Clayton Church Homes - Summerhill

Performance Report

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**Commission ID:** 6104

**Provider name:** Clayton Church Homes Inc

**Assessment Contact - Site date:** 29 July 2020

**Date of Performance Report:** 31 August 2020

# Publication of report

This Performance Report **may 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** | **Compliant** |
| Requirement 3(3)(b) | Compliant |
| **Standard 8 Organisational governance** | **Compliant** |
| Requirement 8(3)(d) | Compliant |

# Detailed assessment

This performance report details the Commission’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 on 18 August 2020.

# STANDARD 3 COMPLIANT Personal 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

The Quality Standard is assessed as Compliant as one of the seven specific Requirements has been assessed as Compliant.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(b) in this Standard. All other Requirements in this Standard were not assessed.

The Assessment Team assessed Requirement (3)(b) as Non-compliant. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 3 and find the service is Compliant with Requirement (3)(b).

The service has implemented a range of actions to address the deficiencies identified which I have detailed below.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(b) Compliant

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

The Assessment Team found the service was unable to demonstrate effective management of high impact or high prevalence risks associated with the care of each consumer. In particular, the service did not have effective falls management strategies for staff to follow for consumers who are required to use the ramp to access their rooms. Procedures used by staff to address the risks posed to consumers who use the ramp were not clear or consistent and the service was unable to demonstrate adequate training had been provided to staff on how to safely traverse the ramp with consumers.

The Assessment Team provided the following evidence relevant to my decision, including:

* The Assessment Team noted there had been three incidents involving a consumer who had fallen while being traversing the ramp with the assistance of staff.
* The organisation had identified a risk in 2017 when the service was purchased and had put in strategies to address this risk which included staff using an electric wheelchair to traverse the ramp. The service was unable to demonstrate that this strategy was effective, as agency staff did not always follow the directive.
* The service had a Standard Operating Procedure entitled ‘Attendant Operated Powered Wheelchair’ dated January 2017. This document did not contain information on how staff are to use a manual wheelchair when consumers traverse the ramp and did not state that staff were to use an electric wheelchair at all times when traversing the ramp in line with the service’s reason for purchasing the wheelchair.
* The Assessment Team noted the incidents occurred when the consumer was using a manual wheelchair.
* Management said training had been provided to nursing staff in 2017 and staff were informed to use the electric wheelchair when traversing the ramp. No other formal training had been completed by staff and staff are provide manual handling training at any of the organisation’s sites. Management said new staff are provided with the Standard Operating Procedure dated January 2017 but are not provided with formal training on the ramp.
* The Physiotherapy Assessment which in turn populates the care plan did not clearly identify for staff how to traverse the ramp and was ambiguous.
* Management said while staff had been informed to go backwards when traversing a consumer down the ramp when using a manual wheelchair, management said there was no memoranda to staff.

During the visit, management acknowledged the following:

* The previous Standard Operating Procedure ‘Attendant Operated Powered Wheelchair’ did not contain information on traversing the ramp with a manual wheelchair and was only updated following the third incident.
* The consumer’s care plan did not contain safety strategies for traversing the ramp.
* There were no training records to demonstrate staff had undertaken appropriate training to safely traverse the ramp with a wheelchair and to travel backwards prior to the third incident.

Since July 2020 and prior to the Assessment Contact visit on 29 July 2020, management had implemented the following:

* The organisation reviewed, updated and endorsed the supporting Policy and Standard Operating Procedure ‘Negotiating the Ramp’ using a manual wheelchair or attendant power wheelchair. This document clearly identifies how to traverse the ramp and has pictures to inform staff. Staff were advised of the Standard Operating Procedure by a memorandum.
* Signage and pictures have been placed at the top of the ramp to alert staff on how to traverse the ramp.
* Management said all agency staff are shown the ramp and have access to the Standard Operating Procedure ‘Negotiating the Ramp’ using a manual wheelchair or attendant powered wheelchair to guide them.
* Two staff are required when traversing the ramp with a consumer.
* The third incident was discussed at a staff meeting.

A sample of consumer files viewed, and information provided to the Assessment Team by consumers, representatives and staff through interviews demonstrated:

* Consumers said they regularly see medical and nursing staff and they have no complaints or issues to raise. Consumers said they are satisfied with how the service is managing their personal and clinical care.
* Staff described the clinical and personal care risks for individual consumers, such as mobility and transfer needs, skin injuries, behaviours of concern, and managing pain.
* A review of care documentation for the three consumers who traverse the ramp confirmed strategies in each care plan have been updated to reflect for staff how to safely traverse the ramp with a wheelchair.

The approved provider submitted a response to the Assessment Team’s report and provided further supporting evidence and documentation on the improvements implemented prior to and since the Assessment Contact visit on 29 July 2020. These included:

* On 23 July 2020 a staff meeting was held to discuss the procedure for using wheelchairs on the ramp for all transfers, including always going backwards down the ramp. The type of wheelchair to be used will be dependent on the consumer’s weight. After the meeting, a manual handling training was held on the use of the wheelchairs when transferring consumers up and down the ramp. Staff were also advised a copy of the Standard Operating Procedure was available in the nurses’ station.
* The service’s ‘Pre-admission Resident and Building Risk’ assessment has been updated to include questions on whether risks associated with particular areas of the building have been discussed with the consumer and/or their representative and include the balcony area, elevated living, stairwell and the lift. A copy of the assessment was provided.
* Additional manual handling training has been provided to 34 staff from 23 July to 14 August 2020. As part of the training staff complete a manual handling competency on the use of the ramp. Training records provided confirmed staff have undertaken this training.
* The service has introduced Manual Handling champions. In August 2020, eight staff were trained and are available on site to coach and support staff on the correct use of the ramp. A copy of the training presentation was provided.
* The organisation has reviewed the ‘Orientation for New Staff’ booklet to include for Summerhill: ‘Manual Handling – Safe use of ramp. Competency on using attendant operated wheelchair and manual wheelchair to negotiate ramp’.
* The Agency staff checklist has been updated to include ‘Ramp usage and SOP attended’ for the Summerhill site only. Prior to the introduction of the new Agency staff checklist forms, it is noted that staff inducting Agency staff have written a notation at the bottom of the form that the Agency staff have been made aware of the protocols to be used for traversing the ramp.
* The organisation held a training session was held on 6 August 2020 for physiotherapists on effective documentation.
* From 3 August 2020, the service introduced weekly environmental audits as part of their Continuous Improvement Plan ‘to monitor the environmental presentation of the service and the practice of staff when traversing residents from one level of the facility to another’. A copy of the ‘Environmental Observational Audit Tool’ for 4 August 2020 and 13 August 2020 confirmed that while the observation audits are being completed for five staff, no observations occurred of staff using the ramp. The explanation provided is that ‘no resident required a wheelchair for transport’ and the audits reflect a ‘not applicable’ against these questions. Based on the results for these audits, there is no evidence that staff are following the service’s practice when traversing the ramp.
* Between 14 July 2020 and 21 July 2020, the service conducted an audit of the mobility plans for the consumers who reside in the lower area. Physiotherapy assessments have been reviewed and updated if required. The service’s electronic care plan assessments have been updated to reflect an additional three risk questions in relation to each consumer’s specific preferences and choices, and strategies to be put in place to minimise risk in line with consumers’ preferences and choices.

Following the last incident in July 2020 the service has reviewed and updated their procedures and protocols for the use of the ramp and identified improvements to be made to staff practice. While not all improvements were completed at the time of the Assessment Contact on 29 July 2020, the approved provider had commenced training staff on the use of the ramp.

The approved provider has submitted further evidence and documentation to substantiate the improvements which have now been implemented. These have included additional training and manual handling competencies for staff, the introduction of manual handling champions, a review of those consumers’ mobility assessments and care plans who reside in the lower area, and improvements to the procedure for the orientation of new and Agency staff members.

For the reasons detailed above, I find the approved provider, in relation to Clayton Church Homes – Summerhill, is Compliant in relation to Standard 3 Requirement (3)(b).

# STANDARD 8 COMPLIANT Organisational governance

### Consumer outcome:

1. I am confident the organisation is well run. I can partner in improving the delivery of care and services.

### Organisation statement:

1. The organisation’s governing body is accountable for the delivery of safe and quality care and services.

## Assessment of Standard 8

The Quality Standard is assessed as Compliant as one of the five specific Requirements has been assessed as Compliant.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(d) in this Standard. All other Requirements in this Standard were not assessed.

The Assessment Team assessed Requirement (3)(d) as met. I have considered the Assessment Team’s findings, the evidence documented in the Assessment Team’s report and the approved provider’s response to come to a view of compliance with Standard 8 and find the service is Compliant with Requirement (3)(d).

Overall consumers and representatives sampled said the organisation is well run and they can partner in improving the delivery of care and services. For example:

* Consumers said they are happy with the staff as they listen and follow things up.
* Consumers said they have input into the service through monthly resident meetings and various surveys.

The organisation has a governance framework with a Board that meets on a monthly schedule. Various reports and key performance indicators are provided to the Board. The organisation’s risk management framework supports all business activities and risks are monitored at service, Executive and Board level.

Management advised the organisation’s risk management framework includes policies and procedures in relation to corporate risks and risks associated with the care service delivery to consumers. The governance model includes monitoring of the service’s performance at governance level through meetings and reporting.

The Chief Executive Officer said following the incident in July 2020, the Executive team visited the service and a report had been prepared for the Board.

The service has a range of policies and procedures to support the effective management of high impact or high prevalence risks associated with the care of consumers, identifying and responding to abuse and neglect, and supporting consumers to live the best lives they can. High impact or high prevalence risks are monitored through monthly reporting to the Executive team and the Board, such as clinical incidents, clinical indicators, infection data, mandatory reporting of incidents, feedback and complaints, call bell response times and consumers identified at high risk.

Management and staff described being involved in the development of policies and procedures. Documentation viewed showed the Board is involved in the review and approval of policies and procedures and the monitoring of corporate risks and risks associated with the care and service delivery toconsumers.

Staff interviewed confirmed policies and procedures in relation to risks to consumers are provided to them and they provided examples of consumers at risk and how they provide care and services according to their needs.

For the reasons detailed above, I find the approved provider, in relation to Clayton Church Homes - Summerhill, is Compliant in relation to Requirement (3)(d) of Standard 8.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(d) Compliant

*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.*

# 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, however, required to actively pursue continuous improvement in order to remain compliant with the Quality Standards.