Jacaranda Lodge

Performance Report

55 Belgrade Road
WANNEROO WA 6065
Phone number: 08 9306 2311

**Commission ID:** 7132

**Provider name:** Shire of Wanneroo Aged Persons Homes Trust Inc

**Assessment Contact - Site date:** 24 September 2020

**Date of Performance Report:** 23 December 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

|  |  |
| --- | --- |
| **Standard 1 Consumer dignity and choice** |  |
| Requirement 1(3)(d) | Compliant |
| **Standard 2 Ongoing assessment and planning with consumers** |  |
| Requirement 2(3)(a) | Compliant |
| Requirement 2(3)(e) | Compliant |
| **Standard 3 Personal care and clinical care** |  |
| Requirement 3(3)(a) | Compliant |
| Requirement 3(3)(b) | Compliant |
| Requirement 3(3)(d) | Compliant |
| **Standard 7 Human resources** |  |
| Requirement 7(3)(a) | Compliant |
| Requirement 7(3)(c) | Compliant |
| **Standard 8 Organisational governance** |  |
| Requirement 8(3)(b) | Compliant |
| Requirement 8(3)(c) | Compliant |
| Requirement 8(3)(d) | Compliant |
| Requirement 8(3)(e) | 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
* on 15 October 2020 the approved provider indicated they would not be submitting a response to the Assessment Contact - Site report.

# STANDARD 1 Consumer dignity and choice

### Consumer outcome:

1. I am treated with dignity and respect, and can maintain my identity. I can make informed choices about my care and services, and live the life I choose.

### Organisation statement:

1. The organisation:
2. has a culture of inclusion and respect for consumers; and
3. supports consumers to exercise choice and independence; and
4. respects consumers’ privacy.

## Assessment of Standard 1

During an Assessment Contact visit on 24 September 2020 the Assessment Team assessed Requirement 1(3)(d). No other Requirements within this Standard were assessed.

The Assessment Team have recommended Requirement 1(3)(d) is met. The Approved Provider advised they were not submitting a response to the Assessment Team’s report.

Based on the Assessment Team’s report I find Requirement 1(3)(d) Compliant. The reasons for my decision are detailed under the specific Requirement below.

## Assessment of Standard 1 Requirements

### Requirement 1(3)(d) Compliant

*Each consumer is supported to take risks to enable them to live the best life they can.*

Following a Site Audit conducted from 8 to 10 October 2019 the service was found to be Non-complaint in Standard 1 Requirement (3)(d). The Assessment Team found the service was unable to demonstrate it supported consumers to take risks safely and did not monitor some risks consumers were taking. In response to the Non-compliance the service identified consumers who wished to take risks, completed risk assessments and developed a risk register. Staff were provided with training to support them in identifying and responding to risks. The service now demonstrates it understands and monitors staff compliance with this Requirement.

During interviews with the Assessment Team consumers confirmed they can take risks and do the things they like to do. Consumers described a variety of risks they take such as smoking and using the kitchen to cook meals. A consumer said they cook all their meals in the kitchen. The consumer said the occupational therapist observed them performing some tasks in the kitchen to make sure they were ‘okay to cook’ and they recall signing a form about it.

The Assessment Team reviewed policies and procedures in place to guide staff in supporting consumers to take risks while keeping them as safe as possible.

Documents reviewed by the Assessment Team included care plans and risk assessments which outline the risks consumers wish to take and detail mitigating strategies for each risk taken to guide staff in providing appropriate care. The risk register includes the risks taken, records of discussions about risks, how the service supports consumers to take risks, and consent from the appropriate decision-maker.

During interviews with the Assessment Team care staff described the risks consumers take such as those who like to cook for themselves, and consumers who choose not to eat textured modified foods. Staff reported supervising these consumers when they are eating and informing clinical staff when they see other consumers taking risks that have not previously been identified. The occupational therapist described how they assess consumers to ensure they are as safe as possible using the kitchen to prepare hot drinks and meals.

The Assessment Team reviewed processes in place to monitor ongoing compliance with this Requirement.

For the reasons detailed above I find the service Compliant with this Requirement.

# STANDARD 2 Ongoing 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

During an Assessment Contact visit on 24 September 2020 the Assessment Team assessed Requirements 2(3)(a) and 2(3)(e). No other Requirements within this Standard were assessed.

The Assessment Team have recommended Requirements 2(3)(a) and 2(3)(e) are met. The Approved Provider advised they were not submitting a response to the Assessment Team’s report.

Based on the Assessment Team’s report I find Requirements 2(3)(a) and 2(3)(e) Compliant. The reasons for my decisions are detailed under the specific Requirements below.

## Assessment of Standard 2 Requirements

### Requirement 2(3)(a) 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.*

Following a Site Audit conducted from 8 to 10 October 2019 the service was found to be Non-complaint in Standard 2 Requirement (3)(a). The Assessment Team found assessments and care planning did not consistently consider risks to consumers’ health and well-being to inform the delivery of safe and effective care and services.

The Assessment Team now finds the service demonstrates assessment processes are consistently used by staff and risks are considered as part of the assessment process.

The Assessment Team reviewed policies and procedures in place to guide staff in the assessment and planning process.

During interviews with the Assessment Team consumers and representatives confirmed they regularly speak with care or clinical staff about their care and service needs.

Documents reviewed by the Assessment Team include assessments and care plans. Care plans were developed using information from a range of sources including discharge summaries, aged care assessments and information from the consumer and/or their representative. The service uses validated assessment tools such as the Falls Risk Assessment Tool (FRAT), Cornell, Braden Scale, Psychogeriatric Assessment Scale (PAS) and the Abbey Pain Scale. Where risk is identified assessments and care planning documents followed the organisation’s dignity of risk guidelines.

During interviews with the Assessment Team care staff reported they record information about consumers, such as continence, behavioural symptoms of dementia and risk-taking behaviour, which is used by clinical staff to develop care plans. Clinical staff confirmed allied health professionals complete assessments which also inform care plan development.

The Assessment Team reviewed a process in place to monitor ongoing compliance with this Requirement.

For the reasons detailed above I find the service Compliant with this Requirement.

### Requirement 2(3)(e) 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.*

Following an Assessment Contact conducted on 18 December 2019 the service was found to be Non-complaint in Standard 2 Requirement (3)(e). The Assessment Team found the service did not demonstrate that care and services were reviewed regularly for effectiveness, when circumstances change, or incidents occurred, impacting on the needs, goals and preferences of consumers, specifically in relation to pressure minimisation strategies, pain management, weight loss, falls, and management of behavioural symptoms of dementia.

The Assessment Team now finds the service demonstrates care and services are regularly reviewed for effectiveness, including when circumstances change, or incidents occur.

The Assessment Team reviewed policies and procedures in place to guide staff in the assessment and planning process.

During interviews with the Assessment Team consumers and representatives stated staff regularly speak with them to ensure their care and services are appropriate and staff make changes when required. Specific feedback was provided in relation to staff speaking with consumers about the progress of wound healing and weight management and liaising with representatives after incidents occur.

Documents reviewed by the Assessment Team confirm care staff are observing consumers and reporting their observations to clinical staff who re-assess, and update care plans as required, and refer to other health care professionals as deemed necessary. Care plan entries confirm they are assessed six-monthly or as care needs change. Consumer files contained formal assessments completed annually.

During interviews with the Assessment Team care and clinical staff spoke about observing consumers, reporting changes, completing re-assessments and updating care plans as care needs change. A clinical staff member gave an example of engaging Dementia Support Australia to support consumers who display behavioural symptoms of dementia when their interventions are not effective.

The Assessment Team reviewed processes in place to monitor staff compliance with this Requirement.

For the reasons detailed above I find the service Compliant with this Requirement.

# STANDARD 3 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

During an Assessment Contact visit on 24 September 2020 the Assessment Team assessed Requirements 3(3)(a), 3(3)(b) and 3(3)(d). No other Requirements within this Standard were assessed.

The Assessment Team have recommended Requirements 3(3)(a), 3(3)(b) and 3(3)(d) are met. The Approved Provider advised they were not submitting a response to the Assessment Team’s report.

Based on the Assessment Team’s report I find Requirements 3(3)(a), 3(3)(b) and 3(3)(d) Compliant. The reasons for my decisions are detailed under the specific Requirements below.

### Assessment of Standard 3 Requirements

### Requirement 3(3)(a) 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.*

Following a Site Audit conducted from 8 to 10 October 2019 the service was found to be Non-complaint in Standard 3 Requirement (3)(a). The service was not able to demonstrate care plans were reviewed regularly and contained sufficient information to ensure consumers received individualised care and services to optimise their health and well-being. The Assessment Team now finds the service meets this Requirement.

During interviews with the Assessment Team all consumers confirmed they get the care they need. Specific feedback includes:

* A consumer said staff discuss wound management with them and they are happy their wounds are improving.
* A representative confirmed they are updated regularly about the consumer’s condition and are happy the consumer’s choices are respected, including choosing not to wear pressure-relieving booties.
* Another representative confirmed staff contact them regularly to provide updates and speak with them during their weekly visits to try and get to know the consumer better. They said ‘staff put in a lot of effort’ during the COVID-19 lockdown to ensure they could stay in touch, including weekly video calls.

The Assessment Team reviewed policies and procedures available to guide staff in providing personal and clinical care.

Documents reviewed by the Assessment Team include assessments, care plans and progress notes. Care plans included individualised interventions to meets consumers’ personal preferences and needs. Progress notes reflected a coordinated approach to the delivery of care and services, including input from a range of other health care professionals as required. Records confirmed recommendations made by external health care professionals were added to care plans and implemented.

During interviews with the Assessment Team clinical staff described a coordinated approach to the assessment and care planning process and positive outcomes of recent wound and behaviour management interventions, including the successful use of non-pharmacological strategies.

The Assessment Team reviewed a process in place to monitor compliance with this Requirement.

For the reasons detailed above I find the service 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.*

Following a Site Audit conducted from 8 to 10 October 2019 the service was found to be Non-complaint in Standard 3 Requirement (3)(b). The service was not able to demonstrate they identified, and effectively managed risks associated with smoking, food intolerances, falls and independent food preparation. The service has since reviewed, reassessed and implemented risk management strategies for all consumers identified as being at risk.

The Assessment Team now considers the service meets this Requirement.

The Assessment Team have reviewed policies and procedures to guide staff in the effective management of risks to consumers.

Documents reviewed by the Assessment Team include assessments, care plans, incident reports and clinical incident data. Records confirm all high impact and high prevalence clinical and personal risks for consumers are recorded. When incidents occur, the cause is identified to ensure what occurred is understood and interventions are implemented to avoid recurrence.

During interviews with the Assessment Team staff described the high impact and high prevalence risk for consumers, including those who fell frequently, displayed behavioural symptoms of dementia and lost weight. Staff could discuss the strategies that were in place to manage these and what steps to take if the strategies were not effective.

The Assessment Team reviewed a process in place to monitor compliance with this Requirement and to identify opportunities for improvement.

For the reasons detailed above I find the service 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.*

Following an Assessment Contact on 18 December 2019 the service was found to be Non-compliant in this Requirement. The service was unable to demonstrate that changes to a consumer’s function or condition was consistently recognised and responded to in a timely manner.

The service now demonstrates that it monitors and reviews consumers with altered health needs. The changes implemented by the service has seen the provision of the right care and services to consumers to support their changing needs.

During interviews with the Assessment Team all consumers and representatives reported they were satisfied with the care provided at the service. Specific examples provided relate to wound management, assistance with mobility and post-operative support and all confirmed staff knew the consumers and responded appropriately to changes they observed to ensure their care remained appropriate.

Documentation reviewed by the Assessment Team included general and wound management care plans and progress notes. All supported a coordinated approach to identifying changes, completing assessments and updating care plans with revised interventions to ensure changing care needs continued to be met.

During interviews with the Assessment Team all staff provided recent examples of when a deterioration or change in a consumer’s condition was recognised and responded to. Staff spoke of receiving additional training in relation to wound care, skin integrity and falls and confidently spoke about the process they follow when they identify deterioration in a consumer.

The Assessment Team reviewed processes in place to monitor compliance with this Requirement.

For the reasons detailed above I find the service 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

During an Assessment Contact visit on 24 September 2020 the Assessment Team assessed Requirements 7(3)(a) and 7(3)(c). No other Requirements within this Standard were assessed.

The Assessment Team have recommended Requirements 7(3)(a) and 7(3)(c) are met. The Approved Provider advised they were not submitting a response to the Assessment Team’s report.

Based on the Assessment Team’s report I find Requirements 7(3)(a) and 7(3)(c) Compliant. The reasons for my decisions are detailed under the specific Requirements 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.*

Following an Assessment Contact visit on 18 December 2019 the service was found to be Non-complaint in Standard 7 Requirements 7(3)(a). The service did not demonstrate they reviewed the number and skill-mix of staff when the number of consumers residing in the memory support unit. The service has since demonstrated they meet this Requirement.

During interviews with the Assessment Team consumers and representatives indicated staff were available when needed and their call bells were generally answered quickly. While one representative of a consumer who resides in the memory support unit expressed concern about the number of staff on duty during a morning shift they were unable to describe actual impact on consumers.

Documentation reviewed by the Assessment Team included rosters and allocation sheets. Records confirm all shifts in the fortnight prior to the Assessment Contact visit were filled. Agency use was minimal during this period.

During interviews with the Assessment Team staff did not express concern about staffing levels. They said staff are replaced if they are unable to attend for their rostered shift and while on some occasions they are busy, they generally have enough time to complete their duties.

The Assessment Team focused their observations on the memory support unit where while staff appeared busy, all consumers were attended to in a timely manner. Lifestyle staff escorted some consumers to an activity. Consumers were not observed wandering without supervision or left unsupervised in common areas.

The Assessment Team reviewed the process in place to monitor and review staffing levels to ensure ongoing compliance with this Requirement.

For the reasons detailed above I find the service Compliant with this Requirement.

### Requirement 7(3)(c) Compliant

*The workforce is competent and the members of the workforce have the qualifications and knowledge to effectively perform their roles.*

During an Assessment Contact visit on 18 December 2019 the service was found to be Non-complaint in Standard 7(3)(a). The service was not able to demonstrate staff consistently followed policy or instruction in regard to consumer care or safety. This included not documenting neurological observations following a fall, not following dietician’s recommendations for a consumer with weight loss and pressure injuries and not consistently documenting wound status, including not taking measurements and photographs.

To address the Non-compliance the service reviewed staff training and competencies and has provided additional training to ensure policies and procedures are understood and followed by staff. The position descriptions and duty statements of each role have been revised to ensure staff understand their roles and responsibilities.

The Assessment Team finds the service now meets this Requirement.

During interviews with the Assessment Team consumers said they felt the care they are receiving is satisfactory and staff are competent and qualified to perform their roles. The following specific feedback was provided:

* A consumer said they get a lot of pain due to a medical condition and staff always seem to know when they are getting a bit stiff and will ask them if they would like some Panadol. They also get massages and heat packs if they want them.
* Another consumer and their representative said they were satisfied with their care. They previously had a pressure injury which has now healed because of the wound care they received.

Documentation reviewed by the Assessment Team included duty statements and position descriptions which had been recently reviewed and contained information that was easy to understand. Training records confirmed all mandatory training had been completed or was scheduled to occur in the near future. A new electronic training system has been implemented allowing management to ensure staff training needs are being met. If training needs are identified, relevant training packages are allocated to the staff member and monitored for completion.

During interviews with the Assessment Team staff reported receiving recent training relating to infection control, record keeping, skin care, wound care and falls. Clinical staff confirmed they are now photographing and measuring wounds as directed by their procedure. A cleaner confirmed they found their new duty statement helpful, especially when they are required to work in a different area of the service.

The Assessment Team reviewed processes in place to monitor compliance with this Requirement.

For the reasons detailed above I find the service Compliant with this Requirement.

# 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

During an Assessment Contact visit on 24 September 2020 the Assessment Team assessed Requirements 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e). Requirement 8(3)(a) was not assessed.

The Assessment Team have recommended Requirements 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e) are met. The Approved Provider advised they were not submitting a response to the Assessment Team’s report.

Based on the Assessment Team’s report I find Requirements 8(3)(b), 8(3)(c), 8(3)(d) and 8(3)(e) Compliant. The reasons for my decisions are detailed under the specific Requirements below.

## Assessment of Standard 8 Requirements

### Requirement 8(3)(b) Compliant

*The organisation’s governing body promotes a culture of safe, inclusive and quality care and services and is accountable for their delivery.*

Following a Site Audit conducted from 8 to 10 October 2019 the service was found to be Non-complaint in Standard 8 Requirement (3)(b). The service could not demonstrate staff consistently followed their policies and procedures and their governing body did not effectively monitor the provision of safe and quality care.

The service now demonstrates it meets this Requirement. The following action has been taken to address this Non-compliance:

* Review of the governance framework, updating policies and procedures and implementing new communication processes, such as a clinical governance committee.
* All staff have received training in policies and procedures including falls, wound management and responsive behaviours.
* Updating of the Board meeting agenda to include an agenda item specific to clinical governance and risk enabling risks and key performance indicators to be discussed and monitored.
* Allowing a consumer representative to participate in Board meetings to provide information on a more personal level, providing a more transparent and inclusive way for consumers to give feedback or raise complaints.
* Improved communication between the Board and consumers and representatives using alternative methods such as iCare messenger in addition to meetings and pamphlet distribution.
* Board members have attended an education session on the new Quality Standards.
* The service’s management team is participating in ongoing workshops to develop a new strategic plan.

Documentation reviewed by the Assessment Team includes evidence of the above action being taken.

I consider the action taken by the service in response to the Non-compliance is appropriate.

For this reason, I find the service Compliant with this Requirement.

### 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.*

Following a Site Audit conducted from 8 to 10 October 2019 the service was found to be Non-complaint in Standard 8 Requirement (3)(c). Following an Assessment Contact on 18 December 2019 the service was found to have ongoing Non-compliance specifically in relation to information management and governance frameworks. The service now demonstrates it has adequate systems in place to meet this Requirement and is working toward the introduction of more robust governance systems, including a revised strategic business plan.

The Assessment Team found the service demonstrated they had appropriate processes and procedures in place in relation to continuous improvement, regulatory compliance and feedback and complaints.

In relation to information management, a clinical handover and task allocation sheet have been introduced to improve communication of consumer information between staff. A service intranet is being developed to give staff access to training modules and policies and procedures online. Clinical indicator data is now collected, analysed and reported to the Board monthly. An electronic incident reporting system prompts staff to complete investigations and make recommendations about appropriate follow up action. A mandatory and discretion not to report log, including an electronic spreadsheet of incidents populated by management, enables detailed record keeping and monitoring of incidents.

In relation to governance frameworks a planning workshop aimed to assist the senior management team to focus on strategic needs surrounding its governance frameworks, including development of a new strategic plan, which feeds into the service’s annual business and budget plans. A newly developed ‘clinical governance lines of accountability’ flow chart identifies what members of the workforce are held accountable for, and decisions and processes at different levels. The clear assignment of responsibilities reflected in this document allows for the appropriate delegation of authority of decision making to staff at different levels.

Documentation reviewed by the Assessment Team includes evidence of the above action being taken.

I consider the action taken by the service in response to the Non-compliance is appropriate.

For this reason, I find the service Compliant with this Requirement.

### 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.*

Following a Site Audit conducted from 8 to 10 October 2019 the service was found to be Non-complaint in Standard 8 Requirement (3)(d). The Assessment Team found while the service had a risk management framework, it was not effective in managing high impact or high prevalence risks. While the service was supporting consumers to live their best lives, they were not identifying risks associated with them doing this.

In response to the Non-compliance the service has taken the following action:

* A risk management framework incorporates clinical risk. A matrix guides staff in risk assessment and all incidents and hazards are risk rated on the electronic system.
* A clinical risk and governance committee oversees risk. Identified risks such as clinical risks, and hazard and reputational risks are escalated to the Board for consideration and action as required.
* All staff have received training in risk management policies and procedures including falls, wound management and responsive behaviours.
* Monthly clinical meetings occur to review clinical indicators and respond to identified trends.
* A risk register has been developed detailing information about consumers who choose to take risks to support them to live their best lives.
* Elder abuse training is up to date. Staff could explain what elder abuse meant and when and who to report any concerns to.

Documentation reviewed by the Assessment Team includes evidence of the above action being taken.

I consider the action taken by the service in response to the Non-compliance is appropriate.

For this reason, I find the service Compliant with this Requirement.

### Requirement 8(3)(e) 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.*

Following a Site Audit conducted from 8 to 10 October 2019 the service was found to be Non-complaint in Standard 8 Requirement (3)(e). The service could not demonstrate they had a robust clinical governance framework in place. The service has taken action and the Assessment Team now consider the service meets this Requirement.

The Assessment Team found the service has governance frameworks to effectively guide staff in relation to antimicrobial stewardship, minimising the use of restraint and open disclosure. During interviews with the Assessment Team staff were able to accurately describe their roles in these aspects of care.

In response to this Non-compliance the service has:

* Reviewed and revised their clinical governance framework (ongoing).
* Established a clinical risk and governance committee to oversee clinical care issues and risk.
* Developed a risk management framework incorporating clinical risk. A matrix guides staff in risk assessment and all incidents and hazards are risk rated on the electronic system.
* Improved communication channels with the Board to ensure appropriate clinical information, including risks, are escalated.

Documentation reviewed by the Assessment Team includes evidence of the above action being taken.

I consider the action taken by the service in response to the Non-compliance is appropriate.

For this reason, I find the service Compliant with this Requirement.

# 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.