Performance

Report

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| Name: | Blue Haven Bonaira |
| Commission ID: | 0094 |
| Address: | 14 Bonaira Street, KIAMA, New South Wales, 2533 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 17 January 2024 to 18 January 2024 |
| Performance report date: | 12 February 2024 |
| Service included in this assessment: | Provider: 238 The Council of the Municipality of Kiama  Service: 110 Blue Haven Bonaira |

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 Haven Bonaira (**the service**) has been prepared by Therese Solomon, 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.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Applicable |
| **Standard 4** Services and supports for daily living | **Not Applicable** |
| **Standard 6** Feedback and complaints | **Not Applicable** |
| **Standard 7** Human resources | **Not Applicable** |
| **Standard 8** Organisational governance | **Not Applicable** |

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 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 |

Findings

Requirement 3(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated consumers’ clinical and personal care is best practice, tailored to the consumer's needs and optimises their health and wellbeing. Consumers and/or representatives voiced their satisfaction with the clinical and personal care they receive. Care and service documents reviewed showed consumers with wounds, pressure injuries, restrictive practices, pain management, and complex care needs, receive the appropriate care that is aligned to their preferences and are best practice. Staff practices relating to the monitoring and management of behaviours of concern, pain, wound/skin integrity, and complex care are consistent with the service’s guidelines and are best practice.

Clinical and care staff described how they access clinical policies and guidelines and receive enough support and training to be able to provide quality and safe clinical and personal care to consumers. Care staff explained the use of strategies to manage consumers’ needs according to their care plans or by consulting with consumers.

The service has policies and guidelines for pain assessment and management. It is referenced to best practice guidelines and includes information to guide staff in determining which pain assessment tool and chart to use depending on the consumers’ cognition and ability to describe the pain. Clinical and care staff demonstrated knowledge of consumers who experience pain, described ways they recognise signs and symptoms of the pain and how they report and manage the pain as it occurs.

The service has a skin integrity and wound management policy and procedure. This relates to the identification of the risk of pressure injury and outlines preventative measures that can be put in place to minimise the risk of a consumer acquiring a pressure injury. The service receives assistance and guidance from a wound care nurse consultant and wound specialist for wound assessment and when clinical staff require guidance and support for wound management and care.

# 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

Requirement 4(3)(f) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated it is providing a dining experience that meets the expectation and needs of consumers. Staff were able to describe the meal preferences and needs for consumers and provided feedback on the improvements made since the commencement of the new chef, and since meals are prepared fresh on site. Observations of the meal service on both days of the Assessment Contact were congruent with the feedback provided by staff and consumers.

Consumers and/or representatives acknowledged the improvements made to the meal service in the recent months and provided positive feedback on the quality of the meals service and staff interaction. Some consumers provided feedback in relation to meal preferences, however stated the chef has addressed these concerns by having one-on-one discussions with the relevant consumers and developing a menu plan more suited to their preferences. Consumers are satisfied with these actions.

Review of service documentation indicates consumers and/or representatives are consulted and issues with meals are discussed at food focus groups and resident meetings. Complaints are addressed, investigated, actioned, and reviewed regularly and consumer satisfaction sought. Weights are regularly reviewed and showed the meal service has not had impact on consumers from a clinical perspective. Additionally, consumers who are able, are supported to choose their own meals from the serveries and serve themselves promoting independence and meal satisfaction.

# 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) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated it has taken appropriate action in response to complaints and is using open disclosure when dealing with complaints. Consumers and/or representatives provided consistent and positive feedback about the facility manager and staff members taking action to resolve their complaints, and stated they have no major complaints and that previous complaints were resolved to their satisfaction. Consumers and/or representatives consistently stated they feel heard by the facility manager and staff members, and appropriate action is taken to resolve any complaints.

Staff members were able to describe complaints made by consumers and/or representatives and how they are resolved on the same day or escalated to a registered nurse or a member of the management team such as a team leader, care manager or facility manager. Staff demonstrated a clear understanding of open disclosure policies and procedures, and can describe how they address consumers immediate needs, apologize, document the incident, and make improvements to prevent future occurrences.

Requirement 6(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated complaints and feedback are reviewed and used to improve the quality of care and services. Consumers and/or representatives stated they have experienced improvements in the quality of meals, an increase in staffing numbers and feel their concerns are heard and actioned to their satisfaction.

The facility manager monitors and analyses feedback and complaint data through the complaints register and clinical indicators. The facility manager meets weekly with all heads of departments and staff about complaints data and works with the chief operating officer and the governing body to review, analyse and implement improvements.

# 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

Type here Requirement 7(3)(a) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The service demonstrated they have actively engaged in recruitment of staff, monitored, and reviewed the roster and allocations to ensure consumers’ needs are met. Consumers and/or representatives acknowledge the efforts made by the service to engage more staff and provided positive feedback on staffing levels and mix. Generally, staff are satisfied with staffing levels and stated they are supported by management. Observations confirmed staff are actively engaging with consumers and answering call bells promptly.

Consumers and/or representatives provided complimentary feedback on staffing attitude, staffing levels, and staffing mix. They stated they do not feel staff rush them when they are delivering their care and ensure they are always respectful and nurturing in their practices.

The Assessment Team reviewed the roster, staff allocations, call bell responses and staff meeting minutes. The documentation indicated the service is actively addressing any incidental vacancies identified with strategies such as use of casual staff, extending shifts and as a last resort service familiar agency staff.

# 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 |
| 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

Requirement 8(3)(c) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation demonstrated it has implemented governance systems to effectively direct and manage policies and procedures to improve consumer outcomes. The governing body shows effective communication of strategies to implement improvements through the executive leadership team and the service management team, and throughout the organisation.

The service has an electronic digital system and the governing body exercises oversight through a dedicated information technology team qualified to manage information systems and consumer privacy. Staff have individual passcode access to access all available information related to consumer care. Consumers and/or representatives stated they have access to their care plans and personal information.

The governing body exercises oversight of continuous improvement strategies through a clinical governance team and in cooperation with the management team. Risks to effective care and services are identified, and strategies formulated through a continuous improvement plan which is regularly monitored and reviewed. Consumers, representatives, and staff confirmed improvements have been made in areas such as increases in staffing numbers, and improvements related to food, laundry services and lifestyle activities. The governing body is informed of operational performance and risks through reports and data gathered from various committees and regular operational meetings.

The governing body and management team have been instrumental in reducing agency staff usage and securing additional permanent staffing, including labour hire staff that are specifically contracted for an ongoing period of two years. This implementation was made to improve staff consistency to engage in long-term regular trained staff and build stronger ongoing relationships with consumers in contrast with casual agency staff.

The governing body engaged with an external catering service to provide food services to consumers while a new chef and permanent catering staff were hired and trained. Additional staffing numbers have increased in relation to care staff, registered nurses, lifestyle, catering, and administration. Consumers, representatives, and staff members confirmed an increase in staffing numbers and stated the service has sufficient numbers of staff available to provide safe and quality care and services.

Requirement 8(3)(d) was found to be non-compliant at a previous assessment. Since that time the Approved Provider implemented actions to address the non-compliance.

The organisation has systems to report, analyse, action, and monitor risk for consumers including responding to risk where they have a legislative responsibility. Consumers and/or representatives stated they are confident the service provides them with safe and effective care and services. Staff are knowledgeable and are aware of their responsibilities in relation to risk and promoting enabling processes that support consumers living the best life they can.

While high impact and high prevalence risks, incidents and accidents are managed and actioned at a service level, they are reported to the Chief Operational Officer who reports it to the Chief Executive Officer and the Blue Haven advisory committee. All risks and high-profile issues are reported to the Blue Haven advisory committee and to the risk committee should the risk be deemed as serious risk and needing additional management. There is a risk register that records all incidents and accidents including a Serious Incident Response Scheme register which is monitored and managed by the residential manager. The Quality Team and Chief Operating Officer have oversight on these registers and are able to escalate any significant issues further. A review of all high-impact and high prevalence risks is undertaken by the risk committee and an audit is completed to ensure these are well-managed or adequately mitigated.

The organisation has systems in place which enable staff to identify and respond to abuse and neglect of consumers. A Serious Incident Response Scheme register was reviewed and noted all incident are recorded, investigated, root-cause identified and reported in a timely manner. Care managers have oversight of these reports and confirm the report before being submitted to the responsible entity. Information is reported up the lines of responsibility through the facility manager and the Chief Operating Officer.

Staff were able to confidently outline and provide examples of what their responsibilities are in relation to elder abuse and neglect, they described what they would do if they witnessed abuse or neglect of consumers and detailed how the reporting mechanism works within the service and more broadly the organisation.

The service has an incident and accident register in place which contains incidents that occurred within the service. There is a risk register which outlines the various risks identified from the incident and accidents, and they have been risk accessed with action to mitigate or minimise the risks of reoccurrence. The quality team, Chief Operating Officer and the risk advisory committee have oversight on all risks at the service.

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)