Performance

Report

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| Name: | Bupa Waratah |
| Commission ID: | 0728 |
| Address: | 219 Christo Road, WARATAH, New South Wales, 2298 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | on 18 July 2024 |
| Performance report date: | 12 September 2024 |
| Service included in this assessment: | Provider: 1297 Bupa Aged Care Australia Pty Ltd  Service: 5863 Bupa Waratah |

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 Waratah (**the service**) has been prepared by Julia Durston, 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 provider’s response to the assessment team’s report received on 8 August 2024

# Assessment summary

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| Standard 3 Personal care and clinical care | Not applicable as not all requirements assessed |
| **Standard 5** Organisation’s service environment | **Not Compliant** |
| **Standard 6** Feedback and complaints | **Not applicable as not all requirements assessed** |
| **Standard 7** Human resources | **Not applicable as not all requirements assessed** |

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.

Requirement 5(3)(b) – The approved provider is to ensure there are systems and processes in place to ensure the service environment is safe, clean and well maintained, including but not limited to consumer rooms and utility rooms.

# 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

The service was previously found non-compliant in Requirement 3(3)(a) following a Site Audit from 22 August 2023 to 24 August 2023. The service did not demonstrate consumers were receiving safe and effective personal and clinical care. Consumers requiring 2 or more staff to mobilise were not receiving appropriate support with personal hygiene care, consumers’ preferences regarding when they rise were not being respected and consumers, representatives and some staff said the service was short staffed, and this negatively impacted the care of some consumers.

During the Assessment Contact conducted on 18 July 2024 the Assessment Team found the service’s plan for continuous improvement dated 22 August 2023 contained actions to return to compliance in this Requirement. The care plans for consumers who require assistance from two or more staff with activities of daily living were reviewed and updated. All consumer preferences were documented in their care plans. Staff allocations were adjusted to meet consumer care needs. Care staff now carry mobile phones so they can be redirected to assist with care and transfers across the service as required. Education on best practice bowel management was provided to clinical staff in February 2024.

The Assessment Team found consumers and representatives provided positive feedback about the personal care consumers’ were receiving. The service has policies and guidelines in place to guide the delivery of clinical care, and care documentation showed staff generally follow best practice guidelines to deliver effective personal and clinical care. The service demonstrated safe and effective clinical care in the areas of personal care and continence management, pain management, skin integrity and wound management. However, the Assessment Team found there were deficits in clinical care in the areas of restrictive practices, documentation of changed behaviours and post falls management.

In relation to falls management the Assessment Team found the organisation has processes in place to screen for the risk of falls and monitor and reduce the risk, that were outlined by management, such as falls assessments completed for all consumers on entry to the service and updated when clinically indicted and after each fall. Consumers’ falls risk scores are clearly documented on their care plan. An incident form is completed after every fall and learnings feed into the plan for continuous improvement.

The Assessment Team reviewed the care of a consumer who experienced an unwitnessed fall in May 2024. The consumer was sent to hospital 8 days later with worsening pain and was diagnosed with a fractured femur. The consumer had experienced multiple falls since the end of April 2024 and was classified as a high falls risk. Falls prevention strategies were in place. The consumer was not reviewed by a medical officer after the last fall and there was no follow up with the medical officer in the 8 days post fall. Care documentation showed the frequency of vital observations and neurological observations were not in line with the service’s post fall protocols. There was no follow up for review by the medical officer about the consumer’s low blood pressure and increasing pain on 7 June 2024, nor after an email was sent to the medical officer on 4 June regarding analgesia review for increased pain.

When this was raised with management, they advised the consumer was assessed by the physiotherapist immediately post fall and no injury was identified, the consumer was able to weight bear and mild pain was managed by analgesia. A head-to-toe assessment was completed by the registered nurse finding no injury, and there was no clinical indication for hospital transfer on the day of the fall. The Assessment Team found the service recognised the severity of the incident and made a Priority 1 Serious Incident Response Scheme (SIRS) report. However, the absence of medical review post unwitnessed fall and when the consumer’s pain began to increase and their condition deteriorated was not consistent with best practice, safe and effective care and resulted in delayed diagnosis and increasing pain for the consumer.

In their response to the Assessment Team report the approved provider noted they had been unable to identify any details relating to issues of restrictive practices and documentation of changed behaviours. I agree that although briefly mentioned, these two areas are not addressed in the report.

Regarding the falls incident outlined in Assessment Team report, the approved provider acknowledged the organisation raised a SIRS report due to suspicion that neglect had occurred due to the delay between the incident and diagnosis of the consumer’s fracture. The approved provider advised an investigation was completed with learnings addressed prior to the Assessment Contact, and since the incident there have been no further instances of post incident delayed diagnoses indicating the effectiveness of the actions taken as a result of the home’s investigation. Also, the approved provider noted that the consumer was assessed as having mild pain on 4 out of 22 occasions post fall using the Abbey pain assessment. The consumer’s pain was not acute in nature, was within their baseline and managed with regular analgesia for their chronic knee osteoarthritis with associated chondrocalcinosis. However, the service organised transfer to hospital on 8 June 2024 when there was an acute change in the consumer’s condition identified as lethargy, poor oral intake, shivering and increased pain in limbs.

The approved provider supplied a comprehensive overview of the SIRS incident investigation conducted, the learnings and actions taken to prevent future occurrence of delayed diagnoses post incident and to ensure adherence to organisational post fall monitoring procedures. These actions included but were not limited to one-on-one education provided to the registered nurse responsible for neurological and vital signs observations at the time, discussion of the incident and learnings at registered nurses meeting on 20 June 2024, focusing on follow-up when clinical observations are out of range. Care managers have workplans that include reviewing post falls observation completions and they are address non-completions. The approved provider also noted that as a result of the learnings from the investigation the leadership team has consulted with consumers and offered them the choice to transfer to a General Practitioner that visits the home more frequently.

Having considered the evidence put forward by the approved provider and the Assessment Team report, I put weight on the approved provider’s evidence that the service had already taken action to address the gaps identified in relation to the safe and effective post incident care and had put effective mitigation strategies in place, prior to the Assessment Contact. I am also satisfied the service organised timely transfer to hospital when they identified acute deterioration in the consumer’s condition.

Based on the evidence provided, I am satisfied the service is compliant in Requirement 3(3)(a).

# Standard 5

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| Organisation’s service environment | |  |
| 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. | Not Compliant |

Findings

The service was previously found non-compliant in Requirement 5(3)(b) following a Site Audit from 22 August 2023 to 24 August 2023. The service did not demonstrate the service environment was clean and well maintained, and there was access for consumers to move freely, both indoors and outdoors.

During the Assessment Contact conducted on 18 July 2024 the Assessment Team found the service’s plan for continuous improvement dated 22 August 2023 contained actions to return to compliance in this Requirement, including recruitment of an additional cleaning staff member who commenced in October 2023, unused trolleys were store away from walkways and checks were conducted to ensure breaks were on for those trolleys required in hallways.

During the Assessment Contact the Assessment Team found most consumers and representatives said they were satisfied with the cleanliness of the service environment and they were able to move freely indoors and outdoors. However, some areas of the service environment, such as consumers’ rooms were not consistently safe, clean and well maintained. All clinical waste bins were observed to be unlocked, with some clinical waste bins containing sharps containers and another clinical waste bin containing general waste. Management were unable to provide a response when asked where clinical waste bins are to be stored. Other observations include, water penetrating from underneath the floorboards leading from an ensuite, posing a potential falls safety risk to the room’s occupants, and mould, holes in walls, an unclean utility room with holes in the ceiling and mould, gaps between fire sprinklers and ceiling in one consumer’s room and broken locks on the outdoor gates. There was a complaint currently under investigation from one consumer regarding cold showers. Staff confirmed it takes time for hot water to reach the shared bathroom.

In their response to the Assessment Team report the approved provider did not dispute the recommendation for this requirement, and noted improvements actioned since the Assessment Contact include, rectification of the identified maintenance and cleaning issues evidenced by the PCI confirming new quarterly building report completed on 30 July 2024 and work items actioned for identified items, education provided on cleaning and maintenance, and improved environmental governance with clear accountabilities.

I acknowledge the approved provider’s commitment to make improvements to ensure the cleanliness and safety of the service environment. However, I consider it will take time for these improvements to be embedded and sustained in practice.

Based on the weight of the evidence provided, I find the service is non-compliant in Requirement 5(3)(b).

# 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 |

Findings

The service was previously found non-compliant in Requirement 6(3)(c) following a Site Audit from 22 August 2023 to 24 August 2023. The service did not demonstrate all complaints were logged in the complaints register and responded to appropriately.

During the Assessment Contact conducted on 18 July 2024 the Assessment Team found the service’s plan for continuous improvement dated 22 August 2023 contained actions to return to compliance in this Requirement, including consumer/representative feedback to be discussed with the general manager at 10 at 10 morning meetings with required follow-up, and complaints management education was provided to staff.

During the Assessment Contact, the Assessment Team found most sampled consumers and representatives advised they were satisfied with actions taken following their feedback and several examples of consumers’ positive feedback were provided. Most staff demonstrated their understanding of the principles of open disclosure, and documentation reviewed provided evidence that an apology and explanation was provided to consumers and their representatives. Management described the complaints management process and the incident management system that is used to capture and monitor the progress of complaint investigations, including triggers for open disclosure. Documentation showed the organisation’s complaints policy has been followed. Complaints have been resolved in a timely manner with appropriate actions taken and interviews with consumers demonstrate the issues have not recurred.

Based on the weight of the evidence provided, I am satisfied the service is compliant in Requirement 6(3)(c).

# 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

The service was previously found non-compliant in Requirement 7(3)(a) following a Site Audit from 22 August 2023 to 24 August 2023. The service did not demonstrate all complaints were logged in the complaints register and responded to appropriately.

During the Assessment Contact conducted on 18 July 2024 the Assessment Team found the service’s plan for continuous improvement dated 22 August 2023 contained actions to return to compliance in this Requirement, including consumer/representative feedback to be discussed with the general manager at 10 at 10 morning meetings with required follow-up, and complaints management education was provided to staff.

During the Assessment Contact, the Assessment Team found most sampled consumers and representatives advised they were satisfied with actions taken following their feedback and several examples of consumers’ positive feedback were provided. Most staff demonstrated their understanding of the principles of open disclosure, and documentation reviewed provided evidence that an apology and explanation was provided to consumers and their representatives. Management described the complaints management process and the incident management system that is used to capture and monitor the progress of complaint investigations, including triggers for open disclosure. Documentation showed the organisation’s complaints policy has been followed. Complaints have been resolved in a timely manner with appropriate actions taken and interviews with consumers demonstrate the issues have not recurred.

Based on the weight of the evidence provided, I am satisfied the service is compliant in Requirement 7(3)(a).

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)