Performance

Report

**1800 951 822**

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| Name: | Latrobe Valley Village Hostel |
| Commission ID: | 3113 |
| Address: | 5 Ollerton Avenue, MOE, Victoria, 3825 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 15 November 2023 to 16 November 2023 |
| Performance report date: | 19 December 2023 |
| Service included in this assessment: | Provider: 554 Latrobe Valley Village Inc  Service: 1872 Latrobe Valley Village Hostel |

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 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 (performance assessment) – 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 29 November 2023 acknowledging the accuracy of the report and making one point of clarification.

# Assessment summary

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| Standard 4 Services and supports for daily living | 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 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Compliant |

Findings

The Assessment Team found the service is providing suitably sized quality meals that are varied meeting consumers dietary needs and preferences. All consumers and a representative interviewed expressed satisfaction with the quality and quantity of food provided at the service and said there are plenty of choices for each meal. Consumers are able to request alternate meals if they do not like what is on the menu.

The service has alternate choices at mealtime including soup, sandwiches, salad, and cold meats. If none of these are acceptable the service will prepare something else. The kitchen has a list of all consumers needs and preferences, which is updated as changes are needed or requested. The International Dysphagia Diet Standardisation Initiative (IDDSI) is referred to when preparing texture modified foods for consumers. These preparations follow the standard menu and the needs and preferences of consumers as seen by the Assessment Team in care plans.

I have considered the information in the Assessment Team report and the recommendation that the requirement is met. I find requirement 4(3)(f) 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 with requirement 8(3)(d) following a Site Audit conducted from 19 September 2022 to 21 September 2022 and an assessment contact conducted from 20 June 2023 to 21 June 2023. The service did not demonstrate effective risk management in relation to managing high impact or high prevalence risks and did not demonstrate a system of governance to mitigate deficits in post-fall management, wound care, and pain.

During the assessment contact conducted on 15 November 2023, the service demonstrated improved processes to the risk management governance systems. The service has an established system and processes for identifying and managing high impact high prevalence (HIHP) risks associated with the care of consumers. Management outlined current high-risk areas such as wounds, falls and unplanned weight loss. The service has implemented actions in response to the deficits previously identified including creating a new role, ‘Clinical Practice Support and Education Officer’ (CPSEO). The CPSEO responsibilities included monitoring, evaluating, and developing education for the purpose of improving the clinical indicator performance. The CPSEO has reviewed current policies and has developed wound management and flow charts to guide staff. The wound flow charts included guidelines to ensure accurate documentation in the electronic care document system. A monthly skin and wound audit has been implemented as clarified in the approved provider’s response. A falls prevention strategy is in place. Senior clinical staff track the high impact high prevalence risks through a report, which is discussed with the clinical governance committee. The Assessment Team viewed documents and observed processes indicating improvements have been implemented.

I have considered the information in the Assessment Team report and the response supplied by the approved provider including clarification about monthly skin and wound audits being conducted to ensure all processes are completed and where any gaps are found provision of education is implemented together with a range of other oversight improvements. I consider the implementation of improvements, the engagement of the CPSEO, the review of policies and improvements in risk management support a finding of compliance. I therefore find requirement 8(3)(d) Compliant.

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