Performance

Report

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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:** | 13 September 2022 to 15 September 2022 |
| **Performance report date:** | 16 November 2022 |

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 C Spiller, delegate of the Aged Care Quality and Safety Commissioner (Commissioner)[[1]](#footnote-2).

This performance report details the Commissioner’s assessment of the provider’s performance, in relation to the service, against the Aged Care Quality Standards (Quality Standards). The Quality Standards and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

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

# Material relied on

The following information has been considered in preparing the performance report:

* the assessment team’s report for the Assessment Contact - Site; the Assessment Contact - Site report was informed by a site assessment, observations at the service, review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the assessment team’s report received on 24 October 2022

# 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 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 |

The Assessment Team completed an unannounced Assessment Contact, assessing requirements that were found non-compliant in April 2022. The scope of the assessment was to assess the service’s progress in returning to compliance in 1(3)(e), 2(3)(a), 2(3)(d), 3(3)(a), 3(3)(b), 8(3)(d), 8(3)(e). These requirements were found non-compliant following a site audit conducted on 5 April 2022. However, during the site visit, the requirements to assess were expanded to include: 2(3)(e), 3(3)(d), 3(3)(f) & 7(3)(a).

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.

* Requirement 2(3)(a)-The service ensures assessments are accurately undertaken to identify risks and inform the delivery and effective care particularly in regard to skin integrity, pain and oxygen management, mobility, and managing responsive behaviours.
* Requirement 2(3)(d)-The service ensures outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available, particularly for unexplained weight loss and disruptive behaviours.
* Requirement 2(3)(e)-The service ensures care and services are regularly reviewed for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer, for pain management, psychological assessments
* Requirement 3(3)(a)-The service ensures consumers receive safe and effective personal care in particularly for pain management, skin integrity and complex nursing care.
* Requirement 3(3)(b)-The service ensures high impact or high prevalence risks are managed effectively for aggressive behaviour and their impact on other consumers.
* Requirement 3(3)(d)-The service ensures it is able to recognise and respond to deterioration or change of a consumer condition for worsening pain, wound management, catheter care and emotional distress.
* Requirement 3(3)(f)-The service ensures timely and appropriate referrals to individuals, other organisations and providers of other care and services are completed, especially for dieticians and physiotherapists.
* Requirement 7(3)(a)- The service ensures the workforce is planned and the number and mix of members of the workforce deployed enables, the delivery and management of safe and quality care and services.
* Requirement 8(3)(d) –The Service ensures effective risk management systems are implemented in regard to managing high impact or high prevalence risks and incident reporting and management.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(e) | 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. | Compliant |

Findings

I assess this requirement as compliant

The service was found non-compliant with this requirement following a site audit in April 2022. The service did not communicate information in a clear, accurate and timely manner, about visitation restrictions due to COVID-19. Consumers and their representatives found the information provided by the service did not enable the consumers the choice of how and when they could have visitors. Following this assessment contact, the Assessment Team has recommended the service is met.

Overall consumers said they have received letters recently on changes to management, visitor guidelines and most consumers confirmed they are informed of the day to day activity program and menu options. Representatives confirmed receiving electronic mail with updates on visiting guidelines and management changes at the organisation. Staff said they leave the letters in the communal areas rather than deliver the letters to each consumer’s room. The service was able to demonstrate information is provided to consumers and representatives by various mechanisms. Management provided copies of communications that have been either directly emailed to all representatives who have provided a valid email address and made available throughout the service and the information that has been posted on the organisation’s social media platforms in the past 3 months. The service notice boards in the communal and dining areas were observed to communicate menu options, a weekly activity program and various advocacy and government resources. The Assessment Team observed several copies of a recent organisation letter available at the service.

# 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. | Non-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. | Non-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. | Non-compliant |

Findings

I find the service non-compliant in requirements 2(3)(a), 2(3)(d) and 2(3)(e);

The service was found non-compliant with this requirement 2(3)(a) and 2(3)(d) following a site audit in April 2022. Care documentation of sampled consumers did not always provide evidence of assessment and planning in respect of potential risks to their health and well-being. The service did not effectively communicate outcomes of assessment and planning to the consumer and/or their representative. Representatives expressed overall dissatisfaction with the availability and accessibility of care plans for their loved ones.

The service was not able to demonstrate assessment and planning adequately considers risks to consumers or informs the delivery of safe and effective care and services. Assessments are not completed in a timely manner to identify risks and implement appropriate interventions to manage skin integrity, deterioration, aggressive behaviours, pain and promote safe mobility and transfer. Not all elements of risk were included in the assessment and care planning information for all consumers. Deficits included assessments relating to skin integrity, pain and oxygen management, mobility, and managing responsive behaviours. Following feedback from the Assessment Team, clinical management acknowledged that assessment and care planning for consumers could be improved at the service.

The service was not able to demonstrate that the outcomes of assessment and planning are consistently communicated in a care and services plan that is readily available to the consumer. Four consumer representatives expressed overall dissatisfaction with the provision of information regarding the outcomes of care assessments and planning, including the availability of care planning documentation. Communication of a consumer care plan and recent weight loss did not meet the expectations of one sampled representative. Disruptive behaviours had not been communicated to a consumer’s representative.

The service was not able to consistently demonstrate incident reporting is completed as required for consumers who have reported circumstances of emotional abuse from staff. The service was also not able to demonstrate that care and services are reviewed regularly when circumstances changed. Reassessment of care planning to include emotional and psychological assessments and interventions following reported incidents of abuse of a consumer have not occurred. Review of a dietary assessment and nutrition care plan has not occurred for a consumer following unintentional weight loss. Reassessment of pain management has not occurred where a significant increase in pain arose for one consumer. Reassessment of a catheter care plan has not occurred for a consumer to ensure required catheter change and care is attended.

The approved provider submitted a response to the Assessment Team report and a plan for continuous improvement, providing details of a number of mitigation strategies to address the deficits identified. These include; appointment of a clinical consultant, undertaking a project to revise governance and current consumer care, reviews of care plans, wound management audits, mentoring for staff, Serious Incident Reporting Scheme(SIRS) and incident reporting, education, commencement of head to toe assessments and additional allied health professional support (including from a dietician, physiotherapist and psychologist).

I have reviewed the information from the provider and whilst I commend their commitment to address the deficits summarised above, these strategies are yet to be embedded and evaluated for effectiveness. The Approved provider did not provide evidence that these actions have been embedded. The evidence compiled by the Assessment Team persuasively demonstrates non-compliance in assessing and planning care for consumers. Therefore, I find the service non-compliant with requirements 2(3)(a), 2(3)(d) and 2(3)(e).

# Standard 3

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| Personal care and clinical care | |  |
| Requirement 3(3)(a) | Each consumer gets safe and effective personal care, clinical care, or both personal care and clinical care, that:   1. is best practice; and 2. is tailored to their needs; and 3. optimises their health and well-being. | Non-compliant |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Non-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. | Non-compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Non-compliant |

Findings

I find the service non-compliant with requirements 3(3)(a), 3(3)(b), 3(3)(d) and 3(3)(f);

The service was found non-compliant in requirements 3(3)(a) and 3(3)(b) following a site audit in April 2022. The service’s processes to identify, manage and minimise the use of chemical restraint were not effective. Further, environmental restrictive practices were not recognised or managed, impacting a group of consumers in one of the units. The service did not demonstrate effective management of behaviours of concern for a high a risk consumer at the service, which resulted in overall increased risk and anxiety for other consumers. During the Assessment contact the scope was increased to include 3(3)(d) and 3(3)(f)

In regard to 3(3)(a), the service is not able to demonstrate that each consumer received safe and effective personal and/or clinical care that is best practice, tailored to their needs and optimises their health and well-being. Deficits found by the Assessment included; sub optimal management and transfer recommendation not implemented, resulting in more pain and discomfort for a consumer. Deficits in wound management were identified including; missing wound assessments and documentation, and missed dressing changes for one consumer. Responsive behaviours were not assessed and no behaviour support interventions have documented for one consumer. In relation to chemical restrictive practices, the Assessment Team found the service demonstrated improvements in chemical restrictive practices, however, for environmental restraint, the service is still working towards obtaining consumer consent.

In regard to 3(3)(b), the service was not able to demonstrate that they effectively managed high impact/high prevalence risks for several consumers including aggressive behaviours, oxygen therapy requirement and management of unexplained weight loss. A lack of effective clinical oversight was evident in relation to safely managing clinical risks for several consumers which negatively impacted their quality of life.

In regard to 3(3)(d) the service does not respond effectively to deterioration. The Assessment Team found significant delays in attending to consumers for worsening pain, suffering emotional distress, skin deterioration and development of wounds, and catheter care.

In regard to 3(3)(f), the service is not able to demonstrate that timely and appropriate referrals had occurred for consumers at the service in relation to pain management, behaviour management, decline in emotional and mental well-being, weight loss and mobility issues.

The Approved provider submitted a response to the Assessment Team report and a plan for continuous improvement. Actions included; conducting a wound management and restrictive practices audit, referral of consumers to a wound specialist, education on wound care, restrictive practice and pain management, review of pain management and wound management policies, and a review of roles and responsibilities.

In making this decision, I have reviewed the information available to me. While I note the actions completed and planned by the service, the Assessment Teams findings demonstrate there are significant deficits across many areas of clinical and personal care adversely affecting consumers. The approved provider has indicated these improvements have been planned across three phases, phase two is currently underway, phase three will embed the changes as part of an education plan. Strategies to address these deficits are yet to be fully implemented and sufficient time has not elapsed to evaluate any improvements. Therefore, I find the service non-compliant with four requirements 3(3)(a), 3(3)(b), 3(3)(d) and 3(3)(f).

# 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. | Non-compliant |

Findings

The service did not adequately demonstrate they have a system to plan workforce numbers and the range of skills they require to meet consumers’ needs and deliver safe and quality care and services. Overall, consumers and their representatives said there were not enough staff to adequately attend to consumer needs and staff were always busy. Staffing levels negatively affected consumer personal care with reduced capacity to support showering, attend to toilet requests and take consumers outside were some of the examples provided by consumers and their representatives. One consumer, had to leave their room and go out into the corridor, wrapped in a towel, to look for staff to assist them post showering. Inadequate staffing levels is also negatively impacting clinical care. Significant deficits, inaccuracies and delays were found in assessments and planning of clinical care and assessing risks to effectively manage skin integrity, consumer deterioration, catheter care, aggressive behaviours, pain, enabling safe mobility and transfer, emotional and psychological assessment (refer to Requirement 2(3)(a), 2(3)(d), 2(3)(e), 3(3)(a), 3(3)(b), 3(3)(d) and 3(3)(f).

Staff said they often work short staffed and, in some instances, they work alone with no breaks during their shift, to care for up to nine consumers. Staff described how the lack of staffing negatively impacts directly on consumer care. Staff described an incident, where a consumer had recently had a fall and sustained an injury, the staff member, who was working alone had to leave the consumer, in the care of other consumers, while they sought assistance. Care staff described they are having to work alone on occasions providing care to consumers, working in the pantry and administering medications. The Assessment team were provided with rosters and one shift had only one staff rostered between 15.15-17.00pm on one day. The Assessment Team observed there to be one staff member working alone for a period of 1.5 hours on the second day of the assessment contact.

In addition to the above evidence, the Assessment Team reviewed a Worksafe Improvement Notice issued to Lyndoch Living Limited on 24 August 2022, which identified multiple issues that aligned with consumer, representative and staff interviews. The Assessment Team requested call bell reports on several occasions during the assessment contact. Raw call bell data was provided without any analysis.

The approved provider submitted a response which did not refute the Assessment Team findings, but incorporated them into a plan for continuous improvements. Actions included: engagement of an external HR consultant, meetings with surge workforce providers, recruitment of five new life style employees, dedicated rostering staff for hostel, action plan submitted and accepted by Worksafe and commenced review of clinical roles and scope of practice.

While I note the actions taken and planned to address workforce issues, these strategies have not yet been fully embedded or evaluated for effectiveness. In addition, the weight of evidence collected by the Assessment Team persuasively demonstrates the workforce is not sufficiently planned or deployed to enable the delivery and management of safe and quality care and services and adversely affecting consumers. The Assessment team found numerous examples where consumers’ personal and clinical care has been negatively impacted refer to Standard 2 and 3). Therefore, I find the service non-compliant with requirement 7(3)(a).

# 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. | Non-compliant |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:   1. antimicrobial stewardship; 2. minimising the use of restraint; 3. open disclosure. | Compliant |

Findings

I find requirement 8(3)(d) non-compliant;

The service was found non-compliant in with requirement 8(3)(d) and 8(3)(e) following a site audit in April 2022. The service failed to demonstrate how high impact or high prevalent risks are effectively managed. There were failures by the service to recognise what constituted a restrictive practice with a number of consumers. Following this assessment contact, the Assessment Team has recommended the service continues to be not met in this requirement.

The service has organisational documentation such as frameworks and policies and procedures to support the management of risk in response to incidents, however, the service does demonstrate how high impact or high prevalent risks are effectively managed. The service did not demonstrate appropriate clinical oversight to ensure the consumers are receiving safe and quality care in a number of instances including; catheter care, clinical deterioration, weight loss and pain. The service’s risk management and reporting mechanisms are not capturing all incidents that have an impact on consumers. The service did not demonstrate the risk management system is ensuring risks are managed appropriately for pain, weight loss, skin integrity and behavioural management. Appropriate risk management processes to support consumers who have been impacted by the behaviours of a co-consumer were not in place. Appropriate risk management and review of a consumer’s behaviour to reduce ongoing impact on co-consumers’ wellbeing was not completed.

In their response, the Approved provider submitted a plan for continuous improvement that details a number of actions to address these issues, including; review of Clinical Governance Framework, review of roles of responsibilities of staff, and incident management and SIRS training.

In making this decision, I have reviewed all the information available to me, and while I note the steps taken and planned by the service to address the deficits, the impact on these named consumers is significant. The actions have not been fully implemented and evaluated to assess their impact and effectiveness. Therefore, I find the service non-compliant with requirement 8(3)(d).

In relation to 8(3)(e), I have assessed the service as compliant with this requirement:

The service was found non-compliant in this requirement following a site audit in April 2022. Following this assessment contact, the Assessment Team recommended the service is met in this requirement.

The service is able to demonstrate staff are aware of how to correctly identify and document consumers subject to chemical restraint and ensure regular review occurs and strategies are in place to minimise the use of restraint. The service provided the following documents; clinical governance framework and polices for antimicrobial stewardship, minimising the use of restrictive practices and open disclosure. Staff demonstrated that they understood these policies. The Assessment Team observed staff using open disclosure during the assessment contact when a representative raised a concern. The staff member acknowledged the concern, apologised to the representative and informed them they would rectify the matter.

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-2)