Performance

Report

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| Name: | Blue Care Emerald Avalon Aged Care Facility |
| Commission ID: | 5074 |
| Address: | 126 Borilla Street, EMERALD, Queensland, 4720 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 1 October 2024 |
| Performance report date: | 25 October 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 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 Performance report completed 24 June 2024, following the Site audit conducted 21 to 23 May 2024
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 4 Services and supports for daily living | Not applicable as not all Requirements were assessed |
| **Standard 6** Feedback and complaints | **Not applicable as not all Requirements were assessed** |
| **Standard 7** Human resources | **Not applicable as not all Requirements were assessed** |
| **Standard 8** Organisational governance | **Not applicable as not all Requirements were 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**

Most consumers and representatives provided positive feedback relating to meals at the service. Feedback included that meals were of the correct temperature and of sufficient quality. Consumers were satisfied with the variety of meals offered and the opportunity to have additional servings or an alternative meal.

The service was found to be non-compliant in this Requirement following the Site Audit conducted on 21-23 May 2024, and this related to poor quality of meals, lack of variety of meals and meals served at the incorrect temperature.

The service has taken the following action to address previous non-compliance, and these actions have resulted in improved outcomes for consumers relating to meals. Issues were identified with the regeneration of meals and as a result, staff were provided with additional training and specialised equipment was purchased to achieve consistent meal temperatures. Previously meals were regenerated utilising one large container, by regenerating meals in two container the service was able to provide consumers dining in their rooms, meals at the same time as consumers dining in the dining room. This resulted in meals being plated from a heated container and therefore maintaining meal temperatures. The service purchased thermal pate covers to maintain meal temperatures from plating to delivery to the consumer. Soup kettles and air fryers were purchased and placed in all kitchens. The air fryers were utilised when consumers chose an alternate meal choice.

Temperature testing of first and last meal served was conducted to ensure therapeutic meal temperatures. Management at the service conducted random taste testing of meals, to monitor the quality and temperature of meals. Dining experience feedback forms were displayed throughout the service and management responded immediately to any concerns raised through the feedback forms. Meal service was observed during the Assessment contact and the dining experience was noted to be relaxed and consumers were interacting socially. Assistive cutlery was observed in use by one consumer, and another consumer was being discreetly assisted with their meal by a staff member.

Based on the actions recorded above and the positive feedback from consumers relating to meals, it is my decision this Requirement is now compliant.

# 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 |
| Requirement 6(3)(d) | Feedback and complaints are reviewed and used to improve the quality of care and services. | Compliant |

Findings

Requirement 6(3)(c)

Consumers and representatives stated the service responded appropriately to feedback and complaints. Staff and management were aware of the process of recording and responding to complaints, including the importance of using open disclosure. Feedback and complaints documentation included actions taken to address the concern and the outcome of actions taken, including discussions with consumers and representatives. The service used an electronic system to record feedback and incidents which identified if open disclosure has been practiced.

The service was found to be non-compliant in this requirement following the Site Audit conducted on 21-23 May 2024, and this related to the service not responding to feedback and complaints in a timely manner or using open disclosure and not involving the consumer in the resolution of the complaint.

The service has taken actions to address the previous non-compliance, and this has led to an improvement in complaints and feedback handling for consumers and representatives. Actions included the provision of education for staff relating to complaints handling and their responsibilities. Feedback was introduced as a standing agenda item in general and clinical staff meetings. Consumer and representative meetings included complaints and feedback as a standing agenda item, this was confirmed in meeting minutes. Progress notes wee reviewed to ensure complaints information was captured in the complaints register. The complaints register was reviewed by three members of management to ensure all complaints and feedback was responded to in an appropriate manner.

Based on the actions recorded above and the positive feedback from consumers relating to the management of feedback and complaints, it is my decision this Requirement is now compliant.

Requirement 6(3)(d)

Consumers and representatives expressed confidence the service used feedback and complaints to improve the quality of care and services and confirmed consumers’ suggestions were used to improve care. Management confirmed the service was trending and analysing complaints, feedback, and concerns raised by consumers and representatives and using this information to inform continuous improvement activities. Staff described areas where suggestions from consumers were used to improve care and services.

The service was found to be non-compliant in this requirement following the Site Audit conducted on 21-23 May 2024, and this related to the service was not using feedback and complaints, for review and analysis to improve the quality of care and services.

The service has taken actions to address the previous non-compliance, and this has led to an improvement in quality of care and services following the review of feedback and complaints. Actions have included a plan for continuous improvement used to detail strategies to review complaints data. Complaints data was reviewed to identify trends, which included meals and communication as significant areas of concern. Dining surveys were undertaken for a month and satisfaction levels were monitored. Following the suggestion of consumers, hydration stations were created in the dining rooms, the stations offered cool drinks for consumers to independently access. Concerns raised by consumers in relation to garden areas were addressed through a request for garden maintenance, and a team of workers addressing the garden areas were observed during the Assessment contact.

The service migrated their feedback and complaints to a new risk management program in July 2024. The new system provided more information to management leading to more useful information which was used to review and improve staff behaviour and activity, and outcomes for consumers. The complaints process improved consultation with consumers who made complaints and involved them in the resolution process, brainstorming ideas to resolve concerns. The suggestions were trialled, and the service followed up with the consumers to ensure the issue was resolved to their satisfaction.

Based on the actions recorded above and the positive feedback from consumers relating to improvements based on feedback and complaints, it is my decision this Requirement is now compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Systems were in place to regularly assess, monitor and review staff performance. Staff confirmed they were engaged in their professional development including opportunities to request specific training relevant to their role. Consumers and representatives were satisfied the workforce which provided consumers’ care and services performed their roles well. Staff confirmed they have had a performance development conversation in the last six months and provided feedback about the process such as requesting further training or clarifying their roles and responsibilities. An electronic tracking document was used to monitor the generation of emails to staff members who were due for a performance development conversation.

The service was found to be non-compliant in this requirement following the Site Audit conducted 21-23 May 2024, and this related to a lack regular assessment, monitoring and review of the performance of the workforce.

The service has taken actions to address the previous non-compliance, to ensure regular assessment of the workforce occurred. These actions included an electronic tracking document was established to monitor dates for staff performance reviews. Administration and roster staff scheduled performance discussions in management’s calendar and sent notifications to management and staff members of the due date for the activity. Staff confirmed they have undertaken a performance appraisal process and had been provided with notice, and documentation to complete before undertaking the formal process with management. Probationary staff advised they have undertaken interim performance appraisal processes.

Based on the actions recorded above and the positive feedback from staff regarding performance assessment processes, it is my decision this Requirement is now compliant.

# Standard 8

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| Organisational governance | |  |
| 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. | Compliant |

Findings

The service demonstrated processes for continuous improvement, workforce governance, regulatory compliance and management of feedback and complaints. The organisation restructured regional boundaries and the number of services within the boundaries to provide more consistent senior management support to the service.

The service was found to be non-compliant in this requirement following the Site Audit conducted 21-23 May 2024, and this related to continuous improvement activities were not identified through complaints and feedback mechanisms, workforce governance processes were ineffective in identifying staff had not participated in a review of their performance and incidents requiring reporting to the Serious incident response scheme had not been identified.

The service has taken actions to address the previous non-compliance, to ensure effective organisational systems were in place. These actions included the regional boundary change which resulted in additional allocation of senior management to the region. The service provided education to all staff relating to the management of feedback and complaint processes and the relevance to continuous improvement. Staff demonstrated a shared understanding of their roles in the correlation between complaints and continuous improvement. Feedback information visibility was increased with the additional managerial support. A software system was implemented to track performance conversations with staff. This was evidenced by all staff participating in performance discussions. Retrospective incident reports were completed for incidents that met the threshold of the Serious incident response scheme. Education was provided relating to incident escalation. The organisation amplified organisational clinical monitoring to provide oversight to the incident management system and reporting requirements. The service’s feedback and complaints information appeared as live data, on recently installed software for the review by management and quality partners.

Based on the information recorded above, and the return to compliance for other Requirements, it is my decision this Requirement is now 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)