Belvedere Aged Care

Performance Report

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**Commission ID:** 3600

**Provider name:** Belvedere Aged Care Pty Ltd

**Assessment Contact - Site date:** 13 May 2022

**Date of Performance Report:** 23 June 2022

# Performance report prepared by

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# Publication of report

This Performance Report **will be published** on the Aged Care Quality and Safety Commission’s website under the Aged Care Quality and Safety Commission Rules 2018.

# Overall assessment of this Service

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| --- | --- |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(b) | Non-compliant |
| Requirement 3(3)(g) | Non-compliant |

# Detailed assessment

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 Standard and requirements are assessed as either compliant or non-compliant at the Standard and requirement level where applicable.

The report also specifies areas in which improvements must be made to ensure the Quality Standards are complied with.

The following information has been taken into account in developing this performance report:

* the Assessment Team’s report for the Assessment Contact - Site; the Assessment Contact - 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 Contact - Site report received 02 June 2022

# STANDARD 3 NON-COMPLIANTPersonal care and clinical care

### Consumer outcome:

1. I get personal care, clinical care, or both personal care and clinical care, that is safe and right for me.

### Organisation statement:

1. The organisation delivers safe and effective personal care, clinical care, or both personal care and clinical care, in accordance with the consumer’s needs, goals and preferences to optimise health and well-being.

## Assessment of Standard 3

Most consumers considered they received care that is safe and right for them. There were some consumers who felt the service could be improved if staff spoke the consumer’s preferred language. They thought this may assist with behaviour management.

Wound care and falls management were managed within service protocols. Interventions were in place to assist in the prevention and management of pressure injuries. Charting completed following a fall for one consumer included neurological observations, pain charting and sighting charting. A review of the Falls Risk Assessment Tool and the falls prevention and management care plan was recorded on an additional care plan review chart.

The Assessment Team found the service did not consistently demonstrate effective planning, management and prevention of high impact or high prevalence risks associated with the care of each consumer. Representatives interviewed were satisfied with the care being provided and that risks affecting each consumer were identified and appropriate interventions were in place. Care documentation did not reflect relevant interventions are consistently applied to support the management of identified risks for the consumers; for example, the management of a urinary catheter for one consumer.

Although screening and attestation of staff, consumers and visitors are conducted prior to entry to the service, the service did not demonstrate effective infection prevention and control practices in relation to minimising infection-related risks within the service.

### A decision of Non-Compliant in one or more requirements results in a decision of Non-Compliant for the Quality Standard.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(b) Non-compliant

*Effective management of high impact or high prevalence risks associated with the care of each consumer.*

The Assessment Team found that the service did not consistently demonstrate effective planning, management and prevention of high impact or high prevalence risks associated with the care of each consumer.

For consumer A the Assessment Team found that effective care and management were not provided in relation to a suprapubic catheter resulting in poor drainage and blockages requiring more frequent changes to the drainage bag.

Requirements in relation to the management and care of the catheter were not always done as scheduled on the catheter care plan and fluid intake was also not as per requirements causing issues with output. Progress notes did not document the clinical evaluation or review of the catheter management or after the catheter change which was required ahead of the six-weekly schedule.

One staff member was unable to provide details about when a review and evaluation of the consumer’s fluid balance would be performed and who would conduct or document it. Another staff member was unable to inform the Assessment Team of the catheter interventions they are required to provide to the consumer.

Care plans reviewed by the Assessment Team identified that superseded interventions and outcomes of risk assessments were still available, which created confusion on which interventions were the most appropriate. Examples of documented conflicting levels of risk for falls, skin integrity risks, unplanned weight loss and modified texture for dietary intake were reviewed in three consumer files.

The Approved Provider’s response provided clarifying information and evidence of the specialised care plan for catheter management but acknowledge they failed to document monitoring for infection post catheter change required but stated it did occur. The Approved Provider stated the fluid intake was not prescribed but a generalised strategy used as a prompt for staff. The consumer’s personal strategy was 1-1.5 litres in the bladder care plan. They also provided communication processes in place to inform staff in relation to handover protocols where personal care attendants are alerted to monitor specialised care needs. An allocated personal care attendant team leader on the wing is also responsible to report to the clinical staff in charge as to whether the catheter is draining well or not

The Approved Provider also acknowledged the confusion with the superseded information still appearing on care plans but stated this did not impact consumers negatively.

Based on the information provided by the Assessment Team and the Approved Provider I find there are gaps occurring in the documentation process in relation to the monitoring of consumers with a high prevalence risk. These include issues with the fluid intake for the consumer as outlined in the Specialised Nursing Care plan which includes ensuring the intake is 1.5 -2 litres per day and if cloudy increase to 3 litres per day. This does not appear to be followed as the charting between 17 April to 30 April 2022, regularly documented dark-coloured urine and an output of 900 millilitres per day. Although the Approved Provider stated correct care procedures were followed, this was not always in line with the documented care plans.

I find the service Non-Compliant with this Requirement as although the Approved Provider has acknowledged the gaps in documentation processes and has taken steps to make improvements I find interventions are not consistently applied to support the management of identified risks for the consumers.

### Requirement 3(3)(g) Non-compliant

*Minimisation of infection related risks through implementing:*

1. *standard and transmission based precautions to prevent and control infection; and*
2. *practices to promote appropriate antibiotic prescribing and use to support optimal care and reduce the risk of increasing resistance to antibiotics.*

The Assessment Team found the service did not demonstrate they have implemented effective strategies or addressed all areas of non-compliance documented during a previous assessment contact visit on 7 April 2022 to minimise infection-related risks to consumers.

The Assessment Team noted the following concerns:

* The service utilises a personal protective equipment spotter’s checklist which is undertaken by the Infection and Prevention Control (IPC) lead, however, the Assessment Team noted the current IPC lead is working in another role only during weekdays. Two staff that were to be enrolled in training in order for them to undertake the role of IPC have not yet been trained.
* There are no personal protective equipment drills or methods to ensure the staff’s ongoing competency with personal protective equipment usage.

* The Outbreak Management Plan does not reference the COVID-19 working folder which contains staff information and allocated roles. The working folder currently does not show a consumer’s photo. The service stated at the time of the assessment contact that a comprehensive handover tool was being completed.
* A doffing bin was located inside of a staff room and therefore dirty personal protective equipment was being taken inside of the room. This was corrected during the assessment. The Assessment Team observed a staff member that doffed the gloves they used to hold soiled linen and without sanitising their hands held the hand of a consumer.
* Used mask and face shields were worn following breaks without being sanitised. A staff member entered the break room to collect some items and conversed with another staff member who was not wearing a mask whilst in the break room. Another staff member wore their mask under their chin.
* Toolbox education records for staff on cleaning of equipment between consumer use were not sighted by the Assessment Team. The Assessment Team viewed education records which show all staff have completed PPE competencies. However, 28 staff are currently yet to complete the ‘infection control questionnaire’ with 7 staff currently overdue to complete it.
* Observed numerous staff and management touch several surfaces in the nurses’ station without cleaning after use. Surfaces included the computer keyboard, folders containing consumer records and the telephone.
* Although cough and sneezing etiquette signage was observed at communal hand washing basins, there was no signage throughout the rest of the service advising people to stay home if symptomatic of COVID-19 or influenza.
* There was feedback from representatives that not all visitors wear masks in consumer rooms but that they see staff wearing masks and shields.
* 2 communal commode chairs were dirty around the base of the seat and on top of the wheels housing.
* Communal crockery and cutlery continue to be in the staff room cupboards and drawers.

The Assessment Team viewed the service’s infection control policy, COVID-19 outbreak management plan and antimicrobial stewardship (AMS) plan and the service has a daily COVID-19 screening process for all staff, visitors and consumers.

Management told the Assessment Team during the Assessment Contact that the service’s outbreak management plan has not been practised since the COVID-19 outbreak in October 2021.

The Approved Provider in their response stated that they have a trained IPC working at Belvedere who is a full-time, senior staff member therefore they are meeting requirements. They have PPE spotters who have been trained by the IPC lead who also perform the role.

The Approved Provider state there is conflicting advice received from various different external parties in relation to infection prevention control strategies including where their doffing bins should be located.

The Assessment Team identified issues with appropriate antibiotic prescribing, however, the information provided by the Approved Provider provides evidence that antimicrobial stewardship is adhered to.

The Approved Provider provided documented evidence that shows the outbreak management plan is practised regularly and all staff have up-to-date training on infection prevention, with none overdue.

The Approved Provider also provided evidence of the cleaning schedule which showed all scheduled cleaning was up to date.

The Approved Provider also provided evidence that they have posters reminding staff in relation to cleaning equipment after use and doffing and donning processes. Toolbox sessions were also held in relation to breaches in infection control noted by the Assessment Team. Face shields are now only used once by staff as the service has received adequate stock.

They also commented that the discussion between the unmasked and masked staff members in the lifestyle room was 2 metres apart and only for a few seconds.

Whilst I commend the work done by the Approved Provider for following up on issues identified by the Assessment Team and have implemented changes such as extra signage and training to ensure staff are aware of their responsibilities, a number of these were not in place at the time of the Assessment Contact and therefore have not been fully embedded and evaluated for effectiveness.

I find the service Non-Compliant with this Requirement.

# 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 3(3)(b)

* Ensure that all processes are documented in relation to the care of consumers with high impact risks with their clinical care.
* Ensure catheter care is performed as required per the care plan or the specialised nursing plan.
* Ensure all consumer information is updated on care plans and only the latest information is available for staff to use.

### Requirement 3(3)(g)

* Ensure that all personal protective equipment is used appropriately by staff including using face shields once only.
* Ensure hand hygiene is practised at all times but especially after doffing and having contact with soiled linen.
* Ensure there is appropriate signage to advise staff and visitors to wipe down high-touch surfaces following usage.
* Ensure that IPC training is provided to staff who will perform the role.