Performance

Report

**1800 951 822**

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| Name of service: | ACH Group Residential Care - Highercombe |
| Service address: | 5-11 Sirius Avenue Hope Valley SA 5090 |
| Commission ID: | 6289 |
| Approved provider: | Aged Care & Housing Group Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 26 April 2023 |
| Performance report date: | 18 May 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 ACH Group Residential Care - Highercombe (**the service**) has been prepared by M Glenn, 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.

# Material relied on

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

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff and management;
* an email from the provider received 3 May 2023 acknowledging the Assessment Team’s report and the contents; and
* a Performance Report dated 3 November 2022 for an Assessment Contact – Site undertaken 6 September 2022.

# Assessment summary

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| 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 as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

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

# Areas for improvement

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

# Standard 3

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

Findings

Requirement (3)(a) was found non-compliant following Assessment Contact - Site undertaken 6 September 2022 where it was found each consumer did not receive safe and effective care that was best practice, tailored to their needs and optimised their health and well-being, specifically in relation to use of psychotropic medication. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed restrictive practice processes, including the creation of an online clinical form for use with any as needed chemical restraint medication.
* Reviewed Behaviour support plans to ensure they are more personalised, strategies are comprehensive, including recognising triggers, checking for and effectively managing pain and ensuring plans are reviewed regularly.
* Adjusted the Behaviour support plan structure to capture authorisation or consent by the consumer and/or representative and the Medical officer.
* Provided training to clinical staff to increase understanding of legislative requirements in relation to restrictive practice.
* Changed the clinical management staff structure, with the provision of four Care managers who supervise consumers’ clinical management. Daily leadership huddles are undertaken during the week to coordinate clinical care and monitor clinical risk.

At the Assessment Contact undertaken on 26 April 2023, care files sampled demonstrated consumers receive safe and effective personal and/or clinical care which is tailored to their needs, optimises their health and well-being and is best practice. Care files demonstrated provision of effective and appropriate care, including in relation to diabetes, skin integrity, wounds, pressure area management and restrictive practices, and evidenced input from Medical officers and Allied health specialists. Staff described personal and clinical care needs for sampled consumers in line with their assessed needs and preferences. All consumers and representatives sampled were satisfied with the clinical and personal care consumers receive, including in relation to management of diabetes, wounds, pain, behaviours and falls.

For the reasons detailed above, I find requirement (3)(a) in Standard 3 Personal care and clinical care compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

Requirement (3)(f) was found non-compliant following Assessment Contact - Site undertaken 6 September 2022 where it was found the service did not demonstrate meals were of suitable quality and variety. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Conducted Sensory assessments to identify consumers who may be experiencing decline in taste.
* Provided feedback training with the previous Hotel service’s team leader; a new Team leader has also been identified as requiring this training.
* Completed kitchen upgrades, including new oven installations which provides hospitality staff the ability to cook some meal components.
* Recommenced Food focus committees and registering food and menu complaints in the main Feedback and complaints register.

At the Assessment Contact undertaken on 26 April 2023, consumers were found to be consulted each morning on what they would like to eat for lunch and dinner, and most consumers and representatives sampled were satisfied meals served are varied and of suitable quality and quantity. Care files included recommendations for consumers’ individual dietary needs and nutritionist oversight, with assessment processes capturing information relating to consumers’ likes and dislikes. Care staff described how they are alerted to consumers’ dietary changes and processes to ensure correct meals, suitable for consumers’ dietary requirements and preferences, are served. The majority of meals are prepared at the organisation’s centralised catering facility. Menus are seasonal and developed on monthly basis, with each meal service offering at least two options for main meals, as well as alternatives. Consumers provide input into the meal service and menu, including through the Food focus committees and consumers are consulted prior to seasonal menu changes. Complaints data and trending documents from October 2022 to March 2023 showed complaints relating to food have reduced, which management attributed to the kitchen upgrades and listening to feedback.

For the reasons detailed above, I find requirement (3)(f) in Standard 4 Services and supports for daily living compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |

Findings

Requirement (3)(c) was found non-compliant following Assessment Contact - Site undertaken 6 September 2022 where it was found appropriate action was not taken in response to complaints or an open disclosure process used when things went wrong. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Provided senior clinical staff and team leaders informal training relating to logging feedback into the electronic database.
* Formed a resident representative meeting comprising of volunteer consumers from each section of the service. A standard item includes a commitment that feedback received will be logged into the main register and actioned.
* Introduced a new electronic feedback system to record and track feedback and complaints which is aligned to Quality Standards and provides metrics in relation to days to acknowledge, days to close and differentiates between complex and other complaints.
* As part of the organisational restructure, an executive management and Voice of Customer and Workforce Committee has been introduced to review feedback and complaints.

At the Assessment Contact undertaken on 26 April 2023, feedback, complaints and open disclosure policies and procedures were found to be available to guide management and staff in how to identify, investigate, manage, document and resolve complaints. Management and staff sampled described complaints management processes and most consumers and representatives confirmed appropriate action is taken to address feedback and complaints and felt the service is transparent and an apology is offered when things go wrong. A Feedback and complaints register is maintained and showed actions to be taken in accordance with the organisation's procedure, including prescribed timeframes, acknowledging receipt, providing advice on what the service is doing to address concerns and if further investigations are required. Feedback is reviewed, root cause analysis is undertaken and areas for improvement are discussed at relevant meeting forums.

For the reasons detailed above, I find requirement (3)(c) in Standard 6 Feedback and complaints compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |

Findings

Requirement (3)(c) was found non-compliant following Assessment Contact - Site undertaken 6 September 2022 where the organisation’s governing systems relating to regulatory compliance and feedback and complaints were found not to be effective. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Implemented a new, updated clinical structure which comprises four Care managers.
* Implemented daily meetings between the Residential site manager and Clinical manager, Leadership daily huddles, and a monthly site Customer Meeting to review risks related to consumer care, including use of restrictive practices.
* Appointed a Clinical educator who works across two of the organisation’s sites and provides training for identified gaps in skill or knowledge.
* Introduced a Resident of the day process which includes a full clinical review of consumers, and implementation of whiteboards in nurse’s stations to identify high-risk consumers.
* Implemented regular audits which includes review of clinical documentation; organisational processes and the Plan for continuous improvement.
* Implemented a new feedback system which links feedback and complaints to the Plan for continuous improvement and developing a Continuous improvement dashboard.

At the Assessment Contact undertaken on 26 April 2023, effective organisation wide governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance, and feedback and complaints were demonstrated. Staff confirmed there are processes for dissemination of updated, relevant information, and policies and procedures are centrally located and available to guide practice. A Plan for continuous improvement is maintained and included initiatives aligned to the Quality Standards, as well as actions and outcomes. Continuous improvement is undertaken with interaction between feedback processes and the Plan for continuous improvement. A Finance, Audit and Budget Committee assists the Board in effective discharge of its financial responsibilities, budgets are set annually in conjunction with the Residential services manager, financial delegations are linked to role, and the organisation uses external auditors to ensure compliance with financial reporting. A centralised Human resource function includes governance systems and processes in relation to workforce management, and workforce processes, such as induction and performance appraisal are undertaken. There are systems and processes to identify regulatory changes, and monitoring and review of compliance with regulatory obligations is undertaken. Feedback and complaints are reviewed through the Customer Engagement and Voice of Customer and Workforce Committee, and minutes from October 2022 demonstrated feedback is reviewed to capture trends, performance against key measures and root cause analysis to identify areas for improvement.

For the reasons detailed above, I find requirement (3)(c) in Standard 8 Organisational governance compliant.

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)