Performance

Report

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| Name of service: | James Watson Centre |
| Service address: | 7 Lime Street EAST PERTH WA 6004 |
| Commission ID: | 7199 |
| Approved provider: | St Bartholomew's House Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 11 May 2023 |
| Performance report date: | 22 June 2023 |

This performance report **is published** on the Aged Care Quality and Safety Commission’s (the **Commission**) website under the Aged Care Quality and Safety Commission Rules 2018.

**This performance report**

This performance report for James Watson Centre (**the service**) has been prepared by M Roach, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-1).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

# Material relied on

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

* the assessment team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the performance report, dated 26 October 2022, following a site audit conducted between 30 August 2022 and 2 September 2022
* a Plan for Continuous Improvement submitted by the provider on 21 November 2022 following the site audit conducted between 30 August 2022 and 2 September 2022.

# Assessment summary

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| Standard 2 Ongoing assessment and planning with consumers | Not applicable as not all requirements have been assessed |
| **Standard 3** Personal care and clinical care | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all requirements have been assessed** |

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

# Areas for improvement

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

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |

Findings

The service was found Non-compliant in relation to Requirement 2(3)(a) following a site audit conducted between 30 August 2022 to 2 September 2022. The service did not demonstrate that consumer assessments, specifically in relation to lifestyle, diabetes management and risk, were conducted consistently or in a timely manner.

On 11 May 2023, the assessment team found the service had implemented improvements to address the deficits identified previously, including updating all consumers care records and delivering education to registered staff.

Consumers and representatives said they were satisfied with the care and support consumers receive from staff and described how they are involved in the planning and implementation of strategies to reduce risk for the consumer. Management stated they have undertaken a comprehensive review of electronic assessments and implemented a robust monitoring process to ensure assessments are completed in accordance with the organisation’s policy. Staff described there is a suite of risk assessment tools available to them. Staff demonstrated knowledge of individual consumers’ risks and mitigation strategies to inform delivery of care. The assessment team sampled care planning documentation which mostly demonstrated that risks are considered and assessed, using appropriate assessment tools. Consumer files reviewed contained a risk care plan and outcomes of risk assessments.

The assessment team identified 2 consumer’s care planning documentation did not provide guidance to staff in relation to appropriate strategies. However, I place more weight on:

* staff’s understanding and knowledge regarding the strategies they have implemented to reduce the risk for the 2 consumers
* management’s response that they would review the consumers, engage with their representatives, and document a formal risk management plan
* the provider’s ability to effectively implement continuous improvement actions, as demonstrated through their positive response to deficiencies identified at the previous site audit.

Based on the available evidence, I find Requirement 2(3)(a) Compliant.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

The service was found Non-compliant in relation to Requirements 3(3)(a) and 3(3)(b) following a site audit conducted between 30 August 2022 to 2 September 2022. The service did not demonstrate that:

* clinical care was delivered in line with best practice or tailored to consumers’ needs, in relation to wound care
* effective management of high impact high prevalence risks including of falls where staff did not follow policy and procedures in relation to the monitoring of pain, injury, and neurological observations.

On 11 May 2023, the assessment team found the service had implemented improvements to address the deficits identified previously, including:

* wound toolbox training has been developed and implemented wound toolbox training, and delivered additional wound management training to staff
* reviewed mobility and falls management procedure and educated staff on falls management.

Consumers and representatives said they are satisfied with the clinical care they receive and described how consumer’s care is tailored to their specific needs. Staff said they use validated risk assessment tools to inform care planning. Staff demonstrated their knowledge on when to escalate to wound specialist services for assistance, as well as to other specialist services, to ensure consumers receive best practice care. Care planning documentation detailed individualised care that is safe, effective and tailored to the needs of the consumer. The assessment team found the service is effectively managing consumers’ high impact high prevalence risks. Sampled consumers’ files demonstrated:

* wound care is delivered to consumers in line with their assessed needs; consumers with wounds are assessed, monitored and managed for pain including been referred to wound specialists where appropriate
* consumers who experienced unwitnessed fall were monitored for pain, neurological observations were attended and they were reviewed as required by an allied health professional.

Based on the available evidence, I find Requirements 3(3)(a) 3(3)(b) Compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Compliant |
| Requirement 8(3)(d) | Effective risk management systems and practices, including but not limited to the following:   1. managing high impact or high prevalence risks associated with the care of consumers; 2. identifying and responding to abuse and neglect of consumers; 3. supporting consumers to live the best life they can 4. managing and preventing incidents, including the use of an incident management system. | Compliant |
| Requirement 8(3)(e) | 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. | Compliant |

Findings

The service was found Non-compliant in relation to Requirements 8(3)(c), 8(3)(d) and 8(3)(e) following a site audit conducted between 30 August 2022 to 2 September 2022. The service did not demonstrate that:

* effective organisational governance systems in relation to regulatory compliance and information systems
* effective risk management systems in relation to the management of high impact and high prevalence risks or the management and prevention of incidents
* effective clinical governance in relation to minimising the use of restraint.

On 11 May 2023, the assessment team found the service had undertaken several actions and implemented improvements to address the deficits identified at the previous site audit.

Policies and procedures have been reviewed and updated to reflect current regulatory compliance obligations including restrictive practices. The Assessment Team confirmed that policies and procedures ensure appropriate risk management, accountability, and monitoring is in place to ensure effective management of high impact and high prevalence risks. For example, an antimicrobial stewardship policy and procedure is in place, and staff interviewed gave practical examples of how they apply infection prevention and control measures.

The service has developed and implemented electronic tools to ensure safe and effective care is delivered to consumers. An assessment tracker tool has been developed to ensure consumer assessments and reviews are conducted in appropriate timeframes. The service’s electronic management system has been updated to include behaviour support plans for each consumer who requires, or may require, restrictive practices. The plans include guidance for staff to support consumers.

The Assessment Team verified the service has made improvements in governance processes and procedures. Relevant meeting minutes and documentation, including the Chief Operating Officer’s executive summary, demonstrated that incidents are effectively managed, evaluated, and communicated to the board, management, and staff.

Training has been delivered to all staff in relation to changes in policies and procedures, including falls management, diabetes management, and incident management.

Based on the available evidence, I find Requirements 8(3)(c), 8(3)(d) and 8(3)(e) Compliant.

1. The preparation of the performance report is in accordance with section 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)