

**Performance Report**

**1800 951 822**

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| Name: | Bupa Woodville |
| Commission ID: | 6940 |
| Address: | 104 Woodville Road, WOODVILLE, South Australia, 5011 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 20 November 2024 to 21 November 2024 |
| Performance report date: | 3 December 2024 |
| Service included in this assessment: | Provider: 1297 Bupa Aged Care Australia Pty Ltd Service: 4349 Bupa Woodville |

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 Woodville (**the service**) has been prepared by M Glenn, 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.

# 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, which was informed by a site assessment, observations at the service, review of documents and interviews with consumers, representatives, staff and management;
* an email from the provider received 28 November 2024 acknowledging the Assessment Team’s report and recommendations; and
* a performance report dated 3 May 2024 for a site audit undertaken 28 February 2024 to 4 March 2024.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not fully assessed |
| **Standard 2** Ongoing assessment and planning with consumers | **Not fully assessed** |
| **Standard 3** Personal care and clinical care | **Not fully assessed** |
| **Standard 6** Feedback and complaints | **Not fully assessed** |
| **Standard 7** Human resources | **Not fully assessed** |
| **Standard 8** Organisational governance | **Not fully 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 1

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| Consumer dignity and choice |  |
| Requirement 1(3)(a) | Each consumer is treated with dignity and respect, with their identity, culture and diversity valued. | Compliant |

Findings

Requirement (3)(a) was found non-compliant following a site audit undertaken in February/March 2024 as consumers and representatives felt consumers were not listened to, they were ignored and not heard by staff, and observations showed a consumer’s dignity was not upheld. In response to the non-compliance, the provider has implemented a range of improvement actions, including, but not limited to, staff training on dignity and respect, choice and decision making, and consumer experience; monthly consumer ‘spotlight’ sessions to ensure consumers are receiving care which is respectful and appropriate for them; and consumer experience surveys to ensure consumers are satisfied with their experience at the service.

At the assessment contact in November 2024, consumers and representatives felt consumers were treated with dignity and respect and accepted and valued. Information relating to consumers’ background and service preferences is obtained from consumers on entry and ongoing, and documented in a care plan which is accessible to care staff. Care files sampled include information about each consumer’s background, personal preferences, religion, and cultural practices which aligns with information provided through consumer and staff interviews. Staff described what treating consumers with dignity and respect means and said if they see another staff member treating a consumer in a disrespectful way, they will report the incident to registered staff or management. Staff were interacting with consumers in a respectful manner and in a way which maintained consumers’ dignity.

Based on the Assessment Team’s report, I find requirement (3)(a) in Standard 1 Consumer dignity and choice compliant.

# Standard 2

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| Ongoing assessment and planning with consumers |  |
| Requirement 2(3)(a) | Assessment and planning, including consideration of risks to the consumer’s health and well-being, informs the delivery of safe and effective care and services. | Compliant |
| Requirement 2(3)(e) | Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the consumer. | Compliant |

Findings

Requirements (3)(a) and (3)(e) were found non-compliant following a site audit undertaken in February/March 2024 as assessment and planning did not inform delivery of safe and effective care and services; and systems and processes to ensure care and services provided to consumers were continually assessed and adjusted to meet their changed needs were not effective. In response to the non-compliance, the provider has implemented a range of improvement actions, including, but not limited to, reviewing care files to ensure they are up-to-date, and capture all consumer needs, risks, and mitigation strategies; and training for staff on assessment and planning, including the admission pathway, consumer choice, dignity of risk and return and transfer to hospital.

At the assessment contact in November 2024, processes for assessment and planning, including use of validated assessment tools to identify risks to consumers’ health and wellbeing were demonstrated. Information about consumers is gathered through a pre-admission assessment which includes validated risk assessment tools, and an admission pathway, which is commenced on the day of entry. Where risks are identified, referrals are made to appropriate allied health professionals to further support provision of safe and effective care and services. Consumers and representatives interviewed are satisfied with assessment and planning processes, and aware of strategies implemented where risks are identified.

Care plans are reviewed monthly in conjunction with ‘spotlight’ monthly discussions, and when consumers’ circumstances change or incidents occur. Spotlight discussions consider weight, falls, infections, medications, skin, and any issues occurring during the month. Assessments and care plans are updated, where required, to reflect consumers’ current needs, goals, and preferences. Care staff described their responsibilities for reporting changes in consumers’ health or presentation, including notifying clinical staff. Consumers and representatives said the service regularly communicates with them about consumers’ care, including following incidents, such as falls, diet changes or skin damage and following medical reviews.

Based on the Assessment Team’s report, I find requirements (3)(a) and (3)(e) in Standard 2 Ongoing assessment and planning with consumers compliant.

# 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 |
| Requirement 3(3)(b) | Effective management of high impact or high prevalence risks associated with the care of each consumer. | Compliant |
| Requirement 3(3)(d) | Deterioration or change of a consumer’s mental health, cognitive or physical function, capacity or condition is recognised and responded to in a timely manner. | Compliant |

Findings

Requirements (3)(a), (3)(b) and (3)(d) were found non-compliant following a site audit undertaken in February/March 2024 as personal and clinical care was not tailored to consumers’ needs nor safe and effective; risks relating to falls, pain and pressure injuries were not effectively managed; and deterioration or changes in consumers’ condition were not effectively recognised or responded to. In response to the non-compliance, the provider has implemented a range of improvement actions, including, but not limited to, staff training on skin integrity, skin tears and infection, oral nutritional supplements, wound healing, falls management, clinical deterioration and pain; and daily governance and leadership meetings to increase clinical oversight, identify trends in clinical care and monitor consumers experiencing new and ongoing deterioration.

At the assessment contact in November 2024, consumers and representatives interviewed were confident consumers received safe care that was right for them. Care files evidence safe, effective, tailored care relating to personal hygiene and restrictive practices. There are processes to identify, assess, plan for, manage and review high impact or high prevalence risks relating to consumers’ care. Care files demonstrate effective management of risks relating to falls, wounds, pressure injuries and behaviours. Care files also evidence involvement of medical officers and allied health professionals in the management of identified risks. Staff interviewed are knowledgeable of consumers’ needs, goals and preferences and provided examples of how they ensure care and services are tailored and delivered safely and effectively.

Care files sampled demonstrate timely recognition and response to changes or deterioration in a consumer’s condition. Clinical staff described how they recognise and respond to signs of deterioration, following the service’s policies, procedures and escalation pathway. Consumers and representatives said staff are competent and understand the care and services consumers require.

Based on the Assessment Team’s report, I find requirements (3)(a), (3)(b) and (3)(d) in Standard 3 Personal care and clinical care 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 |

Findings

Requirement (3)(c) was found non-compliant following a site audit undertaken in February/March 2024 as while there were processes to address concerns, respondents were not satisfied with the resolution or outcome of their complaints. In response to the non-compliance, the provider has implemented a range of improvement actions, including, but not limited to, staff training on customer experience and feedback and complaints; ongoing review and reminders relating to feedback, complaints and open disclosure at staff meetings; and increased capturing, trending and analysis of complaints.

At the assessment contact in November 2024, consumers and representatives interviewed said the organisation responds appropriately and promptly to their feedback or concerns, and is open and transparent when things go wrong. A complaint and compliment register is maintained and shows timely action of complaints with apologies recorded where things have gone wrong. The register includes complaints made by consumers and representatives, with dates of the event, acknowledgement, and the source of how the feedback or complaints were lodge. Actions taken to address complaints, as well as feedback provided to consumers, representatives and staff are documented. All staff interviewed described the process of open disclosure and the importance of being open and transparent when things go wrong.

Based on the Assessment Team’s report, I find requirement (3)(c) in Standard 6 Feedback and complaints 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. | Compliant |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Compliant |
| Requirement 7(3)(e) | Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken. | Compliant |

Findings

Requirements (3)(a), (3)(c) and (3)(e) were found non-compliant following a site audit undertaken in February/March 2024 as rostering, access to agency staff and review and monitoring processes used to plan numbers and skill mix of staff were not effective; the workforce was not competent and did not have sufficient knowledge to undertake their roles effectively; and annual appraisals or pre-probationary reviews had not been completed for all staff. In response to the non-compliance, the provider has implemented a range of improvement actions, including, but not limited to, increased and ongoing hiring of new staff; a 2024 workforce management plan with a plan to decrease agency usage; staff training relating to deficits identified at the site audit; captured and addressed all outstanding performance appraisals; and daily governance meetings and review of incidents, feedback and progress notes for ongoing monitoring of staff practice and performance.

At the assessment contact in November 2024, consumers and representatives said there is an appropriate number of staff to attend to consumers’ needs, with several stating they have seen a notable improvement in staffing levels in recent months. A roster is created and implemented based on a range of factors, such as consumer acuity, staff experience and skill mix, and planned leave. There are processes to manage planned and unplanned staff leave. Staff interviewed said they have seen improvements to staffing in recent months, and they have sufficient time to undertake their roles.

Management described processes to ensure staff are competent, including competencies, and regular review of progress notes, incidents, and feedback and complaints. Records demonstrate a range of training topics completed by staff and a high completion rate. Staff interviewed said they are supported to raise requests for additional training, and consumers and representatives said they feel staff providing care are competent and understand consumers’ individual needs and preferences.

Staff performance appraisals are undertaken within the first 6 months of a new staff member’s employment period, and annually thereafter. Records show all current staff are up to date with performance appraisals. Staff performance is monitored on a day-to-day basis, including through incident review, feedback processes, audits, and progress note reviews. Performance management processes are implemented where poor staff performance is identified. Staff confirm they are involved in performance reviews, where they can discuss additional training and support needs, and receive feedback on their performance.

Based on the Assessment Team’s report, I find requirements (3)(a), (3)(c) and (3)(e) in Standard 7 Human resources 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 |
| 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 |
| Requirement 8(3)(e) | Where clinical care is provided—a clinical governance framework, including but not limited to the following:1. antimicrobial stewardship;
2. minimising the use of restraint;
3. open disclosure.
 | Compliant |

**Findings**

Requirements (3)(c), (3)(d) and (3)(e) were found non-compliant following a site audit undertaken in February/March 2024 as organisation wide workforce governance systems were not effective; the risk management framework, was not effective; and systemic issues relating to identifying and minimising restrictive practices, specifically chemical restraint were identified. In response to the non-compliance, the provider has implemented a range of improvement actions, including, but not limited to, increased oversight of feedback and complaints; an electronic staff management system, increasing monitoring and oversight of staff compliance with training and performance appraisals; daily governance meetings, with review of incidents, clinical deterioration and high risk consumers; reviewed psychotropic use to ensure regulatory requirements are met; and increased culture of reporting and transparency in incident management.

At the assessment contact in November 2024, effective organisation wide governance systems, including a governance framework, assigned delegations and accountabilities, monitoring systems and policies and procedures were demonstrated. Information is stored in secure systems, and ensures staff have access to accurate, up-to-date information required to complete their roles. Organisational and service level continuous improvement actions are identified through a range of mechanisms, including quality indicators, feedback, and incidents. The organisation has an annual budget comprised of expected expenditures, and considers items, such as legislated care minutes and planned upgrades service environment upgrades. There are processes for out of budget expenses. There are processes to ensure staff are selected, trained and supported to meet the organisation’s values, and job specifications of their role. A central compliance team monitors regulatory and legislative changes, and there are processes to ensure changes are communicated to the service and staff. There are processes to ensure mandatory reporting obligations, including serious incident response scheme (SIRS) reporting, and care minutes are met. Feedback and complaints are monitored, managed and trended at a service level, reported to the quality team, and escalated to the governing body where necessary.

High impact or high prevalence risk data is collected, analysed and trended, with resulting information reported to sub-committees, and the governing body. An incident register is maintained and captures all incidents, skin tears, falls, responsive behaviours and near misses. Documentation sampled demonstrates reportable incidents are reported to SIRS within legislative timeframes, with SIRS information provided to sub-committees of the governing body, and trends analysed to identify areas for improvement.

Clinical governance systems, supported by policies, procedures and staff training, are embedded across the organisation. The framework includes management of antimicrobial stewardship, minimising the use of restraint and open disclosure, with the governing body maintaining oversight of clinical care. Infections are monitored and reported through monthly trending, and evidence use of appropriate pathology prior to commencement of antimicrobials. A psychotropic register is maintained, identifying consumers subject to chemical restrictive practice. Information relating to use of restrictive practices within the service is trended and reported to sub-committees of the governing body. Monthly clinical reports show prescribed psychotropics are regularly reviewed in consultation with the medical officer, with the aim of minimising or ceasing use, where appropriate for the consumer. An open disclosure policy and staff education supports the organisation’s commitment to the use of open disclosure when things go wrong, with incident reporting and review processes to ensure appropriate investigation to identify strategies for the prevention of reoccurrence.

Based on the Assessment Team’s report, I find requirements (3)(c), (3)(d) and (3)(e) in Standard 8 Organisational governance 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)