Joseph Cooke House

Performance Report

2 Houtmans Street   
SHELLEY WA 6148  
Phone number: 08 9457 9622

**Commission ID:** 7085

**Provider name:** Southern Cross Care (WA) Inc

**Site Audit date:** 8 December 2020 to 10 December 2020

**Date of Performance Report:** 6 May 2021

# Publication of report

This Performance Report **may 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) | Non-compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | 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** | **Compliant** |
| Requirement 3(3)(a) | 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) | Compliant |
| **Standard 4 Services and supports for daily living** | **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) | 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) | Non-compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Non-compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(b) | Non-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) | Non-compliant |

# Detailed assessment

This performance report details the Commission’s assessment of the approved provider’s (provider) 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 on 14 January 2021.

# 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 has been assessed as Non-compliant.

The Assessment Team found most consumers and representatives considered staff treated them or their family member in a way that was respectful and maintained their dignity, enabled them to make choices and live the life they choose however, this feedback was not consistent. Consumers and representatives provided the following feedback relevant to this Standard:

* The majority of consumers and representatives reported staff treat consumers with dignity and respect. A representative confirmed their family member’s cultural background was acknowledged and staff who could speak the consumer’s language assisted with communication.
* Consumers confirmed staff support and encourage them to spend as much time as they wish with other consumers they are close to.
* A consumer reported being spoken to in a harsh manner by a staff member and another consumer reported watching staff rushing consumers when helping them with their meals. A consumer observed a staff member raising their voice and speaking to two consumers in what was considered a disrespectful manner.
* A representative observed their family member left sitting on the toilet for an extended period which they considered was undignified. Another representative noted their family member was not consistently showered.

The Assessment Team reviewed policies and procedures to guide staff practice in relation to maintaining consumer dignity and supporting choice, and evidence of staff receiving training to support them in providing care and services respectfully while maintaining consumer dignity.

Documentation reviewed by the Assessment Team includes care plans, handover sheets and training records. Training records confirm all staff undertake mandatory training relating to consumer choice, customer service and treating consumers with dignity and respect. Care plans clearly details consumers’ preferences for personal care. Handover sheets provide similar information in an abbreviated format.

During interviews with the Assessment Team staff reported they collect information about consumers’ preferences from the time of admission. Staff said consumers can choose how their care and services are delivered and this information is recorded on their care plans. Care staff said they provide personal care when consumers are ready and according to their preferences and meet specific requests for male or female staff to provide this care. Clinical staff described the process they follow to support consumers to take risks and could describe the risks consumers take and how they minimise the risk of harm.

The Assessment Team observed the majority of staff knocking on consumers’ bedroom doors prior to entering however, this practice was not consistently used, and bedroom doors were seen open while care was being provided.

The Assessment Team reviewed processes in place, including surveys and resident/relative meetings, to monitor consumer satisfaction with choices available to them and how their individual preferences are met.

While the Assessment Team found the service has policy and procedure and associated training in relation to treating consumers with dignity and respect they found evidence of this not consistently occurring. The Assessment Team found Requirement (3)(a) in this Standard not met. I find the service Non-compliant with this Requirement at the time of the Site Audit. The reasons for my findings are detailed under the specific Requirement below.

## Assessment of Standard 1 Requirements

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

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

The Assessment Team found the service was not consistently treating consumers with dignity and respect or maintaining their privacy. The Assessment Team have based their recommendation on the following:

* Verbal feedback from two representatives indicating one family member was left sitting on the toilet for an extended period and another was not showered daily.
* Two consumers provided verbal feedback indicating they had either been spoken to in a manner they found harsh, or they had witnessed a staff member speaking rudely in a raised voice to other consumers.
* Three staff members reported hearing a supervisor speak to consumers in a derogatory manner.
* A staff member heard a colleague tell a consumer to use their pad to go to the toilet as there were not enough staff to help them to the toilet.
* Visual observations of staff not knocking before entering consumers’ rooms and not closing doors while providing care.

On 14 January 2021 the provider submitted a response to the Assessment Team’s report indicating a management restructure was underway at the time of the site audit, resulting in three new management positions; a head of residential care, a head of clinical services and a site manager specific to Joseph Cooke House, being filled from 4 January 2021. In addition, clinical hours were increased. Following the Site Audit additional training was scheduled to improve the effectiveness of staff communication with consumers and families and address privacy. The provider’s response reinforced the positive feedback they had previously received from consumers, family members and representatives.

Specifically, in relation to feedback about a consumer being left on the toilet and a consumer not being showered daily, the provider submitted information indicating both occurrences relate to consumer preferences, which are recorded on their care plan.

I acknowledge the provider’s response detailing the positive feedback they have received, an increase in senior management from 4 January 2021, additional clinical staff and training to reinforce appropriate respectful interactions in the future. Despite the action taken I consider sufficient evidence was provided by consumers, representatives and staff to indicate some staff were speaking with consumers in a way that was not respectful, and some staff were not maintaining consumers’ privacy at the time of the Site Audit.

Based on the evidence detailed above I find Joseph Cooke House Non-compliant with Standard 1 Requirement (3)(a).

### 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) Compliant

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

### 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

This Quality Standard is assessed as Compliant as all five specific Requirements have been assessed as Compliant.

The Assessment Team found consumers considered they feel like partners in the ongoing assessment and planning of their care and services. Consumers and representatives provided the following feedback relevant to this Standard:

* Consumers stated they were involved in the assessment and planning of their care and services and clinical and allied health professionals included them in the development of their care plans on admission and at regular intervals.
* Consumers advised clinical staff informed them of the outcomes of assessments and how they would guide the delivery of their care and service. They stated they have access to their care plans whenever they wish to review their care and services.
* Representatives reported they had been involved in regular discussions with staff about their family member’s care over several years and advised staff kept them informed of any incidents that occurred or changes in condition that may impact care and service delivery.

The Assessment Team reviewed policies and procedures to guide clinical and allied health staff in following the assessment and planning process at the time of admission and as required, including the completion of assessments related to advance care planning and end of life care.

Documentation reviewed by the Assessment Team included care plans, progress notes and advance health directives. Care plans included consumers’ care needs, preferences and goals based on an initial assessment process and revised as their condition or preferences changed. Progress notes included detailed information about changes in consumers’ condition and the follow up assessments completed, and care provided to ensure needs continued to be met. Progress notes confirmed allied health professionals such as dietitians and speech pathologists have visited to assess and make recommendations for care and a dentist has visited to provide treatment. The advance health directives reviewed contained individualised consumer wishes.

During interviews with the Assessment Team clinical staff spoke of using validated risk assessment tools to develop an interim care plan within seven days of admission for use while comprehensive assessments and care plans are completed. Clinical staff said they review care plans at least six monthly and re-assess all consumers annually, updating care plans after these assessments are complete and sharing information with consumers and representatives at annual care conferences. Care staff confirmed they follow the directives in care plans to ensure care and services are delivered appropriately.

The Assessment Team observed care plans readily accessible to consumers and staff, in consumers’ rooms and in nurses’ stations.

## 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 COMPLIANT Personal 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

This Quality Standard is assessed as Compliant as all seven specific Requirements has been assessed as Compliant.

The Assessment Team found consumers were generally satisfied they receive personal and clinical care that is safe and right for them. Consumers and representatives provided the following feedback relevant to this Standard:

* Representatives confirmed staff contact them promptly when incidents occur. A representative reported being updated regularly about their family member’s infection, treatment and response to treatment.
* Consumers said they are confident the service shares information about their care needs and preferences appropriately and they do not have to repeat information to all those involved in providing care and services.
* Consumers and representatives confirmed they are satisfied consumers have access to doctors and other relevant health professionals when they need it.
* Consumers advised they felt the service had prepared well and kept them informed about COVID-19.

The Assessment team reviewed policies and processes in place to guide staff in their work and evidence to confirm these were followed in relation to most aspects of personal and clinical care.

Documentation reviewed by the Assessment Team included progress notes, referrals, incident reports and care plans. Records confirm consumers’ needs and preferences are recorded in their care plans and they are receiving best practice care in preventing and treating pressure injuries and wounds, preventing falls and managing consumers after falls, and managing weight loss, pain and diabetes. All files reviewed contained specific care plans relating to palliative care. Referrals and progress notes confirm a range of other health professionals have input into the care provided to consumers, including after incidents. Progress notes confirm clinical staff are aware of and follow the antimicrobial stewardship framework, collecting information to support the appropriate prescription of antibiotics and monitoring the effectiveness of antibiotics when prescribed.

During interviews with the Assessment Team care and clinical staff spoke of monitoring consumers and reporting changes in their condition to senior staff who then refer for medical review. Care and clinical staff confirmed information about consumers’ conditions is shared at handover and in updates from clinical staff during the shift if care needs change.

The Assessment Team reviewed evidence of data about consumer deterioration being collected and analysed each month to assess the adequacy and appropriateness of the service’s response. Minutes of a quality clinical team meeting confirm organisation-wide discussions occur in relation to clinical deterioration and incidents.

The Assessment Team observed hand sanitiser stations in various locations around the service and saw visitors, staff and consumers using hand sanitiser on all days of the Site Audit.

While the Assessment Team found the service has policy and procedure in relation to the use of restraint they found they were not delivering safe and effective care in line with best practice guidelines in relation to the use of physical and environmental restraint to manage risks associated with falls, wandering and aggressive behaviour. The Assessment Team found Requirement (3)(a) in this Standard not met. I have reached a different view and find the service Compliant with this Requirement. The reasons for my findings are detailed under the specific requirement below.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) 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 the service was not delivering safe and effective care in line with best practice in relation with the use of physical restraint, specifically in relation to the use of low line beds and a tray table in front of a chair. The Assessment Team based their recommendation on the following:

* Records confirm low line beds and a half table in front of a chair are used to minimise risk of falls and wandering behaviour without a thorough informed consent process being completed for all.
* The absence of records to indicate consumers in low line beds or restrained by a half table in front of a chair were monitored while these physical restraints were being used.
* Records confirm the service have incorrectly identified low line beds as an environmental restraint.
* The absence of consent forms for all consumers acknowledging they are aware the service is secure, and they cannot leave freely without being given the code to the keypad. Two consumers who entered the service in the six months prior to the Site Audit said they were not aware the service was secure, or aware of how this impacted on their ability to move freely in and out.

On 14 January 2021 the provider submitted a response to the Assessment Team’s report, acknowledging an opportunity to make improvements and confirming they are now trialling new documentation with a view to replacing existing processes to remedy this. The provider confirmed all consumers identified in the Site Audit report have been reviewed since and the use of all physical restraints has ceased in consultation with consumers or their representatives and staff have been provided with education and training relating to the use of restraint and associated policies and procedures.

In relation to the service being secure, the provider advised all prospective residents, and/or their representatives are advised of this when they first tour the service. The code to exit the facility is displayed on the key pad allowing cognitively able consumers to leave as desired. Entry is gained by ringing the doorbell which is answered either by administration staff, or clinical staff after hours. The provider confirmed they are currently updating their site booklet to ensure information about access is current.

I acknowledge the provider has acted promptly to review the use of physical restraint, educate staff and update information for consumers in relation to the secure nature of the service constituting an environmental restraint.

While the Assessment Team did identify gaps in documentation relating to the use of various forms of restraint, other evidence collected confirmed staff sought input from a dementia specialist in the ongoing management of a consumer prior to using restraint. In relation to environmental restraint in the form of a locked exit door, the Assessment Team also identified a gap in documentation as all consumers have not been asked to sign consent forms acknowledging this restraint. As other evidence confirms consumers are advised of this prior to entry to the service I consider this gap aligns more closely with Standard 8 Requirement (3)(e) as is covered later in this report.

Based on the evidence detailed above I find Joseph Cooke House 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) 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.*

# STANDARD 4 COMPLIANT Services and support 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

This Quality Standard is assessed as Compliant as all seven specific Requirements have been assessed as Compliant.

The Assessment Team found overall consumers considered they get the services and supports for daily living that are important for their health and well-being and that enables them to do the things they want to do. Consumers and representatives provided the following feedback relevant to this Standard:

* Consumers said they enjoy attending different activities, within and outside the service, and are encouraged and supported to do so. A consumer said they are supported to have friendships in the service, and that they often enjoy a glass of wine with another consumer.
* A representative confirmed staff provide their family member with emotional support when they feel sad. Consumers said they can attend Church, or the priest will visit them in their rooms if they do not wish to attend the service.
* Consumers reported they were satisfied with the quality, quantity and choice of meals. A consumer spoke of their food allergies and how the service accommodates these without compromising on the quality of meals they receive.
* Consumers and representatives commented on how activities on Sundays are held in the foyer and are often interrupted as the lifestyle assistant is also responsible for completing the COVID screening for visitors on entry.
* Representatives confirmed they were satisfied with how consumers’ information was shared with others who play a role in care provision, and were confident privacy was maintained as required.

The Assessment Team reviewed guidance documents relating to assessing consumers’ needs and preferences and maintaining privacy, and processes in place to support staff in meeting them safely.

Documents reviewed by the Assessment Team include the activity schedule, handover sheets, care plans and consumers’ files, all of which demonstrate a comprehensive program is in place to meet consumers’ social, spiritual and emotional needs utilising internal and external resources as necessary. Care plans and handover sheets confirmed consumers’ dietary needs and preferences are clearly communicated. Records confirm maintenance and repairs are completed within reasonable timeframes based on risk, and a preventative schedule is followed.

During interviews with the Assessment Team staff spoke of completing a comprehensive assessment to identify consumers’ interests and preferences and developing a social and human needs care plan to guide how they provide relevant services and supports. Staff spoke of contacting the pastoral care officer when they considered a consumer would benefit from additional emotional support. Care and clinical staff described how information about consumers is shared during handover, and on a handover sheet, to ensure changes in care and services were passed on at each shift change. Lifestyle staff reported seeking regular feedback from consumers about the activities program and making changes based on the feedback received. The allied health team confirmed appropriate equipment is available to support them in meeting consumers’ needs.

The Assessment Team observed consumers participating in group activities including bingo, Christmas carols, chair aerobics and cards.

The Assessment Team reviewed evidence of processes in place to monitor consumer satisfaction with the services and supports for daily living, including a focus group and surveys.

## 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) Compliant

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

### 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

This Quality Standard is assessed as Compliant as all three specific Requirements have been assessed as Compliant.

The Assessment Team found overall consumers feel they belong in the service and feel safe and comfortable in the service environment. Consumers and representatives provided the following feedback relevant to this Standard:

* Consumers said they liked living at the service and felt safe there.
* A consumer said the service felt like home as they were able to arrange their room how they want to using furnishings of their choice.
* Consumers said they are able to leave the building to access the outdoor garden area if they choose, acknowledging staff need to enter the door code to enable them to do so.

The Assessment Team reviewed evidence of procedures in place to guide staff in ensuring the service environment remains clean, comfortable and safe.

Documents reviewed by the Assessment Team include the maintenance register, hazard report and incident register. All confirm hazards are reported and rectified promptly, and incidents are appropriately followed up and remedial action taken as required.

During interviews with the Assessment Team staff reported they support consumers to move around the service environment and participate in activities occurring in different areas. Staff said they feel safe using different pieces of equipment and consider it is safe and well maintained. Management provided examples of how they have acted on feedback from consumers and representatives to make improvements to the service environment. Maintenance staff described on request and preventative maintenance activities, completing work themselves or engaging contractors as required. Cleaning staff described how their roles have changed in response to COVID-19 with an increased focus on regular cleaning of high touch areas, such as handrails and doorknobs, while undertaking regular cleaning duties.

The Assessment Team observed the service is clean and tidy, and safe and easy to navigate through wide uncluttered hallways with handrails. Consumers were seen engaged in group activities in common areas and appeared happy while having their hair done at the hairdressers on each day of the Site Audit. Consumers’ rooms were personalised with their belongings, including photographs of loved ones and easy to read signs on each door.

The Assessment Team observed evidence of processes in place to monitor consumer satisfaction with the service environment, including resident/relative meetings and surveys.

## 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-COMPLIANT Feedback 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

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

The Assessment Team found while the service has a formal complaint process the process was not consistently followed by staff and consequently did not result in follow up action being taken to improve the quality of care and services. Most consumers interviewed reported they knew how to make complaints. Consumers and representatives provided the following specific feedback relevant to this Standard:

* Two representatives advised they were comfortable speaking with management if they wanted to make a complaint. Two representatives provided feedback confirming complaints they had made were acted on and did result in improvements to each consumer’s care.
* A consumer said they were worried they would get in ‘trouble’ if they complained about their care. Another consumer said they were ‘worried’ to make complaints as they had observed staff ‘raising their voice’ at other consumers and said they were ‘worried this may happen to them’.
* A consumer said they felt they couldn’t raise complaints because of the ‘dynamics’ of staffing roles at the service. They said they didn’t feel supported to raise concerns directly with staff as no action would be taken and were concerned about repercussions from some staff who provide their care.

The Assessment Team reviewed the organisation’s client feedback procedure which details what is required of staff when they receive feedback.

During interviews with the Assessment Team staff spoke of how they could arrange advocacy services to support consumers to raise concerns, and interpreters if required. Some staff were able to describe the various ways they could assist consumers to lodge complaints and others could not describe how the organisation’s complaints and feedback policy applied to their role. Management advised consumers have opportunities to provide feedback during resident/relative meetings and through meal surveys, and at any other time. Staff accurately described their role in open disclosure and were aware of the related policy.

The Assessment Team observed information about the organisation’s feedback and complaints procedure and pamphlets about advocacy services displayed on noticeboards and in other prominent areas around the service.

While the Assessment Team found the service has a formal complaints procedure the majority of information provided to them at interview indicated consumers are reluctant to complain and staff do not consistently escalate complaints they receive to management for action. The Assessment Team found Requirements (3)(a) and (3)(c) in this Standard not met. I find the service Non-compliant with these Requirements at the time of the Site Audit. The reasons for my findings are detailed under the specific Requirements below.

## Assessment of Standard 6 Requirements

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

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

The Assessment Team found the service did not encourage and support individuals to make complaints. The Assessment Team based this finding on the following:

* Multiple consumers reported feeling concerned about lodging complaints for fear of repercussions,
* other consumers said they saw no point in lodging complaints as no action would be taken, and
* documentation confirmed at the time of the Site Audit (8 December 2020) two complaints had been received in 2020.

On 14 January 2021 the provider submitted a response to the Assessment Team’s report, inclusive of results from a satisfaction survey completed in August 2020, the analysis of which indicated a high level of satisfaction, and meeting minutes from August to November 2020 conflicting with the Assessment Team’s findings that consumers were not satisfied with care and services. The provider also submitted evidence of action taken since the Site Audit to reinforce and support the existing feedback and complaint procedure, including engaging a full-time manager for the service to oversee improvements to this procedure as part of their role.

Despite the action taken by the service in relation to this requirement I consider there were perceived barriers to making complaints, and complaints have not been lodged for this reason. The Assessment Team did not indicate there was significant dissatisfaction with care and services. They did indicate there were some consumers who were not satisfied with care and services, and who were either not comfortable to complain or not confident their complaints would result in improvements.

Based on the evidence detailed above I find Joseph Cooke House Non-compliant with Standard 6 Requirement (3)(a).

### 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 appropriate action was not being taken in response to complaints. The Assessment Team based this finding on the following:

* Staff reported they were aware of their responsibility to pass complaints on however, also expressed concern about potential repercussions of doing so.
* Staff reported they did not always pass on complaints to more senior staff.
* Management advised, and documentation confirmed they had received two complaints in 2020.

On 14 January 2021 the provider submitted a response to the Assessment Team’s report, inclusive of evidence of action taken since the Site Audit to reinforce and support the existing complaint procedure, including engaging a full-time manager for the service, overseeing improvements to their complaint process as part of their role, as detailed above.

Despite the action taken by the provider since the time of the Site Audit I consider appropriate action was not being taken in relation to complaints prior to the Site Audit. Staff acknowledged they were not escalating complaints to senior staff for action, and management and records confirm only two complaints were received in 2020, up to the date of the Site Audit which commenced on 8 December 2020. Staff were not taking appropriate action in response to receiving complaints as they were not escalating the information received to senior staff for follow up. If senior staff are not made aware of complaints, they are not able to take follow-up action.

Based on the evidence detailed above I find Joseph Cooke House Non-compliant with Standard 6 Requirement (3)(c).

**Requirement 6(3)(d) Compliant**

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

# STANDARD 7 NON-COMPLIANT Human 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 two of the five specific Requirements have been assessed as Non-compliant.

The Assessment Team found while the service has a system in place to support workforce planning to enable the delivery and management of safe and quality care and services, the system is not consistently effective, and disrespectful behaviour by staff towards consumers is not acted on appropriately. Consumers and representatives provided the following specific feedback relevant to this Standard:

* While most representatives stated they consider there are not enough staff, generally, they were happy with the way staff provided care to consumers and expressed confidence in staff knowing what they are doing.
* Most consumers confirmed they were happy with the care they received from most staff members.
* One consumer said they “couldn’t be looked after better”.

The Assessment Team reviewed guiding documents in relation to minimum staff qualifications and a performance management process to support management staff to employ staff with the appropriate knowledge and skills to fulfil their roles and monitor their performance.

Documents reviewed by the Assessment Team included rosters, allocations sheets, competency assessments, position descriptions, duty statements, training records and the plan for continuous improvement. Rosters confirmed the same number of care and registered and clinical nurse staff hours across each day of the week. The allocation sheet confirms vacant shifts are filled and indicated a clinical management role includes hands-on care Monday to Friday only, which is not covered on weekends.

During interviews with the Assessment Team management advised care staff must have a Certificate III in aged care qualification, and registered nurses must be registered with the Australian Health Practitioner Regulation Agency (AHPRA) and undertake continuous professional development as required by that registering body. Management confirmed they have a ‘buddy system’ where new staff are partnered with an experienced staff member in the same role as them to orientate them for the first few weeks of employment. A laundry staff member said they recently filled a shift as a kitchen hand; they are up to date with their food safety training, completed annually, enabling them to work in the kitchen when needed. All staff interviewed confirmed they are provided with regular training and given opportunities to up-skill when this is requested, and they have received onsite and online training in relation to infection control and the COVID-19 pandemic specifically.

While the Assessment Team found the service has a workforce that is skilled and qualified to provide quality care and services there was evidence of delays in providing care and services and consistent reports from staff and consumers about disrespectful behaviour from specific staff that has impact on consumers’ feelings of safety and security. The Assessment Team have recommended Requirements (3)(a) and (3)(b) within this Standard not met. I agree with the Assessment Team’s recommendations. The reasons for my findings are detailed under the specific Requirements below.

## 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 while the service has a process in place to plan their workforce the process does not consistently enable the delivery and management of safe and quality care. They base this finding on the following:

* A consumer uses their call bell for assistance to dress each morning and reports it takes a long time for staff to come. The consumer said they try to dress themselves while they are waiting which causes them pain.
* A representative spoke of arriving to pick their family member up for an outing and finding them sitting undressed on the toilet waiting for assistance from staff.
* A consumer reported the lifestyle assistant shift on Sundays is responsible for running activities in the foyer and completing visitors’ entry screening. A consumer reported they do not attend these activities as they are ‘stop and start’ and in full view of all who enter. A representative confirmed only small numbers of consumers can participate as space is limited.
* Consumers report staff seem busy and rushed when providing personal care.
* Staff reported lifestyle shifts are not consistently filled when staff are on leave creating backlogs of assessments needing to be completed.

On 14 January 2021 the provider submitted a response to the Assessment Team’s report, inclusive of informative provided to the Assessment Team and not reflected in the Site Audit report. The provider indicated a staffing review in November 2020 resulted in: an increase in clinical hours across afternoon and night shifts seven days per week, meaning the service now has registered nurse cover at all times; and the introduction of a dedicated head of residential care and head of clinical services to support all of the provider’s residential sites – both roles in the final stages of recruitment at the time of the Site Audit. The provider also indicated they have allocated additional registered nursing hours across all shifts, increased the lifestyle program to seven days per week and introduced a weekend administration officer to manage visitor screening between the time of the Site Audit and when they received the Site Audit report for comment. The provider also indicated the chief operating officer was interviewed by the Assessment Team and provided information relating to planned redevelopment in 2021, upgrades to the call bell system as part of the redevelopment process, introduction of a full-time onsite manager model commencing in January 2021, and ongoing review of rosters and staffing to ensure numbers and skill mix are sufficient.

I acknowledge the additional information submitted by the provider in relation to the range of improvement initiatives and activities conducted both prior to and promptly after the Site Audit.

While I consider all action taken to be positive I also consider the evidence collected from consumers and representatives at the time of the Audit indicated deficits in the provision of personal care, impacting consumers’ comfort, dignity and opportunities to be meaningfully engaged in activities at the time of the Site Audit.

Based on the evidence detailed above I find Joseph Cooke House Non-compliant with Standard 7 Requirement (3)(a).

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

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

The Assessment Team found workforce interactions with consumers are not consistently kind, caring and respectful. They base this finding on the following:

* A representative advised their family member does not like to use the call bell as when they first arrived at the service they were “told off” by staff for using the call bell at night.
* Two representatives reported one staff member speaks to their family member, and other consumers in an abrupt and disrespectful manner.
* A consumer said they have seen staff members assisting consumers with meals in a rushed manner, stating they felt sorry for the consumers when they saw this.
* Five staff members reported observing one staff member interacting with, and providing care to, consumers in a manner that is not kind, caring or respectful. Examples of disrespectful and unkind interactions included having a verbal altercation, swearing and using derogatory language, and using tone of voice and body language that viewed as intimidating.
* Observations of staff providing dental care to a consumer with the door open, in full view of all passing by.

On 14 January 2021 the provider submitted a response to the Assessment Team’s report, inclusive of information provided to the Assessment Team while onsite, that was not reflected in the Site Audit report. The provider indicated a staffing review in November 2020 resulted in: an increase in clinical hours across afternoon and night shifts seven days per week, increasing clinical oversight of care staff; and the introduction of a dedicated head of residential care and head of clinical services to support all of the provider’s residential sites – both roles in the final stages of recruitment at the time of the Site Audit. The provider also indicated the chief operating officer was interviewed by the Assessment Team and provided information relating to the introduction of a full-time onsite manager commencing in January 2021. The provider’s response also included details of site support groups being introduced for consumers in February 2021, including input from pastoral care, a dementia specialist and the clinical governance and quality teams, and indicated the human resources team have provided staff with information on the organisation’s confidential whistle-blower hotline.

I acknowledge the additional information submitted by the provider in relation to the range of improvement initiatives and activities conducted both prior to and promptly after the Site Audit, including advising staff of how they can confidentially report concerns on the whistle-blower hotline in the future, and consider them appropriate.

While I consider the improvements taken and planned to be appropriate I consider at the time of the Site Audit staff interactions with consumers were not consistently kind, caring and respectful.

Based on the evidence detailed above I find Joseph Cooke House Non-compliant with Standard 7 Requirement (3)(b).

### 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-COMPLIANT Organisational 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

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

The Assessment Team found overall, consumers consider the service is well run and they can partner in the delivery of care and services. The following feedback was provided specific to this Standard:

* Consumers and representatives described having input into the proposed refurbishment of parts of the dining area, including making a request for new and more comfortable and practical chairs.
* Consumers stated they were involved in the assessment and planning phase of their care and services and clinical staff involved them in the development of their care plans during admission and at regular intervals.
* Representatives confirmed being involved in annual care planning conferences to discuss care needs.

The Assessment Team were advised of the organisation’s ‘Strategic Journey’ document detailing the Board’s intent for the future, focused on consumer outcomes. Board members are required to attend professional development sessions, and a professional development register is maintained.

During interviews with the Assessment Team management confirmed they encourage consumers and representatives to provide feedback through the complaints and feedback system or during resident/relative meetings and advised that members of the Board visit the service at least once every six months, having lunch and speaking with consumers to receive feedback and suggestions. Management confirmed the Board have recently had input into a newly released inclusion policy and are provided with the service’s clinical indicator data and financial status on a regular basis through relevant committees.

The Assessment Team reviewed evidence of the service having effective risk management systems and practices in place, noting management of high impact and high prevalence risk is not consistently in line with legislative requirements, as has been referred to under Standard 3 Requirement (3)(a) above. Evidence reviewed supports that staff understand and apply antimicrobial stewardship and open disclosure.

In addition to the above the Assessment Team also found the service was unable to demonstrate effective governance systems in relation to information management, workforce governance, regulatory compliance and feedback and complaints. The Assessment Team also found while there is a clinical governance framework in place staff are not consistently following policies and processes specifically in relation to minimising the use of restraint. I agree with the Assessment Team’s recommendations and have found Requirements (3)(c) and (3)(e) within this Standard Non-compliant. The reasons for my findings are detailed under the specific Requirements below.

## 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 aspects of the organisation-wide governance system ineffective and base these findings on the following:

* In relation to information management, while staff have access to policies and procedures in relation to sharing of consumers’ information staff practice is not always effective. Specifically, verbal handover of changes in a consumer’s condition is not always consistent and some staff are not made aware of changed care needs; a consumer’s care plan was not consistent with staff understanding of their needs in relation to transferring; and a consumer had no entries in their progress notes for the month prior to the Site Audit.
* In relation to workforce governance, policies and procedures are not consistently followed by staff at several levels. Five staff reported a ‘culture of bullying’ underpinned by several related staff members working in management and other positions, receiving preferential treatment from each other. The organisation’s code of conduct specifically directs that related individuals are not to work at the same site, except under exceptional circumstances, and only with approval from senior management at the organisational level.
* Also, in relation to workforce governance, information collected indicates staff were not clear of their responsibilities in relation to escalating complaints for follow up; and escalating their observations of unkind, uncaring and disrespectful conduct towards consumers.
* In relation to regulatory compliance, while the service maintains a mandatory reporting register, it does not record incidents that meet the threshold of a compulsory report, where discretion not to report is applied, and does not consistently review behaviour management care plans within 24 hours of incidents when discretion not to report is applied.
* In relation to feedback and complaints, staff were not escalating complaints made to them to senior staff for follow up action, as detailed in Standard 6.

On 14 January 2021 the provider submitted a response to the Assessment Team’s report, inclusive of information about the engagement of three new fulltime corporate appointments to oversee clinical governance and risk management and learning and development; a further five corporate appointments, and the engagement of a dedicated manager for the service. In addition to creating and filling new senior management positions the organisation’s intranet site is being upgraded to facilitate staff access to updated, current guidance materials and mechanisms for reporting incidents and high risk to the executive and Board.

I acknowledge the significant range of action taken and being taken to strengthen governance processes and practices at both the organisation and Board level. While the action taken may have a positive impact on how care and services are delivered, they have not been adequate to enable management to detect the identified gaps in the service’s systems listed above prior to the Site Audit occurring.

For this reason, I find Joseph Cooke House 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.*

### Requirement 8(3)(e) Non-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.*

The Assessment Team found while the service has a governance framework inclusive of policies in relation to open disclosure, antimicrobial stewardship and the use of restrictive practices, staff had an inconsistent and inaccurate understanding of the appropriate use of restraint, did not consistently obtain informed consent for use, and did not appropriately monitor use. These findings were based on the following:

* A consumer was observed with a half table in front of them preventing them from standing when they tried. The half table was seen in place for at least two hours. Two staff reported the consumer displayed wandering behaviour and had previously tried to leave the service; has been physically aggressive towards three other consumers; and is a falls risk. Staff working in the area including a shift supervisor, therapy and care staff did not consider the half table a form of physical restraint.
* One of three ambulant consumers with a low line bed to minimise risk of injury from falls did not have a signed restraint authorisation with associated evidence of discussions of risk.
* All exit doors require a code to be opened, restricting consumers from leaving independently if they have not been given the code. Two consumers were not aware they could not leave independently without a code. Staff at all levels did not consider this a form of environmental restraint.

On 14 January 2021 the provider submitted a response to the Assessment Team’s report. Information submitted in relation to this requirement resembled that relating to other requirements, specifically in relation to increasing the size and scope of the senior management team and engaging a site-specific manager. The provider also advised all staff have been provided with policies and online training relating to minimisation of restraint, with training automatically scheduled by the human resource team and systems.

While I acknowledged the scope and thoroughness of the action taken I consider the provider’s own systems did not detect and prompt remedial action specifically in relation to the understanding and use of restraint prior to the Site Audit occurring.

For this reason, I find Joseph Cooke House Non-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 Requirement (3)(a)**

* Ensure all staff communicate respectfully with consumers.

**Standard 6 Requirement (3)(a)**

* Ensure consumers are encouraged and supported to provide feedback and make complaints.

**Standard 6 Requirement (3)(c)**

* Ensure all levels of staff take action appropriate to their position in response to complaints.

**Standard 7 Requirement (3)(a)**

* Ensure the workforce is planned to enable personal care to be provided in line with consumer preferences and assessed care needs.
* Ensure the workforce is planned to enable consumers to be meaningfully engaged in activities.

**Standard 7 Requirement (3)(b)**

* Ensure staff interactions with consumers are kind, caring and respectful.

**Standard 8 Requirement (3)(c)**

* Ensure governance systems relating to information management, workforce governance, regulatory compliance and feedback and complaints are effective, and monitored for effectiveness.

**Standard 8 Requirement (3)(e)**

* Ensure the governance framework surrounding minimising the use of restraint is understood and practiced.