Performance

Report

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| Name: | Millhaven Lodge |
| Commission ID: | 4275 |
| Address: | 54-64 Princes Hwy, PAKENHAM, Victoria, 3810 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 30 January 2024 |
| Performance report date: | 20 February 2024 |
| Service included in this assessment: | Provider: 239 Pakenham & District Hospital Inc  Service: 2797 Millhaven Lodge |

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 Millhaven Lodge (**the service**) has been prepared by M Waniczek 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 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 was previously found non-compliant with Requirement 3(3)(a) following a site audit on 9 May 2023 as it did not demonstrate improvement in identifying, monitoring, and managing chemical and environmental restrictive practices. The Assessment Team noted several actions have been implemented since then specifically related to restrictive practice and pain management.

The Assessment Team noted the service has undertaken a review of the psychotropic register for all consumers receiving psychotropic medications. It has implemented a process to ensure all consumers receiving psychotropic medications have either a medical, physical or mental illness and appropriate authorisation by a medical practitioner. All consumers on antipsychotic medication are identified as at-risk factors on the ‘medication alert’ form and the electronic care system clinical information and individualised support plans in place for all consumers.

Education has been provided to all staff, including Board members, around restrictive practice, with further education sessions planned. Clinical staff were also provided with education about the need for appropriate charting and evaluation after ‘as required’ medication usage.

A review of documentation demonstrated informed consent for the use of chemical restraint with detailed information regarding the use of antipsychotic medications. Monitoring, review and evaluation was completed in collaboration with the consumer, medical practitioner/physiotherapist, representatives and clinical staff.

The service demonstrated the provision of individualised personal and clinical care that is safe and right for each consumer. Documentation demonstrated that consumer pain, restrictive practices and changed behaviours are effectively managed.

After considering the information provided in the Assessment Team report and the recommendation that the requirement is met, I find the Requirement 3(3)(a) 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

The service was previously found non-compliant with Requirements 8(3)(c) and 8(3)(e) following a site audit on 9 May 2023 as it did not demonstrate effective identification and monitoring of the use of chemical and restrictive practices. The Assessment Team noted several actions have been implemented since then in relation to governance.

The service reviewed its documented framework and demonstrated effective organisation wide governance systems relating to information management, continuous improvement, and regulatory compliance around restrictive practices.

The governance framework identifies, records, and monitors the use of restrictive practices, with registers and care plans reviewed every 2 months to ensure that legislative requirements are met, and that care is person-centred. Care plans are reviewed by a registered nurse, clinical co-ordinator and a quality manager.

The communication component of the framework includes quarterly quality assessment reporting to the Board about the use of restrictive practices, in conjunction with benchmarking to assess its effectiveness. The Board is informed of new strategies, policies, processes, and the effectiveness of restrictive practices, as well as actions being taken to rectify non-compliance.

Changes in legislative requirements are communicated to staff through email and memorandums and the service engages and works collaboratively with medical practitioners to highlight their obligations. The Assessment Team observed electronic communication from the Chief Executive Officer to clinical staff, and to medical practitioners about legislative requirements for restrictive practices.

The service demonstrated staff training is provided to ensure a consistent understanding and application in minimising the use of restrictive practices, the management of pain and ensuring behavioural support plans are planned, implemented, and evaluated.

After considering the information provided in the Assessment Team report and the recommendation that the requirement is met, I find Requirements 8(3)(c) and 8(3)(e) Compliant.

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)