Lynden Aged Care

Performance Report

49 Lynden Street   
CAMBERWELL VIC 3124  
Phone number: 03 9809 7025

**Commission ID:** 3102

**Provider name:** Lynden Aged Care Association Inc

**Site Audit date:** 1 December 2021 to 3 December 2021

**Date of Performance Report:** 25 January 2022

# Performance report prepared by

Alice Redden, delegate of the Aged Care Quality and Safety Commissioner.

# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** | **Non-compliant** |
| Requirement 1(3)(a) | Compliant |
| Requirement 1(3)(b) | Compliant |
| Requirement 1(3)(c) | Compliant |
| Requirement 1(3)(d) | Non-compliant |
| Requirement 1(3)(e) | Compliant |
| Requirement 1(3)(f) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** | **Compliant** |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(b) | Compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(c) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| Requirement 3(3)(f) | Compliant |
| Requirement 3(3)(g) | Compliant |
| **Standard 4 Services and supports for daily living** | **Compliant** |
| Requirement 4(3)(a) | Compliant |
| Requirement 4(3)(b) | Compliant |
| Requirement 4(3)(c) | Compliant |
| Requirement 4(3)(d) | Compliant |
| Requirement 4(3)(e) | Compliant |
| Requirement 4(3)(f) | Compliant |
| Requirement 4(3)(g) | Compliant |
| **Standard 5 Organisation’s service environment** | **Compliant** |
| Requirement 5(3)(a) | Compliant |
| Requirement 5(3)(b) | Compliant |
| Requirement 5(3)(c) | Compliant |
| **Standard 6 Feedback and complaints** | **Compliant** |
| Requirement 6(3)(a) | Compliant |
| Requirement 6(3)(b) | Compliant |
| Requirement 6(3)(c) | Compliant |
| Requirement 6(3)(d) | Compliant |
| **Standard 7 Human resources** | **Non-compliant** |
| Requirement 7(3)(a) | Non-compliant |
| Requirement 7(3)(b) | Compliant |
| Requirement 7(3)(c) | Compliant |
| Requirement 7(3)(d) | Compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(a) | Compliant |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | Non-compliant |

# Detailed assessment

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 Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies areas in which improvements must be made to ensure the Quality Standards are complied with.

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Site Audit; the Site Audit 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 Site Audit report received 4 January 2022.

# STANDARD 1 NON-COMPLIANT Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

The Quality Standard is assessed as non-compliant as one of the six specific requirements have been assessed as non-compliant.

Information from the Assessment Team’s reports from the Site Audit conducted on 1 to 3 December 2021 has been considered in the finding of non-compliance in relation to Standard 1 Consumer dignity and choice.

Based on information in the Assessment Team’s report and the Approved Provider’s response I have found the service non-compliant in Requirement (3)(a) and have provided reasons in the relevant Requirement below.

In relation to the remaining requirements in this Standard, the service demonstrated compliance.

The Assessment Team observed staff interacting with consumers in a respectful and friendly manner. Consumers and their representatives considered, overall, that staff treat them with courtesy and dignity. Feedback indicated the service makes a considered effort to learn about the cultural and religious identities and needs of their consumers and staff feedback reflected knowledge of consumer’s diverse backgrounds, communication needs, dietary rules and cultural holidays. The Assessment Team sampled consumers’ care planning documents which consistently contained information on the consumers’ preferences, wishes, cultural needs and things they value. The organisation has policies and procedures in place to ensure consumer’s individuality, life stories, cultural and religious identities are valued and services delivered are inclusive and culturally safe.

The Assessment Team found consumers feel supported to exercise choice in their relationships, how their care is delivered and who is involved in their care. Management, staff, consumer and representative feedback provided various examples of ways that consumers are supported to communicate their decisions.

Sampled consumers and their representatives reported the service is communicative and uses emails and regular newsletters to provide information. Staff and management gave a detailed account of how information is provided to consumers in line with their needs and preferences. The Assessment Team observed a range of information on display throughout the service, including the weekly activities program, daily meal options and COVID-19 health promotion messaging. The most recent newsletter was reviewed and found to contain a comprehensive snapshot of current information about the service, including upcoming activities and themed days, updates on the service’s quality improvement program, introductions to new staff members and updates on vaccination programs in the service.

Consumers and representatives interviewed indicated consumers are satisfied privacy is maintained and their personal information is kept confidential. Staff provided numerous examples of practical ways they respect privacy and the Assessment Team observed interactions between staff and consumers which demonstrated this. The organisation’s policies support staff to maintain confidentiality of documents which contain consumers’ personal information.

## Assessment of Standard 1 Requirements*.*

### Requirement 1(3)(a) Compliant

*Each consumer is treated with dignity and respect, with their identity, culture and diversity valued.*

### Requirement 1(3)(b) Compliant

*Care and services are culturally safe.*

### Requirement 1(3)(c) Compliant

*Each consumer is supported to exercise choice and independence, including to:*

1. *make decisions about their own care and the way care and services are delivered; and*
2. *make decisions about when family, friends, carers or others should be involved in their care; and*
3. *communicate their decisions; and*
4. *make connections with others and maintain relationships of choice, including intimate relationships.*

### Requirement 1(3)(d) Non-compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

The Assessment Team were provided examples of times when the service supported consumers to risk-take, however, consumers were not consistently supported to do so, when they were, there was no evidence they were assisted to understand the specific risks they were taking or how to mitigate them and risk assessments were not consistently completed. For example:

* A sampled consumer had been prevented by staff from independently accessing the outdoor areas of the service, despite having approval to leave the service alone. The consumer also lacked the swipe card required to independently access the outdoor areas and had no Dignity of Risk (DOR) form on file.
* Two consumers with falls risks and health concerns were able to leave the service unaccompanied but did not have risk assessments completed for that activity; while another consumer, unhappy with a recommendation for a minced diet, did have a risk assessment completed so that she could instead enjoy a soft diet.
* Two consumers, one who refused to have fall prevention bed sensors installed and the other, who was not following recommendation for a minced diet, both had completed acceptance of responsibility of risk-taking forms which did not list out specific risks they were accepting. Neither form contained risk mitigating strategies.

The Approved Provider’s response recognises improvements are required to support consumer’s risk-taking, and they supplied a detailed action plan to improve their performance, along with evidence the plan is being implemented. Planned improvements include a review of the service’s processes for supporting consumer risk-taking, updated DOR and risk assessment forms and an audit of all consumer risk assessments, to identify consumers requiring DOR forms. However, while the provider has demonstrated commitment to improving their performance, I find that at the time of site audit, the service did not demonstrate they had adequate mechanisms in place to support consumers to safely assume risks to enhance their quality of life. The service also did not demonstrate consistent use of the DOR and risk assessment tools already in place.

Based on the summarised evidence above I find the service Lynden Aged Care, non-compliant in relation to Standard 1 Requirement (3)(a).

### Requirement 1(3)(e) Compliant

*Information provided to each consumer is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice.*

### Requirement 1(3)(f) Compliant

*Each consumer’s privacy is respected and personal information is kept confidential.*

# STANDARD 2 COMPLIANT Ongoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The Quality Standard is assessed as compliant as five of the five specific requirements have been assessed as compliant.

Consumers and representatives interviewed considered themselves involved in assessment and planning of consumers’ care. Most consumers reported they feel listened to and staff know them, their current needs and preferences and end of life wishes.

Care planning documents reviewed by the Assessment Team evidenced assessment and planning, regular scheduled reviews, and reviews conducted in response to incidents and changes in consumer needs, preferences or condition. Staff are guided by assessment and planning policies and described their use of care planning documents and handovers to inform them of consumer needs and preferences. Staff outlined the process followed to update care planning documents when a consumer’s condition changes.

The service demonstrated their planning and assessment processes address current needs, goals and preferences as well as advanced care and end of life planning, where consumers’ request it. The provider’s assessment and planning policy guides staff and management in their practice, stating that consumers and representatives must have direct input into care planning and are to be kept advised of planning outcomes. Representatives interviewed confirmed they are involved in assessment and planning processes and are routinely consulted via telephone, during visits and during care conferences.

Sampled care plans show consumer input into how daily care occurs, and consumer feedback confirmed the service collaborates with both consumers, representatives and other professionals involved in their care. Feedback demonstrated staff know consumers’ current needs and what is important to them. Consumers and representatives are involved in end of life and advanced care planning, either upon admission or when consumers and representatives are comfortable doing so.

Care planning documentation reviewed was comprehensive, current and reflected individualised goals and preferences for care and service delivery. Care planning documents were in an easily understood format and sampled consumers confirmed that they are familiar with their care plans, which are accessible to them.

Consumers confirmed their care and services are reviewed regularly for effectiveness and when their circumstances change. Management and staff feedback outlined that care plans are reviewed every three months, after incidents and when a change in conditions, preferences or needs occurs. Reviews include a case conference involving the consumer, representatives and relevant health care professionals.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Compliant

*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.*

### Requirement 2(3)(b) Compliant

*Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes.*

### Requirement 2(3)(c) Compliant

### *The organisation demonstrates that assessment and planning:*

1. *is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and*
2. *includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.*

### Requirement 2(3)(d) Compliant

*The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.*

### Requirement 2(3)(e) Compliant

*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.*

# STANDARD 3 NON-COMPLIANT Personal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

The Quality Standard is assessed as non-compliant as one of the seven specific Requirements have been assessed as non-compliant.

The Assessment Team recommended Requirement (3)(a) in relation to this Standard as non-compliant. Based on the evidence in the Assessment Team’s report and the Approved Provider’s response, I find the service non-compliant with Requirement (3)(a).

The Assessment Team found that although sampled consumers and their representatives consider consumers are provided with safe and effective care which meets their needs, the service’s approach to restrictive practice does not align with best practice. The Assessment Team identified several deficiencies, which are outlined below at Assessment of Requirement 3(a).

In their response to the Site Audit Report, the provider supplied a detailed action plan to address the concerns raised by the Assessment Team and produced evidence to demonstrate the service had commenced implementing an improvement process. However, the provider’s commitment to address the deficiencies does not displace the non-compliance identified at the time of audit. Detailed reasons for my decision have been provided in the relevant Requirement below

The remaining requirements in this Standard are assessed as compliant.

Consumer and representative feedback confirmed high-impact and high-risk health care needs are managed effectively by the service, and their care changes as they near end of life, with their goals, preferences, and specific needs accounted for. The service demonstrated consumers’ and their representatives are involved in planning to ensure end of life wishes are met. Palliative care is arranged for consumers who need it and their changing needs and care preferences are documented in care plans. Advanced Health Directives were detailed and correspond to the care plans. The service has policies and procedures on deteriorating residents, advanced care planning, palliative care and end of life care.

Document review and other observations made during the site audit demonstrated the service effectively manages high-impact and high-prevalence risks and adequately responds to incidents.

Consumers confirmed they receive care and services from external clinicians and allied health providers when needed and information about consumers’ conditions and current needs are communicated within the service via the Electronic Care Management System (ECMS), handovers and communication books. The service demonstrated timely and relevant referrals to a range of clinicians, allied health professionals and other external service providers.

Staff know the contents of care plans for sampled consumers and the response procedures for clinical incidents. Staff were able to describe palliative care needs of sampled consumers and showed how they work with family members to address changing needs and to fulfil end of life wishes.

The service has an Infection Prevention and Control (IPC) lead who, along with clinical staff, described the service’s antimicrobial stewardship policy, its’ implementation and the service’s COVID19 management plan. Clinical staff described the process followed when a consumer is diagnosed with an infection, which aligns with best practice. The service receives quarterly reports from the service pharmacy and monitors prescribing and infection trends, supporting the service to identify recurring infections and minimise cross-infections.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-compliant

*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.*

The Assessment Team found that although most consumers reported they receive clinical and personal care which is safe and right for them, the service has an inadequate approach to restrictive practices that is not aligned with best practice.

Some care plans and progress notes for sampled consumers indicated consumers receive safe and effective personal and clinical care that reflects their needs and optimises their health and well-being. For example, sampled consumer care plans contained instructions for clinical care, personal care and daily living support that was tailored to the consumers’ diagnoses of diabetes, peripheral neuropathy, asthma and pressure injuries. The consumers had detailed management plans and care plans which incorporated the necessary clinical, personal care and daily living support tasks required to manage their diagnoses effectively.

Most consumers and representatives considered they receive safe and effective personal and clinical care. Sampled staff gave descriptions of how they provide effective and individualised care. Staff also outlined the steps they would take if concerned about a consumer’s wellbeing, how they minimise use of chemical restraints and their use of care plan documentation and handover instructions to deliver safe and effective care. The Assessment Team also found the service employs a best practice approach to pain management, which is guided by documented policies and procedures, and their approach to skin integrity is in line with expected practice.

However, the Assessment Team found the service’s approach to restrictive practices does not accord with best practice and there was inconsistent compliance with the service’s falls management policy. Summarised relevant evidence included:

* One of three recent consumer falls was not handled in accordance with the service’s falls and neurological observation policy.
* The service’s chemical restraint register was revised during the site audit to reduce the number of consumers subject to restraint. The revised register was inaccurate, and numerous consumers who had been removed from the list were prescribed psychotropic medications not supported by their diagnoses.
* Behaviour support plans were not individually tailored. Consumers subject to chemical restraint had generic non-chemical interventions listed and were not properly tailored to the individual consumer.
* Monitoring of chemical restraints did not include monitoring for distress, harm, side-effects or the impact of the restraint on independent function and the consumer’s ability to perform tasks of daily living.
* The service reported there were no consumers subject to environmental restraints in the service, however environmental restraints were in use. It was observed that swipe cards were required to move freely between indoor and outdoor areas and to leave some wings. It was found consumers were not offered a swipe card automatically upon entering the service and the decision to allocate a swipe card was made without assessment. The Assessment Team also found a decision to deactivate a consumer’s swipe card was not supported by reasoning and no record of the decision was found in the consumer’s behaviour management plan.
* The service had no systems in place to consider the impact of environmental restraints on any consumers subject to them, and there was no evidence that those consumers were monitored for signs of harm, distress, impact on daily functioning or other adverse impacts.

In their written response to the Assessment Team’s findings, the provider acknowledged the deficiencies identified by the Assessment Team and provided a detailed action plan to rectify them. The provider also supplied evidence the action plan is being implemented. Improvements in the action plan include:

* performance discussions with staff on the falls management policy.
* review of the policies and procedures on restrictive practices and repeat restrictive practices training for all staff.
* review of the chemical restraint register and new monthly audits of the service’s psychotropic medication use.
* education for staff on documentation requirements for chemical restraints, their effects and efficacy of non-pharmacological interventions.
* review of Behaviour Support Plans and tailoring of non-pharmacological interventions for consumers subject to chemical restraint.
* removal of swipe card access for all internal doors and doors accessing the internal courtyard.
* development and implementation of procedures and tools for monitoring the effects of chemical and environmental restraints.

In response to findings that environmental restraints are used at the service, the provider outlined the results of an environmental restraint audit which was conducted after swipe card access around the service was disabled. The new environmental restraint register contained five consumers and the service has commenced consultation with those consumers and their representatives to obtain and document consent for the use of restraints.

I acknowledge the provider’s commitment, and numerous actions to date, to rectify the deficits identified by the Assessment Team. However, at the time of the site audit, the Assessment Team found widespread use of environmental restrictive practices which impacted consumers. The service also did not demonstrate the presence of effective systems and processes to ensure consumers subject to chemical restraints received best practice care or that use of restraints was appropriately documented and authorised. I acknowledge that the service’s revised chemical restraint register lists just four chemically restrained consumers, but I also note more than half of the service’s 91 consumers are currently prescribed at least one form of psychotropic medication and many of those consumers were, until the time of the site audit, formally categorised by the service as being subject to chemical restraint.

Based on the summarised evidence above I find the service Lynden Aged Care, non-compliant in relation to Standard 3 Requirement (3)(a).

### Requirement 3(3)(b) Compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

### Requirement 3(3)(c) Compliant

*The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved.*

### Requirement 3(3)(d) Compliant

*Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner.*

### Requirement 3(3)(e) Compliant

*Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 3(3)(f) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 3(3)(g) Compliant

*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.*

# STANDARD 4 COMPLIANT Services and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

The Quality Standard is assessed as compliant as seven of the seven specific requirements have been assessed as compliant.

Consumers interviewed confirmed they receive supports that allow them to do the things they want to do, including accessing the community, spending time in the garden and outdoor areas of the service and participating in the service’s lifestyle program. Consumers and staff provided examples of individual and group activities consumers participate in, and how consumers with different sensory or mobility needs are supported to participate. The Assessment Team observed consumers participating in lifestyle program activities and there was information about daily activities displayed throughout the service, which evidenced a wide range of group activities and one-to-one activities.

Care plan documents showed that consumers’ spiritual, cultural and social preferences are recorded and re-assessed by lifestyle program staff and consumers confirmed they receive supports and services for daily living that promote their emotional, spiritual and psychological wellbeing. The service has a spiritual policy that sets out their approach to consumer spiritual growth and wellbeing and consumer feedback confirmed staff are supportive of individual consumers who are feeling low. Consumers confirmed their spiritual and religious needs are catered for. The service also employs an emotional wellness coordinator.

Consumers confirmed they are supported to maintain their links to the community and the social and personal relationships that are important to them, through video calls, visits and by accessing the community with their families, or independently.

Consumers said staff know about them, their needs and likes; and most sampled care plans were sufficiently detailed. Information is shared between team members, by phone, through communication diary and staff handovers. The lifestyle program is reassessed tri-monthly, and while the Assessment Team found that the reviews where behind schedule for the month of November, consumer feedback against this requirement was positive, with sampled consumers stating that staff “never forget” and that staff “know you and what you need and what you like.”

Most consumers considered the meals they receive are of good quality, variety and quantity. Whilst two sampled consumers expressed that some dishes were not to their liking, they explained that when they complained, they were heard. Consumers confirmed their food preferences are known by staff at the service and consumers’ dietary needs and preferences are recorded upon their entry to the service. Kitchen staff know the specific dietary needs and preferences of sampled consumers, which were also displayed where food and drinks are prepared and delivered to consumers. The care planning system will be updated with all consumer dietary needs and preferences in the future.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(a) Compliant

*Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life.*

### Requirement 4(3)(b) Compliant

*Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being.*

### Requirement 4(3)(c) Compliant

*Services and supports for daily living assist each consumer to:*

1. *participate in their community within and outside the organisation’s service environment; and*
2. *have social and personal relationships; and*
3. *do the things of interest to them.*

### Requirement 4(3)(d) Compliant

*Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared.*

### Requirement 4(3)(e) Compliant

*Timely and appropriate referrals to individuals, other organisations and providers of other care and services.*

### Requirement 4(3)(f) Compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

### Requirement 4(3)(g) Compliant

*Where equipment is provided, it is safe, suitable, clean and well maintained.*

# STANDARD 5 COMPLIANT Organisation’s service environment

### Consumer outcome:

1. I feel I belong and I am safe and comfortable in the organisation’s service environment.

### Organisation statement:

1. The organisation provides a safe and comfortable service environment that promotes the consumer’s independence, function and enjoyment.

## Assessment of Standard 5

The Quality Standard is assessed as compliant as three of the three specific requirements have been assessed as compliant.

Consumers and representatives interviewed confirmed they feel safe and comfortable living in the service and that they have a sense of belonging, with consumers describing the service as having a “village feeling,” and being a “great big family.” The service has a café for use by consumers with their visitors, multiple library areas and a multi-purpose room attached to each wing.

The Assessment Team observed a welcoming environment with internal and outdoor areas which appeared clean and comfortable. There is signage and railing to support consumers in navigating and mobilising, whilst the layout of the service and placement of consumers is arranged according to levels of functioning and level of care required. The Assessment Team found, however, that although the service has multiple outdoor areas, not all consumers could access those areas freely or move between different areas within the service (refer to Standard 3 (3) (a) for discussion of environmental restraints employed by the service). Consumers who could access the outdoor areas confirmed they enjoy the service’s rose gardens, fish ponds, courtyards and outdoor decks.

Consumers and representatives advised the service is clean and any issues are resolved quickly, with cleaning staff on hand. Cleaning of equipment is the responsibility of care staff while general cleaning staff work according to a schedule in designated areas. There are both preventative and reactive maintenance systems in place to ensure equipment is clean and maintained and that routine testing of fittings and equipment occurs. Contractors are engaged for some preventative maintenance, such as maintenance of lifting machines and fire equipment and Legionella testing. Maintenance and other staff were able to describe how the maintenance systems operate.

## Assessment of Standard 5 Requirements

### Requirement 5(3)(a) Compliant

*The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function.*

### Requirement 5(3)(b) Compliant

*The service environment:*

1. *is safe, clean, well maintained and comfortable; and*
2. *enables consumers to move freely, both indoors and outdoors.*

### Requirement 5(3)(c) Compliant

*Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer.*

# STANDARD 6 COMPLIANT Feedback and complaints

### Consumer outcome:

1. I feel safe and am encouraged and supported to give feedback and make complaints. I am engaged in processes to address my feedback and complaints, and appropriate action is taken.

### Organisation statement:

1. The organisation regularly seeks input and feedback from consumers, carers, the workforce and others and uses the input and feedback to inform continuous improvements for individual consumers and the whole organisation.

## Assessment of Standard 6

The Quality Standard is assessed as compliant as four of the four specific requirements have been assessed as compliant.

Consumers and representatives interviewed confirmed they know how to provide feedback and make complaints. Most confirmed they feel encouraged and supported to provide feedback or make complaints and feel comfortable to do so. Consumers and representatives also confirmed they can raise concerns in a variety of ways, including verbally, through feedback forms, consumer surveys or through participation in boards and committees, such as the residents and relatives committee.

Staff interviewed were knowledgeable about the ways consumers and representatives can make complaints or provide feedback and outlined how they respond to consumer complaints, seek out and follow on resolutions. Staff support consumers to complete feedback forms if they are unable to do so and they assist consumers who have difficulty communicating, to raise concerns. Staff were aware of how to access interpreter and advocacy services if needed and reported they are comfortable advocating for consumers or approaching management if needed.

The service supports consumers to lodge written or verbal complaints and feedback. Physical forms, QR code forms, informal conversations with consumers and formal avenues such as the consumer representative meetings and food focus groups are used to gather feedback and complaints. The Assessment Team observed feedback forms display and reviewed consumer representative meeting minutes, the feedback register, and the complaints register, which evidenced that the service actively captures complaints, feedback and suggestions from consumers, representatives and staff.

The service demonstrated that most consumer complaints are resolved to a satisfactory standard for the consumer and that open disclosure principles are understood and applied at all levels. The service has policies on complaints, open disclosure and feedback to guide complaint management and both staff and management were able to describe the processes in place. Consumer feedback mostly confirmed that the processes are followed, and complaints addressed in a satisfactory way. The service has a Continuous Improvement Plan in place and consumer and representative feedback is incorporated into the Plan. The service demonstrated that consumer feedback has resulted in tangible improvements to the service, including recent refurbishments and more regular staff number reviews. The service monitors complaints and can identify increases or trends.

## Assessment of Standard 6 Requirements

### Requirement 6(3)(a) Compliant

*Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints.*

### Requirement 6(3)(b) Compliant

*Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints.*

### Requirement 6(3)(c) Compliant

*Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong.*

### Requirement 6(3)(d) Compliant

*Feedback and complaints are reviewed and used to improve the quality of care and services.*

# STANDARD 7 NON-COMPLIANT Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

This Quality Standard is assessed as Non-compliant as one of the five specific requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirement (3)(a) this Standard as non-compliant. Based on the evidence in the Assessment Team’s report and the Approved Provider’s response, I find the service non-compliant with Requirement (3)(a) because document review and call bell data indicated, and consumer feedback confirmed, that the service does not always have enough staff to deliver safe and quality care. I have provided detailed reasons for my decision in the relevant Requirement below.

In relation to the remaining requirements in this standard, the Assessment Team recommended all were compliant.

Sampled consumers and representatives confirmed that staff at the service are kind, respectful and caring toward consumers, and overall, staff are knowledgeable, experienced, well-trained and effective in their roles.

Staff were knowledgeable about consumer’s personal circumstances, backgrounds and preferences. Staff could explain their roles, responsibilities and steps they would take if they required support to do their jobs. Staff receive training upon induction and on an ongoing basis. Management described the training modules staff are required to complete and human resources documents, such as recruitment materials, reference checks, police checks, and qualifications of staff were sighted by the Assessment Team.

Management is guided by a performance management policy, which requires regular assessment, monitoring and review of the performance of each staff member. The Assessment Team found this was complied with, though was not current at the time of the Site Audit.

## Assessment of Standard 7 Requirements*.*

### Requirement 7(3)(a) Non-compliant

*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.*

The Assessment Team recommended Not Met in relation to this requirement. Some sampled consumers felt that call bells were not answered in a timely enough manner, leading to consumer needs going unmet. An analysis of call bell response times confirmed consumer feedback regarding long wait times, while a review of rosters showed several uncovered shifts.

Summarised relevant evidence included:

* Most consumers felt that staff were able to complete tasks and provide safe and effective care. However, some consumer and representative feedback indicated there are not always enough staff to deliver safe and quality care and services. For example, five consumers reported that the service is short staffed in mornings, that call bells are sometimes responded to slowly and at times, it is more effective not to use the call bell for urgent assistance.
* Staff reported that when they are busy and cannot attend to call bells immediately, they inform the consumer they are attending to someone else and will respond to them as soon as possible.
* Management said that consumers had previously complained about there being insufficient staff to answer the call bell but that in response, they now review rosters every two weeks to identify trends and ‘staff feedback is used to find solutions.’
* The Assessment Team sampled call bell response times for a sample of ten consumers. Eight of the ten had a minimum response time of over ten minutes, and six of the ten had call response times of over one hour. When this information was put to management, they advised that an internal audit was conducted in August and September 2021 which idetified an error in data output from the call bell system. The call bell system provider had been contacted and were to attend the service and review data outputs from the system.
* The Assessment Team sighted staff rosters, allocation sheets and shift vacancies for a recent 13-day period and found that unplanned leave led to a total of seven care staff shifts and one clinical staff shift not being covered. Uncovered shifts occurred across three of the four wings.

In their response, the Approved Provider advised they had completed an audit of call bell escalation flow which confirmed problems in the system. The issue had been reported to the call bell company. The provider argued that seven of the ten consumers whose call bell response times were sampled had falls prevention equipment in place and that prior to the Site Audit, it had been identified staff were at times inadvertently activating the sensors or not cancelling them after they had provided care. Training has been given to staff to address this performance issue.

The provider acknowledged the seven unfilled shifts during the sampled period, however noted the remaining 532 shifts for the period had been filled, and they outlined the difficulties they have experienced in recruiting staff and filling vacant shifts with agency staff. The provider also noted that four of the seven vacant shifts in the sampled period occurred in a wing which had eleven vacant beds at the time. Lastly, the Approved Provided argued that their direct care minutes for the sampled fortnight were within published industry averages. While acknowledging that their direct care minutes may be in within industry averages, consumer feedback and past complaints to management about the service being short-staffed, demonstrates there are not always enough staff to deliver safe and quality care.

I acknowledge the Approved Provider’s response that there are identified issues with the call bell system and the data outputs may not be reliable. In the absence of reliable call bell response data either at the time of audit or at the time I am making my decision, I find that the consumer feedback regarding long call bell wait times supports the Assessment Teams’ recommendation of non-compliant against this requirement.

I also acknowledge the Approved Provider’s difficulty, given current shortages, in recruiting aged care staff and I accept their argument that their direct care minutes are within industry averages. I also note their commitment to addressing shortages by engaging with a Registered Training Organisation to arrange student placements in the future. However, I find the poor consumer outcomes noted at the time of audit, including statements by some consumers that they have, or would in future, opt not to use the call bell system in an emergency, supports the Assessment Team’s recommendation of non-compliant against this requirement.

Based on the summarised evidence above I find the service, Lynden Aged Care, non-compliant in relation to Standard 7 Requirement (3)(a).

### Requirement 7(3)(b) Compliant

*Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity.*

### Requirement 7(3)(c) Compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

### Requirement 7(3)(d) Compliant

*The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards.*

### Requirement 7(3)(e) Compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

# STANDARD 8 NON-COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

This Quality Standard is assessed as Non-compliant as one of the five specific requirements have been assessed as Non-compliant.

The Assessment Team recommended Requirements (3)(c) and (3)(e) in this Standard as non-compliant. However, my finding differs from the recommendation and I find the service non-compliant with Requirement (3)(e) and compliant with Requirement (3)(c) and have provided detailed reasons for the finding in the relevant Requirements below.

In relation to Requirement 3(e), the Assessment Team found that the organisation has a documented clinical governance framework, which includes policies that guide the service’s practice in relation to antimicrobial stewardship, minimisation of restraints and open disclosure. Staff interviewed were able to describe how the policies and framework were relevant to their work and demonstrated their understanding with practical examples. However, the service was not able to demonstrate they have effective systems in place to manage the use of restraints where deemed clinically necessary.

The service has effective organisation-wide governance systems relating to information management, continuous improvement, financial governance, regulatory compliance and feedback and complaints.

Consumers and representatives considered the service is well run and they are actively engaged in the development, delivery and evaluation of care and services through the organisation’s governance structure. The service uses several mechanisms to gather consumer feedback, supporting consumers to have a voice, and the service gave specific examples of ways consumer feedback has led to changes in care and services.

The service has a documented risk management framework, with policies for managing high impact and high prevalence risks, responding to incidents, abuse and neglect and for supporting consumers to live the best life possible. Management and staff were able to provide specific examples which demonstrated that the service’s risk management systems and practices are effective.

There is oversight of the service by a governing body, which carries responsibility for promoting a culture of safety, inclusion and quality care. There are documented processes and mechanisms in place for service-wide governance of information management, continuous improvement, financial governance and regulatory compliance. Staff and management feedback demonstrated understanding of these processes and the way they impact their day-to-day work.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(a) Compliant

*Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement.*

### Requirement 8(3)(b) Compliant

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

### Requirement 8(3)(c) Compliant

*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.*

At the time of the site audit, the service was able to demonstrate effective service-wide systems were in place for governance of information management, continuous improvement, feedback and complaints, financial governance and regulatory compliance.

However, the Assessment Team found the service was not able to demonstrate that they have effective systems for workforce governance. Relevant summarised evidence included:

* As previously discussed under Requirement 7(3)(a), the Assessment Team found deficiencies in:
  + Coverage of shifts during a recent 13-day period.
  + Call bell response times for a sample of ten consumers during a recent 13-day period, found eight of the ten sampled consumers had a maximum response time of over ten mins, and six of the ten had call response times of over one hour.
  + Consumer feedback identified that some consumers were dissatisfied with the call bell response times, and some indicated that they had not, or would not, would not use the call bell in the event of a fall.

When the identified deficiencies were put to management, they advised that the call bell response data was not reliable, which had been reported to the call bell company who were to attend the service and review the data.

In their response to the Site Audit report, the provider referred to their Action Plan, which detailed that the service is communicating with the governing body about the Assessment Team’s findings. The provider has scheduled an internal audit of the service’s performance against this requirement and a staff engagement survey has also been scheduled.

I acknowledge the provider’s plan to improve their performance in relation to call bell response time and workforce governance, and the provider’s argumentative response to the Assessment Team’s finding against 7(3)(a). I also acknowledge that the provider has demonstrated they have effective, organisation wide governance systems relating to information management, continuous improvement, financial governance, regulatory compliance and feedback and complaints.

I find the service has a workforce governance system including actively monitoring and reviewing staff rosters and call bell response times to identify and monitor workforce sufficiency and performance. The deficits identified have been addressed in the finding of non-compliance in Requirement 7(3)(a), where the evidence is more relevant.

Based on the summarised evidence above, I find the service, Lynden Aged Care, compliant in relation to Standard 8 Requirement (3)(c).

### Requirement 8(3)(d) Compliant

*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.*

### Requirement 8(3)(e) Non-compliant

*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.*

The organisation has a documented clinical governance framework, which includes policies that guide the service’s practice in relation to antimicrobial stewardship, minimisation of the use of restraints and open disclosure. Staff interviewed were able to describe how the policies and framework were relevant to their work and demonstrated their understanding with practical examples. The service demonstrated their clinical governance framework is effective as it relates to open disclosure and antimicrobial stewardship.

However, while management could describe how the service implemented changes to restrictive practice management after legislation changes came into effect, at the time of audit, the Assessment Team found the service did not demonstrate effective systems were in place to manage how restraints are used when deemed clinically necessary and to identify, monitor and review when restraints are used, with the goal of minimising the use of the restraint overall.

Refer to Standard 3 for detailed discussion of the Assessment Team’s findings in relation to chemical and environmental restrictive practices.

In their response, the provider acknowledged the deficits identified by the Assessment Team. The service supplied an action plan detailing how they will address the deficits identified in relation to the use of restraints. The service also demonstrated they have commenced implementing the plan. Improvements to strengthen clinical governance where the use of restraints is concerned includes:

* A review of policies and procedures on restrictive practices.
* Repeat restrictive practices training for all staff.
* Review of the chemical restraint register.
* New monthly audits of the service’s psychotropic medication use.
* Education for staff on documentation requirements for chemical restraints, their effects and efficacy of non-pharmacological interventions.
* Review of Behaviour Support Plans and tailoring of non-pharmacological interventions for consumers subject to chemical restraint.
* Development and implementation of procedures and tools for monitoring the effects of chemical and environmental restraints.

The provider also advised they are communicating with the governing body about the Assessment Team’s findings, however the action plan does not detail how the existing clinical governance arrangements and flow of information between the service and the governing body will be increase oversight of the service’s use of restrictive practices in future.

Consequently, while I acknowledge their Action Plan for improvement and their clinical governance framework which effectively addresses antimicrobial stewardship and open disclosure, I find that at the time of site audit, the service had not effectively implemented their clinical governance framework in relation to the use of restrictive practices. I also find their Action Plan for improvement insufficiently detailed to support a decision that the service is compliant with this Requirement.

Based on the evidence summarised above and the provider’s response, I find the service, Lynden Aged Care, non-compliant in relation to Standard 8 Requirement (3)(d).

# 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.

* Standard 1 Requirement (3)(d): Ensure consumers are supported to take risks they want to take. Ensure the service consistently completes risk assessments for each risk-taking activity performed and ensure consumers are supported to understand all the risks they are assuming, and how to mitigate them. Ensure consumer’s decisions, the specific risks being accepted, and mitigation strategies are documented.
* Standard 3 Requirement (3)(a): Ensure consumers receive safe and effective personal care and clinical care which is in line with best practice, specifically in relation to falls management and restrictive practices. Ensure consumers subject to restrictive practices are monitored to determine the impacts and effectiveness of those restraints and that chemical and environmental restraint registers and decisions are documented, accurate and current. Ensure the service’s falls and neurological Observations policy is followed by staff.
* Standard 7 Requirement (3)(a): Ensure sufficient staff at the service to deliver safe and quality care to consumers in line with their needs. Ensure effective monitoring systems are in place to identify and action areas for improvement in staffing allocations, including through monitoring of call bell response data. Action reactive maintenance of the call bell system in a timely manner.
* Standard 8 Requirement (3)(e): Ensure the organisation’s clinical governance framework and policies and procedures for minimising use of restraints are in line with best practice and adhered to at the service level.