Joseph Cooke House

Performance Report

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SHELLEY WA 6148  
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**Commission ID:** 7085

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

**Assessment Contact - Site date:** 21 July 2021 to 22 July 2021

**Date of Performance Report:** 21 September 2021

# 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** |  |
| Requirement 1(3)(a) | Compliant |
| **Standard 6 Feedback and complaints** |  |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(c) | Compliant |
| **Standard 7 Human resources** |  |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(b) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(e) | Non-compliant |

# Detailed assessment

This performance report details the Commission’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 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 others
* the provider’s response to the Assessment Contact - Site report received 13 August 2021 and 17 September 2021
* the Performance Report dated 6 May 2021 for the Site Audit conducted 8 December 2020 to 10 December 2020.

# STANDARD 1 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 Assessment Team assessed Requirement (3)(a) in Standard 1 Consumer dignity and choice as part of the Assessment Contact. All other Requirements in this Standard were not assessed and, therefore, an overall rating of the Standard is not provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(a) in Standard 1. This Requirement was found Non-compliant following a Site Audit conducted 8 December 2020 to 10 December 2020. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended Requirement (3)(a) met.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and based on this information, I find Southern Cross Care (WA) Inc, in relation to Joseph Cooke House, Compliant with Requirement (3)(a) in Standard 1 Consumer dignity and choice. I have provided reasons for my finding in the specific Requirement below.

## 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.*

The service was found Non-compliant with Requirement (3)(a) following a Site Audit conducted 8 December 2020 to 10 December 2020 where it was found some staff were not speaking with consumers in a way that was respectful, and some staff were not maintaining consumers’ privacy. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Provided additional training to staff to improve effectiveness of communication with consumers and families.
* Toolbox sessions and mandatory training provided to staff relating to privacy and dignity and promoting equality, diversity and inclusion.
* Added additional care and clinical staff to reinforce appropriate respectful interactions.
* Conducted a Privacy and confidentiality audit to monitor and report on the service’s performance against this Requirement.
* Conducted a Resident family and friend survey to understand the attitudes and level of engagement with families of consumers.
* Twenty-six or 78% of families responded with a score of 9 out of 10 recorded to the questions ‘How caring and respectful do you feel our staff are towards your loved one?’ and ‘Do you feel your loved one is treated with dignity and respect?’.

Information provided to the Assessment Team by consumers, representatives and staff through interviews and documentation sampled demonstrated:

The Assessment Team found overall, consumers and representatives considered that consumers are treated with dignity and respect and staff make them feel respected and valued as individuals. All staff stated staffing levels have improved leading to a positive difference in day-to-day practice of respectful care and services. Representatives felt the needs of consumers were being met and could not be happier with the way staff respond to consumers.

Consumers are informed of their rights, such as their right to have their dignity maintained, be treated with respect and about how the organisation supports the identity, culture and diversity of consumers when delivering care and services on entry. Assessment processes assist to identify consumers’ backgrounds, personal history, diversity and cultural identify. Information gathered through assessment processes is included in each consumer’s care plan to assist staff to deliver care in line with consumers’ needs and preferences.

Staff demonstrated an understanding of the importance of consumers’ culture, diversity and what is important to them. Staff were observed to treat consumers with dignity and respect while attending to their daily care needs.

For the reasons detailed above, I find Southern Cross Care (WA) Inc, in relation to Joseph Cooke House, Compliant with Requirement (3)(a) in Standard 1 Consumer dignity and choice.

# STANDARD 6 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

The Assessment Team assessed Requirements (3)(a) and (3)(c) in Standard 6 Feedback and complaints as part of the Assessment Contact. All other Requirements in this Standard were not assessed and, therefore, an overall rating of the Standard is not provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(a) and (3)(c) in Standard 6. These Requirements were found Non-compliant following a Site Audit conducted 8 December 2020 to 10 December 2020. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended Requirements (3)(a) and (3)(c) met.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and based on this information, I find Southern Cross Care (WA) Inc, in relation to Joseph Cooke House, Compliant with Requirements (3)(a) and (3)(c) in Standard 6 Feedback and complaints. I have provided reasons for my finding in the specific Requirements below.

## 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.*

The service was found Non-compliant with Requirement (3)(a) following a Site Audit conducted 8 December 2020 to 10 December 2020 where it was found there were perceived barriers to making complaints, and complaints had not been lodged for this reason. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* An easy to use new Feedback form for consumers, representatives, staff and others has been implemented.
* A copy of the new Feedback form has been provided to consumers and emailed to consumers’ representative/family.
* Installed additional lodgement boxes.
* Provided information to consumers on avenues to make comments and complaints and resolution processes through meeting forums.
* Conducted a Resident family and friend survey to understand attitudes and level of engagement with families.
* Twenty-six or 78% of families responded and a score of 100% was recorded to the question ‘Do you feel it’s easy to access the Facility manager if required?’, 96% to the question ‘Do you know how to complain or provide feedback – good and bad if you needed to?’ and 100% to the question ‘Would you feel comfortable and safe complaining if you felt you needed to?’.

Information provided to the Assessment Team by consumers, representatives and staff through interviews and documentation sampled demonstrated:

The Assessment Team found overall, consumers considered that they are encouraged and supported to give feedback and make complaints, and appropriate action is taken. All consumers and representatives said they feel safe to raise concerns about consumer care or services and generally feel confident action would be taken.

Information related to feedback processes is provided to consumers. Information is provided on an ongoing basis through meeting forums and is displayed throughout the service, easily accessible to consumers, representatives, staff and others.

Staff indicated the new manager listens to their concerns or concerns raised on behalf of consumers and feedback raised is actioned. Management indicated the volume of feedback has increased since their appointment and their presence within the service entrance, dining area and at meeting forums has encouraged consumers and families to provide feedback.

For the reasons detailed above, I find Southern Cross Care (WA) Inc, in relation to Joseph Cooke House, Compliant with Requirement (3)(a) in Standard 6 Feedback and complaints.

### Requirement 6(3)(c) Compliant

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

The service was found Non-compliant with Requirement (3)(c) following a Site Audit conducted 8 December 2020 to 10 December 2020 where it was found appropriate action was not being taken in relation to complaints. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Appointed a full-time manager who is responsible for overseeing improvements to the complaints process and actioning complaints in line with the organisation’s policy and procedure.
* Transcribed feedback information into Continuous improvement forms recording the acknowledgement, resolution process, open disclosure as appropriate and outcome. Summary of the feedback information has been transferred into an excel spreadsheet for tracking, trending and governance purposes.
* Conducted a Resident family and friend survey to understand attitudes and level of engagement with families.
* Twenty-six or 78% of families responded and a score of 75% was recorded to the question ‘If you made a complaint in the past, was the home responsive to you needs?’.
* Conducted a Feedback and complaints audit which identified staff and consumers were fully aware of the organisation’s procedure for feedback and the pamphlets on entrance to site. The audit also identified consumers needed reminders about the brochures for external complaint avenues which were provided during subsequent meeting forums.
* Provided toolbox training to staff in relation to comments and complaints.

Information provided to the Assessment Team by consumers, representatives and staff through interviews and documentation sampled demonstrated:

Consumers and representatives indicated they are now confident that the organisation acts appropriately and promptly when responding to feedback and complaints.

Management described actions taken in response to complaints received, including providing an acknowledgement letter and communicating with the complainant throughout the resolution process, including actions implemented to prevent similar issues. Staff are aware of open disclosure principles and how they relate to complaints.

Documentation for May and June 2021 demonstrated feedback processes are being implemented in line with the service’s processes. Feedback forms are acknowledged and investigated by management or delegated to others to action. Consumers and representatives are involved in assisting to find solutions where appropriate. Results of the investigation are provided to the complainant and their satisfaction with the outcome is sought. Meeting forum minutes also record actions taken in response to feedback and relevant outcomes.

For the reasons detailed above, I find Southern Cross Care (WA) Inc, in relation to Joseph Cooke House, Compliant with Requirement (3)(c) in Standard 6 Feedback and complaints.

# STANDARD 7 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 Assessment Team assessed Requirements (3)(a) and (3)(b) in Standard 7 Human resources as part of the Assessment Contact. All other Requirements in this Standard were not assessed and, therefore, an overall rating of the Standard is not provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(a) and (3)(b) in Standard 7. These Requirements were found Non-compliant following a Site Audit conducted 8 December 2020 to 10 December 2020. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended Requirements (3)(a) and (3)(b) met.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and based on this information, I find Southern Cross Care (WA) Inc, in relation to Joseph Cooke House, Compliant with Requirements (3)(a) and (3)(b) in Standard 7 Human resources. I have provided reasons for my finding in the specific Requirements below.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) 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 service was found Non-compliant with Requirement (3)(c) following a Site Audit conducted 8 December 2020 to 10 December 2020 where it was found evidence collected from consumers and representatives indicated deficits in provision of personal care, impacting consumers’ comfort, dignity and opportunities to be meaningfully engaged in activities. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Employed a new full-time Facility manager and incorporated additional care staff, lifestyle staff and registered staff shifts into the roster.
* Reviewed all staff duty statements, incorporating staff preferences into the new statements.
* Implemented a new call bell system, which is currently being installed.
* Changes to staffing have been implemented, including:
  + Registered nurse coverage on the weekends.
  + A care staff float shift added to the morning and afternoon shift.
  + A full time Enrolled nurse rostered on to assist with day shifts Monday to Friday.
  + One of the Occupational therapists has increased working days from two to three days a week.
  + Lifestyle shifts have been altered on the weekends with a lifestyle staff member now working six hours on both Saturday and Sunday.

Information provided to the Assessment Team by consumers, representatives and staff through interviews, and documentation sampled demonstrated:

All consumers sampled felt there was enough staff, and that call bells were answered in a reasonable amount of time when they used them. Two representatives stated there appears to be enough care staff on the floor, however, one indicated that there were not enough lifestyle staff available to engage consumers in meaningful activities on the weekends.

A roster is maintained and there are processes to manage staff shortfalls. Where agency staff are utilised, consumers are advised in advance to enable them to have a choice to alter the time activities of daily living are completed and to allow these tasks to be completed by a permanent staff member in line with their preferences. Care staff stated staffing levels had improved, and indicated the addition of the float shift in the mornings had made a positive difference.

For the reasons detailed above, I find Southern Cross Care (WA) Inc, in relation to Joseph Cooke House, Compliant with Requirement (3)(a) in Standard 7 Human resources.

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

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

The service was found Non-compliant with Requirement (3)(c) following a Site Audit conducted 8 December 2020 to 10 December 2020 where it was found staff interactions with consumers were not consistently kind, caring and respectful. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Provided toolbox sessions and/or mandatory training to staff in relation to privacy, call bell response, person-centred care, culture and diversity and consumer dignity and choice.
* Added promoting equality, diversity and inclusion training to the organisation’s mandatory training program.
* Held discussions with staff at meeting forums and through the performance appraisal processes relating to the importance of kind, caring and respectful interactions with each consumer’s identity, culture and diversity.

Information provided to the Assessment Team by consumers, representatives and staff through interviews, observations and documentation sampled demonstrated:

Consumers and representatives indicated staff are kind, caring and gentle when providing care to, and interacting with, consumers. One representative stated they were more than happy with the care and services provided by staff, indicating staff go out of their way to make the consumer feel comfortable.

Throughout the Assessment Contact, staff were observed interacting with consumers in a kind, caring and patient manner. Management stated they continue to monitor staff practice through feedback from consumers, representatives and staff and directly through observations.

For the reasons detailed above, I find Southern Cross Care (WA) Inc, in relation to Joseph Cooke House, Compliant with Requirement (3)(b) in Standard 7 Human resources.

# 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

The Quality Standard is assessed as Non-compliant as one of the two specific Requirements assessed has been found Non-compliant.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(c) and (3)(e) in Standard 8 Organisational governance. These Requirements were found Non-compliant following a Site Audit conducted 8 December 2020 to 10 December 2020. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Site Audit and have recommended Requirement (3)(c) met. However, the Assessment Team were not satisfied the actions implemented sufficiently addressed the deficits identified in Requirement (3)(e) and have recommended this Requirement not met. In relation to this Requirement, the Assessment Team were not satisfied the service demonstrated:

* Compliance with policies, procedures or legislative requirements relating to use of psychotropic medications.

I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the provider’s response and based on this information, I find Southern Cross Care (WA) Inc, in relation to Joseph Cooke House, Non-compliant with Requirement (3)(e) and Compliant with Requirement (3)(c) in Standard 8 Organisational governance. I have provided reasons for my findings in the specific Requirements below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(c) 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 service was found Non-compliant with Requirement (3)(c) following a Site Audit conducted 8 December 2020 to 10 December 2020 where it was found the organisation’s governance systems relating to workforce governance, regulatory compliance and feedback and complaints were not adequate to enable identified gaps in the service’s systems to be identified. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Taken steps to address workforce governance issues, including engagement of an external investigator to investigate allegations relating to staffing issues, including allegations of nepotism. The investigation is ongoing.
* Implemented a new Code of conduct policy.
* Reviewed the role of the Care supervisor to ensure staff understand and are aware of their obligations and responsibilities in line with duty statements.
* An Incident Management System is in place and used to record relevant incidents.
* A Serious Incident Response Scheme register is in place to record priority one incidents.
* Improved the complaints management system which is underpinned by policies and procedures to guide staff in the open disclosure process.

Information provided to the Assessment Team by staff through interviews and documentation sampled demonstrated:

The organisation demonstrated effective organisation wide governance systems in relation to information management, continuous improvement, financial governance, workforce governance, regulatory compliance and feedback and complaints.

Policies and procedures are accessible to staff to guide practice, including in relation to management, storage and destruction of confidential and sensitive information.

A Plan for continuous improvement is maintained and updated on a monthly basis. Improvement initiatives are identified through audits, feedback and complaints, surveys and meeting forums. There are processes to track progress of initiatives and whether they have been successful or require further review.

Management have access to a capital expenditure budget to purchase urgent items and equipment. A Finance team manages and monitors the service’s budget expenditures and monthly budget reports are reported to and discussed at Board meetings.

For the reasons detailed above, I find Southern Cross Care (WA) Inc, in relation to Joseph Cooke House, Compliant with Requirement (3)(c) in Standard 8 Organisational governance.

### 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 were not satisfied the service demonstrated compliance with policies, procedures and legislative requirements in relation to use of psychotropic medications for the purpose of restraint for three consumers. The Assessment Team’s report provided the following evidence relevant to my finding:

Consumer A

* A General practitioner (GP) progress note on the second day of the Assessment Contact states, ‘patient has BPSD (behavioural and psychological symptoms of dementia) and anxiety - this is controlled with Mirtazapine and Oxazepam’.
  + The psychotropic medications register indicated the consumer was prescribed regular Quetiapine and Mirtazapine and ‘as required’ Oxazepam prior to this notation.
* Documentation sampled, and clinical staff confirmed, Oxazepam was prescribed for sedation purposes. Documentation also confirmed Oxazepam has not been administered since it was prescribed.
* There was no evidence the service had completed a consent form/restraint authorisation form. This was not identified in the restraint authorisation forms file.
* The representative did not recall being asked to complete a consent form in relation to the use of, or potential for the use of restrictive practices.

Consumer B

* The consumer’s diagnosis was updated on the second day of the Assessment Contact to include Bipolar disorder. The GP’s notation indicates, ‘Reviewed psychotropic medications, patient has anxiety with Bipolar disorder and is on Risperidone for this’.
  + The consumer’s current prescribed medications are regular Mirtazapine for anxiety/depression, Oxazepam for sleep/anxiety and Risperidone for restlessness at night (GP’s notes 26 August 2020), prior to 22 July 2021.
  + Management did not provide information as to why Risperidone (supporting diagnosis) was prescribed prior to 22 July 2021.
* The sleep assessment dated August 2019 recorded restlessness on two occasions on two separate days; the summary recorded ‘resident sleeps well at night, nil issue’. A sleep assessment for August 2020 showed no restlessness was recorded and documented. The current care plan (sleep and rest domain) indicated: ‘rising time routine not specified, bedtime routine prefers to go to bed when (they) wants, two pillows on bed to promote effective sleep, lights off except side light’.
* A consent/restraint authorisation form was not provided for Consumer B and was not contained in the restraint assessment and authorisation file. Evidence the consumer’s representative was consulted to provide consent for the use , or potential use of restrictive practices was not provided.
* The representative indicated they were not aware the consumer was still being administered Risperidone. They advised that following a hospital admission in late 2019, they expressed concerns with the consumer being on this medication and was of the view that Risperidone had been reduced and ceased since then. The representative stated they did not provide consent and did not fill out a consent form.
  + The representative advised they were contacted by the service to discuss the consumer’s medication, specifically the prescribed Risperidone and new diagnosis of Bipolar. They advised they were never told the consumer had a diagnosis of Bipolar prior to 22 July 2021. The representative advised they attend the service almost every day.

Consumer C

* The consumer is currently prescribed as required Temazepam, with staff stating this is for ‘sleep and restlessness’. A GP’s notation states Temazepam has been prescribed ‘for sedation’.
* Temazepam was administered 18 times in a 23 day period from June to July 2021 with progress notes indicating that on all occasions this was provided to assist the consumer to go to sleep and assist with restlessness. Effectiveness was documented each time the medication was provided.
  + Alternative strategies were documented on some occasions prior to Temazepam being provided.
* The representative stated they had not filled out a consent form for the use of Temazepam but had been advised the consumer was prescribed this medication.
  + Clinical staff stated the family provided verbal consent for the use of Temazepam.
  + No formal consent form for the use of Temazepam had been completed, noting risks of its use discussed with the consumer and their representative.
  + The care plan contained no details surrounding assessments or consent in relation to the use of restraint, in line with the service’s restraint policy.
* On day two of the Assessment Contact, clinical staff provided the Assessment Team with a restraint authorisation form for the consumer and stated they had organised a meeting with the representative to discuss the risks associated with the use of this type of restraint.

The provider’s response provided further clarification relating to the consumers identified in the Assessment Team’s report and have expressed a commitment to address the gaps identified by the Assessment Team. The provider’s response included, but was not limited to:

In relation to Consumer A

* Review of the consumer’s file confirms a restraint assessment and authorisation and includes the signature of the family member. The consumer’s representative has also signed consent for use of psychotropic medication.
  + Evidence of the documentation was not included in the provider’s response.
* Progress notes for March 2021 confirm the family member was involved in a case conference which included discussion relating to the consumer’s medication and provision of information relating to restrictive practices.
  + Progress notes included as part of the provider’s response notes ‘Reassured that (consumer) has been reviewed by Doctors. Medication reviewed and (representatives) are kept informed’. No further information is provided in relation to psychotropic medication use.

In relation to Consumer B

* Records confirm the consumer’s family member is aware of the use of psychotropic medication. Progress notes for February, April, July and August 2021 all include medication conversations with the consumer’s family, either in person, on the phone or as part of a case conference.
  + Only progress notes for June 2021 were included as part of the provider’s response. The case conference notation indicates ‘pamphlet given on restraints, psychotropic medication. Explained psychotropic medications are reviewed every three months by the GP and when needed’.
* GP progress notes for February 2021 detail use of Risperidone and a phone call to the consumer’s family.
  + Evidence of the notation was not included as part of the provider’s response.
* A review of the consumer’s clinical file notes restraint assessment and authorisation documents were completed as required.
  + A copy of the documentation was not included in the provider’s response.
* The consumer’s family member has confirmed with both the GP and the Clinical nurse their consent for the use of and/or changes to medication in both medical and General practitioner notes, including information that confirms the family member’s knowledge of the prescribed Risperidone.
  + Evidence to support this statement was not included in the provider’s response.

In relation to Consumer C

* Review of progress notes for February 2021 confirms the representative has been communicated with and has given the service confirmation for the use of psychotropic medication.
  + Progress notes provided indicate the consumer was ‘seen by the doctor, medication changes, send to pharmacy, sister informed’. No further information is documented.
* Progress notes for May and June 2021 confirm the representative was contacted and communicated on changes to psychotropic medication needs.
  + Progress notes for May 2021 indicated an increase in dose of medication and notification to next of kin. No further information is documented.
  + Progress notes for June 2021 included in the response indicate medications for sleep were reviewed and reduced and next of kin informed. No further information is documented.
  + Progress notes for June 2021 indicate as required ‘extra Temazepam’, next of kin notified’. No further information is documented.
* The family has provided consent for the use of psychotropic medication and this is recorded in the progress notes. The progress note is dated August 2021.

The service was found Non-compliant with Requirement (3)(e) following a Site Audit conducted 8 December 2020 to 10 December 2020 where it was found the provider’s own systems did not detect and prompt remedial action specifically in relation to the understanding and use of restraint. The Assessment Team’s report did not provide evidence of actions taken to address deficiencies identified at the Site Audit.

I acknowledge the provider’s response and the additional information provided. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Assessment Contact, while the organisation has a clinical governance framework, this framework has not been effectively implemented in line with policy, procedures or legislative requirements in relation to restrictive practices.

I have considered that for Consumers A and B, while psychotropic medications were prescribed and being administered, diagnoses to support use of some of these medications were only documented by the GP during the Assessment Contact. Consumer B’s representative indicated they were contacted by the service during the Assessment Contact to discuss use of Risperidone and the new diagnosis of Bipolar. Additionally, consent/restraint authorisation forms for both consumers were not included in the service’s restraint assessment and authorisation file.

For Consumer B, while a GP notation in August 2020 indicates Risperidone was prescribed for restlessness at night, sleep assessments for August 2019, August 2020 and the most current care plan do not identify any issues with sleep or restlessness. Additionally, the representative indicated they were not aware the consumer was being administered this medication. The provider asserts the family member was aware of the use of psychotropic medication. However, progress notes provided do not indicate informed consent was obtained or discussions relating to the specific medication, the risks associated with the medication and strategies to be implemented to mitigate the risks were undertaken.

In relation to Consumer C, GP notes indicate Temazepam has been prescribed for ‘sedation’. I acknowledge the consumer’s representative was aware of the use of the medication. However, discussions relating to use of the medication were only undertaken subsequent to the Assessment Contact. Additionally, the progress note entry does not indicate risks related to use of the specific medication were discussed and strategies to mitigate risks associated with the medication or to minimise use were undertaken. Additionally, while the provider asserts the consumer’s representatives were notified on an ongoing basis of changes to psychotropic medications, progress notes provided only indicate the representative was ‘informed’ and do not provide any further detail as to what was discussed in relation to use, risks, strategies or ongoing monitoring of the medication.

For the reasons detailed above, I find Southern Cross Care (WA) Inc, in relation to Joseph Cooke House, Non-compliant with Requirement (3)(e) in Standard 8 Organisational governance.

# 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 8 Requirement (3)(e)**

* Ensure policies, procedures and legislative requirements in relation to minimising use of restrictive practices are effectively communicated and understood by staff.
* Monitor staff compliance with legislative requirements and the service’s policies, procedures and guidelines in relation to restrictive practices.