Performance

Report

**1800 951 822**

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| Name of service: | Millhaven Lodge |
| Service address: | 54-64 Princes Hwy PAKENHAM VIC 3810 |
| Commission ID: | 4275 |
| Approved provider: | Pakenham & District Hospital Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 9 May 2023 |
| Performance report date: | 7 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 Millhaven Lodge (the service) has been prepared by V Stephens, 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 on 1 June 2023.

# 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 | **Non-compliant** |
| **Standard 5** Organisation’s service environment | **Not applicable as not all requirements have been assessed** |
| **Standard 8** Organisational governance | **Non-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.

* Ensure chemical and environmental restrictive practices are identified, managed and reviewed in line with legislative requirements, including obtaining informed consent for all consumers subject to chemical or environmental restraint.
* Implement effective clinical governance arrangements to ensure monitoring, evaluation and reporting on the use of chemical and environment restraint occurs.

# Standard 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

The service was found non-compliant with Requirement 2(3)(e) following a site audit conducted from 30 March 2022 to 1 April 2022. The service at that time did not demonstrate that care and services were reviewed when changes in consumer needs were identified following falls, skin integrity breakdown and complaints of pain. The service has implemented remedial action in response to the non-compliance identified at the site audit in 2022 including implementing a new electronic care management system, increasing clinical staff numbers at the service and engaging an external wound consultant.

During this assessment contact, for this requirement assessors drew on evidence from 14 sampled consumers with changed needs, wounds, and/or who have experienced incidents such as a fall or changes in behaviour. Twelve of 14 consumer care plans reviewed by assessors reflected timely review following a fall, change in mobility, pressure injury or change in behaviour. Management and staff described how consumer care plans are reviewed following an incident or change in capacity. All consumers and/or their representatives indicated they are consulted bi-monthly or when consumer health needs change outside of the bi-montlly schedule. While I note two sampled consumers did not have their behaviour support plans reviewed for effectiveness following behaviour-related incidents, considering the service has implemented actions outlined in their plan for continuous improvement, the positive feedback received from consumers, their representatives and staff, on balance, I find the service compliant with Requirement 2(3)(e).

# 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. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

The service was found non-compliant with Requirement 3(3)(a) following a site audit conducted from 30 March 2022 to 1 April 2022. The service at that time did not demonstrate safe and effective management of pain, skin integrity, and restrictive practices. The service has implemented remedial action in response to the non-compliance identified at the site audit in 2022 including staff training and engagement of an external wound consultant.

During this assessment contact, for this requirement assessors reviewed care documentation for 14 sampled consumers with a history of pain and/or wounds. The review undertaken by assessors reflects that pain and wounds are appropriately assessed, managed, and monitored. However, assessors found the service did not demonstrate improvement in identifying, monitoring, and managing chemical and environmental restrictive practices. Assessor observations and feedback from representatives and staff illustrate some consumers are restricted from accessing areas of the service. Management and staff did not demonstrate understanding of what encompasses environmental restrictive practice and how this is identified, managed and reviewed.

Management advised there were no consumers subject to chemical restrictive practices, however assessors identified 13 consumers who are prescribed psychotropic medications to manage behaviour. In addition, the service did not demonstrate that informed consent was obtained or that appropriate behaviour support plans were developed for consumers subject to chemical and restrictive practices. Two sampled consumers are currently prescribed benzodiazepine medication which is administered as required for agitation. The service did not classify these consumers as subject to chemical restrictive practice when the psychotropic medication is used for the purpose of influencing behaviour. Informed consent from the consumers’ substitute decision‑maker was not obtained as required by legislation, and one consumer did not have a behaviour support plan. There was no evidence these consumers were monitored for adverse effects or harm or reviewed by their prescribing medical practitioner. At the time of the assessment, management acknowledged feedback from assessors and undertook to address the gaps identified.

In their response to the assessment team report received on 1 June 2023, the approved provider states staff are currently undertaking education on restrictive practices and that training on restrictive practices was also provided in April 2023. The service has implemented a process to obtain informed consent, and has obtained consent from consumers sampled by assessors. The service has also updated behaviour support plans and care plans for consumers sampled by assessors. In relation to environmental restrictive practices, the service states they have conducted a thorough assessment and is working on obtaining written consent from the representatives of consumers residing in a secured area. Commencing in June 2023, the board will be kept informed regarding the occurrence and use of restraints within the service.

While these remedial actions are welcome, some actions have only recently been implemented, or are yet to be fully implemented or evaluated, this is despite the service being advised of these deficits more than a year ago. Based on the evidence before me I am not satisfied that all consumers subject to environmental and chemical restrictive practices are identified and that consent and behaviour support plans are in place. Therefore, I am not satisfied that all consumers subject to chemical and environmental restrictive practices receive safe and effective care. Accordingly, I find the service non‑compliant with Requirement 3(3)(a).

The service was found non-compliant with Requirement 3(3)(b) following a site audit conducted from 30 March 2022 to 1 April 2022. The service at that time did not demonstrate effective processes to manage high impact and high prevalence risks associated with the care of consumers including falls, medication management and specialised care needs. The service has implemented remedial action in response to the non-compliance identified at the site audit in 2022 including reviewing its assessment and care planning policy, providing staff education on falls, and introducing a comprehensive care plan review checklist.

During this assessment contact, assessors drew on evidence from 10 sampled consumers for this requirement. Care file review and feedback from staff, consumers and/or their representatives demonstrate that consumer falls, medication management, and urinary catheter care needs are identified, assessed and actioned effectively. Care documentation demonstrates medication incidents are investigated and reviewed to ensure safe medication management. Clinical staff and management described how individual consumer risk prevention strategies are planned and implemented. Assessors observed a range of fall prevention strategies including the use of vertical sensor beams, crash mats, floor-line beds and call bells were within reach. Accordingly, I find the service compliant with Requirement 3(3)(b).

The service was found non-compliant with Requirement 3(3)(g) following a site audit conducted from 30 March 2022 to 1 April 2022. At that time staff at the service did not demonstrate how they minimise the use of antibiotics. The service has implemented remedial action in response to the non-compliance identified at the site audit in 2022 including reviewing its policy on antimicrobial stewardship, providing staff training and including antimicrobial stewardship as a standing agenda item in medication advisory committee meetings.

During this assessment contact, clinical and care staff demonstrated an understanding of the principles of antimicrobial stewardship and file review for a sampled consumer with a suspected urinary tract infection demonstrated appropriate antibiotic use after pathology results were received. Service management also explained how the service maintains and monitors an infection surveillance register which is used to identify themes and to determine if additional staff training is required. Accordingly, I find the service compliant with Requirement 3(3)(g).

# 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 service was found non-compliant with Requirement 5(3)(c) following a site audit conducted from 30 March 2022 to 1 April 2022. At the time of the site audit, management, staff and consumers acknowledged persistent issues with the service’s call bell system which impacted consumer care. Since the site audit in 2022 the service has replaced the call bell system.

During this assessment contact, assessors observed the call bell system working effectively. Six sampled consumers and representatives expressed their satisfaction that the service’s call bell system facilitates the delivery of quality care. All staff interviewed expressed their satisfaction with the improvement in the service’s call bell system and management explained that they receive daily call bell reports for trending and analysis to ensure timely call bell response. Accordingly, I find the service compliant with Requirement 5(3)(c).

# 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. | Non-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. | Non-compliant |

Findings

The service was found non-compliant with Requirement 8(3)(c) following a site audit conducted from 30 March 2022 to 1 April 2022. The service at that time did not demonstrate an effective governance system for obtaining informed consent and implementing behaviour support plans for consumers subject to restrictive practices. In addition, the service did not demonstrate effective information management systems relating to staff understanding antimicrobial stewardship and restrictive practices. Following the site audit, the service undertook several initiatives including providing staff education on antimicrobial stewardship and restrictive practices, completing behaviour care plans for 73 consumers and obtaining consent for three consumers who were identified as subject to mechanical restrictive practice.

During this assessment assessors identified existing gaps in information management and regulatory compliance including a lack of information provided to consumers and/or their representatives in relation to the use of chemical and environmental restrictive practices. The service did not adequately demonstrate a two-way information sharing and advice between the service to the board, particularly in relation to restrictive practices, and its relevant regulatory and legislative requirements. Assessors identified 14 consumers who are potentially subject to chemical restrictive practice and a number of consumers potentially subject to environmental restrictive practices, particularly in the memory support unit. Of these consumers, there was no evidence of informed consent and behaviour support plans outlining the use of restrictive practices.

In their response to the assessment team report received on 1 June 2023, the approved provider does not make any specific submissions in relation to this requirement. Therefore, based on evidence presented by assessors in this requirement and Requirement 3(3)(a), I find that the service does not have effective governance systems in relation to information management and regulatory compliance. Accordingly, I find the service non‑compliant with Requirement 8(3)(c).

The service was found non-compliant with Requirement 8(3)(e) following a site audit conducted from 30 March 2022 to 1 April 2022. At that time management and staff demonstrated a lack of knowledge in relation to antimicrobial stewardship, minimising the use of restraint and open disclosure. In addition, the service did not consistently demonstrate that appropriate consent and authorisations were in place for all restrictive practices, nor demonstrate that restrictive practices were regularly reviewed and monitored. The service has implemented remedial action in response to the non-compliance identified at the site audit in 2022 including staff education on the use of open disclosure and antimicrobial stewardship.

During this assessment the service did not adequately demonstrate effective identification and monitoring of the use of chemical and environmental restrictive practices, findings in Requirement 3(3)(a) refer.

In their response to the assessment team report received on 1 June 2023, the approved provider submits it has implemented a collaborative process to obtain consent for the use of restrictive practices, noting it is imperative that medical practitioners obtain consent prior to prescribing psychotropic medication. The response further submits that from June 2023, the board will be kept informed regarding the occurrence and use of restraint within the service.

I have considered the evidence before me and find that where restrictive practices were employed to influence a consumer’s behaviour or to ensure a consumer’s environmental safety, the service did not demonstrate effective clinical governance to manage the use of restrictive practices. The service has an updated restrictive practice policy in line with current legislation, however as per deficits in care described in Requirement (3)(3)(a), the service did not demonstrate embedding this policy into practice. Accordingly, I find the service non‑compliant with Requirement 8(3)(e).

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)