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

**Assessment Contact - Site date:** 30 March 2022

**Date of Performance Report:** 26 April 2022

# Performance report prepared by

Michelle Glenn, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

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

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 8 Organisational governance** |  |
| Requirement 8(3)(e) | Compliant |

# Detailed assessment

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

The 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 management
* the provider did not respond to the Assessment Contact - Site report
* the Performance Report dated 21 September 2021 for the Assessment Contact undertaken from 21 July 2021 to 22 July 2021.

# STANDARD 8 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 Assessment Team assessed Requirement (3)(e) in Standard 8 Organisational governance as part of the Assessment Contact. All other Requirements in this Standard were not assessed, therefore, an overall rating of the Standard is not provided.

Requirement (3)(e) in Standard 8 was found Non-compliant following an Assessment Contact undertaken from 21 July 2021 to 22 July 2021 where it was found that while the organisation had a clinical governance framework, this framework had not been effectively implemented in line with policy, procedures or legislative requirements in relation to restrictive practices. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Assessment Contact and have recommended Requirement (3)(e) met.

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

**Assessment of Standard 8 Requirements**

**Requirement 8(3)(e) Compliant**

*Where clinical care is provided—a clinical governance framework, including but not limited to the following:*

1. *antimicrobial stewardship;*
2. *minimising the use of restraint;*
3. *open disclosure.*

The service was found Non-compliant with Requirement (3)(e) following an Assessment Contact undertaken from 21 July 2021 to 22 July 2021 where it was found that while the organisation had a clinical governance framework, this framework had not been effectively implemented in line with policy, procedures or legislative requirements in relation to restrictive practices. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed and updated Behaviour support plans.
* Completed restrictive practice consent forms for consumers receiving psychotropic medications.
* Reviewed and updated the Restrictive practice register noting consumers receiving psychotropic medications.
* Provided training to staff in relation to antimicrobial stewardship and restrictive practices.

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

* A suite of policies and procedure documents are available, including in relation to antimicrobial stewardship, restraint and restrictive practices and open disclosure, and training has been provided to staff, specific to their roles, in relation to these areas.

Antimicrobial stewardship

* The organisation’s Antimicrobial stewardship policy is in its infancy and still in draft. The policy outlines the effectiveness of reviewing appropriate prescribing of antimicrobials to prevent and manage infections and to improve consumer safety and quality of care.
* Consumer medications are reviewed every 12 weeks. The service works closely with General practitioners and has strategies in place to reduce use and prescription of antibiotics.
* Clinical update meetings occur regularly where medication breakdowns are provided, analysed and compared with previous months for efficacy. All restraints and psychotropic medications are reviewed three monthly and the forum provides staff with updates on infection control and COVID-19 related matters.
* Registered staff review the report on antibiotics and usage to determine clinical indicators and reduce the incidence of infection.

Minimising use of restraint

* Effective management of restrictive practices was demonstrated, including use of Behaviour support plans for consumers requiring psychotropic medications and consent forms completed by the consumer’s legal representative with supporting diagnosis.
* However, the Assessment Team noted one consumer’s diagnosis did not reflect the medication prescribed by the General practitioner. While consent from the consumer’s representative had been obtained and a Behaviour support plan was in place, staff did not follow policy and procedure by implementing strategies within the Behaviour support plan or by noting the efficacy of strategies implemented.
* I find that this information is more aligned with Standard 3 Personal care and clinical care Requirement (3)(a), that is provision of care, which was not assessed as part of the Assessment Contact. The evidence does not indicate a systemic issue with the organisation’s clinical governance framework.
* Management and staff sampled confirmed they have been provided information, education and training, relevant to their role, including in relation to use of restraint, behaviour management, alternatives to use of restraint, correct application of restraint, and assessment, review, monitoring and reporting requirements.

Open disclosure

* Staff directly involved with consumers’ personal and clinical care understand the principles of open disclosure. Staff are provided education consistent with incident management identification and protocols. An increased awareness in the process ensures staff do not pre-empt the cause of an adverse event prior to the conclusion of an investigation.
* Complaints documentation sampled demonstrated open disclosure incorporates an apology, where appropriate, with an explanation of the facts and an open opportunity for the consumer to be heard and listened to, in line with the adverse event. Staff undertake a commitment to effectively detail what happened and an explanation of the steps the organisation has taken to reduce the risk of the event happening again.

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

# 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, however, required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Other relevant matters

As part of the Assessment Contact, the Assessment Team conducted a review of the service’s communication and complaints handling processes. A full assessment of Standard 6 Feedback and complaints Requirement (3)(d) was not completed. The Assessment Team noted:

* Consumers and representatives sampled provided positive feedback in relation to how complaints are reviewed and acceptable measures put in place to address concerns raised.
* Management demonstrated how information from complaints and feedback is used to inform continuous improvement.
* In response to a clinical audit conducted 25 November 2021, the service implemented a range of improvements, including, but not limited to, creating a Psychotropic medication register, review and update of all Behaviour support plans, updating the Restrictive practices register and updating consent forms.