Performance

Report

**1800 951 822**

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| Name: | Blue Care Emerald Avalon Aged Care Facility |
| Commission ID: | 5074 |
| Address: | 126 Borilla Street, EMERALD, Queensland, 4720 |
| Activity type: | Site Audit |
| Activity date: | 21 May 2024 to 23 May 2024 |
| Performance report date: | 24 June 2024 |
| Service included in this assessment: | Provider: 314 The Uniting Church in Australia Property Trust (Q.)  Service: 3431 Blue Care Emerald Avalon Aged Care Facility |

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 Blue Care Emerald Avalon Aged Care Facility (**the service**) has been prepared by Kimberley Reed, 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 Site Audit 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 14 June 2024
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| --- | --- |
| Standard 1 Consumer dignity and choice | Compliant |
| **Standard 2** Ongoing assessment and planning with consumers | **Compliant** |
| **Standard 3** Personal care and clinical care | **Compliant** |
| **Standard 4** Services and supports for daily living | **Not Compliant** |
| **Standard 5** Organisation’s service environment | **Compliant** |
| **Standard 6** Feedback and complaints | **Not Compliant** |
| **Standard 7** Human resources | **Not Compliant** |
| **Standard 8** Organisational governance | **Not 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.

* Meals are to be of suitable quality for consumers.
* Appropriate action is required in response to complaints
* Feedback and complaints is to be used to improve care and services
* The performance of the workforce needs to be regularly assessed, monitored and reviewed
* Effective organisational systems are required, relating to continuous improvement, workforce governance, regulatory compliance and feedback and complaints.

# Standard 1

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| Consumer dignity and choice | |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |
| Requirement 1(3)(b) | Care and services are culturally safe | Compliant |
| Requirement 1(3)(c) | Each consumer is supported to exercise choice and independence, including to:   1. make decisions about their own care and the way care and services are delivered; and 2. make decisions about when family, friends, carers or others should be involved in their care; and 3. communicate their decisions; and 4. make connections with others and maintain relationships of choice, including intimate relationships. | Compliant |
| Requirement 1(3)(d) | Each consumer is supported to take risks to enable them to live the best life they can. | Compliant |
| 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 |
| Requirement 1(3)(f) | Each consumer’s privacy is respected and personal information is kept confidential. | Compliant |

Findings

Consumers confirmed staff at the service treat them with dignity and respect. The service was identifying and recognising consumers from diverse backgrounds. The service was engaged in a variety of activities throughout the calendar year to celebrate the diversity of consumers in the service. The service accurately documented consumer identities and incorporated this information into care planning and delivery. Observations of staff interactions with consumers demonstrated services were being delivered in a caring and dignified nature. The service’s calendar noted celebrations of diversity throughout the year. These celebrations included a diverse range of activities but not limited to lesbian, gay, bisexual, transgender, and queer or questioning events, observing various religious holidays, and National Reconciliation week.

Consumers confirmed the services they received were culturally safe. Consumers were able to determine what services and supports they needed and how they would like them delivered. The service demonstrated their assessment, planning and care delivery was underpinned by consumer and representative input. Care staff identified consumers who came from diverse cultural backgrounds. They described which consumers liked to attend religious services and how they supported them to attend.

Consumers were able to make decisions about the delivery of their care. Consumers confirmed they could choose who they wanted to be involved in their care and to what extent they wanted representatives involved. Care planning documentation confirmed the consumer feedback. The service also demonstrated supporting consumers to maintain both personal and intimate relationships. The organisation had policies and frameworks to guide staff to support consumers’ choice and independence in the delivery of care and services.

The service demonstrated how they supported consumers to take risks. These risks were underpinned by risk assessments, risk management strategies and communication with consumers. Consumers felt supported by the service to take risks that maintained their quality of life. Care staff described how they would escalate to the Registered nurse on duty if a consumer wanted to engage in an activity which presented a risk to them.

The service effectively demonstrated how they provided information and supports to help consumers exercise choice. Information was provided to consumers in various ways, with consideration of sensory impairments. The service had a consumer information book containing details about the service and consumers’ rights. It explained how consumers can seek support, make a complaint, or engage with external agencies such as advocacy services. The service held monthly consumer meetings. Consumers and representatives could attend in person or access the written meeting minutes.

Consumers confirmed their privacy and confidentiality was respected by staff at the service. Consumers stated their personal care was conducted in a way which maintained consumer privacy and dignity. The service was utilising an information management systems and service delivery processes that maintained the privacy of consumers’ health information. When staff were conducting cares, all doors were observed to remain closed until care had been completed.

Based on the above information, it is my decision this Standard is Compliant.

# 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)(b) | Assessment and planning identifies and addresses the consumer’s current needs, goals and preferences, including advance care planning and end of life planning if the consumer wishes. | Compliant |
| Requirement 2(3)(c) | The organisation demonstrates that assessment and planning:   1. is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and 2. includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer. | 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 assessing risks to consumers’ health and wellbeing and planning care and services with consumers to ensure effective and safe delivery of care and services. Consumers and representatives confirmed care was planned to meet consumers’ care needs and preferences, with strategies to manage risk to consumers’ health and wellbeing. Consumer care documentation demonstrated staff assessed risk to consumers’ health and well-being and plan consumer care to manage risk. The service has risk assessment tools and policies to guide staff in assessment and planning for consumers’ care and services.

The service was ensuring consumers’ preferences and goals for care and services, including end of life care was assessed and planned. Consumers and representatives confirmed consumers’ current needs, goals, and preferences for care and services were identified by the service, including end of life care if the consumer wished to discuss. Care documentation demonstrated consumers’ care needs including end of life preferences were identified on entry to the service or as the consumer moves towards the end of life pathway, and preferences were documented in the care plan. The service had palliative care guidelines to guide staff practice for planning consumers’ end of life preferences.

The service demonstrated consumers and representatives and other organisations were involved in assessment and planning of consumers’ care needs. Consumers stated staff included them, and their representatives they wished to include, in the assessment, planning and review of their care and service needs. Consumers’ care documentation demonstrated consumers and representatives and other healthcare services such as the medical officer and allied health professionals were involved in assessment, planning, and review of consumers’ care and service needs.

The service was ensuring effective communication to consumers, representatives, staff, and other health professionals in relation to consumers’ care and service needs. Consumers confirmed staff discussed with them their care needs and provided a copy of their care plan if requested. Staff had access to care plans for consumers they are providing care for, through the electronic care system, summary care plan, and handover records. Consumers’ care documentation demonstrated the outcomes of assessment and planning were documented. Care planning documents and handover records were readily available to staff delivering care.

The service demonstrated consumers’ care and services were reviewed for effectiveness and when incidents occurred or with changes in care and service needs. Consumers and representatives stated clinical staff regularly discussed consumers’ care needs with them, and any changes requested were addressed in a timely manner. Consumer care documentation demonstrated consumers’ care plans were reviewed every three months and when circumstances changed, such as consumer deterioration or an incident. Staff were aware of incident reporting processes and how these incidents may trigger a consumer’s reassessment or review. The service’s care plan evaluation report demonstrated all care plans reviews prior to May 2024 were completed, and the care plans due for review in May 2024 were undergoing review.

Based on the above information, it is my decision this Standard is 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)(c) | The needs, goals and preferences of consumers nearing the end of life are recognised and addressed, their comfort maximised and their dignity preserved. | 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)(e) | Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 3(3)(f) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 3(3)(g) | Minimisation of infection related risks through implementing:   1. standard and transmission based precautions to prevent and control infection; and 2. practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics. | Compliant |

Findings

While the service was able to demonstrate consumers received individualised safe and effective care, the service was not identifying consumers subjected to environmental restraint. Consumers confirmed they received safe and effective clinical and personal care. Consumer care documentation demonstrated consumers received care in accordance with their assessment and planning needs. Staff described consumers’ individual needs and preferences and how these were managed in line with their care and service plan. The service had policies and procedures, to guide care and clinical practice.

Care documentation for four consumers identified episodes where the consumers had left the service and voiced to staff, they did not want to return to the service. However, staff had verbally encouraged the consumers to return to the service and the consumers returned to the service. The consumers’ care documentation identified a diagnosis of dementia and an individualised behaviour support plan. The care documentation also evidenced discussions with the consumers’ representatives, in relation to strategies to monitor the consumers’ whereabouts and a requirement of an escort when leaving the service for safety. However, these practises were not identified as constituting environmental restraint, and therefore consent and authorisation for the restraint had not been sought.

The Provider in its response to the Site Audit report accepted the practice of encouraging consumers to return to the service when they are expressing a wish to leave the service is a form of environmental restraint. The four consumers named in the Site Audit report were known to have a diagnosis of dementia and the strategy used by staff to redirect the consumers had been implemented in consultation with each consumer’s decision maker. The Provider has stated in its response, while staff understand the different forms of restrictive practice and had a basic understanding of environmental restraint, staff did not interpret the practice of returning consumers when they try to leave the service as restrictive practice. Actions have been taken to address the deficit of an absence of consent for restrictive practise for the four consumers and training for staff has occurred. The Provider evidenced behaviour support plans and risk assessments had been completed for the four named consumers. Retrospective incident reports were sent to the Serious incident response scheme in relation to unauthorised use of restrictive practice.

In coming to my decision of Compliance regarding Requirement 3 (3) (a), I am influenced by the fact conversations had previously occurred with the consumers’ representatives regarding the practice of encouraging consumers to return to the service, when they have expressed a wish to leave the service. I do not think the service was intentionally restricting consumers, rather there was a deficit in staff knowledge relating to restrictive practices. It is my decision this deficit has been rectified by staff education, ongoing monitoring by management of care documentation and staff practices and the completion of risk assessments to include consent for environmental restraint. Therefore, it is my decision Requirement 3 (3) (a) is Compliant.

The service demonstrated effective management of high-impact or high prevalence risks associated with the care of each consumer. Management stated the changing behaviours of one named consumer was the service’s current highest risk. Whilst most consumers and representatives said consumers’ felt safe at the service and risk in relation to consumers’ care was well managed in relation to falls management and pressure injury care, some consumers stated the named consumer’s behaviour had impacted on them feeling safe at the service. Interviews with staff and documentation demonstrated the service was actively investigating methods to effectively manage changes in the named consumer’s behaviours. Staff were observed engaging the consumer with activities and conversations.

Consumers’ comfort was maximised when they were nearing end of life. Consumers and representatives felt confident staff would provide end of life care in line with consumers’ preferences to maximise dignity and comfort. Consumers’ end of life care preferences were documented in a care and service plan. The service’s registered staff discussed with consumers and representatives the consumer’s end of life preferences during entry to the service, case conferences and as consumers moved through palliative care phases. The service had end of life and pain management policies to guide staff practice.

Staff responded to consumers’ deterioration in an appropriate and timely manner. Consumers confirmed staff respond to their needs quickly. Care documentation demonstrated staff recognised consumer clinical deterioration. Registered and care staff discussed changes to consumers’ mental health, physical function, or cognitive wellbeing at handover. The service had policies and clinical guidelines, such as deteriorating consumer and delirium assessment tools, to guide staff practice when monitoring for a consumer’s deterioration.

The service had effective communication systems to those providing care to consumers. Consumers and representatives confirmed consumers’ care needs and preferences were effectively communicated between staff and other health care services. Health professionals visiting the service had access to the electronic care system where consumers’ information was held. Care documentation evidenced consumers’ condition, needs and preferences were communicated to other services and the consumer’s representatives.

Consumers were appropriately referred to other services in a timely manner. Consumers and representatives confirmed consumers were referred to other health care services as they needed them and were reviewed regularly by the medical officer and Podiatrist. Care documentation demonstrated timely referrals to other health care services such as Allied Health, medical officers, pharmacy for medication supply and medication reviews, and local hospital specialists.

The service was able to demonstrate the minimisation of infection related risk and antimicrobial stewardship practices. Consumers were satisfied the service implemented strategies to minimise infections to consumers. The service had documented policies, procedures, and an outbreak management plan to guide staff in relation to antimicrobial stewardship, infection control, and for the management of infectious outbreaks. The service had influenza and COVID-19 vaccination programmes for consumers.

Based on the above information, it is my decision this Standard is Compliant.

# Standard 4

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| Services and supports for daily living | |  |
| Requirement 4(3)(a) | Each consumer gets safe and effective services and supports for daily living that meet the consumer’s needs, goals and preferences and optimise their independence, health, well-being and quality of life. | Compliant |
| Requirement 4(3)(b) | Services and supports for daily living promote each consumer’s emotional, spiritual and psychological well-being. | Compliant |
| Requirement 4(3)(c) | Services and supports for daily living assist each consumer to:   1. participate in their community within and outside the organisation’s service environment; and 2. have social and personal relationships; and 3. do the things of interest to them. | Compliant |
| Requirement 4(3)(d) | Information about the consumer’s condition, needs and preferences is communicated within the organisation, and with others where responsibility for care is shared. | Compliant |
| Requirement 4(3)(e) | Timely and appropriate referrals to individuals, other organisations and providers of other care and services. | Compliant |
| Requirement 4(3)(f) | Where meals are provided, they are varied and of suitable quality and quantity. | Not Compliant |
| Requirement 4(3)(g) | Where equipment is provided, it is safe, suitable, clean and well maintained. | Compliant |

Findings

The service provided safe and effective services and supports for daily living. Consumers stated services and supports for daily living met their needs and preferences. The service had policies and procedures to guide staff in assessments, risk assessments, the preparation of care and service plans, care and service reviews. Care documentation evidenced initial and ongoing assessments of consumers’ needs and preferences in relation to daily living. Staff demonstrated knowledge of consumers’ needs and preferences. The service’s activity program was discussed at consumer meetings. Staff were observed providing services and supports that were consistent with consumers’ needs and preferences. Consumers were observed attending groups activities such as book reading and singing.

The service promoted and supported consumers’ emotional, spiritual, and psychological well-being. Consumers were satisfied their emotional and spiritual needs were met. Consumers had access to Chaplains and a chapel that was always available. Consumer’s emotional, spiritual, and psychological needs were assessed with care strategies incorporated into their care and service plan. Staff were observed providing emotional support to consumers. The service partnered with a community wellbeing service to refer consumers requiring psychological support through a telehealth service.

Services and supports for daily living assisted consumers to participate in the community, have social and personal relationships and do things that interested them. Consumers confirmed supports were available to do the things that interested them. Leisure and lifestyle staff met with consumers individually and as a group to discuss the services and supports they required or would like. Staff supported consumers to participate in activities. The service’s records evidenced consumers’ needs, and preferences were accurately assessed, and the planning of support services was based on these assessments. Consumers were observed having social relationships, attending appointments outside of the service and doing things of interest to them.

The service had effective processes for the communication of information about consumers’ condition, needs and preferences. Consumers were satisfied with communication. The service used the electronic care system, daily handovers, and meetings to manage and communicate consumers’ information. The Lifestyle coordinator identified consumers’ needs and preferences in relation to communication. Care and support staff had knowledge of individual consumer’s needs and preferences. Consumers’ care documentation included lifestyle preferences such as their birthday, preferred religious denomination, meal preferences, food allergies, entertainment preferences and the celebration of special occasions. Lifestyle staff met daily and discussed consumers’ individual lifestyle preferences for the day.

Consumers were satisfied with the referral process. Policies and procedures guided the referral process, staff made appointments or supported consumers to make the appointment. The service referred consumers to individuals, other organisations and providers of care and services for support with their daily living needs. Contracted allied health providers and a Chaplain were available. Care documentation demonstrated the service referred consumers to other service providers when required such as the Chaplain.

Consumers were not satisfied with the quality of meals at the service. Consumers stated the meals were served cold, of poor quality and lacked choice or variety. Main meals for the service were pre-prepared offsite by a third party contractor and delivered to the service weekly. Meals delivered to consumers’ rooms were plated and placed on trolleys, then delivered to consumers’ rooms by care staff. Temperature checks of meals were not conducted prior to the delivery of meals to consumers’ rooms. Management at the service confirmed they were aware of consumer dissatisfaction and had commenced collecting data through food groups, audits and complaints. However, the service was unable to evidence any effective interventions taken in response to consumer feedback.

The Provider in its written response to the Site Audit report has stated it is actively working to address the consumer dissatisfaction with meal service, as evidenced in the Site audit report. Meetings have been held with organisational hospitality staff and management from the service. An audit was conducted, the outcomes of which will inform the next steps and timeframes for achievement. Hospitality staff will also attend the consumer meeting to seek any additional feedback to further inform follow up actions. Dining experience surveys have been distributed to all dining rooms and consumers, with an aim to survey all consumers by the end of June 2024. At the time of the Provider’s submission, 151 responses have been received and 83% reported positively regarding satisfaction with meals. Information will be trended and collated at the end of June 2024, to identify possible themes. A member of management will continue to taste test meals, this process has identified some regeneration processes of food is resulting in less than satisfactory appearance and quality. Tray service to consumers who prefer to eat in their rooms has been staggered, and a maximum of four trays are plated at any one time. The first and last meal for both dining room and room service will be checked for temperatures. Toolbox talks for hospitality staff have commenced in relation to correct regeneration of food processes.

In coming to my decision regarding Compliance in Requirement 4 (3) (f), I acknowledge the actions taken and planned by the Provider to improve consumer satisfaction with meal quality. I have also considered not all of the actions have been completed or tested for their effectiveness. It is my decision the Provider will need additional time to test improvement actions and gain further feedback from consumers relating to meal quality. Therefore, it is my decision Requirement 4 (3) (f) is Not compliant.

Equipment provided for daily living was safe, suitable, clean, and well maintained. Consumers were satisfied the equipment provided to support daily living was suitable, clean, and well-maintained. Staff confirmed stocks of equipment were available if needed and they had the capacity to purchase new equipment if required. The service had an effective equipment maintenance program. Safety checks were conducted regularly. Equipment was observed to be safe, suitable, clean, and well maintained.

Based on one Requirement being Non-compliant, this Standard is Not compliant.

# Standard 5

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| Organisation’s service environment | |  |
| Requirement 5(3)(a) | The service environment is welcoming and easy to understand, and optimises each consumer’s sense of belonging, independence, interaction and function. | Compliant |
| Requirement 5(3)(b) | The service environment:   1. is safe, clean, well maintained and comfortable; and 2. enables consumers to move freely, both indoors and outdoors. | Compliant |
| Requirement 5(3)(c) | Furniture, fittings and equipment are safe, clean, well maintained and suitable for the consumer. | Compliant |

Findings

The service’s indoor environment was welcoming, with wide unobstructed corridors and all common rooms opening to outdoor areas providing a light and airy atmosphere. There were several areas for consumers and representatives to relax, socialise and congregate. Consumers had their rooms decorated with furnishings and personal items that reflected individual tastes and styles. The service had an allocated activity room, multiple indoor common areas and a café that was open on Sundays for consumers and representatives to enjoy.

Whilst consumers confirmed the service was clean, comfortable and they can move freely indoors, consumers were dissatisfied with the maintenance of the service. Observations of the outdoor areas included overgrown garden beds and pathways obstructed by grass and shrubs.

Consumers provided feedback they were unable to manoeuvre their mobility aids safely on the footpaths, they missed looking at the flowers and plants and that there had not been a groundskeeper at the service for a long time. The complaints and feedback register contained multiple complaints regarding the state of the gardens since January 2024. Maintenance staff confirmed the service had been without a Maintenance officer since March 2024. Maintenance staff from another service was visiting the service three to four times a month to complete work as directed by the Residential service manager.

The Provider in its written response to the Site Audit report acknowledged delays in the maintenance of the gardens at the service and has escalated processes to expedite this. A priority work order for urgent action to be completed at the service was generated on 22 May 2024, with work completed onsite 23 and 24 May 2024. The maintenance team attended to hedge trimming, mowing and removal of overgrowth that encroached on walking paths. The Provider noted that paths were not completely blocked, but also acknowledged any encroachment of shrubs on walking paths was unacceptable. The Provider noted weather conditions in the region had an impact on the flowers and green grass at the service, and the service has been balancing the wish for green grass and flowers and the appropriate use of water. Recruitment processes continue for a dedicated Maintenance officer and the service continues to be supported by a maintenance officer from another service located three hours away.

In coming to my decision regarding Compliance in Requirement 5 (3) (b), I have considered the actions taken by the Provider to rectify deficits in the outdoor environment have been appropriate and timely. I have considered positive feedback from consumers in relation to the internal living environment, and the commitment of the Provider in attempts to secure a permanent Maintenance officer to the service. Therefore, it is my decision Requirement 5 (3) (b) is Compliant.

Consumers and representatives confirmed the furniture, fittings and equipment assisted consumers to be independent and they were kept clean and well maintained. Cleaning and maintenance of equipment were scheduled and monitored by management. Care staff were aware of the process for cleaning equipment utilised for providing personal cares and advised they recorded any maintenance issues for the maintenance team to coordinate repairs. Records demonstrated reactive maintenance items are usually completed within one to three days and the service had a preventative maintenance schedule which was developed and monitored by head office.

Based on the above information, it is my decision this Standard is Compliant.

# Standard 6

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| Feedback and complaints | |  |
| Requirement 6(3)(a) | Consumers, their family, friends, carers and others are encouraged and supported to provide feedback and make complaints. | Compliant |
| Requirement 6(3)(b) | Consumers are made aware of and have access to advocates, language services and other methods for raising and resolving complaints. | Compliant |
| Requirement 6(3)(c) | Appropriate action is taken in response to complaints and an open disclosure process is used when things go wrong. | Not Compliant |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Not Compliant |

Findings

Consumers and representatives felt encouraged, safe, and supported to provide feedback and make complaints and could describe the various methods available for them to do so including speaking to management or staff directly. Staff described how they escalate consumers’ or representatives’ feedback or complaints to management or assist the consumer or representative to fill out feedback forms. Complaints forms and information on how to make a complaint were located throughout the service with a locked feedback and complaints box located at reception.

Consumers and representatives were aware of external advocacy organisations and language services available to assist in making complaints. Staff had a shared understanding of the external services available and how they would support the consumer or representative and management described how advocacy and language services were promoted within the service. The service promoted methods to raise complaints externally and access interpreter services if required through posters on the noticeboards, an information stand located at the entrance to the service and promotional inclusion and contact details within the service’s entry pack and newsletters.

Consumers and representatives were not satisfied the service appropriately actioned and addressed complaints. Complaints documentation demonstrated the service does not always involve consumers or representatives in the resolution process to ensure complainants are satisfied with outcomes. Consumers stated they had raised concerns relating to the current state of the grounds, quality of food and call bell wait times. Consumers stated they had raised these concerns both formally at consumer and representative meetings, directly with management and informally with staff. Consumers and representatives stated when they raised concerns staff and management acknowledged their concerns and apologised, however they continued to see no improvement.

The Provider in its written response to the Site Audit report has committed to capturing all complaints in the feedback register. All open complaints are being addressed by the relevant department and the Residential service manager has overall accountability for effective complaints management. The feedback register will be reviewed weekly by the Quality, compliance and innovation partner and the findings will be reported to the Operations manager. The Residential service manager will be required to report any delays in complaints resolution to the Operations manager. This process will continue until improvements are evidenced. Each complainant named in the Site Audit report has met with the Residential service manager or their delegate to discus actions being taken in response to their concerns, updates will be provided to the complainant until resolution is reached and the complaint closed.

While I acknowledge the actions taken and planned by the Provider to address deficits in relation to complaints management, these actions are in their infancy and have not been tested for effectiveness or sustainability. Therefore, it is my decision Requirement 6 (3) (c) is Not compliant.

The service did not consistently use feedback and complaints to improve the quality of care and services. Management could not demonstrate how complaints were analysed, trended, or used to make improvements. Staff knew how to provide feedback to management but did not know how this information was used to improve care and services.

The Provider in its written response to the Site Audit report has recorded education was provided to management at the service in relation to what constitutes a complaint and the organisational expectation of how a complaint must be addressed. It was identified management did not comprehend the value of ensuring all feedback was captured to enable trending and inform opportunities for improvement. Any improvements identified from complaints will be recorded in the Quality register. Toolbox education sessions were delivered to staff to ensure a sound understanding of response to complaints. All meeting minutes were reviewed to ensure feedback and complaints were identified and recorded. Progress notes and case conference records are reviewed as part of daily clinical monitoring processes, and complaints and compliments that arise have been entered into the system. The organisation’s Clinical educator has been scheduled to deliver training to staff on feedback and complaints; this training is scheduled 25 to 28 June 2024.

I acknowledge the actions taken and planned by the Provider to ensure feedback and complaints are reviewed and used to improve the quality of care and services, however I am not convinced these actions have been embedded into daily practice at the service or tested for their sustainability. Therefore, it is my decision Requirement 6 (3) (d) is Not compliant.

Based on two Requirements being Non-compliant, this Standard is Not 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 |
| Requirement 7(3)(b) | Workforce interactions with consumers are kind, caring and respectful of each consumer’s identity, culture and diversity. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(d) | The workforce is recruited, trained, equipped and supported to deliver the outcomes required by these standards. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Not Compliant |

Findings

The workforce was planned to enable the delivery of safe and quality care and services. Consumers and representatives considered there were enough staff at the service to meet consumer needs, however noted at times waiting for assistance with personal cares. Management had contingency plans in place to replace staff when required and rosters were reviewed on a regular basis to ensure staff allocations were adequately meeting changing consumer needs and preferences. Staff confirmed there were adequate staff numbers to provide care and services in accordance with consumers’ needs and preferences and staff generally had enough time to undertake their allocated tasks and responsibilities.

Consumers and representatives described staff as kind, caring and respectful of consumers’ identity and culture. Staff described consumers’ backgrounds, culture, and identity and those people important to the consumer. Management monitored staff interactions with consumers through observations, and formal and informal feedback and complaints mechanisms. The organisation had a suite of policies and procedures that outlined the expectations and responsibilities of staff in relation to their treatment and interactions with consumers.

Staff were competent and had the qualifications and knowledge to effectively perform their roles. Consumers and representatives believed staff had the knowledge and skills to provide safe and quality care and services that met consumers’ needs and preferences. Staff regularly completed online training modules, including mandatory modules required during orientation. Staff were satisfied with the support the service provided to them in learning new skills. Staff competency was determined through skills assessments and was monitored through observations, feedback from consumers and representatives, surveys, and reviews of clinical records and care delivery. The service monitored criminal history certificates, professional registration, and COVID-19 and annual influenza vaccination records were maintained.

Care staff and management described the process of recruiting and training staff and consumers and representatives provided positive feedback on the staff who delivered care. The orientation and onboarding process included mandatory training, role specific training, training on the Quality Standards and supervised shifts. The service provided ongoing professional development, supervision and management to staff who requested further training and education.

Management at the service was unable to demonstrate regular assessment, monitoring, and review of performance of any member of the workforce had occurred. Management confirmed performance reviews were out of date and staff stated they had not received a review of their performance. Management stated staff performance was managed and responded to in response to complaints and feedback from consumers and representatives, staff and observations.

The Provider in its written response to the Site Audit report acknowledged management were unable to provide evidence of regular assessment, monitoring, and review of staff performance. The Provider noted staff performance was reviewed and assessed through regular monitoring and ad hoc conversations with the Residential service manager. Actions taken to address this deficit include the Administration officer and Roster officer have been tasked with scheduling performance development conversations in management’s calendar. The service created a new tracker for performance interviews that generates dates for regular probationary reviews.

It is my decision Requirement 7 (3) (e) is Not compliant despite the actions already taken by the service to address the absence of performance assessments for staff. Management will need time to complete performance assessments for staff and to test the effectiveness of the performance tracker.

Based on one Requirement being Non-compliant, this Standard is Not compliant.

# Standard 8

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| Organisational governance | |  |
| Requirement 8(3)(a) | Consumers are engaged in the development, delivery and evaluation of care and services and are supported in that engagement. | Compliant |
| Requirement 8(3)(b) | The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery. | Compliant |
| Requirement 8(3)(c) | Effective organisation wide governance systems relating to the following:   1. information management; 2. continuous improvement; 3. financial governance; 4. workforce governance, including the assignment of clear responsibilities and accountabilities; 5. regulatory compliance; 6. feedback and complaints. | Not Compliant |
| 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 |
| 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**

Consumers and representatives were confident in the way the service was run and their engagement in the development, delivery and evaluation of care and services. Consumers were supported to be engaged in the development, delivery and evaluation of care and services through consumer meetings, feedback forms and by providing direct feedback to management. The service conducted monthly consumer meetings, regular surveys, and provides feedback forms to encourage consumers in providing feedback.

The organisation had systems and processes to monitor the performance of the service and to ensure the governing body was accountable for the delivery of safe, inclusive, and quality care and services. The organisation’s policies related to organisational governance identified the leadership structure which outlines the roles and responsibilities of the Board, governance committees, service management, and quality management processes. These policies outlined a shared responsibility and accountability for maintaining compliance with the Quality Standards, with the Board having overall accountability for consumer safety, and quality care delivery.

The service was unable to demonstrate there were effective organisation wide governance systems in place as deficiencies were identified in relation to continuous improvement, workforce governance, regulatory compliance, and management of feedback and complaints. There were effective organisation wide governance processes in relation to information management and financial governance.

Continuous improvement activities were not identified through the complaints and feedback mechanisms. The service was not using feedback and complaints to improve the quality of care and services. The Provider in its written response to the Site Audit report has noted that actions to address Requirements 6 (3) (c) and 6 (3) (d) will ensure the service aligns their local practice with the organisational governance systems, to enable the governing body to monitor practices at the service.

Workforce governance processes were deemed ineffective as the service did not have a process for reviewing staff performance. Performance reviews were out of date and staff confirmed they had not participated in a review of their performance. Actions noted by the Provider in relation to Requirement 7 (3) (e) will ensure the service aligns their local practice with the organisational governance systems, to enable the governing body to monitor practices at the service.

In relation to regulatory compliance, incidents requiring escalation to the Serious Incident Response Scheme had not been identified or escalated by the service. The Provider in its written response to the Site Audit report noted the organisation’s internal processes had identified inconsistent identification of incidents that met the threshold for submission to the scheme. The service was actively working to ensure all historic incidents requiring escalation have been submitted. Management have been provided with extensive coaching and resources to better equip them in identifying incidents and feedback that meet the threshold for reporting to the scheme.

In relation to feedback and complaints the service was unable to demonstrate an effective system to gather consumer feedback and complaints to ensure appropriate and proportionate action is taken or how complaints and feedback drives continuous improvement in care and services. The Provider in its written response to the Site Audit report had noted actions in progress to address the deficits in Requirements 6 (3) (c) and 6 (3) (d) will ensure the service aligns their local practice with the organisational governance systems, to enable the governing body to monitor practices at the service.

In making my decision in relation to compliance for Requirement 8 (3) (c), I acknowledge the organisation had identified deficits in this Requirement prior to the Site Audit, including the identification of notifiable incidents which had not been escalated. However, it is my decision effective organisation governance has not been demonstrated in relation to continuous improvement, workforce governance, regulatory compliance and feedback and complaints. Therefore, it is my decision Requirement 8 (3) (c) is Not compliant.

The service had frameworks and policies to manage risk and respond to incidents at the service. The service demonstrated the management of high impact or high prevalence risks and the identification of abuse and neglect of consumers. Staff and management were able to provide examples of these risks and how they were managed within the service. Consumers were supported to take risks and participate in activities to enable them to live their best life. While some reportable incidents had not been identified or actioned by the service, this information has been considered in Requirement 8 (3) (c).

The service had policies in relation to open disclosure, antimicrobial stewardship, and restrictive practice and training was included within staff orientation and mandatory education. Clinical management and staff had an understanding of the clinical governance framework and provided practical examples of how antimicrobial stewardship, minimising the use of restraint and open disclosure were implemented on a day-to-day basis.

Based on one Requirement being Non-compliant, this Standard is Not compliant.

1. The preparation of the performance report is in accordance with section 40Aof the Aged Care Quality and Safety Commission Rules 2018. [↑](#footnote-ref-1)