Performance

Report

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| Name: | Morrie Evans Wing Nursing Home |
| Commission ID: | 3470 |
| Address: | Coster Street, BENALLA, Victoria, 3672 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 3 October 2023 to 4 October 2023 |
| Performance report date: | 10 November 2023 |
| Service included in this assessment: | Provider: 1699 Benalla Health  Service: 2221 Morrie Evans Wing Nursing Home |

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 Morrie Evans Wing Nursing Home (**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 3 Personal care and clinical care | Not applicable as not all requirements have been assessed |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements have been assessed** |
| **Standard 7** Human resources | **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)(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 the implementation and embedding of required practices for care documentation related to restrictive practices, wound management and pain management.

A review of documentation reflected consumers were receiving individualised personal and clinical care that is safe and right for them. Consumers were satisfied care was delivered to meet their individualised needs and preferences. Clinical staff demonstrated an understanding of individualised personal and clinical needs and management demonstrated improvements in resulting from regular scheduled auditing.

Consumers subject to chemical, mechanical and environmental restraints have been reviewed. A restrictive practice register was developed with senior staff responsible for oversight of the restrictive practice portfolio and to ensure regular 3 monthly reviews are undertaken and documented.

A review of wound management documentation reflected an improvement from paper-based wound charting to the electronic care document system. Wound management is overseen by clinical staff with charting noted to be completed consistent with the service’s clinical practice guidelines for wound management. The Assessment Team noted timely referral for escalation in wound care with involvement of allied health practitioners and wound specialists.

A recent audit of pain management processes demonstrated a significant improvement in completion of pain management care documentation including currency of pain management assessments, charting and care plans. The Assessment Team noted examples of consideration to pain throughout all domains of care and behaviour management as well as trials on non-pharmacological interventions.

Staff described the individual needs and preferences for consumers, and rationale for different aspects of care related to individual responses to care provision. Management demonstrated ongoing auditing of clinical care, and the monthly resident evaluation process includes a review of care planning documentation to identify any subtle changes or needs to be reassessed.

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 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

Consumers provided positive feedback related to the quality and quantity of the meals served including the improved and consistent temperature of the meals served. Staff were observed to assist and encourage consumers requiring meal assistance and a system was in place to support modified diet requirements. Management explained actions are being discussed and researched into the improvements to the kitchen and servery area of the dining room. The Assessment Team noted that all meal courses and hot beverages were served to consumers at the same time and staff did not offer drinks to consumers at the beginning or during the meal service.

Management attends the monthly resident meetings including the food focus group and provide an overview of the improvements and review feedback for actions and resolutions. Consumers who attend the food focus group have an opportunity to taste new menu items prior to them being put on the rotating menu. Management provided additional responses to Assessment Team feedback on the dining experience, confirming they would consider further actions to make improvements including the commencement of a cold drinks trolley and protected meal service time to ensure all staff are available to assist.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with requirement 4(3)(f).

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

The Assessment Team noted consumers had suitable furniture, equipment and fittings that were clean and fit for purpose in their rooms. However, the communal lounge area had a number of recliner chairs that were stained and dirty with worn upholstery. Transfer equipment was observed parked in corridors with furniture and equipment parked in an area deemed an evacuation point. There is a 6 monthly maintenance schedule to review furniture for safety, suitability for service and has a program to replace furniture that is no longer fit for purpose.

Management responded to the Assessment Teams observations by clearing the evacuation point and explaining furniture replacement would be attended to as a priority as previous discussions had already occurred. In response to a previous incident related to a recliner chair management provided further explanation regarding actions taken to remove the model of the chair from the service. A review of the manufacturer’s guidelines was undertaken which identified the ‘tension screws’ that had become loose, were not mentioned in regular safety checks and maintenance interventions. The proactive maintenance schedule was reviewed and all furniture is scheduled for 6 monthly safety checks and review for suitability and use.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with requirement 5(3)(c).

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Consumers and representatives confirmed the service responds to their complaints appropriately and communicates with them to discuss their concerns. Management and clinical staff were aware of the complaint management and open disclosure process. The service’s complaint register included the description of complaints, feedback or compliments, consumer and complaint details, investigation and the action taken in response. The complaint register, continuous improvement registers and meeting minutes demonstrated the service was recording and responding to complaints and demonstrated open disclosure is used.

The Assessment Team noted examples from consumers where feedback was provided to the service and implemented actions and proposed discussions.

Management and staff described a range of methods used to review and analyse feedback and complaints to ensure due consideration is provided. The ‘feedback register and report’ and ‘continuous improvement register’ detailed the changes made in response to feedback and complaints to improve services as well as monthly reporting demonstrating trends on feedback and complaints as part of regular reporting to management.

The Assessment Team noted improvement actions as a result of consumer complaints and resulting continuous improvement actions. The service’s continuous improvement register, complaints and feedback register, consumer interviews, and resident and relative meeting minutes, confirmed the service’s process and commitment to consider the potential for quality improvement when managing all feedback, including complaints.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with requirements 6(3)(c) and 6(3)(d).

# 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 |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |

Findings

Consumers and representatives confirmed there has been improved staffing levels and that their care needs are met in a timely manner. Staff explained they can complete their assigned tasks and attend training with the additional staffing and leadership support provided. Management described how the workforce is structured to ensure there are adequate numbers of staff with the right mix of skills and abilities. Management demonstrated and relevant documents reflect effective roster planning, leave replacement, continuing recruitment, and outlined numerous strategies in place to address staffing challenges.

The Assessment Team’s review of the electronic rostering system, master roster and shift allocation sheets over the 4 weeks preceding the assessment visit, indicated an adequate level of staff in the service across the 3 shifts. The Assessment Team noted the services ongoing Registered Nurse (RN) recruitment to support the 24/7 RN staffing obligations.

Clinical staff described how they receive ongoing training, professional development, supervision, feedback, and support they need to effectively perform their role and responsibilities in line with best practice and legislative requirements. The service has implemented a new agency and staff orientation checklist and induction program to prepare new staff for their role. Training records demonstrate the implementation of a comprehensive training program to support staff training needs and there are specific personnel responsible for recruitment, staff training, and ongoing staff support.

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

# 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 |

Findings

The service demonstrated effective governance systems relating to information management, continuous improvement, financial governance, workforce governance, regulatory compliance, and management of feedback and complaints. The governing body monitors and reviews routine reporting and analysis of data related to consumer experience.

Management and staff confirmed information is communicated through an electronic notification system, newsletters, ‘resident and representative’ and staff meetings. Staff can access policies, procedures and consumer information, changes to legislation, regulatory requirements, through the electronic information management system. Management described how the governing body is informed about the service’s key performance and clinical indicators through the monthly clinical governance committee and quality and safety committee meetings.

Continuous improvement actions are captured, documented, and evaluated from several sources including incidents, consumer feedback, surveys, ‘resident and representative’ meetings, and the quarterly clinical indicators reporting. Actions from internal and external audits, feedback from staff, and Board initiatives are documented in the ‘plan for continuous improvement register’.

Financial accountability occurs through senior management and to the Board. Management provided examples of expenditures recently approved including a new floor in the dining area and the new kitchen garden project. The Assessment Team noted this as an action reflected in the continuous improvement plan.

The service has policies, procedures, and practices to ensure the workforce is managed in accordance with regulatory requirements. Position descriptions established the responsibilities and accountabilities of staff, and the service had relevant training systems in place. Management and roster documents demonstrate the service’s workforce governance over rostering and staffing through meetings with senior management that provides a platform for review, planning, and discussion around consumer care needs and changes if required.

Management, quality and clinical governance staff receive notifications about new legislative requirements and ensure that policies and procedures are up to date. Monthly board, clinical governance and quality meetings include updates to legislative requirements. Actions are managed through the risk register, continuous improvement plan and meeting minutes action lists.

The service documents feedback and complaints which are considered opportunities for continuous improvement. The ‘compliment and complaints’ report, submitted and discussed with the clinical governance committee each month, demonstrates the oversight of the feedback received by the service occurs through regular reviews by the organisation’s management and governance team.

The Assessment Team noted the robust and effective risk management system which enables practices to ensure all reportable and clinical incidents and risks are managed and reviewed. Outcomes of analysis and trends of incidents are discussed at governance and Board meetings and further improvements and strategies are used to reduce or prevent risk or incidents. Reports reviewed for clinical incidents, Serious Incident Response Scheme (SIRS) reporting and WorkSafe reflected all incidents are reported in a timely manner, responded to by appropriate staff, with incidents escalated to the appropriate key personnel for further actions and oversight of outcomes to reduce or mitigate risk to consumers.

With consideration to the available information summarised above, I agree with the Assessment Team recommendations and find the service compliant with requirements 8(3)(c) and 8(3)(d).

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)