)(d) Non-compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

The Assessment Team found the service could not demonstrate how feedback and complaints are used to drive improvements in the quality of care and services. They found the service could not identify trends in complaints and feedback at this specific site. As a result, the Assessment Team found the organisation did not demonstrate that feedback and complaints from the Highercombe site in particular were being reviewed and used to drive improvements at the service. Relevant summarised evidence included:

* A representative considered the service handles complaints inconsistently, that the right things were said by management and apologies immediately given but changes were not maintained over the long term.
* Numerous consumers raised concerns about the quality and variety of food at the service. Refer to Requirements 4(3)(f) and 6(3)(c) for further detail.
* Staff were able to describe trends in complaints at the service to include food and laundry, however did not provide information on how the service addresses the complaints. Staff also could not describe how complaints are used to improve services.
* Management advised they monitor the feedback register for timely resolution of complaints but stated that trend reports are created at the organisation’s Head Office. However, the organisation’s feedback lead advised that they only run trend reports on request from the Site Manager. As a result, the service did not demonstrate there is meaningful review of feedback and complaints to identify trends at the site.
* Review of the complaints register showed complaints raised in consumer meetings were not recorded.
* The organisation’s Plan for Continuous Improvement contained projects that were not reflective of complaints being repeatedly received at Highercombe.
* Management supplied evidence that the previous Site Manager had been advised on 21 November 2021 to bring the complaints backlog of 38 open matters to closure.

In their response to the Site Audit Report, the Approved Provider did not give any direct acknowledgement of the Assessment Team’s findings, or any indication that the service has an adequate plan in plan to address the specific concerns raised by the Assessment Team. The Approved Provider’s response referred to their Post Site Audit Action Plan which specified the following actions to address deficiencies:

* Outstanding feedback to be resolved.
* A new requirement to have all feedback captured within one business day of receipt and “open communication to be used with consumers and representatives.”
* Improvements to be entered on the service’s Continuous Improvements log.

Based on the Assessment Team’s evidence (summarised above) and the Approved Provider’s response, I find that at the time of site audit, the service did not have an adequate system in place to record and review feedback and complaints at the service level. As a result, there was insufficient trending of service-specific complaints data to be used to drive on-site improvements. In making my decision, I also note the Approved Provider’s Action plan to address the deficiencies does not contain any concrete steps to address the governance level factors that may have contributed the backlog of unaddressed complaints at the service, or the worrying apparent intention to administratively close genuine complaints on the basis they were mere queries.

For reasons outlined above, I find ACH Group Residential Care, in relation to Highercombe, to be Non-compliant with Standard 6 Requirement (3)(d).

# STANDARD 7 NON-COMPLIANTHuman resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The Quality Standard is assessed as Non-compliant as one of the five specific requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirement (3)(a) in this Standard as Non-compliant because consumer/ representative feedback and call bell data indicated the service is sometimes understaffed, resulting in poor consumer outcomes. These findings were in alignment with staff feedback that the service sometimes lacks sufficient staff to meet consumer personal care requirements. Based on the Assessment Team’s report and the Approved Provider’s response, I find Requirement (3)(a) in this Standard to be Non-compliant. I have provided reasons for my finding in the respective Requirement below.

In relation to the remaining Requirements in the Standard, the service is Compliant.

Consumers stated staff were kind, gentle and caring in their interactions and respectful of consumer’s religious needs. Assessment Team observations aligned with this feedback and the service supports staff to respect consumer dignity by providing access to online training in dignity and personalised care, and values training.

The service showed it has systems and is supported by the wider organisation to recruit appropriately qualified staff. There are processes in place to ensure prospective staff meet a list of standard competencies, have necessary competence in English and have a minimum of a Certificate III in Aged Care (for care staff). The wider organisation monitors ongoing staff training and completion of training modules is enforced. The service demonstrated that Australian Health Practitioner Regulation Agency (AHPRA) registrations for nursing staff were up to date and expiry dates are tracked.

Feedback showed that consumers and their representatives are mostly satisfied with the competence and training of the workforce and the service demonstrated that on entry to the service, training and information is provided to enable new staff to perform their roles. The service has clinical and non-clinical internal auditors to identify new workforce training topics and demonstrated extensive recent training for staff relating to the introduction of the Serious Incident Reporting Scheme (SIRS), changes in restrictive practices regulation and in response to the November 2021 Assessment Contact visit which returned a finding of Non-compliance with Requirement 3 (3)(a).

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Non-compliant

*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.*

The Assessment Team found the service did not always ensure there are enough personnel deployed to enable the delivery and management of safe and quality care and services. Relevant (summarised) evidence included:

* Some consumers/ representatives considered there were sufficient staff to meet consumer needs and that staff generally attend quickly when called. However, several other consumers reported there were long call bell response times and considered there are not enough staff at the service. Consumers and their representatives described poor consumer outcomes as a result. For example:
	+ Consumer J described being left sitting in pain for up to 30 minutes before a staff member can reposition them, and that they use the bathroom independently at night because the wait time is too long.
	+ Consumer K stated a belief that “there could be more staff,” and documentation review that showed Consumer K had recently not been provided support to use the bathroom as there was no second staff member available for the two-person assisted transfer Consumer K required.
	+ A representative for Consumer L reported their family member will not eat if they do not get assurance and reported that staff had advised Consumer K there were not sufficient staff to help them eat. The representative stated they had observed other consumers experiencing the same issue.
	+ The representative for Consumer M advised they are sometimes left unattended on the toilet and this occurs most often during night shifts.
	+ Consumer M advised they wait up to 10 minutes for staff and this leaves them frightened.
* Management outlined that call bell audits show the service is not meeting the target 10-minute call bell response time consistently and an action plan is being developed to address this.
* Some care workers interviewed described not having as much time as they would like to provide care. For example, one care worker described that sometimes, they need to leave non-high-risk consumers while they are using the toilet, in order to attend to another consumer. Another care worker described not being able to calm a specific consumer when they get agitated, as there is no time to sit with them particularly in mornings. A third care worker advised that when the ‘floater’ staff member does not arrive for their shift, the position is not filled, and the work load becomes heavy.
* Reviewed call bell data for October and November and the first three weeks of December 2021 indicated that 10-12% of call bells were answered outside of the ten-minute target timeframe. October call bell data showed 11% of 290 calls were answered between 10 and 30 minutes, 20 were answered between 30 and 60 minutes and two were answered after 60 minutes. November data showed 385 calls were answered between 10 and 30 minutes and seven were answered after 30 minutes. Data for the first three weeks of December showed a continued trend of 10-12% of calls being answered between 10 and 30 minutes.
* Workforce planning documentation reviewed by the Assessment Team showed several unfilled shifts over the two fortnights preceding the Site Audit. These included 10 unfilled shifts in the fortnight starting 17 November 2021 and 13 in the fortnight starting 1 December 2021. In the latter fortnight, nine unfilled shifts were RN shifts and two were EN shifts.
* A consumer survey with 58 consumer/representative participants in May-June 2021 found only 36% of respondents agreed or strongly agreed there were sufficient staff to meet care needs at the service. 21% disagreed and 10% strongly disagreed.
* Personnel numbers show that there are significantly less care staff rostered on in the evenings as compared to afternoon and morning shifts.

Management described the steps being taken by the service to improve call bell response times, including advising them of the call bell audit results and educating staff to ask for assistance when needed from other staff members, as well as communication training. Management advised some RN staff had been identified to not support care staff in answering call bells. During the Site Audit period, management supplied additional Action Plan steps to address the call bell response time deficiencies, including new staff reflective practices processes, daily call bell checks of response times over 10 minutes and an additional procedure for bells over 10 minutes. However, the Assessment Team noted the PCI supplied did not reflect the plan to address the slow call bell response times or the low consumer satisfaction results from the May-June 2021 survey.

In their written response to the Site Audit report, the Approved Provider stated they have commenced taking steps to address call bell response time deficiencies, through daily call bell monitoring and education for staff. The provider referred also to their post audit Action Plan which also lists training in the service’s phone systems for new and existing staff.

Having regard to the Assessment Team’s findings, and Approved Provider’s, I find the service did not plan their workforce numbers and mix in a way that enables the delivery and management of safe and effective care and services. I find that the service’s consumer and representative feedback demonstrated poor consumer outcomes as a result and that the call bell response times tended to corroborate consumer, representative and staff feedback against this requirement. The Action Plan to address the deficiencies does not contain any steps to review the adequacy of personnel numbers and it is not clear the Assessment Team’s findings are being used to drive improvements against this requirement.

For the reasons detailed above, I find ACH Group Residential Care, in relation to Highercombe, to be Non-compliant with Standard 7 Requirement (3)(a).

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

### Requirement 7(3)(c) Compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

### Requirement 7(3)(d) Compliant

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

### Requirement 7(3)(e) Compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

# STANDARD 8 NON-COMPLIANTOrganisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

The Quality Standard is assessed as Non-compliant as one of the five specific requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirement (3)(c) in this Standard as Non-compliant owing to deficiencies in the monitoring and governance of restrictive practices, workforce planning, information management, continuous improvement and the handling of consumer feedback and complaints. The Assessment Team also recommended Requirement (3)(e) as Non-compliant owing to reported deficiencies in effectiveness of the clinical governance framework as it applied to restraints and antimicrobial stewardship.

Based on the Assessment Team’s report and the Approved Provider’s response, I find that Requirement (3)(c) is Non-compliant. However, I came to a different view than the Assessment Team in relation to Requirement 3(e). I have provided reasons for my findings in the respective Requirements below.

In relation to the remaining Requirements in this Standard, I find the service to be compliant.

The service uses a variety of methods to engage consumers and representatives in the development, delivery and evaluation of care and services. Consumers are supported to engage through monthly consumer meetings hosted by the lifestyle coordinator, a customer experience team who report to the governing body’s ‘voice of the customer’ committee, direct visits to the service by members of the governing body and consumer participation in staff recruitment.

The service demonstrated the governing body promotes a culture of safe, inclusive and quality care and services, and are accountable for their delivery. The governing body is comprised of nine members with a mix of skills and there are also sub-committees aligned with the Quality Standards, addressing topics such as risk, compliance and consumer engagement. The organisation has a Medication Advisory Committee (MAC) that comprises a medical officer, pharmacist and other clinicians. The MAC reviews incidents and clinical trends at the service.

While the Assessment Team identified a lack of specific examples of changes made as a result of feedback or incidents at the service in the previous six months, management advised that this was a result performance issues with previous management, which resulted in deficiencies in governance at the service. See Standard 6 for further information.

The service demonstrated an effective risk management framework, with documented policies guiding staff in the management of high impact or high prevalence consumer care risks, identification of and response to abuse and neglect of consumers and supporting consumers to live their best life. Staff demonstrated their knowledge of both the content of the policies and gave examples of how they apply the policies in their work. The service demonstrated effective incident reporting in relation to a recent incident, which resulted in a SIRS report being lodged.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

### Requirement 8(3)(b) Compliant

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

### Requirement 8(3)(c) Non-compliant

*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.*

The Assessment Team found the service has documented policies and procedures which set out the governance systems relating to information management, continuous improvement, financial governance, workforce governance and regulatory compliance. However, except for in relation to financial governance, the service did not demonstrate these policies and procedures are implemented or monitored effectively. As a result, the Assessment Team found the service did not meet the standards set by this Requirement. Relevant summarised evidence included:

Information Management

* The Assessment Team found inconsistencies between the paper-based and electronic care management systems used to record clinical care provided to consumers.
* When asked, management struggled to supply the Assessment Team with required information, for example, when asked management were not able to provide a list of consumers using wandering pendants or a list of consumers subject to chemical restraints.
* Risk information was not assessed and documented for consumers leaving the service independently or those using tricycles.
* The service welcome pack had outdated information in it.
* Complaints were not consistently documented in the complaint’s register.

Continuous Improvement

* While management were able to explain processes in place to identify areas for improvement in the service, the Assessment Team found the PCI projects did not reflect complaints raised at the service or the known problematic issues at the site, as reported by management. When this deficiency was put to management, they advised that there are separate Actions Plans created to address specific issues and advised that a food survey in 2021 resulted in a food specific action plan. It was noted, however, that the Action Plan is not site specific and covers the entire ACH Group.

Workforce governance

* The service reports to the governing body in relation to management of human resources and the service demonstrated they have effective systems for recruitment of suitably qualified and experienced staff. However, the Assessment Team referred to their previous findings in Requirement 7 (3)(a), which showed strong consumer and staff dissatisfaction with personnel numbers.

Regulatory compliance

* The Assessment Team referred to their previous findings in Requirement 3 (3)(a), noting the service did not demonstrate that they assess, monitor and minimise the use of restraints in the service, and failed to show behaviour support plans compliant with recently amended legislation.

Feedback and complaints

* The Assessment Team referred to their previous findings in Requirements 6 (3)(c) and 6(3)(d), that the complaints system at the service fails to adequately record all complaints and that complaints that are recorded are not being resolved at the service in a timely manner as required by organisational policy.

Based on the evidence (summarised above), the Assessment Team recommended that the service was Non-compliant with this Requirement.

In their response, the Approved Provider disagreed with the Assessment Team’s findings however the written response put forth limited relevant arguments. Their response failed to articulate relevant responses to the Assessment Team’s evidence relating to Information Management, Workforce governance and Regulatory Compliance.

The Approved Provider’s response to evidence regarding Continuous Improvement and feedback and complaints governance was intermingled. They responded that:

* There are Action Plans for addressing specific deficiencies in care and service.
* The Assessment Team used the same evidence across different requirements, suggesting a limited understanding of the interlinked nature of the Quality Standards.
* The organisation had identified performance problems with previous site management who had not addressed complaints in a timely manner and took appropriate performance measures to address them. This was identified through the governance arrangements, namely, through monthly internal reporting of feedback data.
* The backlog of complaints had been addressed and relevant consumer’s families apologised to.
* The Approved provider did not respond to the concerns that the PCI has no projects that address the service specific issues relating to food quality, call bell response times or the complaints raised by consumers/ representatives.

Having regard to the Assessment Team’s findings, and the arguments and evidence put forth by the Approved Provider in their response, I find the service is Non-compliant with this Requirement. I find that the service did not demonstrate:

* There were effective governance systems and planning processes to ensure there is always enough staff at the service to deliver safe and effective care.
* There are effective and site-specific feedback and complaints systems which inform site-specific continuous improvement systems. The service did not demonstrate that the existing systems support the organisation or service management to identify when there are risks to quality of care and to consumer safety at the Highercombe site specifically.
* That there are effective regulatory compliance systems in place to support the service to comply with all relevant legislation, regulatory requirements, professional standards and guidelines, including recent legislative amendments to requirements for behaviour support plans and restrictive practices.

For the reasons detailed above, I find ACH Group Residential Care, in relation to Highercombe, to be Non-compliant with Standard 8 Requirement (3)(c).

### Requirement 8(3)(d) Compliant

*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.*

### Requirement 8(3)(e) Compliant

*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.*

Based on the evidence (summarised above), the Assessment Team recommended that the service was Non-compliant with this Requirement.

The Assessment Team found the service has a documented clinical governance framework and documented policies relating to open disclosure, minimisation of restraints and antimicrobial stewardship. Staff demonstrated their training and knowledge of these policies and could explain how they have implemented the policies in practice and what they mean for their delivery of care and services. The Assessment Team also found the organisation closely monitors antibiotic use through an antimicrobial stewardship committee the service reports to.

However, the Assessment Team also identified deficiencies in how restrictive practices and infection prevention and control policies are implemented at the service, relying on their previous findings that:

* Restrictive practices documentation was not always up to date and the service could not illustrate how they minimise their use of restraints.
* There was not the required consent recorded for all restrictive practices at the service, as previously outlined under Requirement 3(3)(a).
* Management were not aware wandering pendants could be considered a restrictive practice depending on their intent and use.

The Assessment Team also relied on previous findings in relation to reported lapses in PPE use and COVID-19 infection control deficiencies which the Approved Provider addressed previously (see Requirement 3 (3)(g)).

In their response, the Approved Provider disagreed with the Assessment Team’s findings and put forth the following relevant (summarised) arguments:

* The wandering pendants are a risk mitigation strategy that do not restrict the movements, rights or freedoms of the wearers. They alert staff, but wearers can still move about freely. The written response stated again that well-known advocacy network does not consider the bracelets a restrictive practice, however there was no written evidence to support this claim.

Having regard to the Assessment Team’s findings and the arguments and evidence put forth by the Approved Provider in their response, I disagree with the Assessment Team’s recommendation of non-compliance with this Requirement.

I find the Service evidenced they have a documented clinical governance framework that incorporates policies on antimicrobial stewardship, minimisation of the use of restraints and open disclosure. In doing so, the service is compliant with the wording of this requirement.

I find that reported shortcomings in COVID-19 infection prevention measures have only a tangential relationship to the intent of subclause 3(e)(i), which is primarily concerned with reversing practices that have contributed to increased antibiotic resistance. Furthermore, COVID 19 infection prevention deficiencies have already been the subject of assessment, and findings of non-compliance in earlier standards (namely Requirement 3 (3)(g)).

Finally, I note that the wording of this Requirement does not mention effectiveness of the clinical governance framework, only that the service must demonstrate they have one. The service has a clinical governance framework supported by the wider organisation, and where deficiencies in the implementation of the framework at the service have been identified in relation to individual consumer’s restrictive practices, I find this has been more appropriately addressed in Standard 3 Requirement (3)(a).

For the reasons detailed above, I find ACH Group Residential Care, in relation to Highercombe, to be Compliant with Standard 8 Requirement (3)(e).

# 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.

Standard 1 Consumer dignity and choice:

* Ensure consumers are supported to identify the specific risks they want to take, that risk assessments occur, mitigation strategies are used, and all DOR processes are documented.

Standard 3 Personal care and clinical care:

* Ensure tailored non-pharmacological interventions are used and documented prior to use of chemical restraints at the service.
* Ensure Behaviour Support Plans are compliant with legislated requirements.
* Ensure necessary consents/ authorisation for use of restraints is obtained and recorded, in accordance with legislated requirements.
* Ensure there is an on-site, dedicated IPC lead who observes and monitors infection prevention and control practices on site.
* Ensure screening, PPE usage and isolation practices at the service align with recommended practices.
* Ensure hand sanitising stations are in good working order.

Standard 4 Services and supports for daily living:

* Ensure meals are of sufficient quality, nutritional value and variety.
* Ensure consumer involvement in planning and evaluation of the menu.
* Ensure sufficient assistance is provided consumers during meal times.

Standard 6 Feedback and Complaints:

* Ensure all complaints from all sources are recorded on the complaint register to monitor appropriate actions occur, trends are identified and areas for improvements in care and services are identified.
* Ensure more timely response to complaints.
* Ensure complaints and feedback are used to inform continuous improvement efforts at the service level.

Standard 7 Human resources:

* Ensure sufficient numbers of staff are deployed to provide timely, safe and effective care in line with consumer needs and expectations.

Standard 8 Organisational governance:

* Ensure all gaps between policies and practice identified by the Assessment Team are appropriately actioned and that service practice is brought into alignment with policies and procedures.
* Ensure the service is adequately staffed to meet consumer care needs.
* Ensure monitoring and governance in relation to use of restraints is effective and in line with regulatory requirements.
* Ensure Behaviour Support Plans and use of restraints is in line with regulatory requirements.