

**Performance Report**

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| Name: | Bupa Tugun |
| Commission ID: | 5380 |
| Address: | 6 Croft Court, 50-52 Mirreen Drive, TUGUN, Queensland, 4224 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 24 October 2024 |
| Performance report date: | 26 November 2024 |
| Service included in this assessment: | Provider: 1297 Bupa Aged Care Australia Pty Ltd  Service: 6819 Bupa Tugun |

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 Tugun (**the service**) has been prepared by Micheal Cooper, 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 provider’s response to the assessment team’s report received 15 November 2024.

# Assessment summary

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| Standard 3 Personal care and clinical care | Not Compliant |
| **Standard 4** Services and supports for daily living | **Not applicable as not all requirements have been assessed** |
| **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.

* In relation to Requirement 3(3)(a), the approved provider must implement processes and systems to ensure care delivery is best practice and safe, particularly in relation to the delivery and management of catheter care, skin integrity, restrictive practices, medication administration, and behaviour support planning.
* In relation to Requirement 7(3)(a), the service must implement processes and systems to ensure the workforce is planned, skilled, and the deployment of staff is adequate to meet the goals, needs, and preferences for consumers.
* In relation to Requirement 8(3)(b), the service must implement systems in relation to this Requirement and other Requirements to ensure the quality of care and services delivered promotes a culture of safe and inclusive of consumer’s needs and preferences.
* In relation to Requirement 8(3)(c), the service must implement systems to ensure information shared is accurate and reflective of consumer’s current needs and preferences, regulatory systems to ensure the service complies with relevant legislative requirements and legislation.

# 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. | Not Compliant |

Findings

The assessment contact report identified multiple deficiencies related to the clinical care and services provided.

For one consumer who has an indwelling urinary catheter in place and receives nutrition, hydration, and medication via a percutaneous endoscopic gastrostomy (PEG), the service did not have a plan of care documented to guide staff in the delivery of the named consumer’s catheter care needs. The named consumer’s PEG was observed to be administering nutrition at a rate contrary to medical directives.

Service documentation and interviews with management and staff identified the service did not identify changes to consumer’s skin conditions and medical directives are not always followed to optimise and support skin integrity.

Review of one named consumer’s behaviour support plan demonstrated the service is identifying personal strategies to guide staff in managing the needs of consumers who experience changed behaviours. However, staff interviewed did not demonstrate an awareness of consumer’s personalised behaviour support strategies and explained they do not refer to behaviour support plans to guide care delivery.

Two consumer’s who require medication to relieve symptoms of pain explained they do not always receive pain relieving medication on time when labour hire staff are rostered. Both consumers were satisfied internal staff understand their care needs and preferences, however, explained labour hire staff do not provide care that is aligned with their care preferences.

In relation to restrictive practice, a keypad was observed to be used to enter and exit the service and elevators within the service. Interviews with management and staff identified an environmental restrictive practice had not been implemented for some consumers despite consumers not having access to the keypad code and requiring staff assistance to enter or exit the service and elevator. Staff did not demonstrate a shared understanding of environmental restrictive practice and its associated implementation and ongoing monitoring processes.

The approved provider submitted a response to the deficiencies identified and outlined actions the service has taken, and plans to take to remediate the deficiencies identified including:

* All consumer’s skin integrity assessments are due to be medically reviewed by 30 November 2024.
* Education in relation to skin integrity management has been provided to staff and daily toolbox talks are taking place with reference to skin integrity management strategies and relevant escalation processes.
* Skin integrity products are due to be installed in each consumer’s personal bedrooms by 25 November 2024.
* All consumer’s subject to a catheter have received a catheter care plan review. Relevant education in relation to catheter care management and food and fluid monitoring processes has been provided.
* The organisation has provided education to the services clinical management staff to promote a shared understanding of restrictive practice and associated processes and protocols.
* An internal audit has been conducted in relation to pain management procedures and education has been undertaken across all levels of staff within the service to promote a shared understanding of best practice pain management interventions and escalation pathways.

In coming to my decision for Requirement 3(3)(a), I have considered the information in the assessment contact report and approved provider’s response. While I acknowledge the actions taken by the service, and the actions planned to be implemented, I am of the view these actions will take some time to be imbedded and require further evaluation of its effectiveness.

It is my decision Requirement 3(3)(a) is Not Compliant.

# Standard 4

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| Services and supports for daily living | |  |
| 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 |

Findings

Consumers and representatives provided positive feedback in relation to supports for daily living and said they are supported to maintain relationships with those who are important to them. Care planning documentation identified activities of interest and people who are important to individual consumers to guide staff in meeting consumer’s lifestyle and daily living needs. Service documentation including newsletters and activity calendars evidenced a variety of activities delivered to consumers to enhance their daily living requirements and needs. Consumers were observed participating in various activities of interest to them throughout the assessment contact.

I have considered the information provided in the assessment contact report and I have placed weight on effective systems in place to support consumers to participate in their community, maintain relationships with individuals who are important to them, and to participate in activities of interest to them.

It is my decision Requirement 4(3)(c) is 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. | Not Compliant |

Findings

Most consumers and representatives were not satisfied the service is meeting their care and service needs within a timely manner and explained call bells are not always responded to within a reasonable timeframe. One named consumer who requires assistance with fluid intake explained they wait for extensive periods of time to receive the support and assistance they require. One representative raised concern with the deployment of staff within the service and explained there is not enough staff deployed to meet consumers’ needs.

Service documentation evidenced strategies the service implements to replace shifts when unexpected or unplanned leave occurs including the use of labour hire staff and the service has access to obtain internal staff from local sister-sites nearby.

In relation to the service’s workforce responsibilities, service documentation and interviews with staff and management demonstrated the service is not meeting its care minute responsibilities. The service did not demonstrate the deployment of staff is aligned with the service’s allocated care minute target in respect to the service for the quarter.

In response, the approved provider outlined actions the service has taken and plans to take to remediate the deficiencies identified including:

* The service has recruited a number of staff across key care and service delivery departments.
* Recruitment continues to be a priority for the service and support is provided at an organisational level to obtain additional staff.
* Employee retention strategies have been implemented including an employee benefit program.

In coming to my decision for Requirement 7(3)(a), I have considered the information provided in the assessment contact report in relation to this Requirement and other Requirements. I acknowledge the approved provider’s planned actions, however, I am of the view these actions are yet to be imbedded and require further evaluation in relation to its effectiveness.

It is my decision Requirement 7(3)(a) is Not Compliant.

# Standard 8

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| Organisational governance | |  |
| 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. | Not 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 |

**Findings**

Service documentation and interviews with management demonstrated systems in place to promote a culture or safe, inclusive, and quality care and services including monthly consumer meetings, regular staff meetings, internal audits, and feedback processes. However, consumers and representatives were dissatisfied the service delivers care that promotes a culture of safety and inclusivity. For example, one consumer who has poor eyesight raised concern that the service does not always communicate changes effectively and explained they are not always respected by labour hire staff. One consumer explained labour hire staff do not always deliver care that supports their needs and preferences.

Service documentation evidenced limited investigation as concerns are raised and the service’s incident management register identified risk mitigation strategies are not always implemented to reduce the risk of harm to consumers.

The approved provider, in response, acknowledged the deficiencies identified and explained actions the service has taken and plans to take to remediate the deficiencies including:

* The service has recruited and plans to recruit additional internal staff to reduce the use of labour hire staff, enhancing continuity of care and services.
* Formal meetings have commenced to address frequent unplanned leave to reduce leave shortages and unfilled shifts.

In coming to my decision for Requirement 8(3)(b) I have considered the information in the assessment contact report and acknowledge the actions outlined in the approved provider’s response. I am of the view the actions the service has taken and plans to take will take time to be imbedded and evaluated for its effectiveness.

It is my decision Requirement 8(3)(b) is Not Compliant.

Staff reported they have access to relevant information including care planning documentation, policies, and procedures. However, service documentation demonstrated care and service plans does not always accurately reflect consumer’s needs and documentation does not always support appropriate care planning procedures to guide staff in a safe and effective delivery of care.

The service demonstrated systems in place to capture areas for continuous improvement. Service documentation, including the service’s plan for continuous improvement register, demonstrated ongoing monitoring, implementation and review of strategies to improve areas for improvement.

The service demonstrated financial governance systems in place to monitor and maintain the finances and resources the service requires to meet the care needs of consumers. Staff confirmed they have access to resources and equipment to complete their job duties.

The service demonstrated workforce governance systems in place to monitor, support and develop knowledge among members of the workforce including the implementation of an education program and completion of competency assessments. However, the assessment contact reports instances where labour hire staff did not provide safe and effective care in alignment the organisation’s policies and procedures. The service did not demonstrate accountability for the knowledge and skills required by labour hire staff to ensure the delivery of safe and effective care and services.

The service did not demonstrate regulatory compliance systems in place to ensure it is complying with its legislative requirement in relation to care minute responsibilities.

The service evidenced a process to capture feedback and complaints, however service documentation demonstrated complaints and feedback is not always reviewed by the organisation’s governing body to ensure risk mitigations are implemented to reduce the risk of harm or recurrence.

The approved provider, in response to its regulatory compliance obligations outlined recruitment initiatives have been ongoing and continue to improve the service’s care minute responsibilities. Care minute delivery is monitored daily by the service to inform recruitment and workforce management strategies. Dat and analysis forecast the service aims to achieve 201 direct care minutes and 28 registered nurse direct care minutes by December 2024.

In coming to my decision for Requirement 8(3)(c) I have considered the information in the assessment contact report and approved provider’s response. While I acknowledge the service’s planned actions, I am of the view these actions will take some time to be imbedded and require further evaluation of its effectiveness.

It is my decision Requirement 8(3)(c) is Not Compliant.

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