Performance

Report

**1800 951 822**

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| Name of service: | Lyndoch Hostel |
| Service address: | Hopkins Road WARRNAMBOOL VIC 3280 |
| Commission ID: | 3347 |
| Approved provider: | Lyndoch Living Limited |
| Activity type: | Assessment Contact - Site |
| Activity date: | 21 March 2023 to 22 March 2023 |
| Performance report date: | 28 April 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 Lyndoch Hostel (**the service**) has been prepared by S Byers, 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 11 April 2023

# 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 2

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| Ongoing assessment and planning with consumers | |  |
| Requirement 2(3)(a) | 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. | Compliant |
| Requirement 2(3)(d) | 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. | Compliant |
| 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 in Standard 2 in relation to Requirements 2(3)(a), 2(3)(d) and 2(3)(e) following an assessment contact in September 2022 where it was unable to demonstrate:

* assessments were completed in a timely manner to identify risks and implement appropriate interventions
* effective communication to consumers and representatives, and that care plans were available and accessible
* care and services were reviewed regularly, when consumers circumstances change, and consistent incident reporting.

At the March 2023 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous assessment contact.

Consumer’s care planning documentation demonstrated care plans had been reviewed and included a range of validated clinical risk assessment tools to identify relevant risks to each consumers health and well-being. For example, pain assessments were completed and analysed by clinical staff, wound assessment and treatment were recorded in consumers wound management plans, skin care plans included the assessed risk of pressure injury and behaviour support plans included behaviour related risks, triggers, and non-pharmacological interventions. Staff demonstrated understanding of assessment and planning processes and specific risks associated with the care of individual consumers. The Approved Provider submitted a written response with clarifying information and documentation including care plans, progress notes, education records and a plan for continuous improvement. I am satisfied the documentation provided by the Approved Provider further supports consumers are receiving care and services in accordance with their assessed needs and preferences.

All consumers and representatives interviewed were satisfied with staff’s communication in relation to assessment and planning, and confirmed a care and services plan is readily available to them. Care planning documentation and progress notes demonstrated outcomes of assessment and planning were documented and care plan reviews completed in consultation with consumers and representatives and a copy of the care and services plan offered. Staff confirmed completing training in communication and care plan availability.

Consumer files demonstrated care and services are reviewed regularly for effectiveness through monthly ‘Resident of the day’ reviews and consultation with the consumer or their representative. Care documentation reflected assessments and care plans are updated in a timely manner when circumstances change and following incidents. Review of incident reporting documentation demonstrated staff record and investigate incidents in the risk management system and consumers, representatives and the medical practitioner are informed. Incidents are reviewed by management daily and by the Clinical Governance committee monthly.

Based on the available evidence, I find Requirements 2(3)(a), 2(3)(d) and 2(3)(e) are Compliant.

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

Findings

The service was found Non-compliant in Standard 3 in relation to Requirements 3(3)(a), 3(3)(b), 3(3)(d) and 3(3)(f) following an assessment contact in September 2022 where it was unable to demonstrate:

* each consumer received safe and effective clinical care in relation to pain, wounds and behaviour management
* effective management of high impact or high prevalence risks associated with responsive behaviours, oxygen therapy and weight loss
* timely response and effective management and monitoring of deterioration
* timely and appropriate referrals.

At the March 2023 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous assessment contact.

The service demonstrated best practice personal and clinical care are provided according to the consumers individual assessed needs in relation to pain, wounds, responsive behaviours and restrictive practices. Consumers and representatives were satisfied with the personal and clinical care provided by the service. Care documentation demonstrated wounds are reviewed by specialists and wounds are healing, pain-related risks, triggers and non-pharmacological strategies are documented to support individual consumers pain management needs and chemical restrictive practices are effectively managed, monitored and reviewed. Behaviour support plans detailed alternative strategies to be trialled before the use of a chemical restrictive practice and ongoing medical review and monitoring. Informed consent is obtained prior to the use of a restrictive practice. Staff demonstrated knowledge and understanding of each consumer’s care needs that aligned with the consumers assessed care needs. The service has updated its policies and procedures relating to wound and pain management. Staff demonstrated understanding of the updated policies in a practical way and confirmed receiving education in wound and behaviour management.

Consumers and representatives were satisfied risks associated with the care of the consumer are effectively managed. Care documentation and incident reports reflected review and reassessment following falls with individualised prevention strategies documented. A review of consumers who have experienced unplanned weight loss demonstrated referral and ongoing review by the dietitian and updated nutrition care plans that include current dietary information to manage the risk of malnutrition. Specialised nursing care plans detailed assessment and care planning information to guide staff in the effective management of the consumers specialised needs including oxygen therapy. Staff demonstrated an understanding of the high impact and high prevalence risks associated with each consumer and the strategies to manage and minimise risk to the consumer.

Consumers and representatives were satisfied the service responds to deterioration in a timely manner. Care documentation demonstrated the timely identification of, and response to, deterioration or changes in the consumer’s condition. Care documentation also reflected ongoing monitoring and management of deterioration with follow up review by medical specialists and allied health practitioners, where necessary. This aligned with staff knowledge and understanding. The organisation has updated their ‘recognising and responding to consumer deterioration’ procedure that guides staff practice in the prompt assessment and escalation of a deteriorating consumer.

The service demonstrated an effective system is in place to ensure timely and appropriate referrals. Consumer’s and representatives expressed satisfaction they have access to medical practitioners, allied health practitioners and other external specialists, as required. Care planning documents reflected timely and appropriate referrals to individuals, other organisations and providers of other care and services. Management and staff described the services referral processes.

Based on the available evidence, I find Requirements 3(3)(a), 3(3)(b), 3(3)(d) and 3(3)(f) are Compliant.

# 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 Non-compliant in Standard 7 in relation to Requirement 7(3)(a) following an assessment contact in September 2022 where it was unable to demonstrate:

* an effective system was in place to ensure the number and mix of members of the workforce are planned and deployed to deliver safe and quality care and services.

At the March 2023 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous assessment contact.

Consumers and representatives were satisfied with the improved staffing levels at the service and provided positive feedback in relation to staff response to calls for assistance. Staff were satisfied there is enough staff to complete tasks and described the strategies in place to manage vacant shifts or unplanned leave. Management described various strategies employed by the organisation to recruit and retain staff. The service has recruited and appointed several key personal in the last 5 months and additional clinical and care staff. Improved workforce rostering systems have been implemented with oversight by management and education provided to staff. Roster documentation demonstrated registered and enrolled nurses are rostered each shift and a significant reduction in the number of unfilled shifts since the previous assessment contact. Care staff are rostered in blocks within the service to ensure continuity of care for consumers, and staff are shared across the collocated residential aged care services within the organisation. Call bell reports demonstrated call bells are responded to in a timely manner. The Assessment Team observed staff attending to consumers’ needs in an unrushed manner and responding to call bells promptly during the assessment contact.

The Approved Provider submitted a written response with clarifying information about the additional workforce strategies in place to further support compliance with this requirement. I have considered the information in the Assessment Team’s report and the response from the Approved Provider and I am satisfied the service has in place systems and processes to ensure 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. I find Requirement 7(3)(a) is Compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(d) | 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. | Compliant |

Findings

The service was found Non-compliant in Standard 8 in relation to Requirement 8(3)(d) following an assessment contact in September 2022 where it was unable to demonstrate:

* the risk management system ensured risks were managed appropriately, including the effective management of high impact or high prevalence risks, and appropriate clinical oversight of clinical risks to ensure the delivery of safe and quality care to consumers.

At the March 2023 assessment contact, the Assessment Team found the service had implemented improvements to address the deficits identified at the previous assessment contact.

The organisation demonstrated strengthened risk management systems are in place in relation to high impact or high prevalence risks and incident management, supported by an updated clinical governance framework, established committees and associated guidelines, policies and procedures. Most consumers and representatives described their engagement in the planning and implementation of risk mitigation strategies.

The organisation has implemented a new risk register that is managed with oversight by management and senior leadership. Incidents are reported through an information management system, with management oversight to ensure the incidents are reviewed, and investigated and appropriate actions are undertaken to manage consumer risks. Management confirmed and the risk register and associated documentation including audit reports and meeting minutes demonstrated high impact and high prevalence risks are identified, managed, reported and actions to minimise risk are implemented. Incidents and clinical indicator data are collected, analysed, and reviewed by relevant clinical staff and management. Clinical data and key performance indicators are reported to the clinical governance committee and the governing Board. Clinical staff confirmed completing education relating to the identification of high impact high prevalence risks, risk assessment and management, and incident reporting.

Based on the available evidence, I am satisfied the service has in place effective risk and incident management systems. I find Requirement 8(3)(d) is Compliant.

1. The preparation of the performance report is in accordance with section 68A of the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)