Crossley House Hostel Inc

Performance Report

14 Nicol Street
YARRAM VIC 3971
Phone number: 03 5182 0222

**Commission ID:** 3091

**Provider name:** Yarram & District Health Service

**Assessment Contact - Desk date:** 8 October 2021 to 22 October 2021

**Date of Performance Report:** 16 January 2022

# Performance report prepared by

Adrian Clementz, 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 2 Ongoing assessment and planning with consumers** | **Non-compliant** |
| Requirement 2(3)(a) | Non-compliant |
| Requirement 2(3)(c) | Compliant |
| Requirement 2(3)(d) | Compliant |
| Requirement 2(3)(e) | Non-compliant |
| **Standard 3 Personal care and clinical care** | **Non-compliant** |
| Requirement 3(3)(a) | Non-compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(d) | Compliant |
| Requirement 3(3)(e) | Compliant |
| **Standard 4 Services and supports for daily living** |  |
| Requirement 4(3)(f) | Compliant |
| **Standard 7 Human resources** |  |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(e) | Compliant |
| **Standard 8 Organisational governance** | **Non-compliant** |
| Requirement 8(3)(c) | Non-compliant |
| Requirement 8(3)(d) | Non-compliant |
| Requirement 8(3)(e) | 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 - Desk; the Assessment Contact - Desk report was informed by review of documents and interviews with staff, consumers/representatives and others
* the provider’s response to the Assessment Contact - Desk report received 7 December 2021.

# STANDARD 2 NON-COMPLIANTOngoing assessment and planning with consumers

### Consumer outcome:

### I am a partner in ongoing assessment and planning that helps me get the care and services I need for my health and well-being.

### Organisation statement:

1. The organisation undertakes initial and ongoing assessment and planning for care and services in partnership with the consumer. Assessment and planning has a focus on optimising health and well-being in accordance with the consumer’s needs, goals and preferences.

## Assessment of Standard 2

The service was found non-compliant in four of the specific requirements under this Quality Standard during the previous visit conducted on 9 December 2020.

The focus of this assessment contact was to assess the service’s progress in returning to full compliance with the Quality Standards.

The service demonstrated that actions undertaken to date have addressed deficits previously identified in this Standard for two of the four requirements.

Evidence shows ongoing deficits in two requirements which has been assessed as ongoing non-compliant.

The Quality Standard is assessed as Non-compliant as two of the five specific requirements have been assessed as Non-compliant.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) Non-compliant

*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.*

The Assessment Team found deficits identified at the audit on 9 December 2020 have not been fully addressed. Review of care documentation for five consumers identified incomplete assessments and plans of care, including consideration of risk, for three of the consumers sampled. During the audit management acknowledged risk-based assessment and planning had not occurred for all consumers in line with protocols. Staff said they do not do not use assessments and plans of care to inform the care they deliver.

The provider’s response acknowledged some of the areas of deficit identified by the Assessment Team, included further information to refute or contextualise some evidence, and, set out action commenced by the service to strengthen processes and practice.

Information made available by the provider included evidence for a consumer that demonstrated the consumer at the time of the audit was engaged as a respite resident and, as such, assessment protocols that apply to a permanent resident did not apply to this consumer. Information was also provided to refute the Assessment Team’s evidence in relation to assessed risk for the consumer.

For two other consumers named in the report, the provider included documentation of action taken since the audit to address deficits identified in relation to assessment and planning of care. Evidence refuting that a mobility aid was not provided for one consumer is noted.

The provider’s response, based on subsequent interviews with staff, disagreed with the Assessment Team’s evidence from staff interviews they do not refer to assessments or plans of care to guide care, instead relying on handover sheets.

The provider acknowledged not all consumers with diabetes had relevant assessments and plans of care.

The provider’s response states staff practice is not aligned with the organisation’s admission protocols and clinical and specialised care policy. The provider highlighted that the director of clinical services who commenced a few weeks prior to the had already identified at the time of the audit ‘risk based assessments had not been completed for all consumers in accordance with the organisations protocols’ and had commenced action to address the deficits by the time the audit commenced.

The provider has commenced action based on the Assessment Team’s evidence to:

* Strengthen permanent and respite admissions processes, including the introduction of respite admissions checklist to support staff practice.
* Ensure that ‘assessments are occurring in a timely and appropriate manner’.
* Provide education to staff in relation to the requirements for assessment and care planning, including the identification of risk. This will be provided by the clinical nurse educator employed in November 2021.

In making this decision I have taken into consideration the additional evidence made available by the provider correcting and contextualising some of the Assessment Team’s evidence. I have considered evidence of action taken to address the deficits relating to consumers named in the report. I note the provider had been recently aware of the deficits in this Requirement at the time of the audit and note the remedial action commenced at the time of and since the audit, including updated consumer documentation.

However, I have placed weight on evidence and acknowledgement that at the time of the audit assessment and care planning, including consideration for risk, was not effective to inform the delivery of care and services, albeit the provider had commenced corrective action. For this reason, I am satisfied the service does not yet meet the Requirement and I find the service remains non-compliant with this Requirement.

### Requirement 2(3)(c) Compliant

*The organisation demonstrates that assessment and planning:*

1. *is based on ongoing partnership with the consumer and others that the consumer wishes to involve in assessment, planning and review of the consumer’s care and services; and*
2. *includes other organisations, and individuals and providers of other care and services, that are involved in the care of the consumer.*

The Assessment team found the service had not fully addressed deficits identified at the audit on 9 December 2020. Care documentation for two of five consumers reviewed indicated that while the service collaborates with other organisations, individuals and providers of care and services in the care of the consumer, this is not consistently achieved in partnership with the consumer of representative. Representatives interviewed provided feedback and examples they are not always informed on care and services delivered.

The provider’s response acknowledged some gaps in relation to consistency in partnership, however included further information and evidence to demonstrate the consumer/representative had been consulted or why not required for a number of the examples provided by the Assessment Team.

In recognition of these gaps the provider has implemented actions to strengthen staff practice. This includes a memorandum reiterating communication and open disclosure requirements, further education for staff, and change to dietitian’s practice.

In making this decision I have taken into account the Assessment Team’s evidence the service demonstrates assessment and planning includes other organisations, individuals and providers. I have also taken into consideration the provider’s additional evidence that demonstrates consultation or partnership has occurred for much of the Assessment Team’s illustrative evidence. I have concluded, while there are gaps in consultation or partnership with consumers/representatives, based on the available evidence, this largely occurs. I also note the additional steps taken by the service to strengthen practice.

Thus, on balance, I have formed a view different to that recommended by the Assessment Team and find the service is compliant with this requirement.

### Requirement 2(3)(d) Compliant

*The outcomes of assessment and planning are effectively communicated to the consumer and documented in a care and services plan that is readily available to the consumer, and where care and services are provided.*

The Assessment team found the service had not fully addressed deficits identified at the audit on 9 December 2020 and presented evidence the care documentation for three of five consumers reviewed showed outcomes of assessment and planning are not consistently communicated to the consumer or representative. Representatives interviewed were unable to confirm if outcomes of assessment and planning are effectively communicated to them. Staff said communication of outcomes of care changes are documented in progress notes but acknowledged this was inconsistent.

The provider’s response acknowledged some gaps in relation to the consistency in communicating outcomes of planning to the consumer or representative, specifically in relation to timely communication of dietary changes. The provider’s response included further information to demonstrate communication of outcome of care changes for each of the three consumers named had occurred, while acknowledging this did not always occur at time of change. The provider’s response included evidence that indicated communication of outcomes to representatives for most of the examples presented in the Assessment Team’s representative feedback evidence.

The provider has implemented action to strengthen staff practice through education, a memorandum reiterating communication and open disclosure requirements, audits tools to monitor staff practice, and changes the dietitian process.

In making this decision I have taken a holistic view of the evidence that indicates while there are gaps in the communication of outcomes to representatives, communication of outcomes largely occurred across the sample of five consumers. In support of this have also drawn my analysis of relevant evidence presented by the Assessment Team and the provider in relation to Standard 2 Requirement (3)(c). I have noted the provider’s commitment to additional measures to further educate staff and strengthen monitoring processes.

Thus, I have formed a view different to that recommended by the Assessment Team and find on balance the service is compliant with this requirement.

### Requirement 2(3)(e) Non-compliant

*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.*

The Assessment Team found deficits identified at the audit on 9 December 2020 have not been fully addressed and presented evidence care and services are not reviewed regularly for effectiveness, when circumstances change and when incidents impact on the needs of the consumer. This was illustrated through the documented care experience for two consumers in relation to lack of monitoring of effectiveness of administration of aperients, no review of a medication an incident, and ineffective diabetes management. The Assessment Team also identified use of psychotropic medications were not systematically or consistently reviewed or monitored and not all wounds had assessments and treatment plans in place. The Assessment Team identified periodic reviews of plans of care were not occurring in line with the organisations processes.

The provider’s response acknowledged areas of deficit set out above for the two named consumers and stated action has been taken to address the identified deficits, and included education for staff and the completion of the implementation of a new electronic medication management system. Education is planned for staff in relation to incident management and reporting, while in the interim a memorandum has been issued to staff.

The provider acknowledges deficits in the scheduled consumer review process and stated this was identified just prior to and during this audit. In response a ‘resident of the day’ form has been created and memoranda issued to staff and representatives.

While I acknowledge the action implemented by the service since the audit, the Assessment Team’s evidence as outlined above is also acknowledged by the service. I am satisfied the service does not yet meet the Requirement and I find the service is not compliant with this Requirement.

# 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 service was found non-compliant in four of the specific requirements under this Quality Standard during the previous visit conducted on 9 December 2020.

The focus of this assessment contact was to assess the service’s progress in returning to full compliance with the Quality Standards.

The service demonstrated that actions undertaken to date have addressed deficits previously identified in this Standard for three of the four requirements.

Evidence shows ongoing deficits in one requirement which has been assessed as ongoing non-compliant.

The Quality Standard is assessed as Non-compliant as one of the seven specific requirements have been assessed as Non-compliant.

### 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 found deficits identified at the audit on 9 December 2020 have not been fully addressed. While assessment of this requirement identified the service manages skin integrity in a safe and effective manner, deficits were identified in the management of wounds, pain, diabetes and restrictive practices, specifically in relation to psychotropic medications.

In relation to restrictive practices, the Assessment Team presented evidence the use of psychotropic medications did not reflect best practice. Consumer documentation sampled showed ineffective processes for assessment, monitoring and review of restrictive practices, including the identification of triggers for behaviours and non-pharmaceutical interventions. Evidence for two consumers indicated occasions of administration of as required psychotropic medication without consideration for non-pharmaceutical alternatives. Authorisation/consent forms were not signed by the consumer/representative. The service’s register for monitoring psychotropic medications made available to the team was incomplete.

The provider’s response acknowledged gaps in the management of restrictive practices, including documentation and application, and described improvements taken since the audit to address the deficits. Remedial action includes education for staff with further education planned and management is progressively working through a review of all assessments and care plans. Evidence of action taken to address deficits for one consumer named in the evidence was provided and the response stated action was taken to address deficits for another named consumer.

The provider stated the psychotropic register made available during the audit was the incorrect one and the response included evidence of the current psychotropic register. The provider included evidence of an authorisation/consent form signed since the audit by the consumer’s representative and stated all authorisations were now in place.

In relation to wound care, the team provided evidence for a consumer that not all wounds had assessments and treatment plans, monitoring of their wounds did not always occur, including lack of progress images.

The provider acknowledged gaps in the monitoring of wounds and stated local wound consultants have been engaged to support the service and provide education for staff. The response provided additional information indicating images of wounds are generally taken and records of review that contradicted some of the team’s evidence.

In relation to pain, the Assessment Team identified there was no evidence pain charting was reviewed or analysed when pain charting was attended and that occurrence of pain was not reviewed during period reviews, and, pain charting was not always commenced at entry. The team noted the guidance material for incidents did not reflect best practice as it did not prompt for the assessment of pain.

The provider’s response highlighted the evidence in the Assessment Team’s report regarding the to satisfactory management of pain. The response also acknowledged deficits in pain charting and review and have commenced action to address this through education for staff. Evidence was also provided that pain resources had been strengthened to promote consideration of pain at review or following an incident. The provider noted the pain charting is not necessarily commenced when a consumer enters the service on respite.

In relation to diabetes management, I have considered the majority of the evidence under Standard 2 Requirement (3)(a). I note the Assessment Team’s evidence in relation to the monitoring of blood glucose levels in relation to a consumer and the additional evidence made available by the provider to demonstrate this had occurred.

In making this decision, I have considered the evidence in its totality. I have noted feedback from consumers and representatives indicated they are satisfied with the care provided meets the needs of consumers evidence. I have noted evidence of satisfactory pain management reflected in the Assessment Team’s report. I have considered the remedial action already commenced by the service to address identified issues and additional evidence refuting and clarifying the Assessment Team’s evidence.

However, I have placed weight on deficits identified in the management of restrictive practices, in particular evidence of practice non-pharmaceutical alternatives are not considered prior to the administration of psychotropic medications. I have also considered the evidence not all wounds had assessments and treatment plans and monitoring of wounds did not always occur and the deficits in pain charting and review. It is for these reasons I have formed the view the service does not yet meet the Requirement and I thus find the service is not compliant with this Requirement.

### 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 had not sufficiently addressed deficits in this requirement and presented evidence clinical documentation for sampled consumers indicated continuing gaps in post-falls management and incident reporting as well as weight loss not being managed in line with organisational guidance and specialist recommendations.

The provider’s response included additional information and evidence in relation to the management of the weight loss evidence, whilst acknowledging some documentation gaps. The provider pointed to evidence in the Assessment Team’s report that indicated the service was managing weight loss effectively for the consumer. I have considered this along with the positive feedback from the consumer’s representative. The provider’s response also included additional information, evidence and context in relation to a consumer’s post-falls management and further information to refute falls incidents for a consumer.

The provider acknowledged evidence that showed no incident reports were raised for two other consumers for medication incidents, and provided evidence of action subsequently taken.

In considering the evidence I have taken a view that some of the deficits in documentation presented as evidence under this requirement, reside in Standard 2. I have placed weight on the additional information made available by the provider demonstrating the care delivered to the consumers in relation to management of weight loss and post-fall. Whist the provider acknowledged the medication incidents, the Assessment Team’s evidence did not describe the impact, if any, for the consumer in each instance.

For these reasons, I have formed a view different to the Assessment Team and find on balance the service is compliant with this requirement.

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

*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.*

The Assessment Team reviewed documentation for five consumers found acute deterioration of consumers’ health or condition is recognised and acted upon. However, the Assessment Team also found for a consumer whose health had gradually declined, the progression to end of life deterioration had not been recognised and a palliative pathway not commenced. Staff interviewed provided examples how they identify deterioration and described resources to guide them.

While the provider’s response does not address the deficit identified by the Assessment Team, I have considered all the evidence available, and, on balance, I agree with the Assessment Team’s recommendation. I find the service is compliant with this requirement.

### Requirement 3(3)(e) Compliant

*Information about the consumer’s condition, needs and preferences is documented and communicated within the organisation, and with others where responsibility for care is shared.*

The Assessment Team found improvements have been implemented to address deficits identified during the previous site audit, and included education for staff in the electronic care documentation system. Review of care documentation demonstrate information outlining changes are generally documented and communicated within the service and with others involved in care. Care staff confirm progress notes, daily task lists and handover sheets inform their care practice. Staff confirm training in the use of the electronic care documentation system.

In considering all the available evidence, I agree with the Assessment Team’s recommendation and find the service is compliant with this requirement.

# STANDARD 4 Services and supports for daily living

### Consumer outcome:

1. I get the services and supports for daily living that are important for my health and well-being and that enable me to do the things I want to do.

### Organisation statement:

1. The organisation provides safe and effective services and supports for daily living that optimise the consumer’s independence, health, well-being and quality of life.

## Assessment of Standard 4

The service was found non-compliant in one of the specific requirements under this Quality Standard during the previous visit conducted on 9 December 2020.

The focus of this assessment contact was to assess the service’s progress in returning to full compliance with the Quality Standards.

The service demonstrated that actions undertaken to date have addressed the deficits previously identified in this Standard.

The specific requirement assessed in this Standard is assessed as Compliant.

The Assessment Team did not assess all requirements and therefore an overall rating for the Quality Standard is not provided.

## Assessment of Standard 4 Requirements

### Requirement 4(3)(f) Compliant

*Where meals are provided, they are varied and of suitable quality and quantity.*

The Assessment Team found improvements have been implemented to address deficits identified during the previous site audit, including the introduction of processes ensure temperature of meals is maintained. Consumers and representatives are satisfied with meals provided by the service. Documentation reviewed indicates consumers are engaged about their meal experience and dietary information is generally consistent with consumer needs and communicated to staff. Staff described processes for maintaining meal temperatures and how they are aware of consumer dietary needs and preferences. I find the service is compliant with this requirement.

# 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 service was found non-compliant in two of the specific requirements under this Quality Standard during the previous visit conducted on 9 December 2020.

The focus of this assessment contact was to assess the service’s progress in returning to full compliance with the Quality Standards.

The service demonstrated that actions undertaken to date have addressed the deficits previously identified in this Standard.

The specific requirements assessed in this Standard are assessed as Compliant.

The Assessment Team did not assess all requirements and therefore an overall rating for the Quality Standard is not provided.

## 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 Assessment Team found improvements have been implemented to address deficits identified during the previous site audit, including review of the roster and the allocation of a registered nurse to each shift. Consumers and representatives interviewed are satisfied their care needs are met in a timely manner. Staff interviewed are satisfied the numbers and mix of staff enable them to deliver care and services. Documentation shows staff are consistently rostered and consumer requests for assistance are met in a reasonable time. I find the service is compliant with this requirement.

### Requirement 7(3)(e) Compliant

*Regular assessment, monitoring and review of the performance of each member of the workforce is undertaken.*

The Assessment Team found improvements have been implemented to address deficits identified during the previous site audit. Management described structured and informal processes for monitoring and reviewing staff performance. Staff confirmed review of their performance occurs. Documentation demonstrates formal assessment and review of staff performance, including following an incident. I find the service is compliant with this requirement.

# STANDARD 8 NON-COMPLIANTOrganisational 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 service was found non-compliant in three of the specific requirements under this Quality Standard during the previous visit conducted on 9 December 2020.

The focus of this assessment contact was to assess the service’s progress in returning to full compliance with the Quality Standards.

The Assessment Team’s evidence showed actions undertaken to date have not been effective in addressing deficits previously identified in two requirements assessed in this Standard.

While the Assessment Team found the service has implemented improvements in relation to clinical governance, evidence within Standard 2 and 3 indicates ineffective clinical governance practices in relation to restrictive practices.

The Quality Standard is assessed as Non-compliant as three of the five specific requirements have been assessed as Non-compliant.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(c) Non-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 Assessment Team found deficits identified at the audit on 9 December 2020 have not been fully addressed. Evidence included incomplete consumer information, as highlighted as evidence presented in Standards 2 and 3 of the report. Evidence also set out that continuous improvements implemented and closed since the audit did not always result in the required outcomes and improved practice, as evidenced in Standard 2 and 3 of the Assessment Team’s report.

The provider’s response acknowledges deficits in the governance of information management and continuous improvement. The provider’s response states action has been commenced to address the deficits since this audit, which includes staff education in the use of the incident management system. The provider has implemented action to strengthen continuous improvement, including structured monitoring and auditing of processes and education for staff.

While I acknowledge the action commenced by the service, the effectiveness of embedding these actions in management and staff practice will still need to be assessed. Based on the above evidence I find the service does not yet comply with this requirement.

### Requirement 8(3)(d) Non-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*
4. *managing and preventing incidents, including the use of an incident management system.*

The Assessment Team found the improvements implemented have since the audit on 9 December 2020 have not been fully effective. While the service has a documented risk management framework, staff were not routinely following policies and procedures to identify and manage risk. Evidence included inadequate risk-based assessment and planning and ineffective use of the incident management system.

The provider’s response does not specifically address this requirement or the evidence provided by the Assessment Team in relation to this requirement. However, I note from the provider’s response to evidence in other areas of the report the service acknowledges and has commenced action to address staff practice in relation to risk-based assessment and planning and incident management. Remedial action includes education for staff, monitoring of the electronic incident management system and monthly audits.

While I acknowledge action commenced by the service, the effectiveness of whether these actions have been embedded in staff practice will still need to be established. Based on the above evidence I find the service does not yet comply with this requirement.

### Requirement 8(3)(e) Non-compliant

*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.*

The Assessment Team found the service has implemented improvements to address deficits identified during the previous site audit, however also referenced evidence in Standard 3 Requirement (3)(a) in relation to ineffective restrictive practices.

While the Assessment Team recommended the service meets this requirement, I have formed a different view. Evidence included in the Assessment Team’s report under Standards 2 and 3 indicate the service is not following best practice in relation to restrictive practices. Evidence highlighted ineffective staff practice in assessment, monitoring and review of restrictive practices, including the identification of triggers for behaviours and non-pharmaceutical interventions. Administration of as required psychotropic medication occurs without consideration for non-pharmaceutical alternatives. Not all consent forms were completed at the time of the audit. Governance processes have not identified deficits in staff practices.

Thus, I disagree with the Assessment Team’s recommendation and find the service is not yet 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 2(3)(a)

* Ensure staff have the required skills and knowledge to carry out effective assessment and planning, including consideration of risk.
* Ensure all consumers have relevant assessments and plans of care in place to inform delivery of care.
* Ensure there are effective processes to monitor staff practice.

Requirement 2(3)(e)

* Ensure staff have the required skills and knowledge to carry out effective structured and ongoing review of consumer care and services and documentation of the review activity.
* Ensure processes and procedures enable the effective review of care and services.
* Ensure there are effective processes to monitor staff practice.

Requirement 3(3)(a)

* Ensure use of psychotropic medication and restrictive practices is best practice and optimised consumer health and wellbeing.
* Ensure wounds assessments and treatment plans are in place for all active wounds and consistent monitoring of wounds occurs.
* Ensure staff have the relevant knowledges and skills.

Requirement 8(3)(c)

* Ensure staff skills and knowledge enable the effective management of information and processes for continuous improvement.
* Ensure effective processes are in place to monitor staff practices in the application of information management frameworks and procedures.
* Ensure continuous improvement processes enable the sustainable implementation and evaluation of improvement activities.

Requirement 8(3)(d)

* Ensure staff have the skills and knowledge to implement risk-based assessment and planning and incident management.
* Ensure effective processes to monitor staff practice in relation to the organisation’s risk management system and associated policies and procedures.

Requirement 8(3)(e)

* Ensure staff have the skills and knowledge to implement best practice management of restrictive practices.
* Ensure monitoring processes identify staff practice that is inconsistent with the organisation’s policies and procedures and best practice.