Performance

Report

**1800 951 822**

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| Name of service: | Latrobe Valley Village Hostel |
| Service address: | 5 Ollerton Avenue MOE VIC 3825 |
| Commission ID: | 3113 |
| Approved provider: | Latrobe Valley Village Inc |
| Activity type: | Assessment Contact - Site |
| Activity date: | 20 June 2023 to 21 June 2023 |
| Performance report date: | 8 August 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 Latrobe Valley Village Hostel (the service) has been prepared by C Spiller, 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 on 13 July 2023 and a further update on continuous improvements actions received on 4 August 2023.

# Assessment summary

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| 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 | **Non-compliant** |

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.

**Standard 8(3)(d**)-The service ensures a system of governance is in implemented and evaluated for wound care, pain care and post-fall management.

# 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 |

Findings

The service was found non-compliant with Requirement 3(3)(b) following a site audit conducted from 19 September 2022 to 21 September 2022. The service at that time did not demonstrate that risks associated with falls and wounds were effectively managed. The service has implemented remedial action in response to the non-compliance identified at the site audit in 2022 including updating assessment tools and providing staff training.

During this assessment contact, the service demonstrated it continuously develops and applies new measures to minimise risk, however assessors found the service is not routinely or consistently documenting consumer wounds or documenting pain monitoring following falls.

In its response to the site assessment report, the approved provider described a range of actions completed or underway to address documentation of wounds. A wound management flow chart has been developed, additional staff education has commenced, the clinical care coordinator will oversee wound management and monitor as part of clinical indicators tracking and the wound management policy has been revised. The provider has conducted a full review all wounds and new checklists have been developed to assist with compliance and documentation for clinical care. To ensure an assessment for pain post falls occurs, the provider has revised their tools and added pain charting to their post falls check list. In their response, they reviewed multiple consumer files and stated that pain assessment is completed and routinely documented, however not routinely copied into pain charting, so the Assessment team finding was a documentation anomaly rather than oversight in care.

I have considered the information from the Assessment team and the provider. The service acknowledged the deficits found by the Assessment Team and have promptly addressed with several improvement actions either completed or underway. In their response, the provider submitted evidence of revised policies, tools, policies and processes to improve their practices. The consumer issues raised by the Assessment Team appear to be isolated instances and mostly linked with documentation, without adverse impact on these consumers. Accordingly, I find the service compliant with Requirement 3(3)(b).

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Compliant |

Findings

The service was found non-compliant with Requirement 6(3)(c) following a site audit conducted from 19 September 2022 to 21 September 2022. The service at that time did not demonstrate that an open disclosure process is followed when things go wrong, with deficits in staff knowledge in relation to open disclosure. The service has implemented remedial action in response to the non-compliance identified at the site audit in 2022 including providing staff training, revising incident forms and implementing a policy on open disclosure.

During this assessment contact, assessors drew on evidence from ten sampled consumer files which demonstrated the application of open disclosure principles when things go wrong, including following a complaint or incident. The majority of consumers and consumer representatives expressed satisfaction that open disclosure processes are used following incidents and incidents are investigated to prevent incidents from re-occurring. Management advised the majority of staff have completed open disclosure training. Accordingly, I find the service compliant with Requirement 6(3)(c).

# 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 with Requirement 7(3)(a) following a site audit conducted from 19 September 2022 to 21 September 2022. The service at that time did not demonstrate an adequate level of staffing which impacted the delivery of care and completion of clinical documentation. The service has implemented remedial action in response to the non‑compliance identified at the site audit in 2022 including additional recruitment and industry engagement, and enhancements to rostering and handover tools.

During this assessment contact, drawing on evidence from 14 consumers, assessors found the majority of consumers expressed satisfaction with staffing levels at the service. Assessors also reviewed documentation which demonstrated the majority of shifts were filled in May 2023, and that the majority of call bells are responded to within the service’s identified benchmark. Accordingly, I find the service 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

The service was found non-compliant with Requirement 8(3)(d) following a site audit conducted from 19 September 2022 to 21 September 2022. The service at that time did not demonstrate that falls were investigated to prevent re-occurrence, incident data was not analysed or used to review staff training needs and staff were unable to recognise high impact or high prevalence risks at the service. The service has implemented remedial action in response to the non-compliance identified at the site audit in 2022 including introducing new checklists, enhancing incident data capture and introducing a clinical governance framework.

During this assessment contact, the service demonstrated a commitment to continuous improvement with incident data now being used to detect care deficits and inform staff training needs. Assessors reviewed the monthly care management report which indicates falls and wounds are consistently captured in the clinical incidents register. However, assessors found the service could not demonstrate a system of governance to mitigate deficits in post-fall management, wound care and pain care.

In its response to the site assessment report, the approved provider described several actions to improve the post fall management, wound care and pain care, refer to Requirement 3(3)(b) for further details of this. In addition, they have updated the skin/wound audit report to include weekly Registered Nurse (RN) reviews together with photos and measurement and this will occur every month to ensure new practices are maintained. A report for falls has been expanded to capture and evaluate falls more broadly and the falls risk assessment tool (FRAT) now includes pain indicator to identify the risk of pain related to falls. A daily RN Team checklist has been created to ensure clinical indicators are being monitored, completed and documented. A transfer/return from hospital checklist has been created and staff have been educated on this. A clinical practice and support officer position description has been created to be responsible for clinical audits, analysis, and the development of educational and training responses from the outcomes of the clinical indicators. The provider submitted a further update on the continuous improvement activities which provided details of progress and review dates and the clinical practice support officer position has now been filled and will commence August 2023.

I have considered the information from the Assessment Team report and the provider. The provider, in their response, has acknowledged, been proactive and provided additional documentation to address the issues found by the Assessment Team. They have provided comprehensive details of a range continuous improvements actions to strengthen the system of governance to mitigate any deficits in post-fall management, wound care and pain care, however these improvements are yet to be fully implemented and embedded and will need to be evaluated for effectiveness. Accordingly, I find the service non-compliant with Requirement 8(3)(d).

The service was found non-compliant with Requirement 8(3)(e) following a site audit conducted from 19 September 2022 to 21 September 2022. The service at that time did not demonstrate consistent use of open disclosure in communication with consumers and/or their representatives. Staff were unaware of open disclosure processes and the service did not have policies and procedures relating to open disclosure. The service has implemented remedial action in response to the non-compliance identified at the site audit in 2022 including providing staff training and implementing a policy on open disclosure.

During this assessment contact, assessors reviewed a range of complaints, incident reports and checklists which demonstrated staff understand and apply open disclosure processes. Sampled consumers and representatives said they feel supported and are encouraged to raise concerns when something goes wrong. Accordingly, 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)