Braemar House

Performance Report

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**Commission ID:** 7758

**Provider name:** The Commissioners of the Presbyterian Church in WA

**Assessment Contact - Site date:** 25 October 2021

**Date of Performance Report:** 3 December 2021

# Performance report prepared by

Michelle Glenn, delegate of the Aged Care Quality and Safety Commissioner.

# 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

|  |  |
| --- | --- |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Non-compliant |
| **Standard 7 Human resources** |  |
| Requirement 7(3)(a) | Compliant |
| **Standard 8 Organisational governance** |  |
| Requirement 8(3)(c) | 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 consumers, representatives, staff and others
* the provider’s response to the Assessment Contact - Site report received 16 November 2021
* the Performance Report dated 11 May 2021 for the Assessment Contact conducted 7 January 2021.

# 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

The Quality Standard is Non-compliant as the two specific Requirements assessed have been found Non-compliant. The Assessment Team assessed Requirements (3)(a) and (3)(b) in Standard 3 Personal care and clinical care as part of the Assessment Contact. All other Requirements in this Standard were not assessed.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirements (3)(a) and (3)(b) in Standard 3. These Requirements were found Non-compliant following an Assessment Contact 7 January 2021 where it was found the service was unable to demonstrate:

* delivery of safe and effective personal and clinical care, specifically in relation to use of chemical and physical restraints and post incident behaviour and falls management; or
* effective management of high impact or high prevalence risks associated with consumers displaying behavioural responses or that strategies relating to behaviours and risk of falls were reviewed for effectiveness following incidents.

The Assessment Team’s report did not include evidence of actions taken to address deficiencies identified at the Site Audit.

At the Assessment Contact, the Assessment Team were not satisfied the service demonstrated:

* each consumer is provided safe and effective personal and clinical care that is based on best practice and tailored to their needs, specifically in relation to management of skin integrity issues and wounds, pain and weight for three consumers; or
* effective management of nutrition and hydration, pain and wound management for three consumers living with dementia.

The Assessment Team’s report highlighted three consumers. The Assessment Team have recommended Requirements (3)(a) and (3)(b) not met.

I have considered the Assessment Team’s findings, the provider’s response and the evidence documented in the Assessment Team’s report and based on this information, I find The Commissioners of the Presbyterian Church in WA, in relation to Braemar House, Non-compliant with Requirements (3)(a) and (3)(b) in Standard 3 Personal care and clinical care. I have provided reasons for my finding in the specific Requirement below.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) Non-Compliant

*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.*

The Assessment Team were not satisfied the service demonstrated that each consumer is provided safe and effective personal and clinical care that is based on best practice and tailored to their needs, specifically in relation to management of skin integrity issues and wounds, pain and weight for three consumers. The Assessment Team’s report provided the following evidence relevant to my finding:

Consumer A

* Wound monitoring did not show regular photographs are taken, wounds are monitored for progression of healing or that the dressing has been left in place for the required time, in line with best practice and the service’s wound care policy, to promote optimal healing.
* Pain is not being managed effectively and the consumer indicated they had pain.
* A narcotic analgesic, prescribed to be administered half an hour prior to hand massages has not been administered since May 2021. Pain assessments during the massages or dressing treatments are not undertaken and staff stated the consumer demonstrates pain during these treatments.
* Consumer A has lost 3.7kg in the past five months. A protein supplement is ordered, however, administration in line with supplement orders was unable to be verified.
* Consumer A indicated they do not take the milk drink as they do not like it. No refusals are reported as an incident.

Consumer B

* Wounds have not been monitored using photographs or measurements to identify progression of wound healing and wound products are not being left in place for the recommended time.
* Consumer B sustained a bruise to the arm and a skin tear in October 2021. Monitoring of pain that may be present due to extensive bruising has not been conducted.
* The Assessment Team observed the consumer to pull the bruised arm away when touched by staff and the representative.
* Consumer B has lost 5kg in the past three months. Specialist’s instructions to monitor evening intake has not been followed.
* An increase in the consumer’s psychotropic medication has not been reviewed to monitor the effectiveness of the increased dose.

Consumer C

* Progression of clinical status of a small wound, present since entry in August 2021, had not been noted until September 2021, approximately 30 days later. The wound had progressed to a stage 3 wound.
* Instructions from a specialist service relating to more testing, given 10 days prior to the Assessment contact, have not been followed up.
* Pain has not been monitored since exacerbation of the wound.

I have also considered the following evidence, included in the Assessment Team’s report in Standard 3 Personal care and clinical care Requirement (3)(b), in my finding for this Requirement:

* In relation to Consumer C, information relating to lack of directives to guide staff in the consumer’s day-to-day care needs.

In response to the Assessment Team’s report and findings, the provider has developed a Plan for continuous improvement addressing the deficits identified in the Assessment Team’s report. The Plan for continuous improvement was included as part of the provider’s response. Actions completed, in progress and/or planned include, but are not limited to:

* Conducted a review of all consumers’ relating to wounds, nutrition, weight loss and pain management to ensure effective charting of directives was occurring.
* Reviewed and updated the Skin care policy in line with best practice.
* Wound management is tabled at Clinical Standards meetings to promote best practice, consistent with the organisation’s policy.
* For the three consumers highlighted in the Assessment Team’s report, specific concerns have been addressed.

The service was found Non-compliant with Requirement (3)(a) following an Assessment Contact conducted 7 January 2021 where it was found the service was unable to demonstrate delivery of safe and effective personal and clinical care, specifically in relation to use of chemical and physical restraints and post incident behaviour and falls management. The Assessment Team’s report did not provided evidence of actions taken to address deficiencies identified.

I acknowledge the provider’s proactive response to address the deficits highlighted by the Assessment Team. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Assessment Contact, for the consumers highlighted, safe and effective personal and clinical care was not being provided which was best practice, tailored to their needs or optimised their health and well-being. Specifically, I have considered evidence in relation to management of wounds and pain for Consumers A and B and care planning for Consumer C.

In relation to Consumer A, I have considered the consumer is not being provided effective pain management which is tailored to their needs and optimises their health and well-being. While the service is aware the consumer experiences pain in the hands and management strategies to relieve the pain are in place, these strategies, specifically administration of a narcotic analgesic, have not been implemented prior to initiating massage/exercises or wound treatments since May 2021. I have also considered that appropriate monitoring of the consumer’s pain during massage/exercise and wound treatments has not occurred which has not ensured the consumer’s pain is being effectively managed with the current management strategies in place.

In relation to Consumer B, I have considered effective monitoring, assessment and review of pain management has not been undertaken to optimise the consumer’s health and well-being. While ongoing pain charting is in place, this has not been effective in identifying possible pain associated with bruising to the arm. As such, this has not ensured appropriate management strategies are implemented to maintain the consumer’s comfort. The Assessment Team observed, and staff sampled indicated the consumer maybe experiencing pain in the affected arm.

For Consumers A and B, I have considered that wounds have not been monitored in line with best practice care. I acknowledge evidence provided in the Assessment Team’s report does not indicate the wounds are deteriorating. However, documentation sampled did demonstrate wounds were not consistently monitored, including documenting measurements and taking photographs. I find it is reasonable for consumers to expect wounds are monitored at each treatment, including consideration of measurements of the wound, undertaken in line with best practice care. Such practices would ensure wound progression is monitored and wound deterioration is identified in a timely manner. I have also considered that wound dressings were not being used in line with best practice or the service’s policy documents which has the potential to impact the progression of wound healing.

In relation to management of weight for Consumers A and B and monitoring of psychotropic medication for Consumer B, I have considered the evidence in another Requirement which reflects the core deficiency associated with the evidence. I have considered that the evidence provided relates to effective management of high impact or high prevalence risks associated with the care of each consumer. As such, I find this information more aligned with Requirement (3)(b) in this Standard and have, therefore, considered this information in my finding for that Requirement.

In relation to Consumer C, I have considered that the service has not ensured personal care is tailored to the consumer’s needs. Despite the consumer entering the service two months prior to the Assessment Contact, documentation, specifically an active care plan, has not been developed to assist and guide staff to provide care in line with the consumer’s assessed needs or their goals and preferences.

In relation to management of wounds and pain for Consumer C, I have considered the evidence in another Requirement which reflects the core deficiency associated with the evidence. I have considered that the evidence provided relates to effective management of high impact or high prevalence risks associated with the care of each consumer. As such, I find this information more aligned with Requirement (3)(b) in this Standard and have, therefore, considered this information in my finding for that Requirement.

For the reasons detailed above, I find The Commissioners of the Presbyterian Church in WA, in relation to Braemar House, Non-compliant with Requirement (3)(a) in Standard 3 Personal care and clinical care.

### 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 were not satisfied the service demonstrated effective management of nutrition and hydration, pain and wound management for three consumers living with dementia. The Assessment Team’s report provided the following evidence relevant to my finding:

Consumer A

* Charts for a stage 1 pressure injury identified in September 2021 do not demonstrate the wound has been measured or photographed to identify progression. The wound dressing being applied is not being left in place for the required time frame, in line with best practice guidelines or the service’s wound care policy.
* The wound was noted to remain at a stage 1 at the time of the Assessment Contact.
* A skin tear has not been photographed or measured to identify wound progression since identification, nine days prior. The wound dressing being applied is being changed every second day and not being left in place for the required time frame of seven days, in line with best practice guidelines or the service’s wound care policy.
* Narcotic analgesia is ordered on an as required basis, half an hour prior to hand massage/exercise. While the medication was administered regularly from January to May 2021, the medication has not been administered since May 2021. Consumer A stated they have pain when they move their hands.
* An allied health staff member stated the consumer has pain at times on massage. Review or monitoring of pain during massage or dressing changes does not occur.
* Consumer A has lost 3.7kg in the past five months. Food intake charts have not been consistently completed to monitor nutrition and hydration.
* Information relating to administration of a nutritional supplement was not consistent. The consumer stated they do not like the milk during and doesn’t have it. No refusals of the supplement are recorded.
* Management indicated the consumer’s weight loss may be related to a fluid restriction. However, fluid restriction records showed the restriction is not being monitored.

Consumer B

* Wounds are not being monitored through photographs or measurements to determine wound progression. Dressing changes are not being implemented consistently or in line with best practice or the service’s policies and procedures.
* Of the four wounds highlighted, there was no indication they were not progressing/healing.
* The consumer sustained a bruise to the arm and wrist in October 2021. The Assessment Team observed the consumer to pull the bruised arm away and guard it when touched the representative. Staff sampled said maybe the arm was causing the consumer some pain.
* While ongoing pain charting is in place, a pain review relating to the skin injury has not been undertaken.
* The consumer has lost 5kg in the past three months. While the consumer has been reviewed by a Dietitian, recommendations to monitor food intake have not been sufficiently implemented with food intake charts sampled noted to inconsistently completed.
* The consumer is prescribed regular antipsychotic medication. The medication dose was increased in August 2021, however, monitoring of the increase in dose for effectiveness has not occurred.
* Behaviour charting for September and October 2021 does not demonstrate a change in behaviours since the change in medication dose.

Consumer C

* The consumer was identified with a small wound to the leg in August 2021 which progressed to a stage 3 wound a month later.
* Progress notes in October 2021 indicate the consumer was complaining of pain in the leg. A regular pain chart is in place to monitor back pain. No charting has been commenced relating to the leg.
* The consumer was seen by specialist services in October 2021 who requested the service arranged for a further assessment. The request had not been actioned at the time of the Assessment Contact
* Directives to guide staff in the consumer’s day-to-day care needs has not been provided to staff despite the consumer entering the service two months prior to the Assessment Contact. An active care plan is not in place; senior clinical staff stated this will be addressed.

In response to the Assessment Team’s report and findings, the provider has developed a Plan for continuous improvement addressing the deficits identified in the Assessment Team’s. The Plan for continuous improvement was included as part of the provider’s response. Actions completed, in progress and/or planned include, but are not limited to:

* For the three consumers highlighted in the Assessment Team’s report, specific concerns have been addressed. This includes aspects of clinical care relating to management of wounds, pain, nutrition and restrictive practices.

The service was found Non-compliant with Requirement (3)(b) following an Assessment Contact conducted 7 January 2021 where it was found the service was unable to demonstrate effective management of high impact or high prevalence risks associated with consumers displaying behavioural responses or that strategies relating to behaviours and risk of falls were reviewed for effectiveness following incidents. The Assessment Team’s report did not provided evidence of actions taken to address deficiencies identified.

I acknowledge the provider’s proactive response to address the deficits highlighted by the Assessment Team. However, based on the Assessment Team’s report and the provider’s response, I find at the time of the Assessment Contact, high impact or high prevalence risks for the three consumers highlighted had not been effectively managed. Specifically, in coming to my finding, I have considered management of weight for Consumer A, management of weight and monitoring of changes to psychotropic medications for Consumer B and wound management for Consumer C.

For Consumer A, I consider the consumer’s risks relating to nutrition and hydration were not effectively monitored or managed which has the potential to impact on the consumer’s quality of life. Food intake charting was not consistently completed, therefore, not enabling the consumer’s nutritional intake to be effectively monitored. Additionally, documentation relating to intake of a nutritional supplement was noted to be inconsistent. While Consumer A clearly articulated to the Assessment Team they did not like the supplement drink, there was no indication in the documentation sampled that the consumer refused the supplement. I have also considered feedback from management indicating Consumer A’s weight loss may be due to a fluid restriction. However, the consumer’s fluid intake is not being monitored.

In relation to management of wounds and pain for Consumer A, I have considered the evidence in another Requirement which reflects the core deficiency associated with the evidence. I have considered that the evidence provided relates to providing clinical care which is best practice and optimises the consumer’s health and well-being. As such, I find this information more aligned with Requirement (3)(a) in this Standard and have, therefore, considered this information in my finding for that Requirement.

In relation to Consumer B, I have considered risks relating to weight management and use of psychotropic medications have not been effectively monitored or managed. In relation to weight management, allied health specialist’s recommendations have not been consistently implemented to ensure risks relating to weight loss are effectively monitored and additional management strategies identified and implemented. In relation to psychotropic medications, monitoring and review processes were not effectively implemented to monitor the effect of an increased dose of medication. In both instances, effective monitoring would ensure early identification of issues and timely implementation of suitable management strategies to mitigate risks to consumers’ health and well-being.

In relation to management of wounds and pain for Consumer B, I have considered the evidence in another Requirement which reflects the core deficiency associated with the evidence. I have considered that the evidence provided relates to providing clinical care which is best practice and optimises the consumer’s health and well-being. As such, I find this information more aligned with Requirement (3)(a) in this Standard and have, therefore, considered this information in my finding for that Requirement.

For Consumer C, I have considered appropriate and timely actions have not been taken in response to the consumer’s changing needs. I find risks relating to skin integrity, specifically wound management, were not effectively monitored or managed with a small wound identified in August 2021 progressing to a stage 3 within one month. While progress notes indicated the consumer was experiencing pain in the limb where the wound was located, monitoring, assessment and review of pain management strategies did not occur. I have also considered specialist recommendations were not initiated in a timely manner. A specialist’s request for further testing to occur had not been initiated at the time of the Assessment Contact, 10 days post the specialist review.

In relation to lack of directives available to direct staff with Consumer C’s day-to-day care, have considered the evidence in another Requirement which reflects the core deficiency associated with the evidence. I have considered that the evidence provided relates to providing personal care which is tailored to the consumer’s needs. As such, I find this information more aligned with Requirement (3)(a) in this Standard and have, therefore, considered this information in my finding for that Requirement.

For the reasons detailed above, I find The Commissioners of the Presbyterian Church in WA, in relation to Braemar House, Non-compliant with Requirement (3)(b) in Standard 3 Personal care and clinical care.

# STANDARD 7 Human resources

### Consumer outcome:

1. I get quality care and services when I need them from people who are knowledgeable, capable and caring.

### Organisation statement:

1. The organisation has a workforce that is sufficient, and is skilled and qualified, to provide safe, respectful and quality care and services.

## Assessment of Standard 7

The Assessment Team assessed Requirement (3)(a) in Standard 7 Human resources as part of the Assessment Contact. All other Requirements in this Standard were not assessed and, therefore, an overall rating of the Standard is not provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(a) in Standard 7. This Requirement was found Non-compliant following an Assessment Contact 7 January 2021 where it was found staffing levels and mix did not support effective monitoring/supervision of consumers or consider the consumers’ needs. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Assessment Contact. The Assessment Team have recommended Requirement (3)(a) met.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and based on this information, I find The Commissioners of the Presbyterian Church in WA, in relation to Braemar House, Compliant with Requirement (3)(a) in Standard 7 Human resources. I have provided reasons for my finding in the specific Requirement below.

## Assessment of Standard 7 Requirements

### Requirement 7(3)(a) Compliant

*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.*

The service was found Non-compliant with Requirement (3)(a) following an Assessment Contact 7 January 2021 where it was found staffing levels and mix did not support effective monitoring/supervision of consumers or consider the consumers’ needs. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Undertaken a dedicated recruitment drive to employ permanent staff. This has resulted in an increase in the number of permanent staff. An increase in the therapy team has occurred with an additional Occupational therapist employed and a Physiotherapist who is in the final stages of onboarding.
* Reduced the frequency of agency staff utilised.
* Reviewed staffing allocations in the memory support unit, resulting in an increase in therapy staff presence and assistance at mealtimes.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* The service demonstrated the workforce is planned to enable, and the number and mix of the workforce deployed enables the delivery and management of safe and quality care and services.
* Most consumers stated staff attend them promptly when they use their call bell. Two representatives indicated staff are visible when they visit and they are happy their relatives in the memory support unit receive care from staff that know them well.
* Call bell response times are monitored regularly. Since January 2021, current trends show no issues of concern, with a general reduction in call bell usage and an increase in response times within five minutes, attributed to more proactive staff behaviour.
* Throughout the duration of the Assessment Contact, staff were observed in communal areas of the memory support unit, providing care and support to consumers.
* Consumers in the memory support unit were observed receiving prompt support from staff, and Therapy staff were observed to be assisting consumers in this area during mealtimes.

For the reasons detailed above, I find The Commissioners of the Presbyterian Church in WA, in relation to Braemar House, Compliant with Requirement (3)(a) in Standard 7 Human resources.

# STANDARD 8 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 Assessment Team assessed Requirement (3)(c) in Standard 8 Organisational governance as part of the Assessment Contact. All other Requirements in this Standard were not assessed and, therefore, an overall rating of the Standard is not provided.

The purpose of the Assessment Contact was to assess the performance of the service in relation to Requirement (3)(c) in Standard 8. This Requirement was found Non-compliant following an Assessment Contact 7 January 2021 where it was found the service did not have effective governance systems relating to information management, regulatory compliance, workforce governance and feedback and complaints. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified at the Assessment Contact. The Assessment Team have recommended Requirement (3)(c) met.

I have considered the Assessment Team’s findings and the evidence documented in the Assessment Team’s report and based on this information, I find The Commissioners of the Presbyterian Church in WA, in relation to Braemar House, Compliant with Requirement (3)(c) in Standard 8 Organisational governance. I have provided reasons for my finding in the specific Requirement below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(c) Compliant

*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.*

The service was found Non-compliant with Requirement (3)(c) following an Assessment Contact 7 January 2021 where it was found the service did not have effective governance systems relating to information management, regulatory compliance, workforce governance and feedback and complaints. The Assessment Team’s report provided evidence of actions taken to address deficiencies identified, including, but not limited to:

* Reviewed the daily handover document. The document includes key information and education for staff, including prompts on incident management and restrictive practices legislation and information in relation to each consumer’s risks, preferences, and care needs.
* Formed Clinical governance and quality improvement meetings resulting in increased monitoring of the delivery of care and services and identification of improvement opportunities and training for staff.
* Conducting regular audits of consumers’ care plans.
* Increased monitoring of staff.
* Education provided to management and staff on the Serious Incident Response Scheme (SIRS). Documentation sampled demonstrated SIRS has been embedded into the incident management system.
* Increased monitoring of feedback and complaints, monthly trends are reviewed and improvement actions identified.

The Assessment Team provided the following evidence and information collected through interviews, observations and documents which are relevant to my finding in relation to this Requirement:

* The service demonstrated effective organisation wide governance systems relating to information management, continuous improvement, financial and workforce governance, regulatory compliance and feedback and complaints.
* In relation to information management, staff confirmed they have access to information about consumers, including through the electronic care system, hard copy documents and handover processes. Information relating to consumer care was also observed in nurse’s stations to prompt staff to complete monitoring tasks clinical and care tasks.
* In relation to Continuous improvement, the agenda for the Clinical governance and quality improvement meetings includes a full multidisciplinary review of clinical indicators, clinical incident analysis, medication management, and issues identified following audits undertaken. This forum, along with feedback and complaints processes, assist the organisation to identify improvement opportunities.
* In relation to financial governance, any request for equipment or services to support consumer needs is usually approved by the organisation.
* In relation to Workforce governance, a central human resource team is in place to support all aspects of the workforce. There are Job descriptions outlining staff roles and responsibilities regular performance monitoring and reviews occur. The Clinical governance and quality improvement meetings also provide an opportunity for role expectations and responsibilities to be communicated to staff.
* In relation to regulatory compliance, a comprehensive clinical review of consumers identified as having high impact high prevalence risks is conducted weekly. The review includes responding to alerts from staff in relation to consumers with complex or escalating care needs and prompts a comprehensive review of the consumer’s management. Consumers reviewed through this weekly group are also discussed monthly Clinical governance and quality improvement meetings along with all incidents and SIRS.
* In relation to feedback and complaints, consumers and representatives were aware meetings are held where they can raise concerns and give feedback. However, several consumers and representatives stated they did not always see improvements following concerns being raised. Management noted there are generally low numbers of complaints received. Complaints are discussed at regular meeting forums.

For the reasons detailed above, I find The Commissioners of the Presbyterian Church in WA, in relation to Braemar House, Compliant with Requirement (3)(c) in Standard 8 Organisational governance.

# 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.

**Standard 3 Requirements (3)(a) and (3)(b)**

* Ensure staff have the skills and knowledge to:
* review and undertake wound treatments in line with wound treatment plans, ensuring wound measurements and regular photographs are taken.
* recognise changes to consumers’ health and well-being, including skin integrity, pain and nutrition and hydration, implement appropriate management strategies and monitor and review strategies for effectiveness.
* in response to medication changes, initiate monitoring processes, develop and/or implement appropriate behaviour management strategies and monitor effectiveness of strategies.
* develop care plans, including for new and/or respite consumers that are accurate and reflective of each consumer’s current care and service needs and preferences to assist staff to deliver appropriate care and services.
* Ensure policies, procedures and guidelines in relation to management of high impact or high prevalence risks are effectively communicated and understood by staff.
* Monitor staff compliance with the service’s policies, procedures and guidelines in relation to management of high impact or high prevalence risks.