Performance

Report

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| Name of service: | Lynden Aged Care |
| Service address: | 49 Lynden Street CAMBERWELL VIC 3124 |
| Commission ID: | 3102 |
| Approved provider: | Lynden Aged Care Association Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 24 October 2022 to 25 October 2022 |
| Performance report date: | 24 November 202 |

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 Lynden Aged Care (**the service**) has been prepared by L Glass, 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.

# Assessment summary

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

A detailed assessment is provided later in this report for each assessed Standard.

# Areas for improvement

There are no specific areas identified in which improvements must be made to ensure compliance with the Quality Standards. The provider is required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |

Findings

The service was found to be Non-compliant following a Site Audit conducted 1 December 2021 to 3 December 2021 in the following Requirement 1 (3)(d). In response to the decision of non-compliance the service commenced a range of initiatives to address the deficits identified and has demonstrated improvement in all these requirements in line with the service’s plan for continuous improvement.

Overall consumers and representatives sampled said risk taking was supported by the service and this provided consumers with opportunities to be independent and have their choices respected. A review of sampled consumers’ care documentation confirmed assessment of individual consumer’s risks and that there are relevant management strategies documented. Management and registered nursing staff interviewed said risk assessments are conducted as consumers risks are identified and provided examples of how consumers have been supported to take risks and how these are managed to enable the consumer to live the best life they can.

The Assessment Team found the service has implemented a number of actions in response to the non-compliance. Since the site audit all consumers identified as not having relevant risk assessments and strategies documented to mitigate risks have been reviewed with up to date assessments completed. Dignity of risk forms now include specific risks that consumers are accepting as well as strategies to mitigate risks. Risk assessments have been mapped to care plans to provide assessment details. An upgrade to the new version of the clinical documentation program has enabled the mapping.

A risk assessment register is in place and shows consumers have been reviewed. The register confirms discussion with consumers/representatives, whether dignity of risk forms have been completed and that care plan information has been updated. An audit was conducted to ensure risk assessments and dignity of risk forms have been completed. Any gaps identified have been followed up and training provided to nursing staff.

Clinical governance committee meeting minutes evidence discussion about mapping risk assessments to care plans and the completion of safety risk assessment and dignity of risk assessments.

I am satisfied the service demonstrated consumers are supported to take risks enabling them to live their lives as they wish to. Risks are assessed, reviewed, documented and managed. Interviews with consumers, representatives and staff documentation review and observations at the service confirmed improvements have been made since the last assessment and consumers are satisfied with the opportunities to live independent lives and make choices with the support of the service. I find the service is Compliant with Requirement 1(3) d.

# 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 found to be Non-compliant following a Site Audit conducted 1 December 2021 to 3 December 2021 in the following Requirement 3 (3)(a). In response to the decision of non-compliance the service commenced a range of initiatives to address previously identified deficits, in particular regarding restrictive practices and falls prevention and management. The service demonstrated improvements have been made and this is reflected in the service’s plan for continuous improvement.

The Assessment Team found the service demonstrated each consumer’s care is in line with best practice, tailored to consumers’ needs and optimises their health and well-being. Overall consumers and representatives sampled said they were satisfied that consumers clinical care was managed well in relation to chemical and environmental restrictive practices, wound care, pain and falls management. A review of consumers’ care documentation confirmed assessment and management plans for consumers clinical care were in place with individual strategies documented to guide staff practices. Management, registered nursing staff and care staff provided examples of how consumers clinical care is assessed, managed and reflective of their needs and preferences.

The falls management policy and the restrictive practice management policy have been reviewed and aligned with best practice and reflected in the service’s plan for continuous improvement. The Assessment Team noted monthly audits of falls were conducted between March 2022 and June 2022 with results analysed and tailored strategies put in place for individual consumers including where appropriate a medication review.

The psychotropic medication register has been reviewed and updated for each individual consumer to reflect when the update occurred and any changes to consumer medication requirements. A monitoring tool was implemented to monitor consumers for any side effects or adverse events, any harm or changes to consumers well-being when they are administered chemical restraint medication and a Registered Nurse signs completed forms. Medication advisory committee meeting minutes show that restrictive practice is a standing agenda item at meetings.

The impact of environmental restraint is documented on a tool within the clinical documentation system. Environmental restraint audits were conducted regarding consumer use of swipe cards and this is noted on the risk register. Consumers are administered PRN medication as a last resort and non-pharmacological interventions are tried first. Behaviour care plans have been updated and strategies are tailored to individual consumers.

I find the service demonstrated improvements are in place since the site audit in December 2021 and clinical and personal care is delivered safely and effectively and tailored to individual consumer needs. Consumers and their representatives confirmed their satisfaction with the care and services delivered. Staff are knowledgeable about best practice approaches to clinical and personal care, including assessing, monitoring reviewing and documenting restrictive practices. I find the service Compliant with Requirement 3(3) a.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(a) | The workforce is planned to enable, and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services. | Compliant |

Findings

The service was found to be Non-compliant following a Site Audit conducted 1 December 2021 to 3 December 2021 in the following Requirement 7 (3)(a). In response to the decision of non-compliance the service commenced a range of initiatives to address the deficits identified and has demonstrated improvement in all these requirements in line with the service’s plan for continuous improvement. The service monitors and manages staffing skill mix and numbers to meet the needs, preferences and choices of consumers. Most consumers and their representatives interviewed commented that there are sufficient staff to provide prompt care to consumers and call bells are answered promptly.

The service completed an upgrade to the call bell system and reporting capabilities with final works completed in September 2022. Call bell reports are now automatically generated every 24 hours enabling prompt review by senior staff, management said that any delays in call bells identified are discussed with staff and the consumer. Call bell reports viewed demonstrated improved call bell response times. Where call bell responses were noted to be slower, management reviewed staffing allocations. Call bell responses viewed for the last two months indicated improved response times. Management stated, and observations confirmed call bell times and analysis are now displayed on notice boards within the service.

In response to analysis of call bell response times completed by the service, replacement of ‘sensor beam’ alarms occurred as staff were inadvertently triggering alerts when checking consumers or leaving the room. Chair and bed sensors were also purchased.

Additional staff have been recruited to provide the service with access to additional ‘bank’ and casual staff to fill ongoing vacancies. Additional staff are provided based on consumer needs for example; allocation of an additional registered nurse each shift during a recent COVID-19 outbreak and in response to a consumer’s complex care needs. Formal agreements are in place with additional agency staff providers and long term leave and known staff shortfalls are monitored and replacement staff engaged to minimise impact on consumers.

I am satisfied the service has a planned workforce enabling, the delivery and management of safe and quality care and services. Consumers are satisfied there are sufficient staff to provide quality care. Call bell systems have been upgraded and improved and documentation reviewed indicated response times are monitored and analysed resulting in ongoing continuous improvement and a review of staffing allocations. Staff shortages have also been managed to address consumer needs and staff leave requirements. I find the service Compliant with Requirement 7(3) a.

# Standard 8

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| Organisational governance | |  |
| 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 found to be Non-compliant following a Site Audit conducted 1 December 2021 to 3 December 2021 in the following Requirement 8 (3)(e). In response to the decision of non-compliance the service addressed the deficits identified and has demonstrated improvement in line with the service’s plan for continuous improvement.

The Assessment Team found the service demonstrated it has a clinical governance framework in place which incorporates antimicrobial stewardship, restrictive practices and restraint and open disclosure. Documentation viewed reflects the service has minimised restraint use at the service and provided education to staff on restrictive practices and is maintaining relevant documentation including information about risk mitigation strategies.

Antimicrobial stewardship policies support the service to minimise the use of antibiotics. Staff explained the minimisation of antimicrobials, the importance of clinical assessment and review by general practitioners and use of pathology where possible prior to administering antibiotics. Infection registers are complete and antibiotic use monitored through the service’s Medication advisory committee meetings. Document review confirms infections are identified and discussed at Medication advisory committee meetings.

Open disclosure education is provided to staff and policies and procedures relating to incident management and comments and complaints reflect open disclosure principles. Incident reports, memoranda and letters viewed, including recent Serious Incident Response Scheme reports indicate that the service practices open disclosure principles when something goes wrong or incidents occur. Consumers and their representatives are satisfied with how incidents are communicated and confirmed the service apologises when an incident occurs, and actions are taken to minimise a reoccurrence. Staff were able to explain open disclosure principles relevant to their role and responsibility.

The service has implemented a number of actions in response to the previous non-compliance, including ensuring policies and procedures are in place relating to the use of restraint and restrictive practices. The service is monitoring consumer’s medication, continues to refer consumers to their general practitioner, geriatricians, aged persons mental health teams, Dementia Services Australia and an independent pharmacist for medication reviews with the aim of deprescribing medications which may constitute restraint. The service is maintaining a psychotropic usage tool to assist in monitoring psychotropic medications.

A risk register is in place which demonstrated all consumers are offered swipe cards with risk mitigation strategies discussed with consumers or their nominated representative and documented on dignity of risk forms. The Assessment Team did not identify or observe any consumers being subjected to physical, mechanical, environmental or chemical restraint.

The service is maintaining a register of psychotropic medications used which reflects consideration of ‘restrictive’ practices/chemical restraint, review dates, completion of behaviour support plans and consent for medication.

Consumers and their representatives interviewed confirmed consumers are able to move freely within and externally to the service based on their individual wishes. Consumers were observed moving freely throughout the service, accessing garden areas and using swipe cards or being assisted to open the main door by staff.

I am satisfied the service has a clinical governance framework in place and is implementing the framework. The service demonstrated antimicrobial stewardship, restrictive practices and restraint and open disclosure are actively managed. Policies and procedures are in place. Staff are aware of their responsibilities and consumers are satisfied with arrangements in place for clinical care. Documentation viewed demonstrated records are up to date and improvements are reflected in a plan for continuous improvement. I find the service Compliant with Requirement 8(3) e.

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)