Performance

Report

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| Name: | ACDMA Aged Care Services |
| Commission ID: | 0365 |
| Address: | 2 First Avenue, CANLEY VALE, New South Wales, 2166 |
| Activity type: | Assessment contact (performance assessment) – site |
| Activity date: | 12 December 2023 to 13 December 2023 |
| Performance report date: | 24 January 2024 |
| Service included in this assessment: | Provider: 950 Australian Chinese & Descendants Mutual Association Ltd  Service: 381 ACDMA Aged Care Services |

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 ACDMA Aged Care Services (**the service**) has been prepared by J 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 12 January 2024.

# Assessment summary

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| Standard 1 Consumer dignity and choice | Not applicable because not all requirements were assessed |
| **Standard 3** Personal care and clinical care | **Not Compliant** |
| **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.

* Requirement 3(3)(a) – the approved provider ensures each consumer receives safe and effective personal and clinical care to meet their needs that is provided by staff, particularly in the areas of nutrition and weight loss management, behaviour support, bowel management, medication management and post fall manual handling.
* Requirement 3(3)(a) - the approved provider implements a system to ensure medication stocked are maintained to prevent incidents resulting from nil stock, of medications, and occurrences of nil stock preventing administration of prescribed medication are documented as medication incidents
* Requirement 3(3)(a) - the approved provider ensures all staff are trained and their competence assessed in correct manual handling techniques and equipment use for lifting consumers from the floor after a fall.
* Requirement 3(3)(a) - the approved provider ensures care and clinical staff and clinical management are trained and their competence assessed in the legislative requirements regarding managing restrictive practices and behaviour support plans and making timely referrals to specialist dementia support services in response to behavioural deterioration.
* Requirement 3(3)(a) – the approved provider ensures care and clinical staff and clinical management are trained and their competence assessed in nutrition and weight loss management, that weight and food intake charting are completed as directed, and consumers’ nutrition and hydration care plans are current, accurate and changes communicated in a timely manner.
* Requirement 7(3)(c) – the approved provider ensures all staff have the required qualifications to effectively perform their role in line with job documentation.
* Requirement 8(3)(d) – the approved provider ensures care and clinical staff, clinical management and service management are trained and their competence assessed in reporting and investigating and responding to resident incidents, accidents and adverse events, and the residual risk level is accurately rated and consistent with the organisation’s risk management system, and an effective risk governance oversite system is established.
* Requirement 8(3)(d) – the approved provider reviews its conflict-of-interest documentation to ensure it includes sufficient information to ensure all conflicts of interest, including those that include board members and staff, are fully identified, disclosed, accurately rated and managed in a timely manner, including any current conflicts of interest.

# 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

An Assessment Contact was conducted on 12 December 2023. The Assessment Team found that overall, the service demonstrated consumers are treated with dignity and respect, and their culture and diversity is respected. This was confirmed by feedback from most sampled consumers and representatives, who advised the service supports those of different faiths, and that meals are culturally suitable. Staff interviewed were able to explain how they incorporate dignity and respect in their practice. Care plans contained information about consumers’ background including their life before entering the service.

In their response to the Assessment Team report, the approved provider did not dispute the Assessment Team’s findings for this requirement

Accordingly, I find Requirement 1(3)(a) 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. | Not Compliant |
| Requirement 3(3)(g) | 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. | Compliant |

Findings

An Assessment Contact was conducted on 12 December 2023.

In relation to Requirement 3(3)(a) the Assessment Team found that overall, the service did not demonstrate safe and effective, best practice clinical care particularly in the areas of nutrition and weight loss management, behaviour support, bowel management, medication management and post fall manual handling. However, the Assessment Team noted pressure injury prevention and management, catheter care, falls and wound management were mostly safe and effective.

The Assessment Team found one consumer experienced significant weight loss at the service, post hospital discharge in early September 2023. Food intake charting did not commence until 12 December2024 the first day of the Assessment Contact. The service did not follow the medical officer’s direction dated 27 October 2023 for the consumer to be weighed weekly. Care documentation reviewed on 12 December showed weights had been recorded sporadically, with the last two records dated 8 November and 2 December 2023.The care manager confirmed the weight charting requirements should have been communicated at handover but were missed. A staff alert was then entered on the electronic care planning system. The consumer’s nutrition and hydration care plan was updated with the dietician’s recommendations. However, the Assessment Team observed the plan also contained incorrect information and provided feedback to management, including, the plan stated the consumer’s weight was stable prior to being weighed on 13 December 2024, they were well nourished and required monthly weight monitoring.

The Assessment Team found that the assessment for one consumer diagnosed with faecal incontinence did not contain information on their usual pattern of bowel opening to inform if/when treatment of constipation is needed.

Medication charts showed multiple entries for multiple consumers where scheduled medications were not administered due to nil stock. Clinical management confirmed the service does not record nil stock incidents as medication errors, preventing effective tracking and trending to identify if there are systemic issues and mitigation strategies to prevent recurrence. The medication incident report showed medication patches not always removed as prescribed. The medication room and trolley also showed some gaps in best practice, including room numbers noted in pen on medication boxes that could cause error if staff wrote the wrong number on the box. There were only large size boxes of gloves located next to cytotoxic medications, which did not provide for staff requiring other glove sizes for administration.

The Assessment Team found that for one consumer, subject to chemical restraint, safe and effective behavioural support is not being provided to this consumer consistent with best practice. The consumer’s care and service records, including their behaviour support plan (BSP), do not contain lifestyle services and supports as behavioural support strategies, and do not evidence input from specialist dementia services to inform a holistic behaviour support strategies. The consumer’s restrictive practices assessment indicated the prescribed psychotropic medication was used for agitation that manifests as refusal of care and yelling that disturbs others. The restrictive practice is not being used as a last resort as per legislative requirements.

The Assessment Team observed staff using poor manual handling techniques as they lifted a consumer from the floor post fall without the use of a hoist, which is not consistent with the service physiotherapist’s recommendation. Documentation showed some this had also occurred for some other consumers.

In their response to the Assessment Team report, the approved provider outlined the improvement actions it will take to address the areas of non-compliance identified by the Assessment Team. I have considered the Assessment Team’s report and the approved provider’s response. I acknowledge the improvement actions outlined by the provider. However, I consider it will take time for the improvements to be embedded and sustained in practice.

Accordingly, I find Requirement 3(3)(a) non-compliant.

In relation to Requirement 3(3)(g) the Assessment Team found the service demonstrated infection related risks to consumers are being minimised. The service has outbreak management plans, trained infection prevention and control (IPC) leads and staff have been trained in infection prevention and control practices. Most consumers interviewed expressed satisfaction with the way the service was managed during COVID-19 exposures and said they felt safe and well looked after. Most observations made by the Assessment Team showed effective IPC is being practised at the service and the service is prepared to manage an infectious outbreak.

In their response to the Assessment Team report, the approved provider did not dispute the findings of the Assessment Team.

Accordingly, I find Requirement 3(3)(g) compliant.

# Standard 7

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| Human resources | |  |
| Requirement 7(3)(c) | The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles. | Not Compliant |

Findings

An Assessment Contact was conducted on 12 December 2023. The Assessment Team found. the service did not demonstrate the workforce is competent and some staff do not have the qualifications to effectively perform their roles. This was evidenced by gaps identified in staff knowledge and practices in the areas of medication management, behaviour support and manual handling.

Consumers and representatives did not raise concerns about staff knowledge and competence. However, the Assessment Team found personnel files showed most staff held qualifications consistent with job documentation requirements and their roles. However, the service was unable to provide evidence that some staff working in RAO roles held qualifications consistent with their job descriptions. In addition, the Assessment Team found some competency assessment records did not include evidence that they were checked and approved by a competency assessor. Some competency assessments contained unanswered questions while the staff members’ were still deemed competent. Gaps in RAO input to BSPS and lack of RAO intervention for a consumer subject to chemical restraint for agitation, refusal of care and yelling were, referred to in Requirement 3(3)(a).

The Assessment Team found there was confusion amongst registered nurses and clinical management as to where BSPs were located. One RN said they did not know. One care manager thought they were located on a shared drive. Another RN advised the team the procedure had recently changed following a decision made at the medication advisory committee (MAC) meeting to enter the plans on the care management system.

The Assessment Team found clinical staff and clinical management demonstrated a lack of knowledge and understanding of the legislative requirements regarding the need for BSPs to be developed for consumers subject to restrictive practices, such as mechanical restraint. There was a lack of behavioural charting for come sampled consumers subject to restrictive practices when behaviour incidents occurred. The care manager advised that if such incidents were considered to be the consumer’s usual behaviour the incident would not be charted. However, results in a missed opportunity to consider triggers and mitigation strategies for effective behaviour support and demonstrates a lack of understanding of best practice dementia and behaviour support.

The Assessment Team observed examples of poor manual handling posing safety risks for both consumers and staff. These were referred to in Requirement 3(3)(a). Medication incident reports showed there were recurring medication errors. However, these have mainly been identified and addressed.

In their response to the Assessment Team report, the approved provider outlined the improvement actions it will take to address the areas of non-compliance identified by the Assessment Team. The approved provider also supplied an attendance record dated 29 December 2023 for a training session on manual handling - after falls procedures that showed almost full attendance by nursing assistants, registered nurses, RAOs, cleaning and maintenance staff. In addition, the approved provider supplied a copy of the service Education and training matrix calendar for 2024. The calendar covers many of the key areas identified by the Assessment Team such as behaviour support plans, medication assistance refresher training, restrictive practice medication, frailty and unplanned weight loss, manual handling and managing high impact high prevalence risks including the incident management system. However, the training schedule does not appear to address some key risk areas identified I the Assessment Team report in a timely manner. For example, the two programs on Behaviour Management Plans and Changed Behaviours and BSPs are scheduled for July and December 2024 respectively, and risk and incident management training is not scheduled until May 2024.

The approved provider supplied a copy of a certificate for the Diploma of Leisure and Health issued by a registered training organisation, dated 13 June 2023 as evidence that one RAO holds the relevant qualification required by the service job documentation for their role. There were no certificates provided for the other two RAOs on the training record, including the RAO the chairperson identified as their partner employed by the service, in their conflict-of-interest declaration form.

I have considered the Assessment Team’s report and the approved provider’s response. I acknowledge the improvement actions outlined by the provider. However, I consider it will take time for the improvements to be embedded and sustained in practice.

Accordingly, I find Requirement 7(3)(c) non-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. | Not Compliant |

Findings

An Assessment Contact was conducted on 12 December 2023. The Assessment Team found the service did not demonstrate effective organisational risk management systems and processes. The organisation has documented guidance covering the 4 sub-requirements, but it was not evident that incident management is fully effective. The Assessment Team found the risk register identified a risk of failure to report and investigate resident incidents, accidents and adverse events, and the residual risk level was rated as low. During the Assessment Contact the Assessment Team found some consumer incidents were still not reported and managed, including medication not dispensed due to nil stock, and not recorded as medication incidents. Minutes of the clinical governance and finance and risk committee identified key risks for the service, but there was no record of the effectiveness of the risk controls for those areas. Moreover, individual consumer risk data is tabled and considered at the committee meetings, but there was no documented evidence of service level trends being covered and therefore there was no evaluation of the effectiveness of risk controls for strategic risks.

The organisation’s conflict-of-interest policy stipulates conflicts of interest must be avoided where possible, or otherwise reported to ensure the associated risks can be assessed and managed. It also requires governing body members to declare conflicts of interest annually, and a register must be kept. The Assessment Team found the governance manuals contained 2 completed declarations, both dated 2020, but did not include the chair-person’s conflict-of-interest declaration form. The organisation has 16 board members. The service manager confirmed the chairperson’s wife and uncle both work at the service as RAOs. The manager also confirmed that the chairperson and his wife, manage the RAO and catering functions. Hence the chairperson is involved in both governing and operating those services. When asked if he has oversite of the RAO and catering functions, the service manager advised there are meetings but they take place without him.

In their response to the Assessment Team report, the approved provider noted improvements made and to be actioned to address the issues identified for Requirement 8(3)(d), such as setting up a conflict-of-interest register. The clinical Governance, Finance, Audit, and Risk (FAR) Committee meeting will be held quarterly and risks identified at the meeting, including care and clinical issues will be discussed and actioned immediately if required, with incident management actioned immediately.

The approved provider supplied copies of the code of conduct and conflict -of-interest declarations for the 16 board members including the chairperson. However, I note the information in the conflict-of-interest declaration form is brief and where a conflict is declared there is insufficient information required and provided to ensure adherence to section 14 of the service’s code of conduct declaration that states ‘…to ensure that all conflicts of interest are identified, disclosed and managed in a rigorous and transparent way...’

The declaration includes the specific personal interest (such as relationship with employee/friend/family) but there are no details required/provided on how this causes actual /potential or perceived conflicts of interest with the board member’s duties and responsibilities, and there is no documented plan to manage the conflict-of-interest. The chairperson’s conflict-of-interest declaration rated the conflict as a level 3 which is a ‘potential’ conflict-of-interest, rather than level 1 the greatest direct conflict or level 2 a perceived conflict-of-interest. This would appear to be inconsistent with the service manager’s statement to the Assessment Team that the chairperson and their partner manage the catering and RAO functions and the service manager is excluded from meetings for those functions. Without the details noted above there is no clear justification as to how the chairman’s conflict-of-interest rating was objectively decided.

As noted in Requirement 7(3)(c) there was no certified qualification supplied in the approved provider’s response as evidence the partner of the Chairman who is an RAO at the service has the relevant RAO qualification/s for their role, as listed in the job documentation.

I have considered the Assessment Team’s report and the approved provider’s response. I acknowledge the actions the approved provider has taken and its planned improvements to address the issues identified for this requirement. However, I am not persuaded by the evidence supplied by the approved provider that the risks associated with conflicts of interest have been accurately assessed, effectively documented and managed, particularly in relation to the Chairperson/President. Moreover, I consider it will take time for the improvements to be embedded and sustained in practice.

Accordingly, I find Requirement 8(3)(d) non-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)