Performance

Report

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| Name: | Lakeview Lodge Hostel |
| Commission ID: | 3324 |
| Address: | 22 Church Street, NAGAMBIE, Victoria, 3608 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 17 July 2024 |
| Performance report date: | 22 August 2024 |
| Service included in this assessment: | Provider: 1663 Nagambie HealthCare Incorporated  Service: 2082 Lakeview Lodge Hostel |

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 Lakeview Lodge Hostel (**the service**) has been prepared by M Murray, 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.
* the provider’s response to the assessment team’s report received 19 August 2024.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not assessed |
| **Standard 2** Ongoing assessment and planning with consumers | Not assessed |
| **Standard 3** Personal care and clinical care | Compliant |
| **Standard 4** Services and supports for daily living | Non-Compliant |
| **Standard 5** Organisation’s service environment | Not assessed |
| **Standard 6** Feedback and complaints | Not assessed |
| **Standard 7** Human resources | Not assessed |
| **Standard 8** Organisational governance | Not assessed |

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 the dining experience for consumers is aligned with good practice and supports their health and wellbeing.

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |

Findings

Requirement 3(3)(b)

The Assessment Team reported that the service did not demonstrate effective management of risks in relation to wounds, weight loss swallowing difficulties and choking for consumers.

The Assessment Team provided the following evidence relevant to this requirement to support their assessment:

* One consumer experienced significant weight loss over a period of 4 months without evidence of a referral to a dietician.
* In June 2024 the consumer returned to the service following a period in hospital. Staff modified the consumer’s meal consistency, and a speech pathologist referral was initiated.
* The consumer’s care planning documents and other information sources have conflicting information about how to support the consumer’s nutrition and hydration and associated care tasks. These tasks include recording food and fluid intake and taking the consumer’s weight.
* Medical officer directions for the management of the consumer’s skin integrity had not been adhered to by nursing staff, including establishing a wound management regime, taking photographs of the wounds and making a referral to a wound specialist.
* A representative reported they were not kept up to date about the consumer’s weight loss and did not have a clear understanding of the reason for a dietary change instigated by the nursing staff.
* Management explained that although the consumer was referred to a speech pathologist when they returned from hospital, the speech pathologist has not had capacity to attend the service. Management explained the challenges with accessing external health professionals such as dietitians and speech pathologists due to the regional location of the service.
* Management acknowledged an opportunity to improve care documentation.

. The provider’s response includes the following additional information:

* Evidence of communications during June 2024 and July 2024 with the representative in relation to the care of the consumer named in the Assessment Team’s report. Communications evidence a full general practitioner assessment occurred in June 2024 and a telehealth family consultation occurred in July with the consumer’s general practitioner. The family consultation included an update to the consumer’s advance care plan.
* Asserts that the service does monitor the wellbeing of consumers effectively and over the last 12 months has had a ‘stop and watch’ process to identify at the earliest opportunity those consumers at risk of poor outcomes.
* Disputes that the wound management protocols have not aligned with best practice and outlines that nurse practitioners have been visiting monthly to provide staff education.
* States policies and procedures are in place however currently exist within two different programs due to historical processes. The service has now subscribed to a peak body service to support their integration of policies and ensure they reflect a best practice approach. A range of policies and audit tools were submitted as part of the response.
* Accepts that there is an opportunity to eliminate inconsistences in staff practice and improve communication and is currently addressing this through a review of systems and processes to ensure all changes in care are captured. A monitoring and auditing schedule has been implemented to ensure ongoing compliance.

In coming to my finding, I have considered the evidence in the Assessment Team’s report and the provider’s response.

I have given weight to the provider’s comprehensive response which has provided evidence that the service either had appropriate policies and processes in place during the audit or has subsequently implemented the required improvements to address the care of the consumer named in the Assessment Team’s report. Furthermore, the provider’s response demonstrates that the concerns identified by the assessment team were not systemic.

While the evidence shows some areas for improvement in relation to this Requirement, I find the provider, in relation to the service, compliant with Requirement (3)(b) in Standard 3 Personal care and clinical care.

Requirement 3(3)(f)

The Assessment Team reported that the service did not demonstrate timely and appropriate referrals to individuals, other organisations and providers of other care and services.

The Assessment Team provided the following evidence relevant to this requirement to support their assessment:

* Care documentation for consumers showed regular and ongoing contributions from medical officers and physiotherapists.
* The referral process for one consumer experiencing weight loss and swallowing difficulties was not timely.
* Staff initiated a change to this consumer’s meal consistency following swallowing difficulties while waiting for the speech pathologist to attend the service.
* Management explained the challenges with accessing dietitians and speech pathologists due to the regional location of the service.

. The provider’s response includes the following additional information:

* The service has secured a commitment from its speech therapist to attend the service every eight weeks. The therapist attended in late July 2024 and will attend again in September 2024.
* Management is working with their dietician to deliver extra support for consumers on site. A dietitian review of the menu has occurred.
* Increased oversight by the clinical care manager has been put in place to ensure that all referrals occur in a timely manner and that relevant documentation is consistently completed and up to date.

In coming to my finding, I have considered evidence in the Assessment Team’s report and the provider’s response.

I have considered that while referrals for one sampled consumer, specifically for a dietician and a speech pathologist were not attended to in a timely manner, there is no further evidence to demonstrate this is a systemic failure. Other referrals to other disciplines are occurring.

I am satisfied that the service has gained a commitment from its dietician and speech pathologist to be responsive to the needs of consumers at the service.

While the evidence shows some areas for improvement in relation to this Requirement I find the provider, in relation to the service, compliant with Requirement (3)(f) in Standard 3 Personal care and clinical care.

# 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. | Not Compliant |

Findings

Requirement 4(3)(f)

The Assessment Team reported that the service did not demonstrate where meals are provided, they are varied and of suitable quality and quantity.

The Assessment Team provided the following evidence relevant to this requirement to support their assessment:

* Three of 6 consumers expressed dissatisfaction with the quality, temperature, and/or meal options. A representative said the food is good.
* Consumers reported that once the kitchen is closed there is no food available and they rely on whatever is available in their room, such as biscuits.
* Two staff interviewed said they referred to the handover sheet to understand each consumer’s individual needs and dietary preferences. A review of care planning documentation for 5 consumers, demonstrated inconsistencies between the handover sheet, consumer care plan, assessments, and the consumer profile.
* During a meal observation, one staff member was observed standing while assisting the consumer to eat, and another staff member was assisting multiple consumers at the same time. It was also observed that the meal plate for another consumer was kept at a distance and the consumer could not easily reach the food.
* Management acknowledged the inconsistencies in documentation and said this has already been self-identified by the service as an area for improvement.
* Management added an action item to their continuous improvement plan in relation to the consumer dining experience.

The provider’s response includes the following additional information to support its assertion:

* The service held a ‘resident meeting’ following the quality audit. Minutes of the meeting outline the introduction of an ‘out of hours’ menu and development of kitchenettes both for high care and hostel.
* The current menu has been reviewed by the dietician.
* Residents were invited to participate in a food focus group to review food choices, presentation and all aspects of dining.
* The service has implemented a new system for timely meal assistance including allocation of staff to specific areas, additional training and competency testing. Initial feedback on changes to the dining experience are positive.
* ‘Maggie Beer’ training is to be completed by relevant staff and food satisfaction surveys have been increased to monthly.
* Submitted an action plan addressing various aspects of the assessment findings dated 17 July 2024 noting a final review date of 30 November 2024.

In coming to my finding, I have considered the Assessment Team’s assessment, evidence in the Assessment Team’s report and the provider’s response.

I have noted that the feedback about meals is mixed with some consumers satisfied and others dissatisfied.

I have placed weight on the observations of the Assessment Team during the meal service which evidence staff did not provide a positive dining experience for four consumers.

I acknowledge the service has instigated a range of improvements as outlined in its action plan.

I find the provider, in relation to the service, non-compliant with Requirement (4)(3)(f) in Standard 4 Services and supports for daily living. I am satisfied consumers have not been experiencing an optimal dining experience. While the service has been proactive in making improvements, these improvements will need to be monitored for their effectiveness in order to demonstrate the required changes in staff practices are embedded in their day-to-day practice.

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)