

**Performance Report**

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| Name: | Bupa Banora Point |
| Commission ID: | 0521 |
| Address: | 18 Ballymore Court, TWEED HEADS, New South Wales, 2485 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 6 November 2024 to 7 November 2024 |
| Performance report date: | 5 December 2024 |
| Service included in this assessment: | Provider: 1297 Bupa Aged Care Australia Pty Ltd Service: 534 Bupa Banora Point |

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 Bupa Banora Point (**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, older people/representatives and others
* the response from the Approved provider received 26 November 2024
* other information and intelligence held by the Commission in relation to the service.

# Assessment summary

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| Standard 3 Personal care and clinical care | 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 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 ensuring consumers received the personal and clinical care they required, and high-impact and high-prevalence risks were assessed and effectively managed to meet the individual consumer preferences in a timely manner. The service demonstrated risks for each consumer, including, falls and pressure injuries were effectively managed. Consumers and representatives were satisfied that consumers’ risks were effectively managed. Key risks for consumers were assessed and documented in the electronic care management system. Care planning documentation identified that effective strategies were in place to manage risks and were recorded in consumers’ care plans and progress notes. Review, analysis and investigations were conducted daily by the clinical nurses and management for all incidents, such as falls, skin injury, challenging behaviours and infections, to identify the contributing factors so that appropriate interventions and actions could be implemented to prevent recurrence.

Consumers were assessed for falls using a validated falls risk assessment tool and seen by the physiotherapist on entry, when they had a significant fall or when circumstances changed with their health. After a fall or near miss, consumers were monitored, post fall assessments were carried out such as vital signs, blood glucose levels, cognition and pain assessments. A referral to the physiotherapist and medical officer was actioned and a clear identification of the level of falls risk for each consumer was included on handover documentation. All staff carried a flip card with assessments and procedure including post falls and other incidents.

Skin and wound care was consistent with best practice. Care planning documents included the use of validated assessment tools for pressure injury risk. There were adequate pressure relieving devices in the service. Staff advised there was adequate staffing levels to perform pressure and wound care and preventing skin tears. Consumers were receiving pressure injury reliving programs that consists of heel protectors, side cushions, regulated repositioning to keep them comfortable. Daily monitoring of wounds and progressive photographs indicated wounds were progressively healing. Consumers with complex wounds were referred to the onsite wound specialist nurse and dietitian referrals were made for the consideration of supplements.

Consumer confirmed skin care practices by staff were appropriate and staff checked their skin frequently and their wounds were healing. Care plans were tailored according to consumer needs, care plans for diabetic consumers include checking consumer feet and other extremities for any changes. Skin tear incidence was monitored through the clinical indicators program and through the consumers at risk register. Clinical staff confirmed and document evidenced consumers received regular skin checks and including consumers with continence concerns, both were tracked and discussed at the clinical meetings. Consumers who were incontinent received skin checks and regular preventative treatment, there were no consumers identified with wounds relating to incontinence.

Based on the above information, it is my decision this Requirement is complaint.

# 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

Consumers and representatives were satisfied with the care and services consumers received. The approved provider had a centralised rostering process; however, the service was responsible for adjusting the roster if unplanned leave occurred and this was reviewed daily by the management team. Management undertook the allocation of shifts to ensure the right staff were in the right areas and to ensure there were enough staff when needed. Management monitored the effectiveness of workforce planning and implemented recruitment strategies to ensure the service staffing levels were fulfilled.

Consumers and representatives stated whilst staff seemed busy, staff always addressed consumers’ care needs and kept them informed if there were delays or changes. Staff confirmed they were able to complete their tasks during their allocated shift times, they could be busy at times and prioritised consumer care and support. Staff stated the service attempted to fill unplanned leave shifts and felt supported as all staff roles in the service helped when needed.

Staff confirmed and training records evidenced staff completed mandatory training and ongoing training to ensure they had the skills and knowledge for their roles. Training was delivered online, face to face, in toolbox talks and in meetings.

The care manager reviewed the roster daily and advised of changes in the morning handover, which included changed or extended shifts due to unplanned leave. The leadership team also reviewed these daily changes and reviewed the roster for the next few days in a daily meeting as a standing agenda item.

The master roster was developed to include all variables at the service such as skill cohort and levels of staff experience, consumer acuity, feedback from consumers, representatives, staff and care managers, call bell response and incident data. The rosters two weeks prior to the assessment contact confirmed changes were made daily according to the roles and services required.

Staff were observed assisting consumers in a calm, caring manner and not rushing consumers with their cares or meals. Staff were observed passing on clinical and care information in team meetings, care huddles and electronic messaging.

Based on the information recorded above, it is my decision this Requirement is 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 demonstrated effective risk management systems and practices were in place. The system included embedding consumer preferences and feedback, providing staff with training and the utilisation of electronic incident management systems which was reported at the service level and monitored at both the service and organisational level. Consumers confirmed the service supports them to enjoy activities which had been risk assessed and they received the appropriate support to enjoy their lives. Processes were in place to manage high-impact and high-prevalence risks, including the management and incident prevention strategies implemented using the components of consumer care needs and incident data reported.

Staff completed training in clinical governance policy and process, incident management procedure, elder abuse policy, the Serious Incident Response Scheme and open disclosure. A training report evidenced 97% of staff had completed mandatory and refresher training with plans in place for ongoing monitoring and compliance of training levels. Staff describe how to identify risks for consumers and the strategies in place to manage them. Staff could also describe the incident management processes in place, how open disclosure was used and when Serious incident response scheme reporting was required.

There was a system in place for staff to identify, and escalate incidents, and concerns of abuse and neglect. Staff reported incidents and registered staff recorded the details in the electronic care system and incident management system. Care managers were responsible for investigating incidents and the General manager monitored all items to ensure they were closed out within the organisational time frame of within one month and completed serious incident reports when required. Documentation confirmed this process was completed. The organisation provided a clinical support line, which was also available after hours, for staff to access regarding consumer incidents or urgent care needs.

Incident data was monitored and reviewed by the leadership team monthly and used to identify risks and training needs and monitor high-impact and high-prevalence risks. The regional team applied a risk rating to the service and reported to the organisational quality and governance division actions in place to manage risks at the service. Remediation for high risks identified were implemented to support the service and reduce risks where possible. The regional team shared quality learnings from the organisational central quality team to provide proactive management and identification of risks.

Meeting minutes of the business services clinical governance meetings, quality learnings communications, clinical review meeting, safety and quality update, consumer and relatives’ meetings, General manager weekly memorandum and the monthly service newsletter contained information and reviews of incidents, risks and plans in place for prevention of incidents occurring, management of current risks and information for wellbeing.

Meeting minutes for the ‘Care home safety, leadership and quality improvement review meeting’ from 18 October 2024 evidenced data collated from September 2024 and results of audits discussed in relation to safety, clinical indicators, consumer and representative feedback, incident and Serious incident registers, maintenance schedules and lifestyle activity coordination. This meeting was held monthly at the service and attended by the Regional Manager and Regional Quality Partner roles for inclusion in reporting to the Chief Operating Officer.

Based on the information recorded above, it is my decision this Requirement is 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)