Performance

Report

**1800 951 822**

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| Name of service: | St Josephs Nursing Home |
| Service address: | 20 Dalley Street LISMORE NSW 2480 |
| Commission ID: | 1494 |
| Approved provider: | The Trustees of the Roman Catholic Church for the Diocese of Lismore |
| Activity type: | Assessment Contact - Site |
| Activity date: | 16 May 2023 |
| Performance report date: | 13 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 St Josephs Nursing Home (**the service**) has been prepared by T Wurf, 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 - 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 provider’s response to the assessment team’s report received 23 May 2023, and
* the Performance Report dated 11 July 2022 for the site audit undertaken from 7 to 9 June 2022, that found 3 requirements of the Quality Standards were non-compliant – 3(3)(b), 8(3)(c) and 8(3)(e).

# Assessment summary

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| 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 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |

Findings

The Performance Report dated 11 July 2022 found the service non-compliant with requirement 3(3)(b) following a site audit undertaken from 7 to 9 June 2022. Deficiencies related to the service’s management of high impact, high prevalence risks associated with the care of some consumers, specifically in relation to falls and pain.

The Assessment Contact – Site Report identified evidence of improvement actions taken by the service, including:

* New policies, clinical pathways, and forms in relation to falls and pain management.
* Education and training for clinical staff on falls management and pain management.

Consumers and representatives interviewed by the Assessment Team were satisfied with the care consumers receive and how the service manages risks, including those associated with falls and pain. For example:

* A consumer’s representative said they were contacted by the service following the consumer’s fall. They were pleased with the way the service managed the fall and mitigated the risk of further falls.
* A consumer described their pain management strategies, including daily pain medication and regular massages by a physiotherapist.
* A consumer’s representative said the service was managing the consumer’s pain well and staff explained what medications they were receiving for pain relief.
* A consumer’s representative expressed they were satisfied with the service’s management of pain after being discharged from hospital.

Management, clinical and care staff understood the service’s policies and clinical pathways to manage falls and pain. They understood individual consumers’ care needs and strategies to manage their risk of falls and pain.

The Assessment Team reviewed care documentation for a sample of consumers who had fallen or who had experienced pain and found:

* Consumers who had experienced a fall were managed in line with the service’s policies and clinical pathways. Consumers were assessed, monitored and reviewed, and falls prevention strategies were put in place.
* Consumers who experienced pain had pain assessment and management plans completed and pain management strategies were in place, such as massage and medication.
* Post Hospitalisation Forms were completed for consumers who had returned to the service from hospital that recorded a pain assessment.

Based on the findings in the Assessment Contact – Site Report and the approved provider’s response that provided some additional supporting information, I am satisfied the service has improved its management of risks associated with falls and pain, and has effectively managed consumers who have had a fall, experienced pain, or who have returned from hospital. Therefore, it is my decision that this requirement is 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)(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 8(3)(c)*

The Performance Report dated 11 July 2022 found the service non-compliant with requirement 8(3)(c) following a site audit undertaken from 7 to 9 June 2022. The deficiency related to sub-requirement 8(3)(c)(v), regulatory compliance. Whilst the organisation had governance mechanisms in place to monitor compliance with legislative and regulatory standards, the service was not consistently identifying and reporting incidents that were required to be reported under the Serious Incident Response Scheme (SIRS).

The Assessment Contact – Site Report identified evidence of remedial actions taken to improve its management and reporting of SIRS. For example:

* Reviewed all incidents since 1 January 2021 and ensured incidents that required reporting under SIRS were accurately recorded and actioned.
* Education and training for staff on SIRS and their roles in identification and reporting.
  + Staff and management had completed the training and understood their role in incident management and SIRS reporting.
* Established organisational governance processes to monitor incidents and SIRS reporting:
  + Daily and weekly monitoring of incidents and SIRS reporting by management.
  + Monthly Resident Care Committee meeting which includes a Board member and senior management, where discussion is based on the service’s performance and responsibilities, including SIRS reporting.
  + Monthly Board of Directors meeting where a Resident Care Committee paper and regulatory compliance are discussed.

The Assessment Team reviewed the service’s record of incidents and found incidents recorded between 1 April 2023 to 16 May 2023 were correctly reported, categorised and actioned, consistent with regulatory requirements. Recent SIRS incidents were reported within legislative timeframes and consumers’ Behaviour Support Plans were reviewed at the time of the incident.

Based on the findings in the Assessment Contact – Site Report, I am satisfied the service has effective governance systems and has remediated deficiencies in relation to its regulatory compliance with SIRS. Therefore, it is my decision that this requirement is compliant.

*Requirement 8(3)(e)*

The Performance Report dated 11 July 2022 found the service non-compliant with requirement 8(3)(e) following a site audit undertaken from 7 to 9 June 2022 because the organisation’s clinical governance framework and clinical oversight were ineffective, including in relation to falls management and pain management.

The Assessment Contact – Site Report identified evidence that the service has taken actions to improve its clinical governance and remediated deficiencies in the areas of falls management and pain management. For example:

* Implemented a Falls Prevention and Management Policy and Procedure and clinical pathways. Staff understood these relevant to their role.
* Education for clinical and care staff on pain and falls management.
* Implemented weekly incident management meetings that:
  + Reviews weekly incidents, including those related to falls and pain.
  + Monitors falls pathways have been completed according to the service’s policy and procedures.
  + Checks pain management plans are in place for consumers who experience pain.
* Clinical data, including falls and pain, are reported and discussed monthly at Resident Care Committee and Board meetings.

Based on the findings in the Assessment Contact – Site Report under this requirement and requirement 3(3()b), I am satisfied the service has a clinical governance framework and clinical oversight that are effective in the areas of falls management and pain management. Therefore, it is my decision that this requirement is compliant.

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