Performance

Report

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| Name: | Pam Corker House |
| Commission ID: | 7125 |
| Address: | 29 Eastcott Street, WAROONA, Western Australia, 6215 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 17 October 2023 |
| Performance report date: | 9 November 2023 |
| Service included in this assessment: | Provider: 938 Quambie Park Waroona (Inc)  Service: 4653 Pam Corker House |

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 Pam Corker House (**the service**) has been prepared by M Dubovinsky, 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.

The report also specifies any areas in which improvements must be made to ensure the Quality Standards are complied with.

# Material relied on

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

* the assessment team’s report for the assessment contact (performance assessment) – site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others; and
* the provider’s response to the assessment team’s report received 31 October 2023, including a corrective action plan dated 30 October 2023.

# Assessment summary

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| Standard 8 Organisational governance | Not Compliant |

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

# 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)(c)

* Review organisational governance systems and processes, including in relation to regulatory compliance and workforce governance. Consider implementing processes to ensure the performance of the workforce is regularly monitored and legislative responsibilities are followed, including in relation to national police certificates.
* Review organisational governance systems and processes to ensure mandatory training is monitored to support effective workforce governance.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| 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. | Not 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

Requirement (3)(b)

Requirement (3)(b) was found non-compliant following a site audit undertaken in June 2023 as the organisation’s governing body did not ensure effective restrictive practice use or identify and was aware of deficits in care planning processes, clinical assessments and review of care and services. The assessment team’s report provided evidence of actions taken to address deficits identified, including, but not limited to;

* The Board supported further training and upskilling of nursing staff.
* Increased reporting to the Board in relation to clinical care, including the psychotropic register.

During the Assessment Contact undertaken on 17 October 2023, the assessment team recommended Requirement (3)(b) met as they found the organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. Consumers and representatives confirmed the service is well run. A range of reports are provided to the governing body which are used to initiate improvements, and a range of improvements have been supported by the governing body. Management demonstrated the governing body is monitoring operations consistent with the business strategy, and the values and strategic direction are being promoted and communicated throughout the service.

Based on the information summarised above, I find the service compliant with requirement (3)(b).

Requirement (3)(c)

Requirement (3)(c) was found non-compliant following a site audit in June 2023 as effective organisation wide governance systems in relation to continuous improvement, workforce governance and regulatory compliance were not demonstrated. The assessment team’s report provided evidence of actions taken to address deficits identified, including, but not limited to;

* Implemented a process to report on continuous improvements to the continuous improvement committee.
* Implemented a new electronic human resources system to manage the monitoring of police checks, performance reviews and completion of training.

However, whilst improvements were implemented, the assessment team recommended requirement (3)(c) not met as the service was not able to demonstrate effective organisation wide governance systems in relation to workforce governance and regulatory compliance. In relation to work force governance, whilst management stated they monitor performance via individual conversations, management were unable to demonstrate this was occurring. In addition, workforce governance processes were not effective in monitoring completion of mandatory training and identifying staff who were working with expired national police certificates.

In relation to regulatory compliance, whilst the service demonstrated compliance with legislative responsibilities and restrictive practices, compliance with legislative responsibilities in relation to staff having a national police certificate were not demonstrated. A number of staff at the service and organisation were identified as not having current national police certificate, despite the service implementing a new electronic human resource system to manage the monitoring of national police certificates.

The provider acknowledged the deficits identified and has submitted a corrective action plan. This includes implementing a human resource system to monitor credentials, review of the rostering system and implementing processes to monitor completion of mandatory training and review of staff performance.

Based on the evidenced summarised above, I find effective organisation wide governance systems, specifically relating to workforce governance and regulatory compliance were not demonstrated. Whilst I acknowledge the provider's willingness to make improvements and implementation of a range of improvements to address deficits identified, the provider did not provide me with sufficient evidence to demonstrate all improvement actions are embedded and effective. I have considered the service demonstrated other aspects of the requirement being effective organisation wide governance systems in relation to continuous improvement, financial governance, feedback and complaints and information management. However, in coming to my finding, I have placed weight on the potential risk to consumers as a result of the workforce not having a current national police certificate nor effective processes to ensure relevant rereview of performance undertaken to ensure the delivery of safe and effective care and services.

Based on the information summarised above, I find the service non-compliant with requirement (3)(c).

Requirement (3)(e)

Requirement (3)(e) was found non-compliant following a site audit undertaken in June 2023 as the clinical governance framework did not support effective monitoring, reporting and use of restrictive practices for consumers sampled. The assessment team’s report provided evidence of actions taken to address deficits identified, including, but not limited to;

* Training provided to staff on restrictive practices.
* Review of governance structures and reporting to support clinical care.
* Review of behaviour management plans.

During the assessment contact undertaken on 17 October 2023, the assessment team recommended requirement (3)(e) met as effective organisational clinical governance, including in relation to antimicrobial stewardship, minimising use of restraint and open disclosure were demonstrated. Monthly reports demonstrated clinical data is monitored and reported on, including in relation to antibiotic usage and restrictive practices. Policies and procedures guide staff practice, including in relation to antimicrobial stewardship, minimising use of restraint and open disclosure. Processes support the reduction of restrictive practices, including mechanical and chemical restraints. Representatives confirmed open disclosure practices, including provision of open disclosure and corrective actions undertaken in response to incidents.

Based on the information summarised above, I find the service compliant with requirement (3)(e).

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)