Residents’ suffering exposed in report on Lyndoch Living

Description

A performance report from earlier this year reveals Lyndoch Living has failed to meet 3 out of 4 quality standards set by the Aged Care Quality and Safety Commission.

Exclusive

Carol Altmann – The Terrier

A string of failings at Lyndoch Living has been exposed in a damning report by the national aged care watchdog.

A report released by the Aged Care Quality and Safety Commission in March – but which I was alerted to only today – lays out a shocking series of inadequacies recorded after a two-day visit by the commission to Lyndoch in January.

The commission is the peak federal body for assessing and accrediting aged care homes and for handling complaints.

Its assessment team found Lyndoch was non-compliant in three out of four key measures for resident care and staffing.

A separate report released at the same time shows the Lyndoch Hostel section passed on all measures, but an 11-page report into other, unidentified, sections of Lyndoch reveals a story of wounds, falls, pain, lack of consent, outdated records and crying out for help.

The report focusses on five specific residents, and it makes for heart-breaking reading.

Here are some of its findings:

Resident one, who was living with severe dementia, experienced “breakthrough” pain levels daily for three weeks without receiving any further pain medication, pain assessment, monitoring or evaluation;

A pain assessment plan set out by a specialist team was not followed;

The specialist’s recommendation that a pain medication patch be increased was not followed;

This same resident also had several wounds which were not adequately overseen by staff;

In regard to one of the wounds, all four management plans failed to record if the wound was getting better or worse, with boxes on wound size either unchanged or left blank;

Another resident was being given antipsychotic drugs “as required” – which is defined as chemical restraint – with no proof of consent:

“The representative of the [resident] told the Assessment Team that they had not provided consent and were unaware of any potential side effects of the use of the medication,” the report says.

A third resident had a fall and was hospitalised overnight with a significant laceration but, upon returning to Lyndoch the next day, was not reviewed for pain or possible brain injury:

“The Assessment Team found that staff did not undertake a timely review of the consumer’s pain on return from hospital and did not undertake neurological observations.”

This same resident later developed shoulder pain, but an order for stronger pain relief was not processed until two days later, with a GP review three days later.

A fourth resident, who lives with dementia, had an unwitnessed fall, but was not assessed for pain or a possible head injury.

Two days later, the same resident had two more falls which “qualifies” for a CT scan, that occurred.

The report says Lyndoch refuted the assessment team’s statements about this incident and also questioned the accuracy of its findings.

The team, however, stood by its report.

It says “the key points were timeliness of pain review following a fall and whether staff undertook neurological observations. Particularly …. for unwitnessed falls where the consumer could have hit their head…”

A review of records of a fifth resident, who was on psychotropic medication, found the medication records were out of date.

As a result of these incidents, Lyndoch was found to be non-compliant in standards for Personal Care and Clinical Care.

It was also found to be non-compliant in Human Resources and had “not ensured the delivery of safe care and services”.

The assessment team said it witnessed staff rushing tasks and staff walking past a resident who was calling out for help without stopping to offer support or assistance.

A review of the roster across a two-week period found some shifts were unfilled.

It also found failings in infection prevention and control, including:

poor use of personal protective equipment by some staff;

social distancing not always being adhered to by some staff and;

not taking all reasonable steps to prevent visitors who do not meet entry requirements from entering the facility.

Staff shortages and a lack of suitably qualified staff also came under fire:

“the skills of the current mix of staff delivering the care are inadequate and are not meeting the current needs of (residents).”

So there it is in black and white: Lyndoch is failing in its core business of caring for our elderly and frail.

It is failing some of the most vulnerable people in our community and yet there are still those within Lyndoch who will deny, deflect and head to the May Races.

This is not the fault of the exhausted Lyndoch staff.

The buck does not stop with them: it stops with those who decide the priorities of Lyndoch.

Right now, the number one priority for Lyndoch is building a $24 million, 3000sq/m medical clinic with no clear benefit to the residents.

This is how disgracefully lop-sided things have become and how far Lyndoch has drifted from its core purpose.

And so we have reports of wounds, falls, pain, missing records, soreness, sadness and crying out for help.

This is not happening in a private aged care home deep in the outskirts of Melbourne: it is happening in Warrnambool, in a place owned by us, the community.

Why has Lyndoch not told us about this report, apologised for its failings and pledged to do better?

Do we simply shrug our shoulders and say “that’s how it is in aged care” and turn away?

I can’t turn away and I know you can’t too.

We have to be the voice of the voiceless and refuse to accept silence as a solution.

[The commission has set down seven areas in which Lyndoch must improve to avoid any risk to its accreditation. You can read those here. It should be noted the commission says Lyndoch has challenged or refuted many of its findings. You can download the full report here.]

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