Performance

Report

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| Name: | Mornington Bay Care Community |
| Commission ID: | 3646 |
| Address: | 185 Racecourse Road, MOUNT MARTHA, Victoria, 3934 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 14 February 2024 |
| Performance report date: | 7 March 2024 |
| Service included in this assessment: | Provider: 3061 DPG Services Pty Ltd  Service: 5418 Mornington Bay Care Community |

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 Mornington Bay Care Community (**the service**) has been prepared by N Eastwood, 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.

# 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 7** Human resources | **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

Consumers and representatives were satisfied with the care consumers receive. This included how risks to consumer health and wellbeing were considered and managed through assessment and care planning, particularly in relation to skin integrity and wound management.

Care files and documentation demonstrated current and appropriate risk assessments including identification of a range of risks, skin integrity, falls, restrictive practice and complex care needs. Where risks were identified individual strategies to minimise risks were documented in consumer care plans. A review of files demonstrated input from allied health professionals where further wound assessment and management were required.

Staff described the rotational resident of the day process at which time they complete a ‘head to toe’ assessment for consumers. The Assessment Team noted one instance of delayed reporting of compromised skin integrity, in response to this feedback management issued a memorandum regarding staff responsibilities related to consumers skin checks and escalation of skin breakdown.

The service has policies and procedures in place to guide staff in clinical assessment and guidelines on identifying risk and risk management. A review of training records also demonstrated evidence of staff training related to skin breakdown with future training also planned for completion.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with requirement 2(3)(a).

# 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 |

Findings

The service demonstrated it provides safe and effective personal and clinical care, particularly regarding skin integrity, wound management, pain management and restrictive practice.

Staff described the process for identifying and reporting deterioration of skin integrity including escalation to medical officers and or a wound specialist. There was evidence of wound monitoring and supporting documentation in progress notes and wound charts. Staff advised they have been provided with training on skin breakdown and wound management.

Management advised a range of initiatives were implemented including education for nursing staff, handover discussions, enhancement to the Registered Nurse role regarding clinical governance and introduction of a skin observation tool. Counselling for those staff who do not practice in alignment with the service’s policies and procedures is provided and there is a plan for continuous improvement.

The service has a policy and procedure regarding skin and wound management. These guide staff practices including identifying risk factors to impaired skin integrity, early risk identification and interventions, wound management treatments and nursing and care staff responsibilities.

Pain charts, pain assessments and pain management care plans are used to monitor, review, and evaluate the effectiveness of pain management strategies including non-pharmacological interventions. Nursing staff explained how they monitor and review consumer pain and when changes to medication or pain occur staff undertake a re-assessment of the pain management strategy.

Training records provided evidence of pain management education for staff and there is a policy and procedure in place to guide staff on identifying and assessing pain management interventions.

Although not all aspects of restrictive practices were reviewed by the Assessment Team, there was evidence of consent, recognition of both regular and as needed (PRN) use of medication as chemical restraint, confirmation of behaviour support plans and evidence of ongoing reviews of psychotropic medication. The Assessment Team noted that there are no mechanical restraints or seclusion in place. The service is currently reviewing environmental restraint related to accessing the outdoors via the front entrance doors.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with Requirement 3(3)(a).

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | 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. | Compliant |

Findings

The service was previously found non-compliant with Requirement 7(3)(a) following a Site Audit conducted between 25 May and 27 May 2022. The service was unable to demonstrate effective workforce management to enable staff to provide all required care and services to consumers within an acceptable time.

Consumers and representatives expressed satisfaction with staffing levels. Staff confirmed the service has enough staff to ensure their workloads are manageable.

Management informed the Assessment Team that it undertook a major recruitment campaign and workforce planning is based on maximum occupancy. The service reviewed and adjusted shift start and end times to allow a one-hour overlap between morning and afternoon shifts. There is 24-hour a day Registered Nurse coverage and a bank of casual staff to backfill any unplanned leave and does not engage agency staff.

The Assessment Team reviewed the master roster and shift allocation which indicated a planned workforce reflective of a suitable allocation and skill mix of staff to deliver safe and quality care and services, including providing meaningful life activities with consumers.

A review of call bell data indicated that most call bell activations were responded to in under 10 minutes. Management explained that all excessive call bell response times are investigated, and data revealed the most common reason was due to staff having stood on the sensor mat and not turning it off when they left the room.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with Requirement 7(3)(a).

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)