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Department of Health and Ageing

National Aboriginal and Torres Strait Islander Flexible Aged Care Program

QUALITY FRAMEWORK

National Aboriginal and Torres Strait Islander Flexible Aged Care Program - Quality Framework

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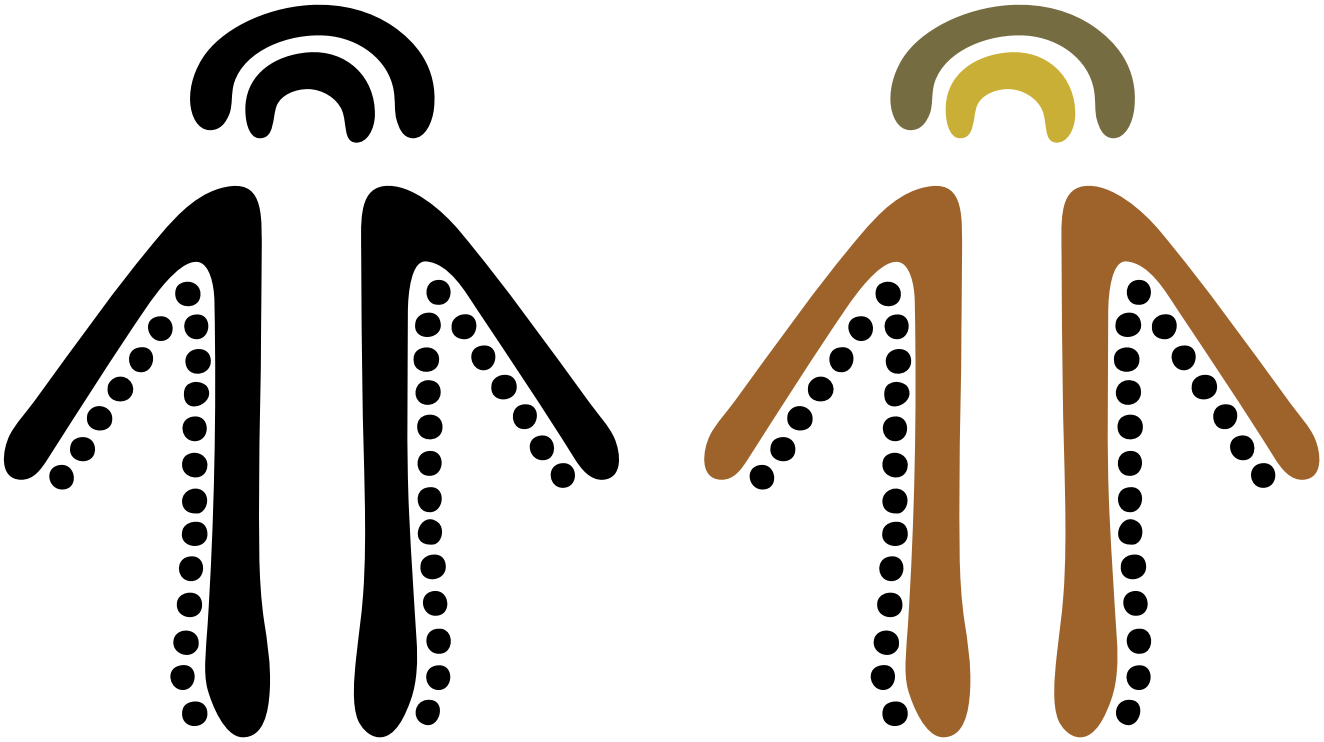

Chris Thyers is a Ngarrindjeri artist from South Australia.

She says her design "symbolises our Elders and their life journey. The dots represent their people and their family who they have nurtured, taught and tended over their life journey."

The Department of Health and Ageing gratefully acknowledges the assistance and participation of the aged care service providers, their Elders and communities in the development of the Quality Framework for the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

SECTION

one

Quality Framework

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1. Executive Summary

The purpose of this document is to provide an overview of:

- the development of the Quality Framework
- the Quality Framework Design
- the Review Process
- the Quality Improvement Cycle.

1.1 Introduction

The Quality Framework for the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (the Program) was developed to provide a set of quality standards for services funded under the Program and a process for monitoring achievements against these standards.

The Program aims to provide quality, flexible and culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to their home and community.

Services funded under the Program can deliver a flexible mix of residential and community based aged care services that can change as the care needs of the communities vary. Funding is based on an allocation of places and not on the occupancy of places. This provides a constant income stream to allow service providers both stability of income and flexibility to manage the delivery of aged care services and respond to community need. Communities are encouraged to participate in all aspects of service provision from planning through to the operation of services.

The objectives of the Program are to:

- provide quality, flexible, culturally appropriate aged care services to older Aboriginal and Torres Strait Islander people close to their home and community
- enable these communities to provide a range of services which are able to respond to individual needs of older people within the community
- develop financially viable cost effective and coordinated services, outside the existing conventional program structures
- facilitate community involvement in the care of their older people through the management of the service.

There are currently 28 services funded under the Program with the majority located in very remote or remote areas.

1.2 The Development of the Quality Framework

The development of a culturally appropriate Quality Framework for the Program is one of a number of Australian Government measures which aim to improve the long-term quality of aged care services for Aboriginal and Torres Strait Islander people.

The Quality Framework includes a set of quality Standards and a process for monitoring achievements against the Standards, designed to assist service providers to continuously improve their services.

The Quality Framework was developed with the support of Australian Healthcare Associates, service providers, the communities they support and representatives from the Department of Health and Ageing (DoHA) and included:

- initial consultation forums with 28 service providers
- initial consultations with representatives from DoHA
- completion of a literature scan
- review and mapping of other Quality frameworks common to flexible aged care services
- design and delivery of five workshops across Australia for the 28 current service providers, to introduce the draft Quality Framework and the resources developed to support service providers to implement the pilot
- provision of support to service providers to complete a self-assessment against the draft Standards
- completion of 21 site visits to validate the self-assessments and the development of a report and action plan to address the findings from the site visit
- consultation with DoHA
- evaluation of stakeholder feedback in relation to the draft Quality Framework.

The themes that emerged from the consultations held across Australia included:

- a culture that ensures each person is cared for, as well as their families and the community
- the Standards developed need to take into account the importance of culture to service users and service providers
- each service provider and their communities have unique and diverse cultural needs that must be accommodated
- there is considerable diversity in the types of services delivered across Australia
- there is wide variation in the level of experience that service providers have in meeting quality standards
- some providers have sound quality systems and processes in place, while others are still learning about quality systems
- all services have struggled at various times to recruit and retain suitably qualified staff
- there is the need to build the capacity of service providers, communities and staff to ensure quality service delivery
- risk management – the need to minimise risk for the people cared for and for staff, while respecting the needs and wishes of all stakeholders
- the relationships of flexible aged care services – with the people they care for and their families, the community, other providers and government.

The literature highlighted that the Standards should:

- be simple in intent, achievable and few in number
- be measurable
- encourage continuous quality improvement.

Taking into account the above themes, the Quality Framework has been developed based on two overarching principles, Continuous Quality Improvement (CQI) and Cultural Safety. It is expected that these two principles will be recognised and embedded in all aspects of each organisation's service delivery and quality systems.

1.3 The Quality Framework

An overview of the design of the Quality Framework is described in Chapter 2 of this document.

The Quality Framework comprises:

1. A set of **Quality Standards**, with Expected Outcomes and a Guide to requirements (described in Chapter 3).
2. The **Quality Improvement Cycle** which outlines the **Review Process** (described in Chapter 4) including:
   - the steps which measure and assess service provider performance against the Standards
   - support for service providers to meet and continually improve their quality performance against the Standards
   - how service provider complaints or feedback about the Review Process are addressed

In addition, Quality Framework Guides and Tools and Templates, have been developed to support Service Providers and Quality Reviewers, as follows:

3. **Quality Framework Guides**
   - Understanding Quality and Continuous Improvement (Section 2)
   - Service Provider Guide to Self-Assessment (Section 3)
   - Quality Reviewer Guide (Section 4)

4. **Quality Framework Tools and Templates**
   - Self-Assessment Tool (Appendix 1)
   - Examples of Completed Self-Assessments (Appendix 2)
   - Quality Reviewer Desk Top Review Record (Appendix 3)
   - On-Site Review Planning templates (Appendix 4)
   - On-Site Review Tools and Templates (Appendix 5)
   - Quality Improvement Plan and Progress Report templates (Appendix 6)

2. Overview of the Quality Framework Design

2.1 Structure of the Quality Framework: Key Elements

The Quality Framework includes:

- a set of standards
- a review process to assess and measure progress against the Standards
- tools and guides to support service providers and quality reviewers to implement the Quality Framework.

2.2 The Quality Standards

The Quality Standards are key elements of the Quality Framework.

In developing the standards for the Quality Framework, ensuring *cultural safety* for all service users and promoting *continuous quality improvement* were recognised as important. Standards themselves need to be simple in intent, achievable and measurable.

Therefore, the standards have been developed to include:

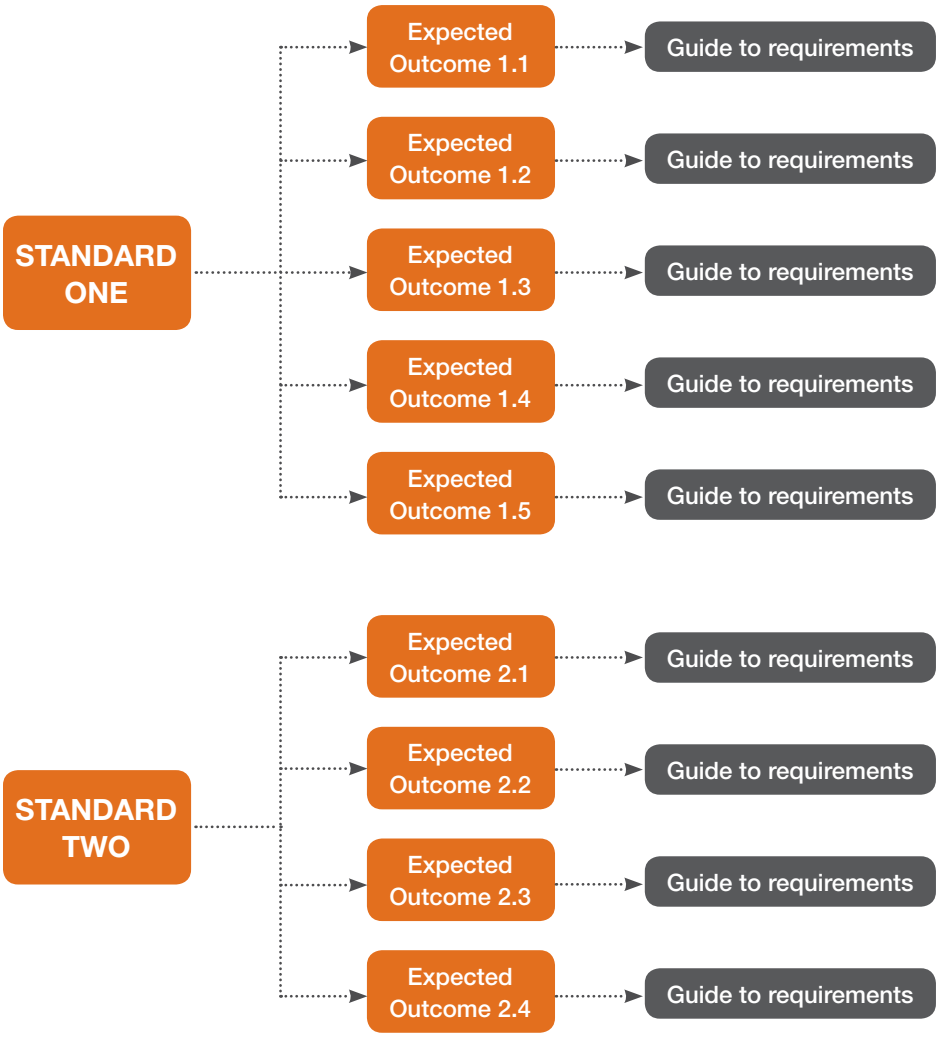
- **overarching principles:** ideals to be incorporated in all aspects of the standards
- **outcome and process driven standards:** standards that focus specifically on outcomes for service users and also on systems and processes to support outcomes for service users (that is, have an indirect influence on service user outcomes)
- **expected outcomes:** which are the results that are expected to be achieved under each standard
- **guide to requirements:** which provide further details and examples of how service providers can show that they are meeting the expected outcomes; i.e. what evidence is needed.

The Quality Standards include:

- The two overarching principles - Cultural Safety and Continuous Quality Improvement (CQI)
  - > ***Cultural safety*** is about recognising, respecting and nurturing the unique cultural identity of Aboriginal and Torres Strait Islander people and meeting their needs, expectations and rights
  - > ***Continuous Quality Improvement (CQI)*** is about always working to improve services and outcomes for people. It means looking for better ways to do things
- Two Standards, each with Expected Outcomes
- Guide to requirements for each Expected Outcome.

Figure 2.1 Diagram of Quality Standards Structure

Overarching Principles - Cultural Safety and Continuous Quality Improvement



2.3 The Quality Improvement Cycle and the Review Process

The Quality Improvement Cycle is implemented over two years. Figure 2.3 provides a visual outline of the timing of the Review Process and the Quality Improvement Cycle. The first year includes a formal review against the Quality Standards including self-assessment by the service provider and a site visit by the Quality Review Team. The second year includes follow up and support visits to ascertain progress against results of the formal review and the agreed Quality Improvement Plan.

The Review Process aims to:

- support capacity building for the service provider, sector and community
- support continuous quality improvement while addressing accountability through quality assurance processes
- promote development of internal systems and processes.

Figure 2.2 Summary Review Process key steps, outputs and timelines

The key steps in the quality improvement cycle are:

Cycle/Year One:

- ***Self-assessment:*** completed by service provider. Service providers will be given eight to twelve weeks notice of the date for submission of the self-assessment. This is provided via a letter from the Quality Review Team.
- ***Desk Top Review:*** completed by Quality Review Team within two weeks of receiving the self-assessment, includes planning for on-site review. The desk top review assists in prioritising areas for focus at the on-site review and examines other information such as records of previous review findings and/or other relevant information provided in the Service Provider self-assessment.
- ***On-site Review:*** Following the desk top review, the on-site review will be scheduled and conducted by at least two reviewers; normally lasting between one and two days, depending on the service types delivered. The Quality Review Team would generally allow one day for on-site review of community care providers, and up to two days for residential and mixed service type providers. Large residential service providers may require two full days for on-site review.

  Prior to an on-site visit, the Quality Review Team will liaise with the Service Provider to make the necessary arrangements, for example:

  > confirming the date, time and duration of the visit

  > discussing the proposed schedule

  > checking if any permits or departmental identification cards are required

  > checking if an interpreter is required

  > asking the Service Provider to notify staff and care recipients that the visit will be taking place and that a reviewer might talk to them about their experience at the service

  > discussing travel and accommodation options (if necessary).

  All of these details will be confirmed in writing by the Quality Review Team prior to the on-site review.
- ***Draft Report and Feedback:*** within two weeks of the visit a draft report of the on-site review is submitted to the service provider. The On-site Review Report will use the same format as the self-assessment report completed by service providers and will include:

  > an Executive Summary

  > an Assessment Matrix

  > evidence examples sighted during the visit to demonstrate compliance with each expected outcome

  > review findings detailing the reasons for the reviewers' rating for each expected outcome and the applicable rating

  > Quality Improvement Plan to address any identified gaps against each Expected Outcome of the Quality Standards and/or plans to support continuous quality improvement, where applicable.

The report will clearly document what needs to be done to meet the Standards and optional actions to support continuous quality improvement. These actions form the basis of the Quality Improvement Plan.

The service provider will have four weeks to work through the draft Report and return their feedback to the Quality Review Team. Feedback may include any service provider comments and factual errors in the draft Report, as well as completing the Quality Improvement Plan, that will include who will be responsible for each action and the due date for completing actions. Feedback may be provided verbally, electronically via email or in a letter. Feedback may include any errors or omissions or requested changes to the draft Report.

- ***Quality Improvement Plan for Next Year:*** the Quality Review Team has two weeks to finalise the draft On-site Review Report and the Quality Improvement Plan with the service provider. The return of the final agreed Review Report and Quality Improvement Plan for the next year to the service provider by the Quality Review Team is a key output of Cycle One.

Cycle/Year Two:

- ***Monitoring Progress of Quality Improvement Plan:*** the service provider will use the Quality Improvement Plan to schedule, monitor and report on the planned actions required to meet the expected outcomes of the Quality Standards.

  The Quality Review Team and Program staff will use the Quality Improvement Plan to monitor the service's progress in implementing the planned actions. The plan will assist to identify any additional support that the service provider may need, including assistance from the Service Development Assistance Panel.

  If serious matters relating to health, safety and well being of care recipients arise, the issue will be referred to the Quality Review Team to manage in consultation with the Program manager and further assessment by the Quality Review Team may be necessary.

- ***Support Visit to achieve Quality Improvement Plan:*** to monitor progress of the Quality Improvement Plan, Program staff and/or the Quality Review Team, must include at least one support visit to the service provider following the On-site Review. The timing of this will depend on the support required by the service provider and their progress in implementing their Quality Improvement Plan.

- ***Progress Report / Quality Improvement Plan for next year:*** in order to maintain the momentum of Continuous Quality Improvement, service providers will be required to submit a Progress Report against their Quality Improvement Plan a year after that plan has been agreed. The service provider will also update their Quality Improvement Plan for the next calendar year.

3. The Quality Standards

As explained in Chapter 2 the standards have been developed to include:

- ***overarching principles:*** Continuous Quality Improvement and Cultural Safety ideals incorporated in all aspects of the standards
- outcome and process driven ***standards:*** standards that focus specifically on outcomes for service users and also on systems and processes to support outcomes for service users (that is, have an indirect influence on service user outcomes)
- ***expected outcomes:*** which are the results that are expected to be achieved under each standard
- ***guide to requirements:*** which provide further details and examples of how service providers can show that they are meeting the expected outcomes; i.e. what evidence is needed.

3.1 The Overarching Principles

3.1.1 Continuous Quality Improvement

Continuous Quality Improvement (CQI) is about making ongoing (continuous) effort to improve the quality of services and outcomes for people. CQI focuses on improving systems, rather than on the performance of people or things. CQI is used in all types of organisations as a method of leadership and management; it is used to assess how well systems are working, the quality of care being provided and to bring about sustained improvement.

The key elements of CQI include:

- accountability
- linking evaluation to planning
- achieving improvement through incremental steps
- being driven by input from all levels of staff, management and other stakeholders
- a commitment to team work
- continuous review of progress.

The benefits of CQI are:

- improved accountability
- improved staff input and morale
- improved services for clients
- ability to recognise and meet changes in service need
- enhanced information management, client tracking and documentation systems.

A variety of people should be involved in CQI, including:

- service users, families and carers
- staff and volunteers
- members of Committee/Board of Management
- community members
- advocates.

CQI is guided by the implementation of a quality cycle. The quality cycle involves prescribed steps that are taken to continually evaluate and improve services and processes, and ultimately outcomes for stakeholders. To be effective, CQI must be a core focus within an organisation that is understood and accepted by all management and staff.

The model shown in *Figure 3-1* is the four phase *Plan-Do-Check-Act* cycle. More information about quality and continuous improvement is included in the *Guide to Understanding Quality and Continuous Improvement*, at Section 2.

The Review Process is designed to support service providers in developing strong CQI processes and to:

- build on the sector's growing quality culture base
- continue to foster a *Planning-Doing-Checking-Acting* approach
- support ongoing sectoral capacity building for quality improvement.

Figure 3-1: Plan, Do, Check, Act Cycle

3.1.2 Cultural safety

Cultural safety is about recognising, respecting and nurturing the unique cultural identity of Aboriginal and Torres Strait Islander people and meeting their needs, expectations and rights.

The quality standards take into account the importance of culture to service providers and people receiving a service. Each service provider and the communities they support have unique and diverse cultural needs.

The concept of culture and cultural safety has been identified as an important component in improving health care with, and for, Aboriginal and Torres Strait Islander people.

Culture is distinctive to a region. Cultural needs and issues may be specific to the individual, their group, or be related to whether they are male or female. Managing a culturally safe environment is a continuous process, as needs and issues may be different for each person.

Each person's needs and issues may be based on their:

- beliefs, values and philosophies (what they think)
- stories, myths, languages, symbols and traditions (what they say)
- lifestyles, customs and behaviours (what they do)
- ambitions and expectations (what they want)
- buildings, technology and food (what they make).

It is very important that services respect and accept the culture in their regions. Services must identify the needs and issues of each person they care for, and have a process to manage and deliver this care. This will ensure that:

- individuals receive care that is culturally appropriate and is respectful of him or her, and his or her family and home
- no one is offended or insulted
- service users feel comfortable and safe.

As service providers and their communities have unique and diverse cultural needs, the Standards do not focus on ***what*** represents culturally appropriate and culturally safe care. Instead, there is emphasis throughout the standards on the issues that must be considered in assessment, planning and service delivery, in order to identify what ***each*** service user considers to be culturally appropriate and culturally safe care.

The Standards include specific requirements which guide and assist a service provider in gathering and then acting upon this information. This begins at assessment with hearing the person's life story and carries through to how information is communicated, the way, and by whom, their service is delivered and the environment in which the service is delivered.

3.2 Pictorial Structure of the Standards

Figure 3.2 provides a visual representation of the two overarching principles. The dotted lines that frame and create linkages within the picture represent **Cultural Safety** and **Continuous Quality Improvement** as key elements of the Standards.

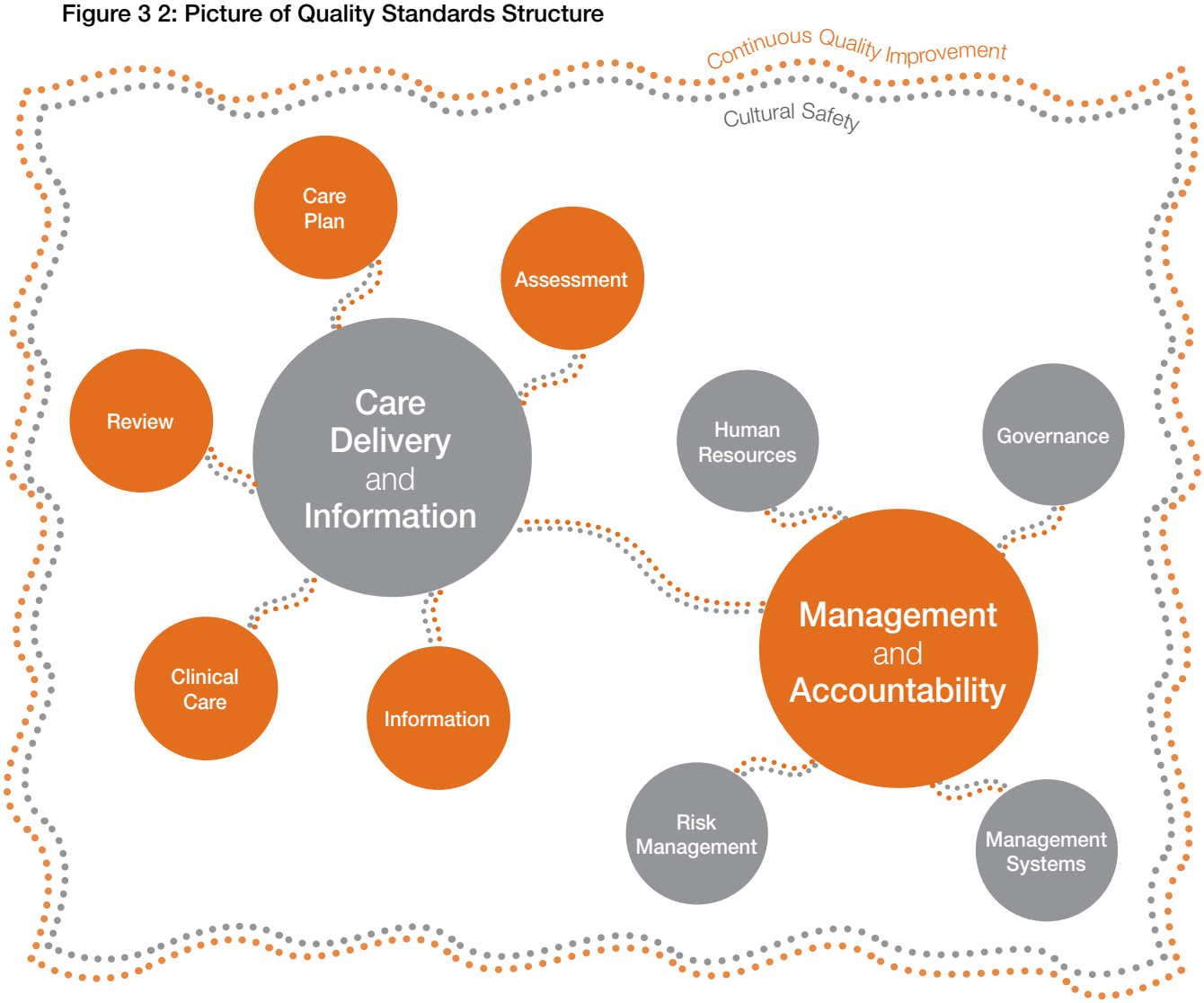
Within the picture the two **Standards** are represented by two large circles:

- **Care Delivery and Information** is about the steps involved in directly providing care to people
- **Management and Accountability** is about support systems and processes.

Within the picture the Expected Outcomes are represented in the small circles and joined by the lines representing the overarching principles. For each Standard there are Expected Outcomes - these are the results to be achieved:

- **Care Delivery and Information:** Assessment, Care Planning, Review, Clinical Care, and Information
- **Management and Accountability:** Governance, Management Systems, Risk Management, and Human Resources.

Figure 3 2: Picture of Quality Standards Structure



Details of each of the Standards and Expected Outcomes are provided pictorially on the following pages.

- Figure 3-3 is a pictorial version of Standard One.
- Figure 3-4 is a pictorial version of Standards Two.
- Figure 3-5 is a plain English version of the Standards which services could provide to service users and community members.
- Table 3-1 is the full version of the National Aboriginal and Torres Strait Islander Flexible Aged Care Program Quality Standards, Expected Outcomes and Guide to requirements.

Figure 3.3: Picture of Quality Standard One

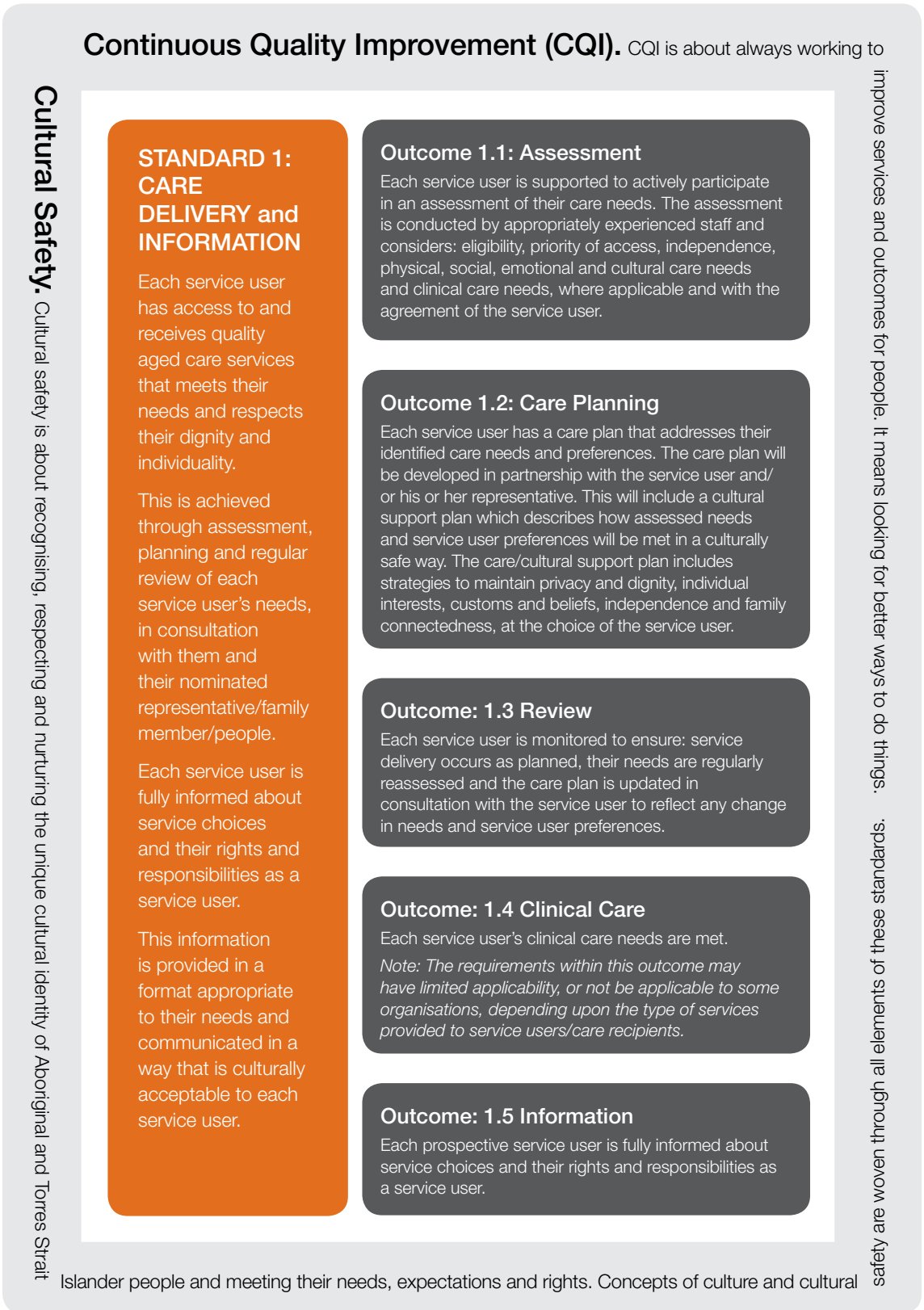


Figure 3.4: Picture of Quality Standard Two

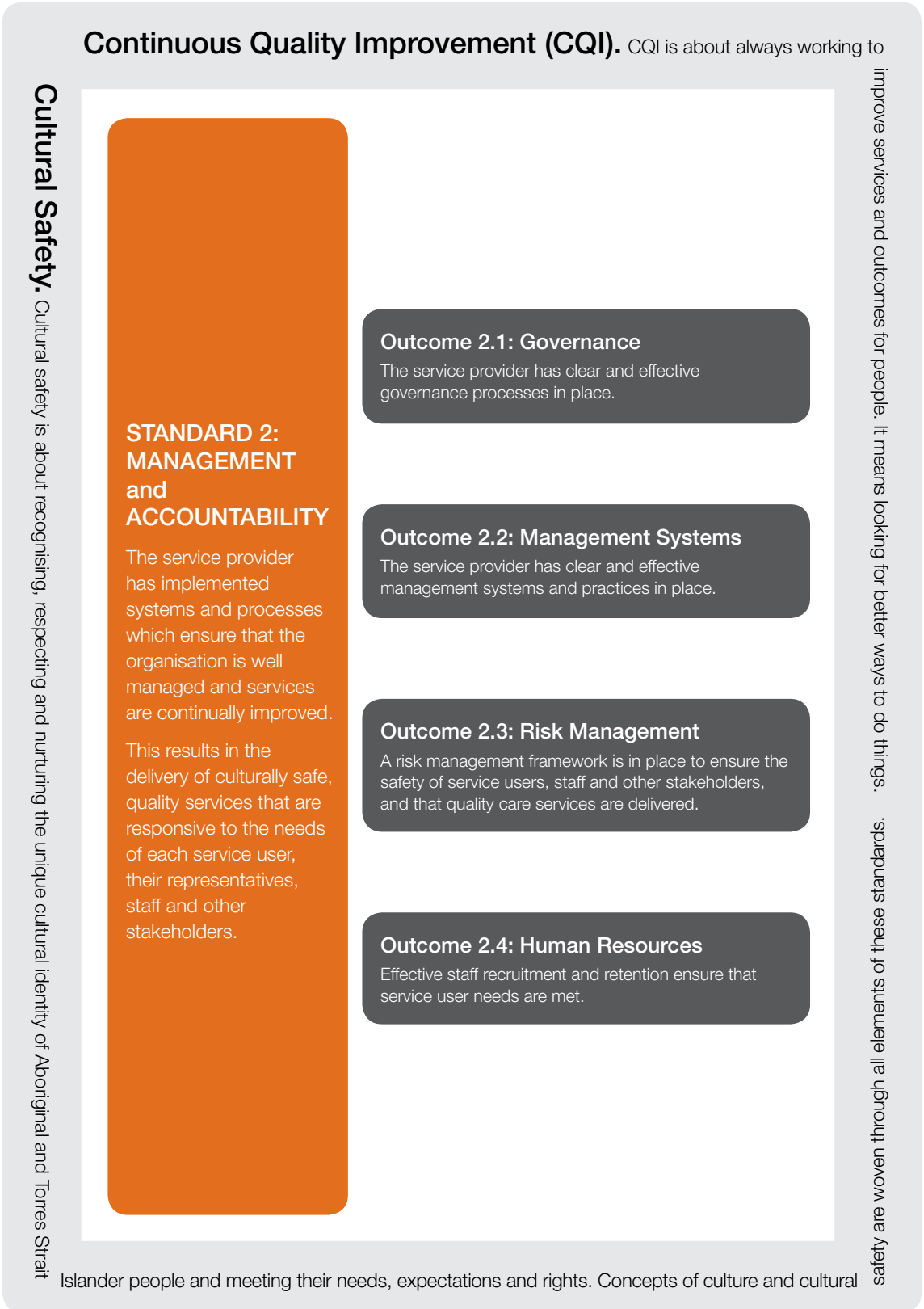


Figure 3-5: Plain English Version

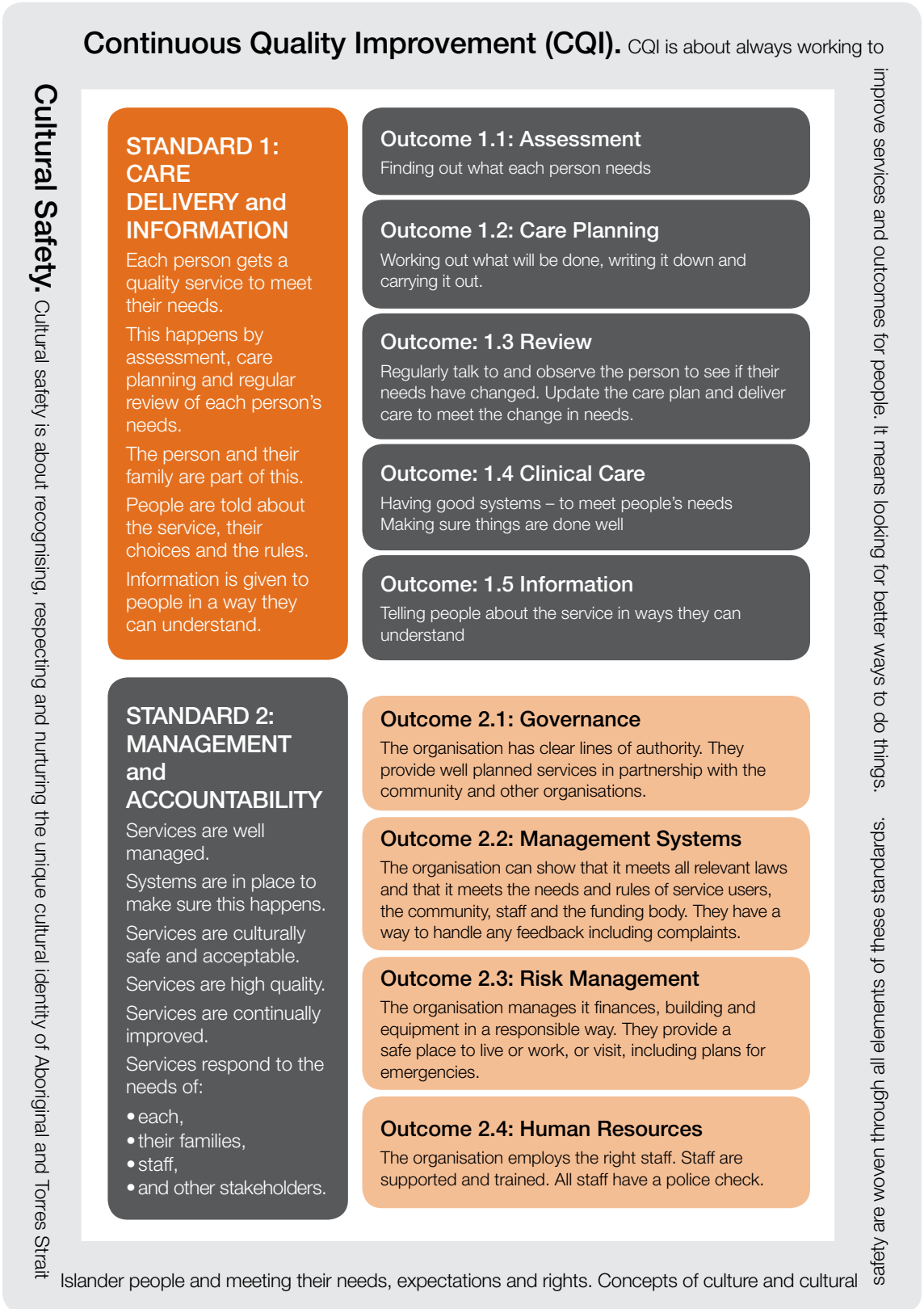


Table 3 1: Standards, Expected Outcomes, Guide to requirements

Standard	Expected Outcome and Guide to requirements
1. Care Delivery and Information *Each service user has access to and receives quality aged care services that meet their needs and respects their dignity and individuality. This is achieved through assessment, planning and regular review of each service user's needs, in consultation with them and their nominated representative/family member/people.* *Each service user is fully informed about service choices and their rights and responsibilities as a service user. This information is provided in a format appropriate to their needs and communicated in a way that is culturally acceptable to each service user.*	**1.1 Assessment** Each service user is supported to actively participate in an assessment of their care needs. The assessment is conducted by appropriately experienced staff and considers: eligibility, priority of access, independence, physical, social, emotional and cultural care needs and clinical care needs, where applicable and with the agreement of the service user. **Guide to requirements:** The assessment includes each service user's: • lfe story • medical history • functional, cognitive and sensory status • nutritional status/needs • personal care needs • special care needs • clinical risk factors. and where applicable: • assessment of the resident's ability to smoke safely, including the need for, and level of, supervision
	1.2 Care Planning Each service user has a documented care plan that addresses their identified care needs and preferences. This includes a cultural support plan which describes how assessed needs and service user preferences will be met in a culturally safe way. The care/cultural support plan includes strategies to maintain privacy and dignity, individual interests, customs and beliefs, independence and family connectedness. **Guide to requirements:** The care plan addresses: • all assessed needs and preferences of the service user • what action is to be taken to meet assessed needs and preferences of the service user in a culturally safe and respectful way • who is responsible for what care (including family members and/or other providers) • when and where care is to be received (ensuring a culturally safe environment).
	1.3 Review Each service user has a documented care plan that addresses their identified care needs and preferences. This includes a cultural support plan which describes how assessed needs and service user preferences will be met in a culturally safe way. The care/cultural support plan includes strategies to maintain privacy and dignity, individual interests, customs and beliefs, independence and family connectedness. **Guide to requirements:** Service user and care plan review: • occurs at least six monthly and where service user needs change • identifies progress against planned goals/actions • results in any change in needs and preferences being documented in the care plan.

Standard	Expected Outcome and Guide to requirements
1. Care Delivery and Information *Each service user has access to and receives quality aged care services that meet their needs and respects their dignity and individuality. This is achieved through assessment, planning and regular review of each service user's needs, in consultation with them and their nominated representative/family member/people.* *Each service user is fully informed about service choices and their rights and responsibilities as a service user. This information is provided in a format appropriate to their needs and communicated in a way that is culturally acceptable to each service user.*	**1.4 Clinical Care** Each service user's clinical care needs are met. **Guide to requirements:** Each staff member works within their scope of practice. Clinical care needs include, as applicable: • special care needs • safe and effective management and administration of medication • effective assessment, treatment and management of pain • access to specialised palliative care services • access to other specialist health care/allied health services • functional care • cognitive care • sensory care • nutritional care • personal care. *Note: The requirements within this outcome may have limited applicability, or not be applicable to some organisations.* **1.5 Information** Each prospective service user is fully informed about service choices and their rights and responsibilities as a service user. **Guide to requirements:** • information about available services and eligibility to receive services is clearly documented. This information is communicated in a manner that is appropriate in format and culturally acceptable to each prospective service user to support choice and decision making • each service user is offered a service agreement by the service provider which sets out the terms and conditions of the service/s to be received and the service user's rights and responsibilities[1] • the service provider ensures that the content of the service agreement is fully explained to each service user (and/or their representative) in a culturally acceptable way prior to entering into the agreement • a process is in place to enable service users to be represented by an advocate of their choice.

1 As per National Aboriginal and Torres Strait Islander Flexible Aged Care Program Service Provider Guidelines, 5. Care Recipient Rights and Responsibilities and 5.3 A Care Recipient has the right to security of tenure, in particular.

Standard	Expected Outcome and Guide to requirements
2: Management and Accountability *The service provider has implemented systems and processes which ensure the organisation is well managed and services are continually improved.* *This results in the delivery of culturally safe, quality services that are responsive to the needs of each service user, their representatives, staff and other stakeholders.*	**2.1: Governance** The service provider has clear, effective governance processes in place. **Guide to requirements:** • Board/Committee members have appropriate skills, knowledge and experience to carry out their role • Board/Committee members have an understanding of, and promote culturally safe service delivery • the roles and responsibilities of the Board/Committee are documented • meeting minutes and other records evidence that the Board/Committee carry out their roles and meet their responsibilities • planning occurs to set strategic directions and promote the delivery of culturally safe quality aged care services • the service actively engages with and consults the community about the services available and reflects this in service planning. **2.2: Management Systems** The service provider has clear and effective management systems and practices in place. **Guide to requirements:** • the service provider understands and complies with the funding agreement, including the Service Provider guidelines • the service provider understands and complies with regulatory and relevant legislative requirements • management and staff accountabilities and delegations are documented, relevant to their roles • service planning and development occurs and aligns with the organisation's strategic directions • financial, human and physical resources are allocated and used in ways that support quality care services that are delivered in a culturally safe and comfortable environment • information management systems are in place to ensure the service users' right to privacy, dignity and confidentiality in relation to the use and collection of personal information • information management systems are in place to ensure the safe and secure storage of documents and records, and enable effective use of information to meet the needs of each service user, staff, management and regulatory bodies • a process to manage positive feedback, complaints and allegations is in place which is effective, accessible, and culturally acceptable to stakeholders • the service provider works in partnership with other organisations to maximise access to services and/or enhance service delivery • a continuous quality improvement program is in place to monitor and improve: > the care and services provided to service users and > the management systems and practices of the service provider.

Standard	Expected Outcome and Guide to requirements
2: Management and Accountability *The service provider has implemented systems and processes which ensure the organisation is well managed and services are continually improved.* *This results in the delivery of culturally safe, quality services that are responsive to the needs of each service user, their representatives, staff and other stakeholders.*	**2.3: Risk Management** A risk management framework is in place to ensure the safety of service users, staff and other stakeholders, and that quality care services are delivered. **Guide to requirements:** • effective financial management processes are in place to ensure the service is, and remains, financially viable. Financial risks are identified and managed in an appropriate manner • an asset management program is in place • purchased goods and services are of a standard that ensure the delivery of quality aged care services • procedures are in place for the management of emergencies including natural disasters • effective infection control procedures are implemented • procedures are in place to identify and address potential risks associated with: > the physical environment > chemicals or dangerous goods > laundry services > kitchen and food handling > cleaning > fire equipment > open fire supervision. • procedures are in place to identify and manage risk related to service delivery.
	2.4: Human Resources Effective staff recruitment and retention ensure that service users' needs are met. **Guide to requirements:** • recruitment and retention processes ensure sufficient staffing levels are maintained at all times for the delivery of safe services • services are provided by appropriately skilled staff that have an understanding of the cultural needs of the key stakeholders, including service users • all staff and volunteers have a current police check that complies with the funding agreement • staff and volunteers are provided with training and development activities relevant to their role • an effective performance appraisal process is implemented for staff and volunteers.

4. The Quality Improvement Cycle and Review Process

4.1 Introduction

The Quality Improvement Cycle outlines:

- the steps which measure and assess service provider performance against the Standards
- support for service providers to meet and continually improve their quality performance against the Standards.

The design of the review process aims to:

- support capacity building for the service provider
- support continuous quality improvement while addressing accountability through quality assurance processes
- promote development of internal systems and processes.

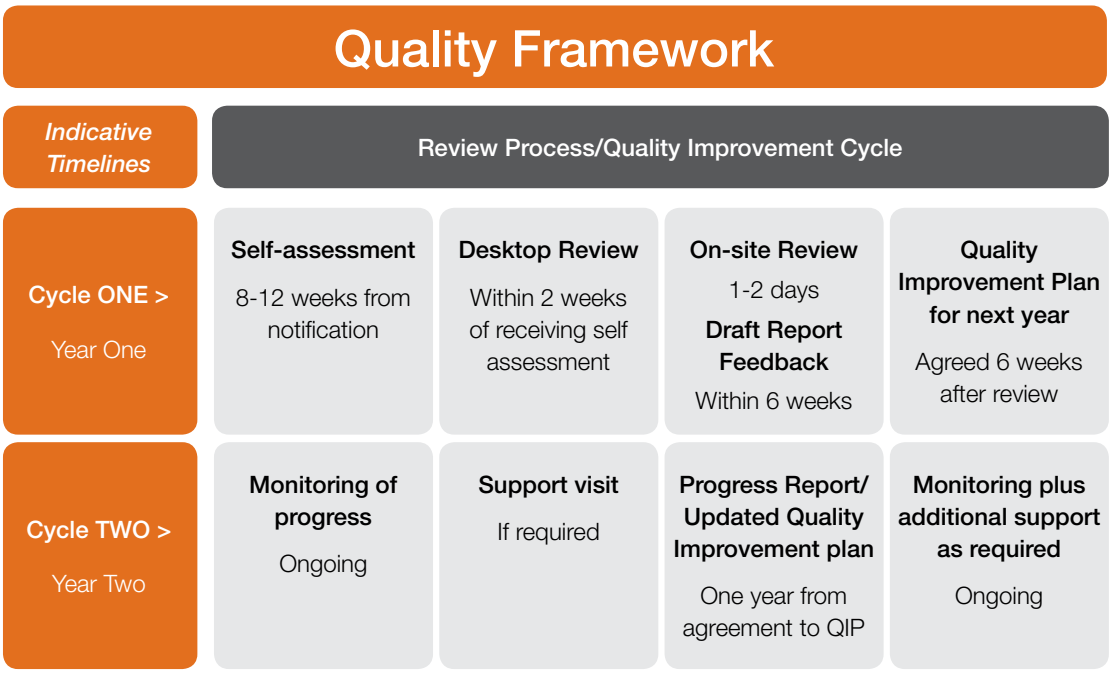
The Quality Improvement cycle is implemented over two years. Figure 4.1 provides a visual outline of the timing of the Review Process and the Quality Improvement Cycle.

The first year includes a formal review against the Quality Standards including self-assessment by the service provider and a site visit by the Quality Review Team. The key output for year one is the agreed Quality Improvement Plan between the Quality Review Team and the service provider.

The service provider then works on actioning the Quality Improvement Plan and activity is monitored and supported by DoHA Program staff and the Quality Review Team.

In the second year, service providers report on their progress in actioning the Quality Improvement Plan and update their Quality Improvement Plan for the next calendar year. The Progress Report and Updated Quality Improvement Plan is submitted to the Quality Review Team and is the key output for the second year of the cycle.

Figure 4 1: Overview of the Quality Improvement Cycle showing key outputs and timelines



4.2 Self-assessment

A letter is generated by the Quality Review Team advising the service provider when the self-assessment is due to be submitted to the Quality Review Team. Service providers should be given 8 to 12 weeks notice of the date for submission of the self-assessment report.

A self-assessment is completed by each service provider. Self-assessment is usually the beginning point and a critical component of a continuous quality improvement process. Self-assessment involves an organisation looking at how it does things, what it achieves, and how it performs against an agreed set of standards. During the process, an organisation's strengths, weaknesses and opportunities for improvement are identified.

The self-assessment enables a service provider to:

- confirm areas where the service is meeting the Standards
- identify gaps in current systems and processes that do not meet the Standards
- plan action to address any identified gaps in systems and processes, prior to the on-site review being conducted
- identify additional opportunities for improvement, even where the Standards are met, to support continuous improvement.

The self-assessment tool records the things an organisation is currently doing, and information about the systems they have in place. It enables the service provider to identify where there are gaps in their systems and processes. During the self-assessment process there may be opportunities to address these gaps, such as writing a policy or procedure to describe practice.

Once completed, the self-assessment forms the basis of the desk top review and is used to inform the on-site review.

Before the self-assessment process can begin, planning should be done by the service provider to ensure the best use of staff time and to anticipate the impact of the process on service delivery. Realistic timeframes must also be allowed. This may be a few weeks for services that have been assessed against other quality standards and regulatory/accreditation frameworks and have established systems and processes in place. However, those services that have not had this experience may need to allow a longer time to complete this process.

During self-assessment, involving the staff who deliver the service can be a valuable way of establishing agreement on how the service is delivered, and assessing alignment with policy and procedure. Involving staff encourages learning about the Standards and fosters understanding about how everyone is responsible for quality.

Service users, their families, visiting health professionals and other stakeholders can also be encouraged to contribute feedback and suggestions on their experience of service delivery.

Completing a self-assessment can assist services to review feedback that has been collected, and identify who else could be consulted for feedback on service delivery.

Regular self-assessment ensures that up-to-date information about the service's performance is available. The results of self-assessment can be used to plan improvement activities and, in turn, the results of these activities can be evaluated and fed into the next self-assessment; so the improvement process continues.

The *Service Provider Self-assessment tool* is included at **Appendix 1**. The Self-assessment tool includes:

- an Assessment Matrix
- a Self-assessment Rating against each Expected Outcome of the two Quality Framework Standards and Quality Improvement Actions
- a Checklist.

Examples of completed *Service Provider Self-assessments* are included at **Appendix 2**.

4.3 Desk Top Review

Within **two weeks** of receiving the completed Service Provider Self-Assessment the Quality Review Team will undertake the desk top review.

The desk top review assists in prioritising areas for focus at the on-site review and examines other information such as records of previous review findings and/or other relevant information provided in the Service Provider self-assessment. Any other relevant information, for example information about compliance with requirements for submission of Financial Activity Reports or Service Activity Reports may also be considered at the desk top review.

Reviewers must complete a *Desk Top Review Record* for each review conducted. The Desk Top Review Record is an itemised checklist incorporating notation of any required actions/follow up where any concerns with the completed self-assessment are identified.

Indicators raising concern about readiness for the on-site visit may include submission of an incomplete self-assessment or a self-assessment with limited relevant information. If necessary, the reviewers will make contact with the service provider for additional information or request that the self-assessment be resubmitted.

Service providers will be notified of the outcome of the desk top review and subsequent plans for the On-Site Review in writing.

The *Desk Top Review Record* Template is at **Appendix 3**.

4.4 On-site Review

Following the desk top review, the on-site review will be scheduled and conducted by at least two reviewers, normally lasting between one and two days, depending on the service types delivered. The Quality Review Team would generally allow one day for on-site review of community care providers, and up to two days for residential and mixed service type providers. Large residential service providers may require two full days for on-site review.

Prior to an on-site visit, the Quality Review Team will liaise with the Service Provider to make the necessary arrangements which will be confirmed in writing. On-site review planning tools and templates are at **Appendix 4**.

The on-site review is a quality assurance process which assesses how the service provider meets the Standards. Reviewers will use the service providers most recent Service Provider Self-Assessment Report and the Desk Top Review Record to guide them in conducting the on-site review.

The visit will be collaborative in approach and focus on acknowledging good practice and encouraging the development of sustainable quality systems.

The on-site review will include the following steps:

- **Entry Meeting** - to introduce key staff and explain the onsite review process
- **Tour of the Site** - to observe e the physical environment from which services are run
- **Document Review** - includes a review of documented evidence to demonstrate if the expected outcomes are being met

- **Review a sample of service user records and staff, carer and volunteer records** - to demonstrate if the expected outcomes are being met
- **Stakeholder interviews** - to confirm written evidence or observations made by the reviewers
- **Exit Meeting** - to provide verbal confirmation of the review findings and advise of ratings against the Standards including actions required to meet the Standards

Quality Reviewer tools and templates are at **Appendix 5**.

The organisation's performance will be assessed against each expected outcome of the Standards by applying the following ratings:

- **Met:** written and verbal evidence clearly demonstrates that the service provider meets all the requirements of the expected outcome.
- **Part Met:** written and verbal evidence clearly demonstrates that the service provider only meets part of the requirements of the expected outcome.
- **Not Met:** written and verbal evidence clearly demonstrates that the service provider does not meet the requirements of the expected outcome.
- **Not Applicable:** a not applicable rating may apply, for example, where a service does not provide clinical care to service users (refer to expected outcome 1.4).

Once each expected outcome has been rated, the overall **Review Result** will be determined as follows:

- **Met:** all the requirements of each expected outcome have been met.
- **Part Met:** the requirements of one or more expected outcomes have not been fully met.
- **Not Met:** the requirements of no expected outcomes have been met.

4.5 Draft Report and Feedback

Within **two weeks** of the visit a draft report of the on-site review is submitted to the service provider. The On-site Review Report will use the same format as the self-assessment report completed by service providers and will include:

- an Executive Summary
- an Assessment Matrix
- evidence examples sighted during the visit to demonstrate compliance with each expected outcome
- review findings detailing the reasons for the reviewers' rating for each expected outcome and the applicable rating
- Quality Improvement Plan to address any identified gaps in meeting the Standards and/or plans to support continuous quality improvement, where applicable.

The report will clearly document what needs to be done to meet the Standards and optional actions to support continuous quality improvement. These actions form the basis of the Quality Improvement Plan.

The service provider will have **four weeks** to work through the draft Report and return their feedback to the Quality Review Team. Feedback may include any service provider comments and factual errors in the draft Report, as well as completing the Quality Improvement Plan, that will include who will be responsible for each action and the due date for completing actions. Feedback may be provided verbally, electronically via email or in a letter. Feedback may include any errors, omissions or requested changes to the draft Report.

Where the service provider disagrees with content in the draft report, the Quality Review Team requires the following information:

- specific detail about the part/s of the draft report that are in dispute
- the evidence the service provider is relying on to substantiate the requested change.

Where agreement on the content of the draft Report cannot be reached, the matter should be referred to the Quality Review Team Manager for review.

The *On-site Review Report* template is at ***Appendix 5*** and the *Quality Improvement Plan* template is at ***Appendix 6***.

4.6 Quality Improvement Plan for next year

The Quality Review Team then has **two weeks** to finalise the draft Report and Quality Improvement Action Plan with the service provider.

The service provider is responsible for completing the plan with:

- name/position of the person responsible within their organisation for completing the action
- timeframe within which the action is to be completed.

The return of the final Report and agreed Quality Improvement Plan for the next year to the service provider by the Quality Review Team is a key output of Cycle One.

4.7 Monitoring Progress of Quality Improvement Plan

The service provider will use the Quality Improvement Plan to schedule, monitor and report on the planned actions required to meet the expected outcomes of the Quality Standards.

The Quality Review Team and Program staff will use the Quality Improvement Plan to monitor the service's progress in implementing the planned actions. The plan will assist to identify any additional support that the service provider may need, including assistance from the Service Development Assistance Panel.

If serious matters relating to health, safety and well being of care recipients arise, the issue will be referred to the Quality Review Team to manage in consultation with the Program manager and further assessment by the Quality Review Team may be necessary.

4.8 Support Visit to achieve Quality Improvement Plan

To monito progress of the Quality Improvement Plan, Program staff and/or the Quality Review Team, must include at least one support visit to the service provider following the On-site Review. The timing of this will depend on the support required by the service provider and their progress in implementing their Quality Improvement Plan.

4.9 Progress Report / Quality Improvement Plan for next year

In order to maintain the momentum of Continuous Quality Improvement, service providers will be required to submit a Progress Report against the agreed Quality Improvement Plan a year after that plan has been agreed. The service provider will also update their Quality Improvement Plan for the next calendar year.

The *Progress Report* - template is at **Appendix 6**.

4.10 Complaints

A service provider may make a complaint about any aspect of the quality review process or the conduct of a Quality Reviewer at any time. In the first instance, service providers are encouraged to discuss their complaint with the Quality Review Team Manager, who may be able to resolve the issue. Alternatively, the service provider may prefer to put their complaint in writing via email or letter to the Quality Review Team Manager.

The following information is required from the service provider:

- specific detail about the nature of the complaint
- the evidence the service provider is relying on in making the complaint
- confirmation the service provider's nominated representative (and contact details) with whom DoHA should liaise during the management of the complaint.

DoHA will investigate the complaint and respond to the service provider as soon as practicable.

4.11 Mutual recognition

Where an Aboriginal and Torres Strait Islander Flexible Aged Care Service is funded separately to provide Home and Community Care Services, the service provider will also participate in reviews under the Community Care Common Standards (CCCS) and may report on some of the same information required under this Quality Framework (or visa versa).

In this event, the quality reviewers and the service provider will liaise to identify any relevant information common to both processes that can potentially be shared between reviewers, to avoid a duplication of effort. It will however, be important for the quality reviewers to determine that the information is current and relevant to the expected outcome of the particular standard.

This will need to be on a case-by-case basis in consultation with the service provider and the relevant areas of DoHA.

SECTION

two

Guide to Understanding Quality and Continuous Improvement

TABLE OF CONTENTS

1. Introduction

1.1 Purpose of the guide

This guide is designed to introduce the concept of quality and quality systems to a broad audience, such as indigenous staff members, Board members, service users, family and community. It uses familiar language and visual prompts.

The guide is structured around the following content:

Standard	Expected Outcome and Guide to requirements
What is a Quality System?	*Explains a quality system.*
Why have a Quality system?	*Explains the benefits of having a quality system. Includes examples of quality processes and prompts for services to think about when planning a quality system.*
Implementing a Quality System	*Discusses the key steps in implementing a quality system including the development of mission and vision statements, a strategic plan and policies and procedures.* *Explains how policy and procedures underpin service delivery and provides simple definitions and examples of easy to follow formats to assist services develop the necessary documentation.*
Continuous Quality Improvement	*Explains the purpose of CQI and the CQI model. Discusses conducting, recording, and reporting quality activities. Emphasises the importance of systems to capture and act upon opportunities for improvement from all stakeholders.*
Quality Improvement Plans	*Discusses the purpose of a Quality Improvement Plan.* *Provides an example plan and quality System checklist.*

2. Quality Systems and Continuous Improvement

2.1 What is a Quality System?

A quality system is the method an organisation uses to make sure that the services it provides are delivered as intended and meet the needs and expectations of stakeholders.

The processes that guide the way that things are done by a service provider are a key part of its quality system. These processes direct the activities of management and staff: ***what*** is to be done, ***when*** it is to be done, ***how*** it is to be done, for ***whom*** it will be done and by ***whom*** it will be done.

A stakeholder is anyone that has an interest, involvement or investment in the organisation. For services funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, stakeholders include:

- **service users, their families and friends**
- **service staff/management/Board**
- **the community**
- **governments which fund the service**
- **other service providers.**

Your stakeholders will have different needs and expect different things from your service. For example:

- service users and the community might expect that:
  - > they can get the service they need when they need it
  - > they can afford the cost of the service
  - > their needs are met by qualified staff
  - > the service is provided in a culturally safe and respectful way
- governments which fund the service expect it to meet:
  - > conditions of funding set out in the funding agreement
  - > program guidelines
  - > any relevant regulatory requirements.

2.2 Why have a Quality System?

Most service providers believe that they provide a good service. However, it may be hard to show this if they do not have an effective quality system.

An effective quality system includes ***systems*** and ***processes*** to:

- clearly identify the needs and expectations of stakeholders
- plan and deliver the agreed services
- check that the services delivered meet stakeholders' needs and expectations
- check that the services delivered are reliable and of a consistently high standard.

These systems and processes are important in ensuring:

- sustainable service delivery: A systems and process approach does not rely on one person's or a few peoples' knowledge about what, when, how and to whom services are delivered. Rather, the 'what, when, how and to whom' is written down and is available to all who may need to know.

A systems and process approach supports the delivery of the right service, at the right time, to each person being cared for, by staff trained to provide the service. This should not change because staff join or leave the organisation.

- consistent practice: We all hear, interpret and respond to information differently. For example, if you ask four people to wash the bathroom floor, all four will probably do this task differently, unless they are given specific instructions.

A systems and process focus supports service delivery that is planned, documented, implemented, reviewed and evaluated. The use of documented systems and processes helps to make sure that staff understand the organisation's way of delivering services.

This reduces the chance of people complaining that '*no one seems to know what to do*' and '*every staff member does things differently*'.

An effective quality system provides ***tools*** and ***information*** to help an organisation show how it monitors, reviews and evaluates the services delivered. In short, it helps the organisation to show how it:

- ***measures*** the ***quality*** of the service provided; and
- tries to ***continually improve*** services and outcomes for all stakeholders.

An effective quality system has processes to pick up if the way things are done may need to be changed.

The need for action or change might come about because of feedback from service users, an accident or incident that has happened, by new policy or change in policy from a funding body, or by the results of file audits.

For example, an audit of service user files might identify that care plans are not consistently reviewed six monthly. Action might include: contacting staff/calling staff together to discuss practice, recirculating the review policy and procedure and more regular file auditing until improvement is noted.

So a service that has a quality system with clear systems and processes might use some of the following examples to show the steps they take to make sure they provide a 'good' service to stakeholders:

Our quality processes include:

- explaining our policies and procedures to all new staff and making sure they understand them
- offering a copy of the policies and procedures to all new staff
- looking at our policies and procedures and talking about any changes with our staff at a weekly meeting
- conducting regular service user file audits
- surveying all service users, their families and our staff once every year
- surveying all service users and their families when a service ends
- looking at all surveys and talking about the results at committee, management and staff meetings
- writing any opportunities for improvement in our Quality Improvement Plan
- involving our stakeholders in service planning and review by asking them to come to our annual meetings and making sure they know they can speak with us at any time
- meeting with our community Elders regularly to talk about our service
- we meet the conditions of our funding agreement and reporting requirements.

Start thinking about . . .

What systems and processes does your service have in place to make sure you are providing a 'good' service to stakeholders?

Implementing a quality system can seem like a big task when starting. It is very important to take the time to plan how your service will develop the quality system and who will be involved. You will find some examples below of things to do in the planning phase to get you started. Your service might choose to make a checklist of these things to work through with other staff.

Examples of things to do when planning a quality system:

- list your services stakeholders
- check that you have a copy of all funding agreements
- list all the regulations that your service must meet (see the 'Resources' section of this guide)
- decide who should be involved in setting up your quality system: think about those people who know most about your service and how it works
- ask these people to gather to talk about what systems and processes you have in place now
- work out how much of what you 'do' is written down
- think about what else should be written down for staff
- think about what else should be written down for the Board/Committee
- think about what else should be written down for service users
- decide who is going to help with doing this and what their job will be
- work out how long it will take to finish the job
- plan regular gatherings to talk about how the work is going
- decide how you will share information with service users and staff: it might be in writing for some stakeholders or talked about at a gathering for others
- decide the best ways for getting feedback from service users to check that they are receiving the service that was planned to be provided and that the service is what your service users want from your service
- decide the best ways for getting feedback from staff to check that what is written down is what your staff do
- decide how you will collect this feedback, who will be responsible for recording it and looking at it
- plan how your service can best use feedback to improve the services you provide
- think about the best person in your service to be responsible for getting back to people to tell them how the service has used their feedback.

Start thinking about . . .

What are the best ways to involve not only management and staff, but other stakeholders such as service users, their families and the community in this process?

You might involve these other stakeholders by asking them about how they want to receive information from the service and how and to whom in the service they would like to give feedback.

All services do some things differently. Are there other things that your service might need to think about in this planning phase because of your location, staff, service users or community?

2.3 Implementing a Quality System

An effective quality system *must* have ways to:

- check that your service is doing what it says it will do and is doing it in the way you said it would be done. That is, that the service is meeting its aims.
- keep checking that stakeholder needs are being met.

The key steps in implementing an effective quality system include developing:

- Mission and Vision statements
- a Strategic Plan
- policies and procedures.

Each of these steps is discussed in detail in the following pages.

2.3.1 Developing a Mission and Vision:

The first step in implementing a quality system is to be clear about what your service is trying to achieve – what is the purpose and aim of your service?

The *mission* statement is usually a short statement about the purpose of an organisation.

The *vision* statement looks to the future and is a statement about what your service wants to achieve for its service users, the community and other stakeholders.

Some organisations also have a *values* statement which describes their approach to service delivery, or their way of doing business.

Example Mission, Vision and Values statements are provided on the next page.

Example Statements:

Mission Statement:

To make sure that all Aboriginal and Torres Strait Islander aged people get quality aged care services that are culturally safe and available when they need them.

Vision Statement:

Our clients, their families and the community will have better health and well being because of the services we provide.

Values Statement:

Our Board/Committee will understand cultural safety and use good governance practices to ensure our service offers quality services that are continually improved.

We will involve our clients, their families and the community in our service planning and review.

We see each client as an individual with unique needs.

We will make sure that each client's needs are met in a culturally safe way.

Start thinking about . . .

Mission, Vision and Values statements should reflect what your service is about. As many stakeholders as possible should be involved in having a say about them.

In what ways will you involve stakeholders in developing these statements?

If you already have these statements in your service, when were they last reviewed?

In what ways will you involve stakeholders in the next review?

2.3.2 Developing a Strategic Plan:

Once these statements about the aims and purpose of your service are written down a plan should be developed to show how they will be met. This is known as a *strategic plan*.

A strategic plan lists the goals of the service and information about what must be done (action to be taken) to meet these.

The plan should be developed with input from stakeholder groups including service users, staff and the community.

There should be a clear link between actions on the strategic plan and the mission, vision and values statement.

A strategic plan would usually include the following information:

- the goal to be met what must be done (the action) to meet the goal
- who will take the action to meet the goal
- by when action is to be taken
- the date when the goal was met.

It is also very important that strategic plans are reviewed and discussed regularly. Each service should have a way to make sure that this happens.

Many services have a strategic plan but it is often not looked at to see if any progress is being made with actions and/or any changes need to be made.

For these reasons it is recommended that a strategic plan:

- is not too lengthy
- uses simple language
- is easily understood
- is made available to all stakeholders
- is regularly discussed and reviewed within the service.

Start thinking about . . .

Who was involved in developing your Strategic Plan?

Is it easy to read and understand?

How often is it reviewed, and who reviews it?

How can stakeholders find out about the Strategic Plan?

2.3.3 Developing Policies and Procedures:

Policies and procedures are a very important part of a quality system. They explain what the service aims to do and how they are to do it.

Some policies and procedures will apply to everyone in the service, but others may just be for the Board/Committee, management or staff.

Earlier in the guide there was information about systems and processes and how they help to make sure that there is *sustainable service delivery* and *consistent practice* (see pages 14-15). Policies and procedures should describe the services systems and processes. They direct management and staff in their daily work and tell other stakeholders about how the service 'works'.

A ***policy*** describes **what** is done and **why** it is done. Policies should reflect current practice and regulatory requirements. For example, there are regulatory requirements about privacy and occupational health and safety that employers must meet.

A ***procedure*** describes **how** to put the policy into practice. It includes the steps to be taken to implement the policy. A procedure usually gives answers about who is to do what, when and where they are to do it and how they are to do it. Procedures are sometimes supported by ***work instructions***.

Policies and procedures are used to inform the service, staff and stakeholders about issues such as:

- governance
- decision making
- compliance management
- risk management
- roles and responsibilities
- communicating with stakeholders, staff training and development
- day to day operations of the service.

How do I start?

How a service develops its policies and procedures may depend on the size of the organisation, the number and type of services it offers and the number and type of staff.

When developing policies and procedures first think about:

- what is the message to the reader?
- how much information do they need?
- who is the reader?

All services will need to communicate policies and procedures to a variety of people. Policies and procedures should use clear and simple language and be in a format that is suited to the user.

The service should ask stakeholders to be involved in developing policies and procedures. For example, Board/Committee members, management, staff, and where possible, service users. It is also a good idea to get stakeholder feedback on draft policies and procedures.

The length and detail of a policy statement will depend on the related issue. Some policies may include definitions or parts of relevant standards, legislation or regulations that the service must meet. Development of policies and procedures should also consider:

- funding agreement requirements
- program guidelines
- current accepted good practice
- services provided by the organisation
- whether the issue is simple or complex
- current work practices
- staff knowledge and skills.

Some services may need more than one procedure for each policy. For example, staff might provide services in different settings and need different safety procedures.

Procedures should also include information about any forms or records that need to be completed.

What should they look like?

There are several options for presenting procedures where staff and other stakeholders have varying language and literacy skills. These include:

- pictograms
- diagrams
- flowcharts
- word documents.

Each service will have to decide the best way to present this information by thinking about their service, staff and service users.

Each service should decide how they will develop, present and review their policies and procedures. This is known as ***document control***.

A system for document control should include:

- a procedure that describes how the service develops, presents and reviews/updates policies and procedures and who is involved in each step
- a process for page layout, print type and size and page numbering
- a process for approval of the document, evidenced by signing and dating by the person responsible
- a record of all documents developed
- a process for communicating new or updated policies and procedures
- a list of people to send policies and procedures to.

What next?

Once a policy and/or procedure is approved, it should be sent to those in the service who need to know about it and put into practice.

Processes to make sure that the policy and/or procedure is put into practice and is current include:

- introducing policies and procedures to all new staff at orientation
- making sure that policies and procedures are in an appropriate format for the user and are understood
- making sure that staff and other stakeholders can access policies and procedures, including staff who do not work on site
- checking that what happens in practice matches what the policy and procedure says is to happen
- having a timeframe to formally review policies and procedures
- having a process for staff to report where changes or updates to policies and procedures may be needed between formal reviews.

The service should also decide whether policies and procedures will be in hard copy, computerised, or a combination of both.

In making this decision, services will again need to think about the skills of their workforce and the services information management systems. This may depend on whether the service is highly 'computerised' or usually relies on hard copy information.

Some example policies and procedures are provided on the following pages in different formats. Keep in mind that the language and format used is very important. There is no value in having policies and procedures that cannot be understood by the user.

Example Policy and Procedure: Dot points

The example policy and procedure below are brief and use dot points. This style may suit a small organisation that does not require more complex policies and procedures.

Client Assessment Policy

- all potential clients will participate in an assessment of their aged care needs
- all referrals must be forwarded to the manager when received
- assessments should be done by the assessment officer within one week of referral
- the date of assessment should be recorded in the appointment book and the client's file, once created
- the number of client assessments is reported to the Board/Committee quarterly.

Date:

Person authorising:

Review due date:

Client Assessment Procedure

- all client assessments are conducted by the assessment officer with their consent
- assessments are done in consultation with the client and their nominated representative/ family member/people
- all sections of the Client Assessment Tool are to be completed at assessment
- all clients are to be informed about service choices, their rights and responsibilities and given a copy of the 'Welcome Pack'
- the client and/or their nominated representative/family people are informed about the outcome of the assessment immediately. The result of the assessment must also be documented in the assessment notes.

Date:

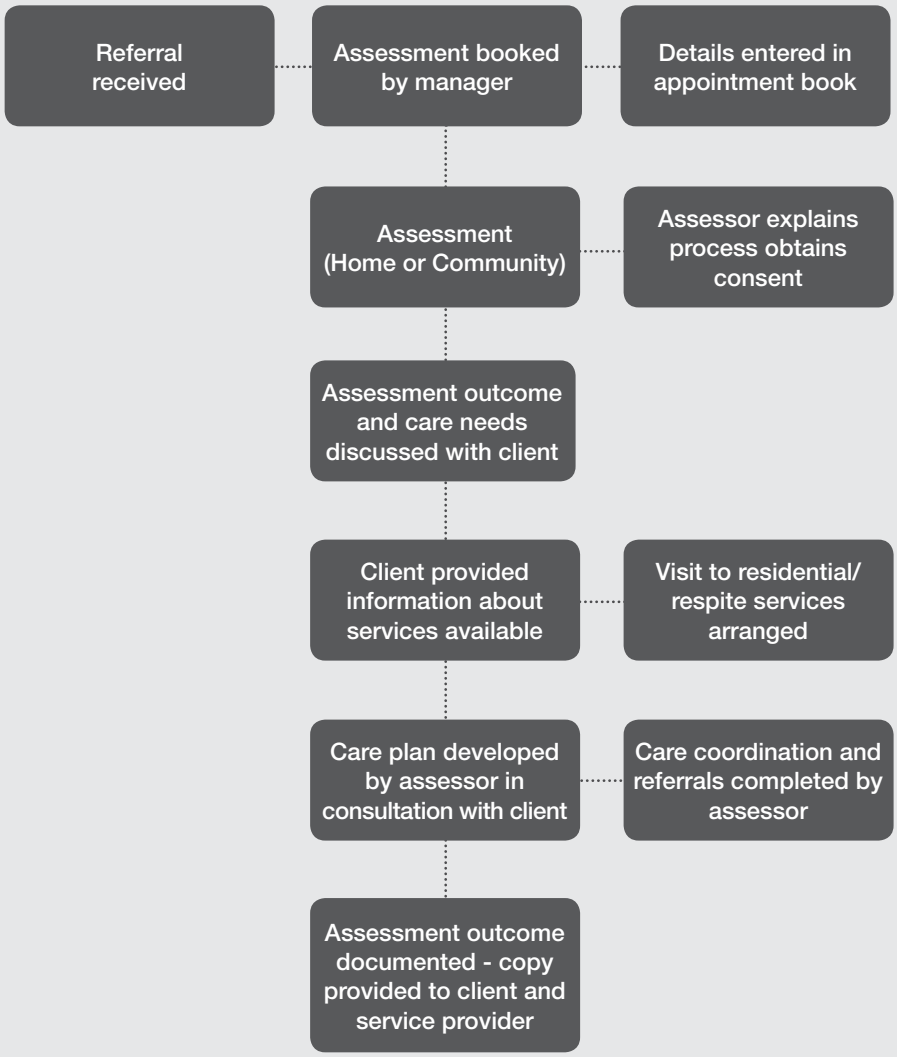
Person authorising:

Review due date:

Example Policy and Procedure: Flow Chart

Procedures can be presented in an alternative format, such as a flowchart to better meet the needs of the target audience.

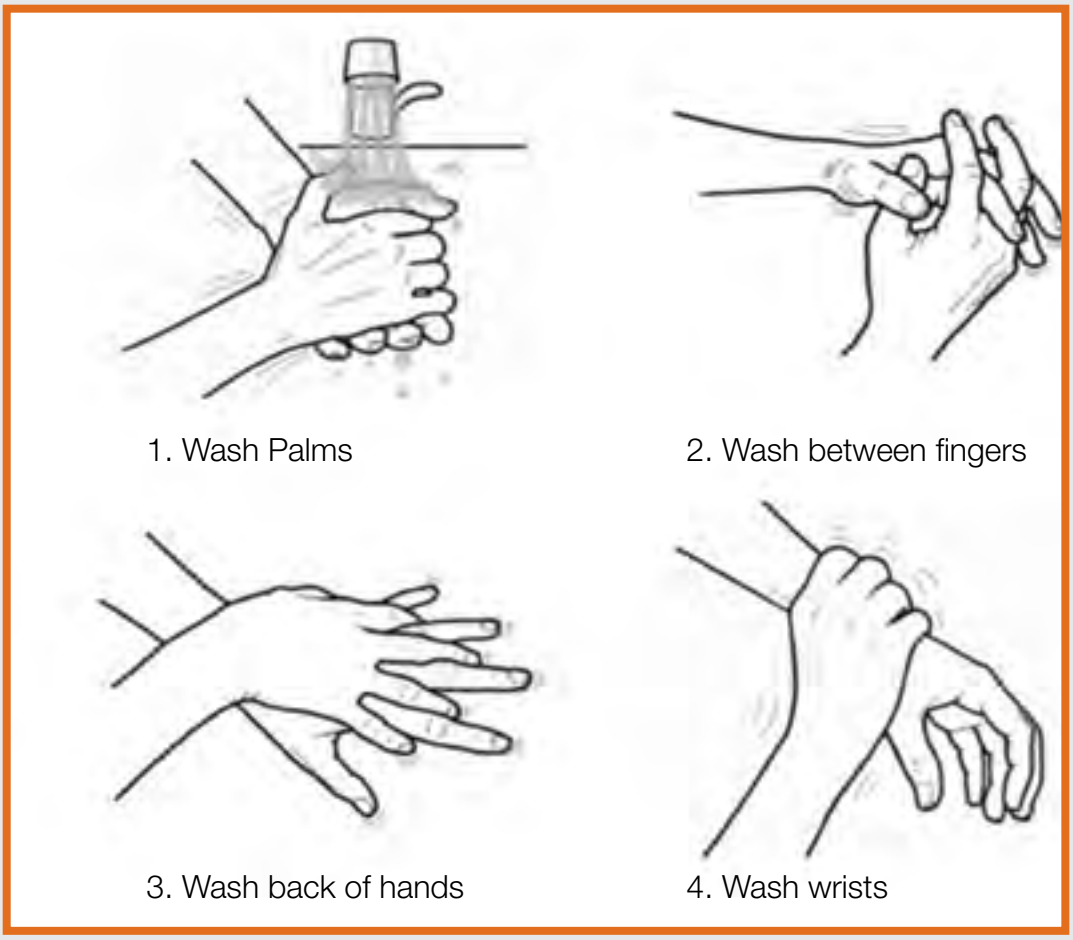
ASSESSMENT FLOW CHART



Example Procedure: Pictogram

Procedures can be presented in an alternative format, such as a pictogram to better meet the needs of the target audience.

HANDWASHING



1. Wash Palms
2. Wash between fingers
3. Wash back of hands
4. Wash wrists

Start thinking about . . .

Who will need to know about your policies and procedures?

What format best suits the needs of your audience?

Will you need to use a few different formats to communicate our policies and procedures?

Who should be involved in developing and commenting on policies and procedures?

Who should be involved in reviewing policies and procedures?

2.4 Continuous Quality Improvement

The previous sections have looked at:

- What is a Quality System?
- Why have a Quality System?
- Implementing a Quality System.

This information highlighted the importance of involving people, having processes and developing documentation in establishing a quality system.

Once a quality system has been developed and implemented the next step is to make sure that the results achieved for stakeholders are continually improved.

Continuous quality improvement (CQI) is about making ongoing (continuous) effort to improve the quality of services and outcomes for stakeholders.

CQI focuses on ***improving systems***, rather than on the performance of people or things. CQI is used in all types of organisations as a way of leading and managing the service; it is used to test how well systems are working, the quality of care being given and to bring about lasting improvement.

The key elements of CQI include:

- accountability
- linking evaluation to planning
- achieving improvement through incremental steps
- being driven by input from all levels of staff, management and other stakeholders
- a commitment to team work
- continuous review of progress.

CQI can improve:

- accountability
- staff input and confidence
- services for clients
- the ability to recognise and meet changes in service need
- information management, client tracking and documentation systems.

To be effective, CQI must be a strong focus within an organisation that is understood and accepted by all staff and management.

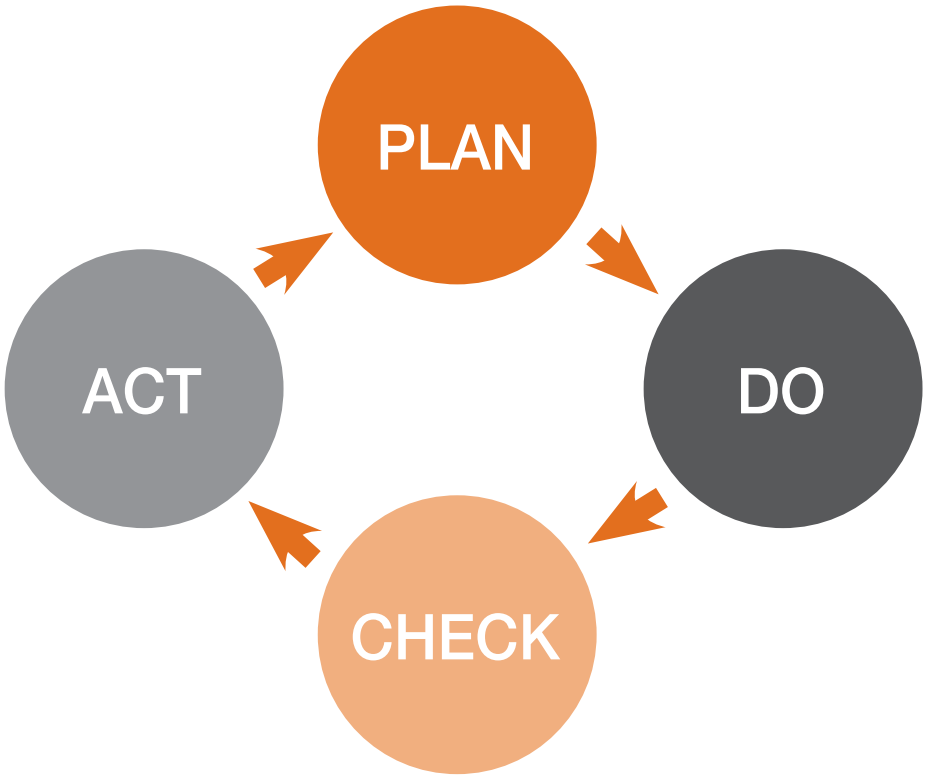
CQI should involve a variety of people, including:

- service users, families and carers
- staff and volunteers
- members of the Board/Committee of Management
- community members
- advocates.

One way of introducing CQI is by using a quality cycle. The quality cycle involves steps to continually evaluate and improve services and the results for stakeholders.

The CQI model shown below is known as the '*Plan-Do-Check-Act*' cycle.

Figure 1: Plan-Do-Check-Act Cycle



The circle shows that CQI does not stop and is never finished.

CQI is ongoing because there will always be opportunities for improvement, with better results seen as each cycle is completed.

The four steps of the CQI model (quality cycle) are as follows:

Step 1: Plan

Plan what it is that you want to change or achieve. Work out what the goal is and then what you need to do to meet it.

Step 2: Do

Put the systems and processes to make the change or reach the goal in place.

Step 3: Check

Look at the results. Did the change work/was the goal achieved?

Step 4: Act

If the last step (check) found that the change was working or the goal was achieved, continue with implementing it into your systems.

If the last step found that the change was not working or the goal not achieved you will need to decide why it did not work and repeat the cycle, starting by planning what you need to do.

The quality cycle helps to identify opportunities for improvement. However sometimes quality improvement activities result from 'gaps' that are found in systems and processes. Action is then taken to 'fix' the gap (corrective action).

Corrective action might be taken in response to a complaint, feedback, an accident or incident or where performance has not met the required standard.

Opportunities for improvement and corrective actions usually identify:

- practice and/or service delivery that does not reflect the services policy and procedure
- where policy and/or procedure need to be reviewed or changed.

An effective quality system must have processes to make sure that opportunities for improvement are identified, documented and reported, and that the action taken is timely and appropriate.

These processes usually include:

- stakeholder feedback processes
- stakeholder complaint processes
- incident and accident reporting
- identification of hazards
- staff appraisal process
- staff grievance and disciplinary processes
- a file auditing process.

For example, corrective action might be taken in response to the findings of service user file audits. File audits are a quality activity and a way of checking that what staff do matches what is written in policy and procedure. File audits might look at practices around assessment, care planning and/or review of service user needs or staff files to check selection, recruitment and induction processes.

A file audit involves looking at the documents in the files to check that they are completed as required by a services policy and procedure. This usually involves using an audit tool, which is similar to a 'checklist' to record the audit findings.

The audit findings should then be reported and any necessary action taken where opportunity for improvement in documentation is identified. How the reporting and follow up occurs will depend on each services quality system and way of doing things. For example, a manager might select one file each week to audit and discuss the results at staff meetings.

An example client file audit tool is provided on the next page. However the audit tool used by your service will need to reflect the practices, policies and procedures of your organisation.

Example service user file audit tool:

Service user file audit tool

Date:

Completed by:

Reported to:

Please audit a sample of x files and complete the following for each:

File Contents	Yes	No	Comments/Action Required
Intake/referral documents			
Details of nominated/authorised representative			
Consent to share information			
Service agreement offered			
Evidence that the following information has been explained and a copy given to the service user: • service brochure • rights and responsibilities • privacy • complaints • feedback • advocacy			
Completed assessment tool			
Completed care plan, including a cultural support plan			
Copy of care plan given to service user			
Care plan reviewed six monthly			

Another way of identifying 'gaps' in systems and processes, is by a service conducting a self-assessment. Service providers are required to meet certain conditions of funding and/or Standards to receive government funding.

Self-assessment involves a service looking at the systems and processes it has in place to meet particular Standards and/or regulatory requirements. Self-assessment can help identify where policies and procedures or other documents may need to be reviewed or changed.

More information about self-assessment required under the Quality Framework can be found in Section 3 *Service Provider Guide to Self-Assessment)*.

Each service should have clear processes to show that the quality cycle and quality activities are key processes in their organisation. Services will have different ways of documenting and sharing information about quality activities.

For example,

- a small service might have CQI as a standing agenda item at staff meetings and activities and opportunities for improvement discuss recent quality
- a large organisation might have a Quality Manager and/or a Quality Committee that regularly reports on quality activities, including file auditing.

Each service should also have a process to inform stakeholders about the quality system.

All CQI requests and activities should be recorded. Depending on the service and their stakeholder group, this may include the use of one or more forms that can be used by service users, staff and other stakeholders. For example, a service may use one form for all stakeholders to record feedback, suggestions and complaints. Another service may have separate forms for feedback, suggestions and complaints.

A third option is to have some forms for staff use only and separate forms for other stakeholders. Each service should collect and record this information in the way that works best for them and their stakeholder group.

Each service should also have processes for collecting and recording information about complaints, accidents and incidents, hazards and maintenance issues.

An example form to record opportunities for improvement is provided on the next page.

Example Opportunity for Improvement Form

Suggestion for Improvement Form	
Name:	Date:
Contact details:	
Tell us about your issue or concern:	
Tell us about your suggestion for improvement:	
Please note: You do not have to tell us your name and contact details. However without this information we will not be able to tell you about the action we have taken on your suggestion.	
Thank you for helping us to improve our services! *Date:* *Person authorising:* *Review due date:* *Page 1 of 2*	

Example Opportunity for Improvement Form

Suggestion for Improvement Form *(This section for Office Use Only)*	
Reported to:	Date:
Action required:	
Date by which action to be completed:	
Describe action taken (include dates):	
Describe outcome (include dates):	
Note further action required (if applicable):	
Note date entered on Quality Improvement Plan:	
Date: *Person authorising:* *Review due date:* *Page 2 of 2*	

Start thinking about . . .

Who is involved, or will be involved in CQI in your service?

How do you/will you make sure that stakeholders know about the CQI program?

What is the best way for your service to collect information about improvement opportunities?

What forms will you use to record this information?

How do you collect information about complaints, incidents and accidents, hazards and maintenance

How do you record and report on the action taken in response to these issues?

2.5 Quality Improvement Plans

A Quality Improvement Plan is one way of recording and checking progress in completing improvement activities. It is used as a central register to help track the progress of and report on quality improvement activities.

The Quality Improvement Plan should be regularly reviewed and updated and record:

- the issue/s raised
- recommended action to address the issue
- responsibility and timeframe for action
- date completed and outcome of the action
- It is important to include dates in the plan to help check that there is a timely response to all issues raised by stakeholders.

An example quality improvement plan is provided on the next page.

Example Quality Improvement Plan

Quality Improvement Plan				
Quality Standard [insert no]				
Expected outcome [insert no]				
Planned action	Who is responsible	Due Date	Date completed	Comments
Date: *Person authorising:* *Review due date:*				

This section has provided a large amount of information and suggestions related to quality systems and continuous quality improvement.

An example checklist is provided below to help you think about your service's systems and processes.

The checklist can help identify areas where you may need to review or further develop documentation and processes as part of your quality system.

It is not suggested that this is a complete list, but instead, some examples to assist your service.

Example checklist for implementing a quality system:

- ✓ Mission and Vision Statement
- ✓ Strategic Plan
- ✓ Policies and Procedures:
  - ❑ Cultural safety
  - ❑ Governance
  - ❑ Strategic and Business Planning (including community consultation)
  - ❑ Service provider networks and partnerships
  - ❑ Regulatory compliance
  - ❑ Risk management
  - ❑ Financial management
  - ❑ Document management systems
  - ❑ Environmental safety (staff, service users and other stakeholders)
  - ❑ Human Resource Management
  - ❑ Training and Professional Development
  - ❑ Service user access, eligibility criteria, service entry and exit
  - ❑ Information to be provided to service users (service agreement, privacy, feedback and complaints, rights and responsibilities)
  - ❑ Assessment, planning and review of service user needs
  - ❑ Service user health and wellbeing, independence, maintaining family/community
  - ❑ Privacy, dignity and confidentiality
  - ❑ Feedback and complaints
  - ❑ Advocacy

Example checklist for implementing a quality system (continued):

- ✓ Quality Cycle implemented
- ✓ Corrective action system:
  - ❑ Service user complaint process
  - ❑ General feedback processes
  - ❑ Incident/accident reporting system
  - ❑ Hazard identification system
  - ❑ Staff grievance/disciplinary process
  - ❑ Staff appraisal process
- ✓ Supporting documentation:
  - ❑ Opportunity for improvement forms
  - ❑ Corrective action forms
  - ❑ Quality Improvement Plan
- ✓ Document Control System

SECTION

three

Service Provider Guide to Self-Assessment

TABLE OF CONTENTS

Tables

Figures

The *Service Provider Guide to Self Assessment* is for use by service providers, particularly staff responsible for quality, management and/or leading the self-assessment process in their organisation.

The Guide is structured around the following content:

Section	Expected Outcome and Guide to requirements
Introduction	*Discusses the background to the guide and the quality framework; the purpose of the guide; and how the guide is structured.*
Overview of the Quality Framework	*Explains the quality framework, including the Standards and the review process.*
Completing the self-assessment	*This chapter explains the layout of the tool and provides instructions for completing each section of the tool and developing an action plan, where applicable.*
Evidence	*Introduces the concept of evidence and what constitutes acceptable evidence. It discusses different types of evidence such as documentation, observation and interviews.*
Identifying Evidence Examples	*Talks through the types of evidence a service may be able to produce to demonstrate how they meet each outcome.* *Evidence examples are given for each expected outcome with reference to the evidence source (document review, interview and/or observation), as applicable.*

1. Introduction

1.1 Background

A Quality Framework has been developed for the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (the Program).

The Quality Framework was developed in consultation with service providers.

The purpose of the Quality Framework is to support and monitor aged care services funded by the Program. The Quality Framework establishes a baseline set of culturally appropriate standards for the provision of aged care services to aged care recipients. It forms the basis of the Department's quality assurance monitoring for the Program and aims to assist service providers to continually improve their services.

The Quality Framework includes:

- The Quality Standards
- The Review Process and Quality Improvement Cycle
- Supporting Guides.

1.2 Purpose of this Guide?

The purpose of this Guide is to help service providers complete a self-assessment of their organisation. The self-assessment measures the organisation's performance against the quality Standards.

That is, self-assessment involves an organisation looking at how it does things, what it achieves and how it measures up against an agreed set of standards. During the process, an organisation's strengths, weaknesses and opportunities for improvement are identified.

Service provider completion of a self-assessment every second year is a requirement of the Quality Framework.

Both the Standards and the Review Process and Quality Improvement cycle are explained in summary in this Guide. It is necessary to understand these elements to be able to complete the self-assessment.

The guide *Understanding Quality and Continuous Improvement* at section 2 provides detailed information about the Quality Framework and may be used by service providers as:

- an induction resource which introduces the Quality Framework
- an induction resource to Continuous Quality Improvement. For example, prompts and exercises about Quality are included which a Manager could adopt to involve staff in quality activities.

1.3 What is in this Guide?

This Guide includes:

- Introduction
- Overview of the Quality Framework
- Completing the Self-assessment
- Understanding Evidence
- Identifying Evidence Examples.

2. The Quality Standards

2.1 Structure of the Standards

Details of each of the Standards and Expected Outcomes are provided on the following pages.

Figure 2.1 illustrates how the Quality Standards work together as an interconnected hierarchy of overarching principles, standards, expected outcomes and guiding requirements as follows:

The two overarching principles of Cultural Safety and CQI:

- The dotted lines that frame and create linkages within the picture represent **Cultural Safety** and **Continuous Quality Improvement** as key elements of the standards.

The two Standards (large circles):

- **Care Delivery and Information** is about the steps involved in directly providing care to people
- **Management and Accountability** is about support systems and processes

Expected Outcomes (small circles):

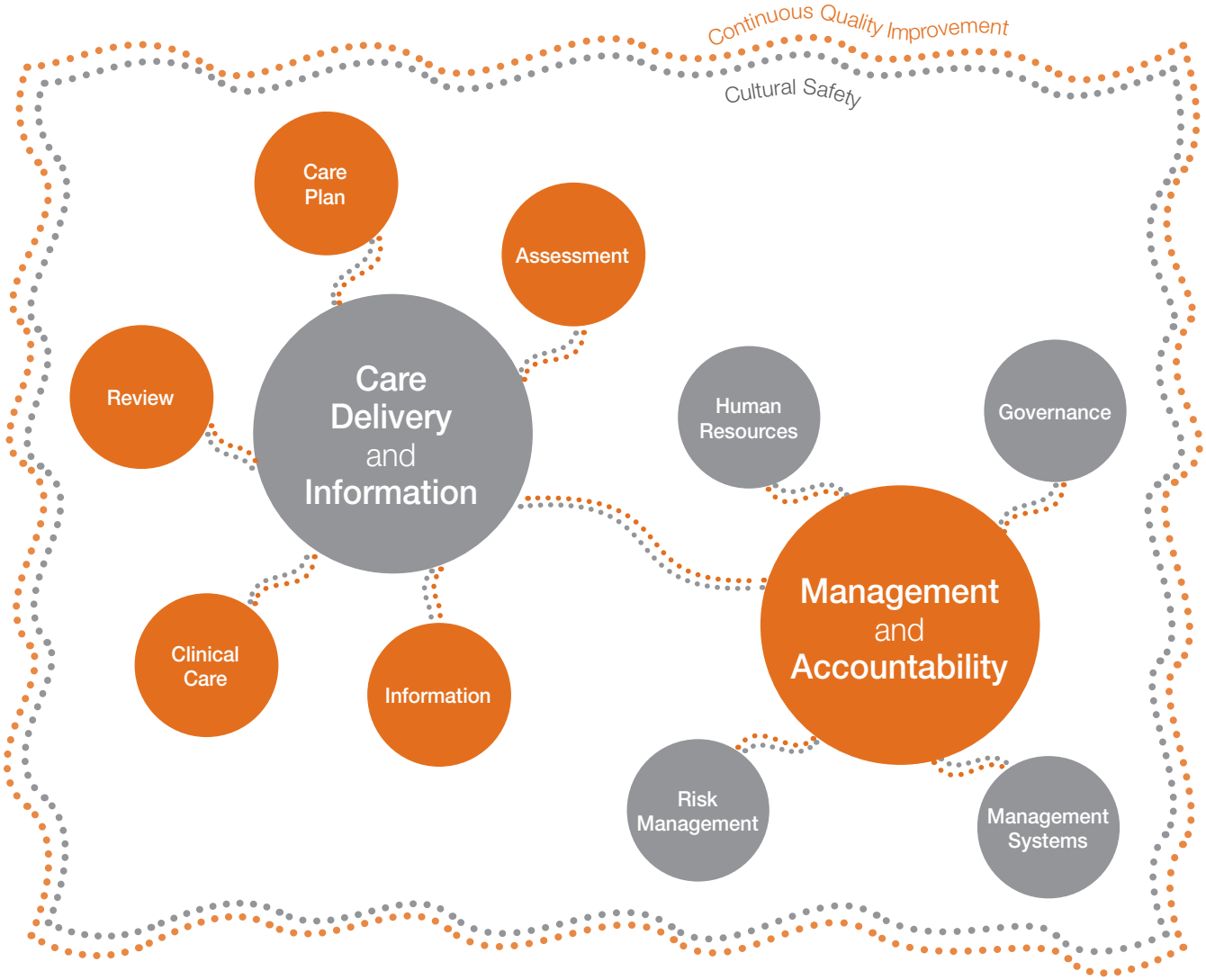
For each Standard there are Expected Outcomes - these are the results to be achieved.

- **Care Delivery and Information**: Assessment, Care Planning, Review, Clinical Care, and Information.
- **Management and Accountability**: Governance, Management Systems, Risk Management, and Human Resources

Guide to requirements (not pictured):

The *Guide to requirements* are explained in *Chapter 5 – Identifying Evidence Examples* which includes examples of how service providers can show that they are meeting the Expected Outcomes, i.e. what evidence is needed.

Figure 2.1: Picture of Quality Standards



The following figures are plain English versions of the Standards that service providers could give to service users and community members.

Figure 2.2: Picture of Quality Standard One

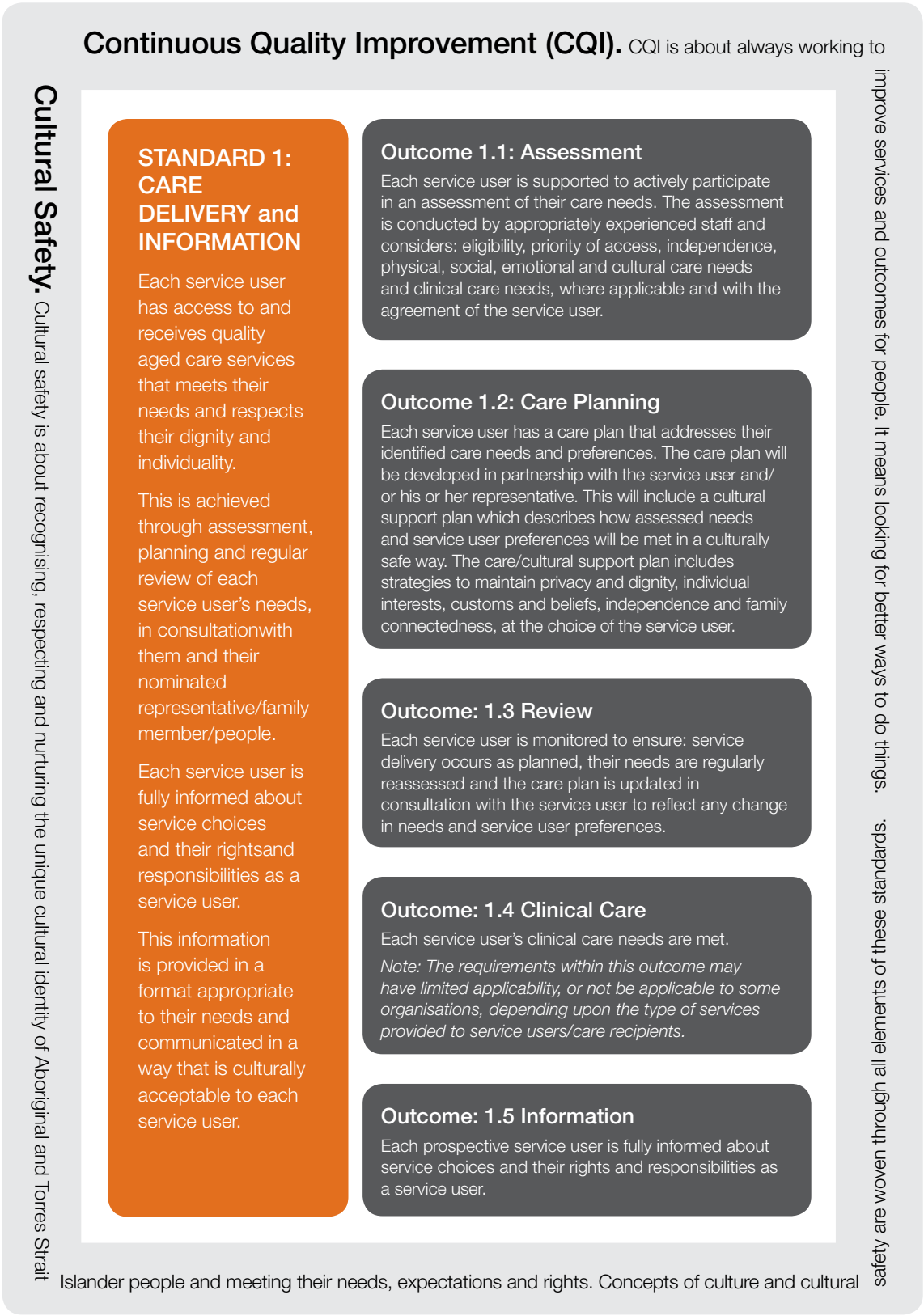


Figure 2.3: Picture of Quality Standard Two

The figure below is a plain English version of the Standards that services could give to service users and community members.

Figure 2.4: Plain English Standards

Table 3 1: Standards, Expected Outcomes, Guide to requirements

Standard	Expected Outcome and Guide to requirements
1. Care Delivery and Information *Each service user has access to and receives quality aged care services that meet their needs and respects their dignity and individuality.* *This is achieved through assessment, planning and regular review of each service user's needs, in consultation with them and their nominated representative/family member/people.* *Each service user is fully informed about service choices and their rights and responsibilities as a service user.* *This information is provided in a format appropriate to their needs and communicated in a way that is culturally acceptable to each service user.*	**1.1 Assessment** Each service user is supported to actively participate in an assessment of their care needs. The assessment is conducted by appropriately experienced staff and considers: eligibility, priority of access, independence, physical, social, emotional and cultural care needs and clinical care needs, where applicable and with the agreement of the service user. **Guide to requirements:** The assessment includes each service user's: • life story • medical history • functional, cognitive and sensory status • nutritional status/needs • personal care needs • special care needs • clinical risk factors. and where applicable: • assessment of the resident's ability to smoke safely, including the need for and level of supervision **1.2 Care Planning** Each service user has a documented care plan that addresses their identified care needs and preferences. This includes a cultural support plan which describes how assessed needs and service user preferences will be met in a culturally safe way. The care/cultural support plan includes strategies to maintain privacy and dignity, individual interests, customs and beliefs, independence and family connectedness. **Guide to requirements:** The care plan addresses: • all assessed needs and preferences of the service user • what action is to be taken to meet assessed needs and preferences of the service user in a culturally safe and respectful way • who is responsible for what care (including family members and/or other providers) • when and where care is to be received (ensuring a culturally safe environment). **1.3 Review** Each service user is monitored to ensure: service delivery occurs as planned, their needs are regularly reassessed and the care plan is updated in consultation with the service user to reflect any change in needs and service user preferences. **Guide to requirements:** The care plan addresses: • occurs at least six monthly and where service user needs change • identifies progress against planned goals/actions • results in any change in needs and preferences being documented in the care plan.

Standard	Expected Outcome and Guide to requirements
1. Care Delivery and Information *Each service user has access to and receives quality aged care services that meet their needs and respects their dignity and individuality.* *This is achieved through assessment, planning and regular review of each service user's needs, in consultation with them and their nominated representative/family member/people.* *Each service user is fully informed about service choices and their rights and responsibilities as a service user.* *This information is provided in a format appropriate to their needs and communicated in a way that is culturally acceptable to each service user.*	**1.4 Clinical Care** Each staff member works within their scope of practice. Each service user's clinical care needs are met. **Guide to requirements:** Clinical care needs include, as applicable: • special care needs • safe and effective management and administration of medication • effective assessment, treatment and management of pain • access to specialised palliative care services • access to other specialist health care/allied health services • functional care • cognitive care • sensory care • nutritional care • personal care. *Note: The requirements within this outcome may have limited applicability, or not be applicable to some organisations.* **1.5 Information** Each prospective service user is fully informed about service choices and their rights and responsibilities as a service user. **Guide to requirements:** • information about available services and eligibility to receive services is clearly documented. This information is communicated in a manner that is appropriate in format and culturally acceptable to each prospective service user to support choice and decision making • each service user is offered a service agreement by the service provider which sets out the terms and conditions of the service/s to be received and the service user's rights and responsibilities[1] • the service provider ensures that the content of the service agreement is fully explained to each service user (and/or their representative) in a culturally acceptable way prior to entering into the agreement • a process is in place to enable service users to be represented by an advocate of their choice.

1 As per National Aboriginal and Torres Strait Islander Flexible Aged Care Program Service Provider Guidelines, 5. Care Recipient Rights and Responsibilities and 5.3 A Care Recipient has the right to security of tenure, in particular.

Standard	Expected Outcome and Guide to requirements
2: Management and Accountability *The service provider has implemented systems and processes which ensure the organisation is well managed and services are continually improved.* *This results in the delivery of culturally safe, quality services that are responsive to the needs of each service user, their representatives, staff and other stakeholders.*	**2.1: Governance** The service provider has clear and effective governance processes in place. **Guide to requirements:** • Board/Committee members have appropriate skills, knowledge and experience to carry out their role • Board/Committee members have an understanding of, and promote culturally safe service delivery • the roles and responsibilities of the Board/Committee are documented • meeting minutes and other records evidence that the Board/Committee carry out their roles and meet their responsibilities • planning occurs to set strategic directions and promote the delivery of culturally safe quality aged care services • the service actively engages with and consults the community about the services available and reflects this in service planning.
	2.2: Management Systems The service provider has clear and effective management systems and practices in place. **Guide to requirements:** • the service provider understands and complies with the funding agreement, including the service provider guidelines • the service provider understands and complies with regulatory and relevant legislative requirements • management and staff accountabilities and delegations are documented, relevant to their roles • service planning and development occurs and aligns with the organisation's strategic directions • financial, human and physical resources are allocated and used in ways that support quality care services that are delivered in a culturally safe and comfortable environment • information management systems are in place to ensure the service users' right to privacy, dignity and confidentiality in relation to the use of and collection of personal information • information management systems are in place to ensure the safe and secure storage of documents and records, and enable effective use of information to meet the needs of each service user, staff, management and regulatory bodies • a process to manage positive feedback, complaints and allegations is in place which is effective, accessible, and culturally acceptable to stakeholders • the service provider works in partnership with other organisations to maximise access to services and/or enhance service delivery • a continuous quality improvement program is in place to monitor and improve: > the care and services provided to service users, and > the management systems and practices of the service provider.

Standard	Expected Outcome and Guide to requirements
2: Management and Accountability *The service provider has implemented systems and processes which ensure the organisation is well managed and services are continually improved.* *This results in the delivery of culturally safe, quality services that are responsive to the needs of each service user, their representatives, staff and other stakeholders.*	**2.3: Risk Management** A risk management framework is in place to ensure the safety of service users, staff and other stakeholders, and that quality care services are delivered. **Guide to requirements:** • effective financial management processes are in place to ensure the service is, and remains, financially viable. Financial risks are identified and managed in an appropriate manner • an asset management program is in place • purchased goods and services are of a standard that ensure the delivery of quality aged care services • procedures are in place for the management of emergencies including natural disasters • effective infection control procedures are implemented • procedures are in place to identify and address potential risks associated with: > the physical environment > chemicals or dangerous goods > laundry services > kitchen and food handling > cleaning > fire equipment > open fire supervision • procedures are in place to identify and manage risk related to service delivery.
	2.4: Human Resources Effective staff recruitment and retention ensure that service users' needs are met. **Guide to requirements:** • recruitment and retention processes ensure sufficient staffing levels are maintained at all times for the delivery of safe services • services are provided by appropriately skilled staff that have an understanding of the cultural needs of the key stakeholders, including service users • all staff and volunteers have a current police check that complies with the funding agreement • staff and volunteers are provided with training and development activities relevant to their role • an effective performance appraisal process is implemented for staff and volunteers.

3. Completing the Self-assessment

Self-assessment enables a service provider to:

- confirm areas where the service is meeting the standards
- identify gaps in current systems and processes that do not meet the standards
- plan action to address any identified gaps in systems and processes, prior to the on-site review being conducted
- identify additional opportunities for improvement, even where the standards are met, to support continuous improvement.

The self-assessment tool assists you to conduct a self-assessment of your service. It records the things your organisation is currently doing, and information about the systems it has in place. It enables your organisation to identify where there are gaps in your systems and processes.

During the self-assessment process there may be opportunities to address these gaps, such as writing a policy or procedure to describe practice. Often the self-assessment process assists organisations to identify priorities for action.

3.1 Planning for Self-assessment

Before the self-assessment process can begin, planning should be done to ensure the best use of staff time and to anticipate the impact of the process on service delivery. Realistic timeframes must be allowed.

This may be a few weeks for service providers familiar with other quality standards and regulatory/accreditation frameworks that have established systems and processes in place. However, those services that have not had this experience may need to allow a longer time to complete this process.

Issues to consider in the planning phase include:

- how is the process going to be managed?
- who will be involved?
- what implications will this have for service delivery?
- who needs training or other information?
- who will deliver the training?
- when and how will the training be delivered?
- how will the organisation get feedback from stakeholders?
- how will the evidence be documented?
- is there another quality management system or accreditation/certification program already in place?

Involving the staff who deliver the service is a valuable way of learning what is really done within the service and whether policy and procedures are directing the activities of the staff. It also becomes a learning and reflection process for the service and individual staff members about self-assessments.

Service users, their families, visiting health professionals and other stakeholders should contribute by giving feedback and suggestions, which will also help them learn about how the service operates. Planning how to gather feedback from the various people will be important, particularly if collecting formal feedback is not routine.

Irrespective of your planning approach, by the end of the process your service will have investigated each of the expected outcomes under the Standards and decided what evidence you will produce to demonstrate compliance.

You will have a completed self-assessment tool and a list of identified evidence (including actual documentation) for each section of the self-assessment tool.

Regular self-assessment ensures up-to-date information about organisational performance is available to stakeholders. The results of self-assessment can be used to plan improvement activities, and in turn the results of these activities can be evaluated and fed into the next Quality Improvement Plan. In this way the improvement process continues.

Every time your service self-assesses against the Standards it will have checked:

- whether the service is meeting each of the expected outcomes
- what service users are gaining from the care and services provided
- if what is intended to happen, actually happens (such as whether policies and procedures are followed)
- if the effectiveness of past improvements has been evaluated
- if planned improvements are being managed and implemented.

The following section explains the lay out of the self-assessment tool and instructions for completing the tool.

Once you have read through the following section you will be ready to start the self-assessment.

3.2 The self-assessment tool

The self-assessment tool at **Appendix 1** includes:

- an Assessment Matrix
- a Self-assessment Report and Quality Improvement Actions required against each Expected Outcome of the two Quality Framework Standards
- a Self-assessment Checklist.

It is the same tool that is used by the Quality Review Team at the on-site review. It is also the basis for the draft report sent to your organisation after the on-site review, and so what becomes your Quality Improvement Plan for the year following the on-site review.

The Assessment Matrix is in the first section of the tool. The Assessment Matrix is a summary of the findings of the self-assessment, and allows services to identify their organisation's overall performance against the standards.

The Assessment Matrix should be completed at the end of the self-assessment. Completing the matrix requires inserting a rating against each outcome, reflecting the self-assessment findings. The following ratings apply:

- ***Met:*** written and verbal evidence clearly demonstrates that your service meets all the requirements of the expected outcome
- ***Part Met:*** written and verbal evidence clearly demonstrates that your service only meets part of the requirements of the expected outcome
- ***Not Met:*** written and verbal evidence clearly demonstrates that your service does not meet the requirements of the expected outcome
- ***Not Applicable:*** a not applicable rating may apply, for example, where your service does not provide clinical care to service users (refer to expected outcome 1.4).

Once each expected outcome has been rated, the overall Assessment Result can be determined. The Assessment Result is applied as follows:

- ***Met:*** all the requirements of each expected outcome have been met
- ***Part Met:*** the requirements of one or more expected outcomes have not been fully met
- ***Not Met:*** the requirements of no expected outcomes have been met.

The second section of the tool is designed to enable service providers to work through each of the expected outcomes in the two Standards and document the following into a self-assessment report:

- *Evidence examples:* list the evidence your service can provide to demonstrate compliance with each expected outcome and its requirements
- *Self-assessment Findings:* provide a brief summary of findings that describes why your service meets the expected outcome or describe the identified gap where the expected outcome is part met or not met
- *Self-assessment Ratings:* rate your service's performance against the expected outcome as met, part met, not met, or not applicable
- *Quality Improvement Plan:* must be developed where you decide an outcome is not fully met.

Improvement plans would normally include the following detail:

- the improvement action that is planned
- the name and position of the person responsible for completing the action
- the timeframe within which action is to be completed
- the date that the action is completed.

Examples of the type of improvement actions that may be required are:

- develop and introduce new or additional policies and or procedures
- review current policies and or procedures
- change orientation and or staff training programs
- further develop written information for service users
- introduce new or additional quality improvement processes, for example:
  - > develop an internal audit schedule
  - > increase opportunities for stakeholders to provide feedback
  - > improve processes for analysing, reporting and acting upon service user feedback.

Service providers are also encouraged to document any opportunities for improvement you identify even where the outcome is fully met. These are considered to be *optional actions* to promote continuous quality improvement and should also be documented in the Quality Improvement Plan.

A Checklist is included at the back of the tool to assist service providers in reviewing the completed self-assessment prior to submitting it.

Three examples of (parts of) completed self-assessments are at **Appendix 2**.

4. Understanding Evidence

4.1 Evidence explained

The self-assessment report by the service provider records their findings about how well they are meeting the Quality Framework standards.

The Quality Review Team's desk top review and on-site visit verifies the service's self-assessment. That is, the reviewers look at all evidence given to them by the service provider and decide if the service meets the Quality Framework standards.

As such it is important that this Guide is clear about what evidence is. *Evidence* is information that confirms or proves something. Evidence can include something that is *written*, something that is seen or something that is *heard*.

Evidence must be *relevant*, *reliable* and *adequate*. That is:

- *relevant* evidence clearly relates to the issue at hand or the question being asked
- *reliable* evidence is from a source or person accepted as having relevant knowledge and/or experience in that area
- *adequate* evidence provides enough information to fully answer the question being asked.

4.2 What evidence is acceptable?

Evidence is usually thought to be most reliable when it can be confirmed by more than one process or piece of information.

The evidence that services have will differ and may depend upon the size and structure of the organisation, the services provided and the staff and service user group. However, to just say that something is done, or describe a system or process that is in place, is not enough evidence to show that a standard is met.

5. Identifying Evidence Examples

5.1 Evidence sources

Evidence sources include:

- documentation
- interviews
- observation.

5.1.1 Documentation

You can use any written information that shows you meet the standards. Think about the types of written information that your service has. Documentation might include:

- stakeholder information such as: *brochures*, *pamphlets* or other written material given to service users or other stakeholders, *newsletters, photographs*, or *posters*
- documents read by staff such as: *policies, procedures, guidelines, meeting minutes, memos, newsletters*
- forms used by staff such as: *referrals, intake and assessment forms, care plans, attendance records, feedback and complaint, improvement forms*
- records: *service user records, staff records, training records, feedback, complaint and incident/accident records, Quality Improvement Plans*
- reports: *quality activities, quality reviews, financial reports, annual reports, reports to the Board/Committee.*

5.1.2 Interviews

Interviews enable information to be obtained verbally from a range of relevant stakeholders. They can be used to confirm written evidence.

Think about your staff and service user group and community:

- *who has knowledge in what area/s?*
- *who is best to speak about a particular service area or program?*
- *are there service users, their representatives, or community members who would be happy to be interviewed?*

Interviewees could include: managers, Board/Committee members, staff, service users, their representatives and community members.

Different people will have knowledge in different areas. For example, a senior manager might have broad knowledge across a number of program areas. A program manager would be expected to have good knowledge of their program area. Someone involved in directly delivering services to service users may have knowledge of many procedures relating to different service activities.

5.1.3 Observation

Observation of staff processes and the physical environment can be used to confirm verbal and/or written evidence.

For example, observation could be used to confirm:

- is there easy access to the centre/building?
- are there appropriate safety and security measures are in place?
- is the service environment culturally appropriate?
- are service users' privacy, dignity and confidentiality maintained?

5.2 Evidence gathering – stakeholder feedback

A key focus is being able to show that you have quality systems in place which include processes to talk to and receive feedback from all relevant stakeholders, on an ongoing basis.

Stakeholder feedback is vital to help your organisation assess the quality and appropriateness of the services you provide to service users. Think about the ways that your organisation seeks feedback from service users and other stakeholders and how you can demonstrate this.

There are many options for gathering feedback from service users, both formal and informal.

These may include: *surveys, focus groups and comments, suggestions and complaints processes.*

5.3 Evidence examples

The following pages are intended to assist service providers to identify evidence examples from your organisation.

The examples are not prescriptive – they are prompts to assist you to think about ways your organisation meets the Standards

The evidence examples / prompts are set out in terms of the Standards, Expected Outcomes and the Guide to requirements. Setting out the evidence examples in these terms should also assist you to become more familiar with the Standards themselves.

In the following pages the '*What's this about?*' section further explains each Expected Outcome.

Standard 1: Care Delivery and Information

Each service user has access to and receives quality aged care services that meet their needs and respects their dignity and individuality. This is achieved through assessment, planning and regular review of each service user's needs, in consultation with them and their nominated representative/family member/people.

Each service user is fully informed about service choices and their rights and responsibilities as a service user. This information is provided in a format appropriate to their needs and communicated in a way that is culturally acceptable to each service user.

Standard 1: Care Delivery and Information

Expected Outcome: 1.1 Assessment

Each service user is supported to actively participate in an assessment of their care needs. The assessment is conducted by appropriately experienced staff and considers: eligibility, priority of access, independence, physical, social, emotional and cultural care needs and clinical care needs, where applicable and with the agreement of the service user.

Guide to requirements: The assessment includes each service user's:

- life story
- medical history
- functional, cognitive and sensory status
- nutritional status/needs
- personal care needs
- special care needs
- clinical risk factors.

and where applicable:

- assessment of the resident's ability to smoke safely, including the need for, and level of, supervision.

What's this about?

Assessment is about making sure that people who want a service and qualify for the service, get the right service to meet their identified needs. The aim of the assessment is to learn from the service user and/or their representative about that person and their care needs.

The assessment tool should include all areas that are listed in the Guide to requirements.

Learning about the service user's 'Life Story' is an important starting point. The 'Life Story' should collect information about: cultural background, country and language group; family/community connectedness and support and living arrangements; cultural customs, beliefs, needs/practices; preferred leisure interests and activities. This information will form the basis of a cultural support plan and determine the services approach to providing any care to that service user in a culturally safe way.

Expected Outcome: 1.1 Assessment (continued)

Documented evidence could include:

✓ Policies and procedures about:

- eligibility
- priority of access
- waiting lists
- service user assessment including who is responsible for assessment
- identifying the service users representative/s, where applicable
- refusing or ending a service
- receiving and making referrals
- cultural safety – assessment
- service quality and continuous quality improvement.

✓ Forms, checklists or other paperwork that is filled out from the time of enquiry or referral and shows how eligibility and priority of access is established

✓ Completed assessment tools that include the information listed under the Guide to requirements

✓ Forms, checklists or other paperwork that evidence the assessment occurred in consultation with the service user and/or their representative

✓ Records show that staff who assess service users have the necessary experience

✓ Records of quality activities such as:

- service user file audit results
- feedback from service users about their entry to the service.

Evidence at interview could include:

Staff responsible for intake and assessment explaining these processes from the time of enquiry or referral. This could include talking about:

- how a prospective service user accesses the service
- intake processes
- how and when an assessment is arranged
- what the service user is told about assessment
- who participates in the assessment
- how staff go about making sure each service user's independence, physical, social, emotional, clinical and cultural care needs are identified in a culturally safe way
- how and when service users are told about the outcome of the assessment
- what service users are told about when service will commence.

Standard 1: Care Delivery and Information

Expected Outcome: 1.2 Care Planning

Each service user has a documented care plan that addresses their identified care needs and preferences. The care plan will be developed in partnership with the service user and/or his or her representative. This will include a cultural support plan which describes how assessed needs and service user preferences will be met in a culturally safe way. The care/cultural support plan includes strategies to maintain privacy and dignity, individual interests, customs and beliefs, independence and family connectedness, at the choice of the service user.

Guide to requirements: Each service user has a copy of the care plan which addresses:

- all assessed needs and preferences of the service user
- what action is to be taken to meet assessed needs and preferences of the service user in a culturally safe and respectful way
- who is responsible for what care, (staff with the necessary skills and qualifications, family members and/or other providers)
- when and where care is to be received (ensuring a culturally safe environment).

What's this about?

A care plan must detail all action to be taken by the service to meet the service user's assessed needs and include a cultural support plan. If looking at the completed assessment and the care plan together, the care plan should clearly show the steps to be taken to address each issue or need identified in the assessment. In other words, assessment identifies the need and the care plan details the service/s to be provided to meet that need.

The care plan also details who is responsible for delivering that care, and when and where this will occur.

Documented evidence could include:

✓ Policies and procedures about:

- service user care planning including who is responsible for care planning
- service user involvement in planning
- identifying the service users representative/s, where applicable
- cultural safety - care plans and cultural support plans

Expected Outcome: 1.2 Care Planning (continued)

- ✓ Service quality and continuous improvement: The care plan and cultural support plan tool used by the service
- ✓ Completed care plans that include all information listed under the Guide to requirements
- ✓ Forms, checklists or other papers that evidence the care plan has been developed in consultation with the service user and that they have agreed to the plan and received a copy of the plan
- ✓ Records that show staff who develop service user care plans have the necessary experience
- ✓ Records of quality activities such as:
  - service user file audit results
  - feedback from service users about their involvement in care planning and their level of satisfaction with the service/s provided.

Evidence at interview could include:

- ✓ Staff responsible for developing care plans and cultural support plans explaining these processes. This could include talking about:
  - expected timeframes between assessment and development of a care plan
  - what the service user is told about care planning
  - who is involved in care planning
  - how staff go about making sure that each service user has a care plan that includes a cultural support plan
  - how staff go about making sure that the care plan/cultural support plan addresses all identified needs relating to independence, physical, social, emotional, clinical and cultural care
  - processes to evidence that the service user agrees with the care plan
  - processes to evidence that the service user receives a copy of the care plan.

Standard 1: Care Delivery and Information

Expected Outcome: 1.3 Review

Each service user is monitored to ensure: service delivery occurs as planned, their needs are regularly reassessed and the care plan is updated in consultation with the service user to reflect any change in needs and service user preferences.

Guide to requirements: Service user and care plan review:

- occurs at least six monthly and where service user needs change
- identifies progress against planned goals/actions
- results in any change in needs and preferences being documented in the care plan.

What's this about?

Regular review of each service user is important for a number of reasons. Review is a way to check that the service that was planned, is being delivered as planned, and is meeting the service user's needs.

Review must occur regularly because service users' needs and preferences often change. Regular review should occur at least six monthly and where there is a change in needs between six monthly reviews. This is to make sure to make sure that any change in needs and preferences is identified and the care plan is updated to include action to meet these needs.

Change could mean the service user has increased care needs, or decreased care needs where a planned action or goal has been met and is no longer relevant for the service user. In some cases, care plan review might identify that although care needs may not have changed, the action being taken/service delivered might not be effective. Therefore the approach or action may need to be changed.

Documented evidence could include:

✓ Policies and procedures about:

- service user care plan review including who is responsible for the reviews and how often they are to occur
- service user involvement in care plan review
- identifying the service users representative/s, where applicable
- cultural safety – review of care plans and cultural support plans
- service quality and continuous quality improvement

Expected Outcome: 1.3 Review (continued)

- ✓ The care plan and cultural support plan tool used by the service which has the provision to record when review is due and has occurred
- ✓ Completed care plans that show review is regularly scheduled and has occurred
- ✓ Forms, checklists or other paperwork that evidence the care plan has been reviewed in consultation with the service user and that they have agreed to the reviewed plan and received a copy of the plan
- ✓ Records that show staff who review service user care plans have the necessary experience
- ✓ Records of quality activities such as:
  - service user file audit results
  - feedback from service users about their involvement in care plan reviews.

Evidence at interview could include:

- ✓ Staff responsible for the review of care plans and cultural support plans explaining these processes. This could include talking about:
  - how often care plan review occurs
  - what the service user is told about care plan reviews
  - who is involved in care plan reviews
  - how staff go about making sure that each service user's care plan is reviewed regularly in a culturally safe way
  - how staff go about making sure that the reviewed care plan/cultural support plan addresses all identified needs relating to independence, physical, social, emotional, clinical and cultural care
  - processes to evidence that the service user agrees with the reviewed care plan
  - processes to evidence that the service user receives a copy of the reviewed care plan.

Standard 1: Care Delivery and Information

Expected Outcome: 1.4 Clinical Care

Each service user's clinical care needs are met.

Guide to requirements:

Each staff member works within their scope of practice.

Clinical care needs include, as applicable:

- special care needs
- safe and effective management and administration of medication
- effective assessment, treatment and management of pain
- access to specialised palliative care services
- access to other specialist health care/allied health services
- functional care
- cognitive care
- sensory care
- nutritional care
- personal care.

Note: The requirements within this outcome may have limited applicability or not be applicable to some organisations, depending upon the services provided.

What's this about?

Clinical care is care that is ***provided*** or ***supervised*** by a registered practitioner, that is, a Doctor, Registered nurse or enrolled nurse. Where clinical care cannot be ***provided*** by a registered practitioner, and care is delivered by staff and/or family members it must be under the supervision of a registered practitioner. In these circumstances, the staff and family members must have received appropriate training and have been assessed as being competent to provide this care.

The different types of clinical care needs are listed above in the Guide to requirements and are explained below:

Special care needs: might include wound management, diabetes management, dialysis, respiratory support or catheter care.

Expected Outcome: 1.4 Clinical Care (continued)

What's this about? (continued)

Safe and effective management and administration of medication: involves responsibility for controlling and giving medicines prescribed by a health professional authorised to prescribe for example a general practitioner or nurse practitioner, provided there are no legal restrictions on doing so. Control of medication includes safe and secure storage and ensuring that medicines are accessed only by those who are authorised to do so. Administration of medication involves making sure that: there is a current order for the medicine from a health professional authorised to prescribe.

Effective assessment, treatment and management of pain: includes making sure that pain is assessed, monitored and reviewed to identify pain location, type, frequency, severity and impact on the service user's mobility and general health and well-being. Strategies to manage the pain (medical and non-medical) and evaluate pain are documented in the care plan; pain management strategies are planned and implemented by qualified staff.

Access to specialised palliative care services: includes making sure that there is a process to assess service user's palliative care needs; strategies to meet service user palliative care needs are documented in the care plan; palliative care is planned and delivered by qualified staff; families are supported by the service provider to assist in the care of their family member.

Access to other specialist health care / allied health services: includes making sure that there is a process to facilitate access and referral of service users to specialist health care/ allied health services, when required.

This would require the service provider to: have knowledge of other relevant service providers; keep information about other relevant service providers such as contact details, information/brochures or other resources.

Services might include: specialist medical or nursing services; allied health services such as speech therapy or a dietician; or services to assist in the management of medication, continence and pain management, behaviour and communication, nutrition and hydration or mobility and dexterity.

Functional care: includes making sure that the service user's functional care needs related to self-care, independence, toileting, mobility and other activities of daily living are assessed; strategies to meet functional care needs are documented in the care plan; functional care is planned and delivered by appropriately qualified staff.

Cognitive care: includes making sure that the service user's cognitive state including their level of cerebral functioning and behaviour are assessed; strategies to meet cognitive care needs are documented in the care plan; cognitive care is planned and delivered by appropriately qualified staff.

Expected Outcome: 1.4 Clinical Care (continued)

What's this about? (continued)

Sensory care: includes making sure that the service user's sensory care needs including eye, ear, nose, taste and skin are assessed; strategies to meet sensory care needs (including the provision and maintenance of any sensory aids) are documented in the care plan; sensory care is planned and delivered by appropriately qualified staff.

Nutritional care: includes making sure that the service user's nutritional care needs are assessed; strategies to meet nutritional care needs (including requirements for dietary preferences, restrictions, modifications or assistance) are documented in the care plan; nutritional care is planned and delivered by appropriately qualified staff.

Personal care: includes making sure that the service user's personal care needs are assessed; strategies to meet personal care needs (including assistance with eating, washing, dressing, undertaking dental and oral care, and sleep) are documented in the care plan; personal care is planned and delivered by appropriately qualified staff.

Documented evidence could include:

✓ Policies and procedures about:

- working within scope of practice
- what is clinical care
- planning clinical care
- who is responsible for delivering clinical care
- service user involvement in clinical care
- family or representative involvement in clinical care
- identifying the service user's representative/s, where applicable
- cultural safety - care plans and cultural support plans: delivering culturally safe clinical care

✓ The care plan used by the service has the provision to record all areas of clinical care needs as listed in the Guide to requirements

✓ Completed care plans include all relevant clinical care needs

✓ Forms, checklists or other paperwork that evidence that clinical care is planned and delivered in consultation with the service user

✓ Records that show staff who plan and deliver clinical care have the necessary experience

✓ Records of quality activities such as:

- service user file audit results
- feedback from service users about the clinical care they receive

Expected Outcome: 1.4 Clinical Care (continued)

Evidence at interview could include:

✓ Staff responsible for planning and delivering clinical care explaining these processes. This could include talking about:

- how clinical care planning occurs
- who is involved in planning and delivering clinical care
- what the service user is told about clinical care
- how staff go about making sure that the care plan addresses all identified clinical care needs in a culturally safe way
- how staff go about making sure that each service user's clinical care needs are reviewed regularly
- processes to evidence that the service user agrees with the reviewed care plan
- processes to evidence that the service user receives a copy of the reviewed care plan.

Standard 1: Care Delivery and Information

Expected Outcome: 1.5 Information

Each prospective service user is fully informed about service choices and their rights and responsibilities as a service user.

Guide to requirements:

- information about available services and eligibility to receive services is clearly documented. This information is communicated in a manner that is appropriate in format and culturally acceptable to each prospective service user to support choice and decision making
- each service user is offered a service agreement by the service provider which sets out the terms and conditions of the service/s to be received and the service user's rights and responsibilities[2]
- the service provider ensures that the content of the service agreement is fully explained to each service user (and/or their representative) in a culturally acceptable way prior to entering into the agreement
- a process is in place to enable service users to be represented by an advocate of their choice.

What's this about?

This is about making sure that prospective service users are given all relevant information about the service to help them with their choices and decision making. This information must be given and explained in a way that each service user can understand the service choices and the rights and responsibilities they have. Service providers will need to identify when information needs to be given in an alternative format and/or an interpreter may be required to ensure the service user fully understands the information they are given.

This information should include an explanation of how the organisation decides who can receive a service and the services that are available.

If the prospective service user qualifies for a service they must be offered a service agreement. The service agreement must set out all the related terms and conditions of the service to be provided.

Prospective service users must also be told about all their rights and responsibilities. They should also be informed about their right to have an advocate represent them in any dealings with the service provider, from the first time of contact.

2 As per National Aboriginal and Torres Strait Islander Flexible Aged Care Program Service Provider Guidelines, 5. Care Recipient Rights and Responsibilities and 5.3 A Care Recipient has the right to security of tenure, in particular.

Expected Outcome: 1.5 Information (continued)

Documented evidence could include:

- ✓ Policies and procedures about:
  - eligibility
  - priority of access
  - waiting lists
  - assessment
  - offering service
  - refusing or ending a service
  - using an interpreter
  - information to be given to prospective service users
  - rights and responsibilities
  - identifying the service users representative/s, where applicable
  - service agreements
  - cultural safety - communicating in a culturally safe way
  - service quality and continuous improvement
- ✓ Information about the service is recorded in a culturally acceptable way
- ✓ The information provided to service users includes all information listed under the Guide to requirements
- ✓ Forms, checklists or other paperwork that evidence that information about the service is provided and explained to each service user in a culturally acceptable way
- ✓ Records of interpreter use
- ✓ The service agreement sets out:
  - the service/s to be received (emergency/planned respite, low/high care or other)
  - the duration of the service (permanent or short term)
  - the frequency of service
  - where services will be provided (residential or community based)
  - who will deliver the service
  - the date services will commence
  - the agreed fees payable and how these charges are determined
  - the care plan
  - the circumstances under which:
    - > either party can terminate the agreement
    - > the service provider can reallocate the service user's place
    - > the service provider must help the service user to access alternative care
    - > the service user may choose to suspend the provision of care

Expected Outcome: 1.5 Information (continued)

- service user rights and responsibilities including:
  - > the right to make decisions about the care to be received
  - > information and consultation
  - > protection of privacy and confidentiality
  - > comments and complaints
  - > advocacy
  - > other rights and responsibilities as a service user

✓ Records of quality activities such as:

- service user file audit results
- feedback from service users about the content and appropriateness of the information they have been given and general communication by the service.

Evidence at interview could include:

✓ Staff responsible for providing information to prospective service users explaining these processes. This could include talking about:

- what information is provided, including the format it is provided in
- when this information is provided
- who receives this information
- service user rights and responsibilities
- how staff go about making sure that each service user and/or their representative understands this information
- under what circumstances an interpreter is used
- how an interpreter service is organised
- how service user consent is obtained to use an interpreter
- how interpreter use is recorded
- processes to evidence that all service users have received all required information
- processes to evidence that all service users have been offered a service agreement
- processes to evidence that all service users have received a copy of the service agreement
- records of staff training in communicating effectively.

Observation of evidence could include looking at:

- displays of posters, brochures, forms or other information at the service in an appropriate format informing service users about:
  - > services provided
  - > their rights and responsibilities
- interpreter use.

Standard 2: Management and Accountability

The service provider has implemented systems and processes which ensure the organisation is well managed and services are continually improved.

This results in the delivery of culturally safe, quality services that are responsive to the needs of each service user, their representatives, staff and other stakeholders.

Expected Outcome: 2.1 Governance

The service provider has clear and effective governance processes in place.

Guide to requirements:

- Board/Committee members have appropriate skills, knowledge and experience to carry out their role
- Board/Committee members have an understanding of, and promote culturally safe service delivery
- the roles and responsibilities of the Board/Committee are documented
- meeting minutes and other records evidence that the Board/Committee carry out their roles and meet their responsibilities
- planning occurs to set strategic directions and promote the delivery of culturally safe quality aged care services
- the service actively engages with and consults the community about the services available and reflects this in service planning.

What's this about?

Governance means the system by which an organisation is controlled or operates. The service provider should implement corporate governance processes so that it is accountable to its stakeholders. Generally, the Board of Management/Committee of Management is responsible for governance of the organisation.

The Board/Committee is responsible for making sure that governance and management systems are in place to ensure there is effective, efficient and quality service delivery. A governance system directs the organisation's ethics, approaches to risk management, compliance, financial management and administration of all parts of service delivery. Strategic planning, including community consultation, should also be driven by the Board/Committee.

In a service funded under the Program this means Board/Committee must have skills in governance and an understanding of, and promote culturally safe service delivery. The roles and responsibilities of Board/Committee members should be well documented to ensure there are clear boundaries separating the Board/Committee's governance role from the role of management staff. There must also be processes in place to record the work the Board/Committee undertakes.

Expected Outcome: 2.1 Governance (continued)

Documented evidence could include:

✓ Policies and procedures about:

- the organisations Mission and Vision
- selection, recruitment and appointment of Board/Committee members
- induction and training of Board/Committee members
- Board/Committee members Code of Conduct/Ethics
- Board/Committee members roles and responsibilities
- Board/Committee subcommittees
- Board/Committee member evaluation
- strategic, business and operational planning including development and review of plans
- stakeholder consultation
- compliance with funding agreements
- financial management and reporting
- risk management
- fraud
- conflict of interest
- delegation of authority
- cultural safety – providing a culturally safe service
- service quality and continuous improvement
- document control.

✓ records evidencing that Board/Committee members have the required skills and a commitment to cultural safety

✓ Board/Committee member selection, recruitment and induction records

✓ Board/Committee member police checks

✓ records of Board/Committee member training in governance and management

✓ the organisation's constitution

✓ organisational chart

✓ Board/Committee meeting schedule, agenda and meeting minutes

✓ information provided to stakeholders about the Board/Committee's role

✓ Board/Committee reports

✓ records of planning activities including stakeholder consultation

✓ demographic data about the community and current service users

✓ strategic and business plans reports against organisational plans, targets and goals

Expected Outcome: 2.1 Governance (continued)

- ✓ budget, financial records and reports including acquittals to funding bodies
- ✓ financial audit records
- ✓ insurances
- ✓ a risk register
- ✓ Quality Improvement Plan
- ✓ Records of quality activities such as:
  - Board/Committee member file audit results
  - Board/Committee member evaluations
  - stakeholder feedback about governance of the organisation.

Evidence at interview could include:

- ✓ Board members talking about:
  - their skills and understanding of cultural safety
  - their selection and recruitment to the Board/Committee
  - the organisation's Mission and Vision
  - induction and access to other training
  - Board/Committee roles and responsibilities
  - service quality and continuous quality improvement
  - management roles and responsibilities
  - Board/Committee policies and procedures
  - processes for policy development, authorisation and review
  - strategic and business planning
  - their knowledge of the community and the demographic profile of service users
  - financial management and reporting
  - risk management.

Standard 2: Management and Accountability

Expected Outcome: 2.2 Management Systems

The service provider has clear and effective management systems and practices in place.

Guide to requirements:

- the service provider understands and complies with the funding agreement, including the Service Provider Guidelines
- the service provider understands and complies with regulatory and relevant legislative requirements
- management and staff accountabilities and delegations are documented, relevant to their roles
- service planning and development occurs and aligns with the organisation's strategic directions
- financial, human and physical resources are allocated and used in ways that support quality care services that are delivered in a culturally safe and comfortable environment
- information management systems are in place to ensure the service users' right to privacy, dignity and confidentiality in relation to the use of and collection of personal information
- information management systems are in place to ensure the safe and secure storage of documents and records, and enable effective use of information to meet the needs of each service user, staff, management and regulatory bodies
- a process to manage positive feedback, complaints and allegations is in place which is effective, accessible, and culturally acceptable to stakeholders
- the service provider works in partnership with other organisations to maximise access to services and/or enhance service delivery
- a continuous quality improvement program is in place to monitor and improve:
  - > the care and services provided to service users, and
  - > the management systems and practices of the service provider.

What's this about?

This is about having systems and processes in place to make sure the service is well managed, that the service provider meets all responsibilities by law and the funding agreement and understands the organisation's financial status. This involves management and staff having a clear understanding of their roles and responsibilities, what they are accountable for, who they report to, when and what they must report.

For example, the day to day management of the organisation may be responsibility of a Chief Executive Officer (CEO) to whom senior management staff report. In turn, the CEO would then regularly report to the Board/Committee about the operation of the organisation.

Expected Outcome: 2.2 Management Systems (continued)

What's this about? (continued)

Effective management processes require that the planning, development and delivery of services to service users supports the organisation's strategic direction. This means that there should be clear link between business plans / operational plans and the strategic plan.

Resources must be well managed to make sure that service users receive quality care services that are delivered in a culturally safe and comfortable environment.

Financial, human and physical resources must be allocated in a way that ensures the service can continue to deliver the expected level of service. Effective management processes ensure that there is enough money, people and materials/equipment allocated to deliver quality care services in a culturally safe and comfortable environment.

Service providers are also required to have appropriate information management systems in place. These systems must ensure that service users right to privacy, dignity and confidentiality in relation to the use of and collection of their personal information is observed.

This includes having clear processes to inform service users and staff about the services practices and policies in relation to privacy, dignity and confidentiality.

Policy issues to consider include: why information is collected, what information is collected, how the information is used, who it may be shared with and under what circumstances, who has access to this information within the service and the measures taken to ensure the information is safe and secure.

Information management systems must also ensure that this information is accessible, as required to meet the needs of each service user, staff, management and regulatory bodies.

Service providers are accountable for the service they provide to stakeholders. Therefore stakeholders must have access to culturally acceptable feedback, complaint and allegation processes.

Service providers are required to have a continuous quality improvement program in place to monitor and ensure ongoing improvement of services. The continuous quality improvement program should include a number of ways to monitor and improve the care and services provided to service users and the management systems and practices of the service provider.

The service provider is responsible for making sure that stakeholders are informed about the continuous quality improvement program. It is expected that management and staff would be active in the program and that the service has a Quality Improvement Plan that is regularly reviewed and updated.

The service provider should also be able to show how the service works in partnership with other organisations to maximise access to services and/or enhance service delivery, where appropriate, to benefit the service user.

Expected Outcome: 2.2 Management Systems (continued)

Documented evidence could include:

✓ Policies and procedures about:

- the organisation's Mission and Vision
- Code of Conduct/Ethics
- selection, recruitment and appointment of staff
- induction and training of staff
- position descriptions
- delegation of authority
- legislative compliance
- compliance with funding agreements
- strategic, business and operational planning including development and review of plans
- internal reporting
- financial management and reporting
- risk management
- subcontracting
- Memoranda of Understanding
- purchasing goods and services
- asset management
- stakeholder consultation
- privacy, dignity and confidentiality
- information management systems
- document control
- feedback
- complaints and allegations
- staff grievances
- working with other service providers
- cultural safety - providing a culturally safe service
- service quality and continuous quality improvement

Expected Outcome: 2.2 Management Systems (continued)

- ✓ organisational chart
- ✓ position descriptions
- ✓ records evidencing that management/staff members have the required skills and a commitment to cultural safety
- ✓ management/staff member selection, recruitment and induction records
- ✓ management/staff training records
- ✓ management/staff meeting schedule, agenda and meeting minutes
- ✓ management reports to the Board/Committee
- ✓ records of business/operational/program planning activities including stakeholder consultation
- ✓ demographic data about the community and current service users
- ✓ reports against organisational plans, targets and goals
- ✓ budget, financial records and reports including acquittals to funding bodies
- ✓ Quality Improvement Plan
- ✓ records of quality activities such as:
  - management file audit results
  - management appraisals
  - stakeholder feedback about management of the organisation.

Evidence at interview could include:

- ✓ Management/staff talking about:
  - the organisation's Mission and Vision
  - their skills and understanding of cultural safety
  - their selection and recruitment
  - induction and access to other training
  - their roles and responsibilities
  - organisational structure – lines of reporting
  - policies and procedures
  - strategic and business/operational planning
  - their knowledge of/access to relevant legislation and updates their knowledge of the community and service user demographic

Expected Outcome: 2.2 Management Systems (continued)

- program funding, budget and targets
- financial management and reporting
- risk management
- service quality and continuous quality improvement
- cultural safety - providing a culturally safe service
- maintaining privacy, dignity and confidentiality in relation to information management with reference to the relevant legislation
- management of feedback, complaints and allegations

✓ management of staff grievances.

Observation of evidence could include:

✓ file storage areas within the service

✓ displays of posters, brochures, forms or other information in an appropriate format informing service users about:

- privacy, dignity and confidentiality
- service quality and continuous quality improvement
- feedback, complaint and allegations processes.

Standard 2: Management and Accountability

Expected Outcome: 2.3 Risk Management

A risk management framework is in place to ensure the safety of service users, staff and other stakeholders, and that quality care services are delivered.

Guide to requirements:

- effective financial management processes are in place to ensure the service is, and remains, financially viable; financial risks are identified and managed in an appropriate manner
- an asset management program is in place
- purchased goods and services are of a standard that ensure the delivery of quality aged care services
- procedures are in place to identify and address potential risks associated with the physical environment, chemicals or dangerous goods, and work practices
- procedures are in place for the management of natural disasters and other emergency events
- effective infection control procedures are implemented
- procedures are in place to identify and manage risk associated with:
  - > laundry services
  - > kitchen and food handling
  - > cleaning
  - > fire equipment
  - > open fire supervision
- procedures are in place to identify and manage risk related to service delivery.

What's this about?

Risk management is about having systems and processes in place to make sure that service users, staff and other stakeholders are safe and that quality care services are delivered. A risk management framework assists in making sure that all actual or potential risks are identified and that strategies are in place to minimise or control that risk. This includes taking steps to prevent that risk occurring and/or having planned action to treat the risk, should it occur.

The Guide to requirements above includes several categories of risk.

Some risks can directly result from a service's operations, for example, ineffective financial management, being uninsured, a breach in privacy and confidentiality, unsafe work practices or the use of poorly maintained equipment. Other risks that do not result from a services operations, for example, a change in government policy impacting on funding or environmental events such as floods, are thought of as external risks.

Expected Outcome: 2.3 Risk Management (continued)

What's this about? (continued)

A Risk Management framework should include policies and procedures to describe an organisations approach to managing risk, which starts with having processes to identify and assess risks. Risks are then generally rated and prioritised in relation to the likelihood of the risk occurring and the impact or consequences if they do.

When thinking about risk consider the following: what will be the result for the organisation and/or stakeholders if this happens? what steps can be taken to lessen the chances of this happening? what action must be taken if this does happen?

In this way risks can be prioritised and strategies to minimise the occurrence/impact of the risk documented. This process is usually documented in a risk management plan and/or risk register that is regularly reviewed and updated.

Documented evidence could include:

✓ Policies and procedures about:

- risk management, including clinical risk management
- financial management and reporting
- insurances
- delegations of authority
- internal reporting
- conflict of interest
- fraud
- legislative compliance
- information management
- compliance with funding agreements
- purchasing goods and services
- asset management
- occupational health and safety (OH&S) including:
  - > staff training in OH&S
  - > environmental risk assessment and reporting
  - > fire safety and equipment including open fire supervision
  - > handling and storing chemicals or dangerous goods
  - > hazard identification and reporting

Expected Outcome: 2.3 Risk Management (continued)

- > incident and accident reporting
- > natural disasters and other emergencies
- > infection control
- > cleaning
- > food safety and food preparation
- > safe work practices
- > travel
- > maintenance (including building, equipment and vehicles)
- > OH&S representatives and/or committee, as applicable
- cultural safety – cultural safety and risk management
- service quality and continuous quality improvement

✓ Board/Committee reports

✓ risk management plan/risk register

✓ management reports to the Board/Committee reports against organisational plans, targets and goals

✓ asset register

✓ records evidencing that management/staff members have the required skills and a commitment to cultural safety

✓ management/staff training records: fire safety and general OH&S

✓ management/staff meeting schedules, agendas and meeting minutes

✓ Forms, checklists or other paperwork that evidence that:

- all work sites have a regular safety assessment that is documented and reported
- staff have received training in fire safety
- fire safety equipment complies with the required standard/regulations
- preventative maintenance occurs
- hazards are identified, documented reported and addressed
- incidents and accidents are documented, reported and action taken as necessary
- infections are monitored and reported
- all of the above are monitored to ensure any emerging trends are identified and addressed

✓ Quality Improvement Plan

✓ records of quality activities such as :

- analysis of work site safety assessments
- analysis of incidents/accidents, infections
- stakeholder feedback about the safety/appropriateness of equipment.

Expected Outcome: 2.3 Risk Management (continued)

Evidence at interview could include:

✓ Board/Committee, Management or staff, as appropriate, talking about:

- the organisation's risk management framework
- their roles and responsibilities
- organisational structure – lines of reporting
- policies and procedures
- strategic and business/operational planning
- their knowledge of/access to relevant legislation and updates
- financial management and reporting program funding, budget and targets
- service quality and continuous quality improvement
- cultural safety – cultural safety and risk management: choice and decision making and risk
- management of emergencies
- OH&S policies, procedures and practices
- preventative maintenance.

Observation of evidence could include:

✓ access to the building

✓ entry and exit points

✓ safety and security measures

✓ facilities and equipment

✓ fire safety equipment

✓ evacuation plans

✓ storage and handling of chemicals

✓ infection control processes

✓ cleaning processes

✓ laundering processes

✓ catering processes, where applicable.

Standard 2: Management and Accountability

Expected Outcome: 2.4 Human Resources

Effective staff recruitment and retention ensure that service users' needs are met.

Guide to requirements:

- recruitment and retention processes ensure sufficient staffing levels are maintained at all times for the delivery of safe services
- services are provided by appropriately skilled staff that have an understanding of the cultural needs of the key stakeholders, including service users
- all staff and volunteers have a current police check that complies with the funding agreement
- processes are in place to provide staff and volunteers with training and development activities relevant to their role
- an effective performance appraisal process is implemented for staff and volunteers.

What's this about?

Human resource management focuses on processes to make sure that there are the right number of appropriately skilled staff at all times to deliver safe services. This requires effective selection and recruitment processes that include adequate screening of applicants. Screening should include interview, checking of qualifications and references and a police check.

Work force planning and monitoring is required to ensure there are the right number of appropriately skilled staff to deliver services. This would include appropriate allocation and rostering of staff and managing staff leave/absences. Staff retention involves looking at staff turnover rates and the strategies the service uses to minimise turnover.

The organisation should also have processes to ensure that staff and volunteers are supported with training and development activities that are relevant to their role on an ongoing basis. This should commence with appropriate induction to the organisation. Ongoing training could include both mandatory training and role related development activities. Support for staff training and development might be evidenced in part by an appropriate budget allocation, a training plan/calendar and strategies to assist staff in attending training.

A performance appraisal system should be in place and appraisal regularly conducted.

Ideally the appraisal tool should consider: performance since the last appraisal, achievement of goals, supervision, training or other support needs required and goal setting for the next period. The appraisal process should be conducted in partnership between the appraiser and the staff member and include steps to be followed where there is any disagreement about the appraisal. The performance appraisal system should also include a clear process for managing employees whose performance does meet the organisation's expectations.

Expected Outcome: 2.4 Human Resources (continued)

Documented evidence could include:

- ✓ Policies and procedures about:
  - selection and recruitment of staff including:
    - > advertising
    - > applications
    - > short listing
    - > interviewing
    - > notifying applicants
    - > referee checks
    - > sighting qualifications
    - > police checks
    - > staff contracts/agreements
  - induction
  - Code of conduct
  - Occupational Health and Safety
  - privacy, dignity and confidentiality
  - service quality and continuous improvement
  - cultural safety – providing a culturally safe service
  - equal employment opportunity
  - workplace bullying and harassment
  - workforce planning/staff retention
  - training and development
  - staff appraisal
- ✓ recruitment advertisements
- ✓ position descriptions
- ✓ interview questions
- ✓ induction agenda, program or handbook
- ✓ forms, checklists or other paperwork that evidence:
  - staff applications
  - interview processes

Expected Outcome: 2.4 Human Resources (continued)

- staff qualifications
- reference checks
- police checks
- staff contracts/agreements
- completion of induction
- ongoing training
- appraisal
- workforce planning, rostering, allocation

✓ training budget

✓ Quality Improvement Plan

✓ records of quality activities such as:

- staff file audits to verify all required information is recorded
- the selection and recruitment process is completed in line with the services policy and procedure
- staff feedback about their selection recruitment and induction experience
- staff feedback about training and support, appraisal and working in the organisation.

Evidence at interview could include:

✓ Board/Committee, Management or staff, as appropriate, talking about:

- selection and recruitment
- screening processes
- induction
- training and support
- appraisal
- their roles and responsibilities
- organisational structure – lines of reporting
- OH&S policies, procedures and practices
- management of emergencies
- service quality and continuous quality improvement
- cultural safety – cultural safety and risk management: choice and decision making and risk.

SECTION

four

Quality Reviewer Guide

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1. Introduction

1.1 Purpose of the Guide

The purpose of this Guide is to assist quality reviewers to perform their role in the various stages of the quality improvement cycle.

Reviewers will be required to assess service providers' performance against the Quality Framework Standards. The review process includes four key steps over two years:

- a self-assessment
- a desk top review
- a site visit
- follow up and monitoring.

All services funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (the Program) are required to complete a self-assessment every second year against the Quality Framework Standards. The self-assessment must be submitted to the Quality Review Team, which conducts a desk top review and then an on-site visit to each service.

The review process supports service providers to build capacity and develop a strong focus on continuous quality improvement (CQI).

1.2 What is in the Guide?

This Guide includes information for reviewers and is divided into three parts:

1. The Quality Framework - explains the background and provides a brief overview of the Framework. The Framework's Standards are introduced and the rationale for the structure of the Standards is explained.
2. The Review Process - details each of the steps of the review process introduced under the Quality Framework. This section also includes the Complaints and Feedback mechanism.
3. Reviewer Methodology - describes a methodology for the collection and analysis of evidence by reviewers and includes evidence examples for each expected outcome with reference to the evidence source (document review, interview and/or observation), as applicable.

A number of templates and tools are included in the appendices. Supporting resources for service providers are also included in the appendices.

It is recommended that reviewers are familiar with the supporting resources for service providers as well as this Guide.

2 THE QUALITY FRAMEWORK

2.1 Introduction

The establishment of a culturally appropriate Quality Framework for the National Aboriginal and Torres Strait Islander Flexible Aged Care Program is one of a group of measures by the Government to support access to quality aged care services for people from Aboriginal and Torres Strait Islander communities.

The Quality Framework includes a set of Standards and a process for monitoring achievements against the Standards, designed to assist service providers to continuously improve their services.

2.2 The Quality Standards

The Standards were developed based on input from consultations, a literature review and the pilot of the Draft Quality Framework. The literature highlighted that Standards should:

- be simple in intent, achievable and few in number
- be measurable
- encourage continuous quality improvement.

Themes that were consistently emphasised during the consultations were the importance of:

- culture: of each person cared for, their families and the community
- risk management: the need to minimise risk for the people cared for and for staff, while respecting the needs and wishes of all stakeholders
- the relationships of flexible aged care services: with the people they care for and their families, the community, other providers and government.

2.3 The Structure of the Quality Standards

The Standards include **two overarching principles:**

Cultural Safety: Cultural safety is about recognising, respecting and nurturing the unique cultural identity of Aboriginal and Torres Strait Islander people and meeting their needs, expectations and rights.

The Standards take into account the importance of culture to service providers and people receiving a care service. Each service provider and the communities they support have unique and diverse cultural needs.

The concept of culture and cultural safety has been identified as an important component in improving health care with, and for, Aboriginal and Torres Strait Islander people.

Culture is distinctive to a region. Cultural needs and issues may be specific to the individual, their group, or be related to whether they are male or female. Managing a culturally safe environment is a continuous process, as needs and issues may be different for each person.

Respect for their region's culture is very important to service providers. Services need to identify the needs and issues of each person they care for, and have a process to manage and deliver this care. This ensures that:

- individuals receive care that is culturally appropriate and is respectful of him or her, and his or her family and home
- no one is offended or insulted
- service users feel comfortable and safe.

As service providers and their communities have unique and diverse cultural needs, the Standards do not focus on ***what*** represents culturally appropriate and culturally safe care. Instead, there is emphasis throughout the Standards on the issues that must be considered in assessment, planning and service delivery, in order to identify what ***each*** service user considers to be culturally appropriate and culturally safe care.

The Standards include specific requirements which will Guide and assist a service provider in gathering and then acting upon this information. This begins at assessment with hearing the person's life story and carries through to how information is communicated, the way, and by whom, their service is delivered and the environment in which the service is delivered.

Continuous Quality Improvement: CQI is about always working to improve services and outcomes for people. It means looking for better ways to do things.

These two principles are recognised throughout the Standards and are integral to the Quality Framework.

Figure 2.1 is a visual representation of the two overarching principles. That is, the dotted lines that frame and create linkages within the picture represent ***Cultural Safety*** and ***Continuous Quality Improvement*** as key elements of the Standards.

Within the picture the two Standards are represented in two large circles:

- ***Care Delivery and Information*** – is about the steps involved in directly providing care to people.
- ***Management and Accountability*** – is about support systems and processes.

For each standard there are a number of ***Expected Outcomes*** that are represented in the small circles and joined by the lines representing the overarching principles; these state the results to be achieved.

Table 2.1 sets out the full version of the Quality Standards, Expected Outcomes and Guide to requirements.

Figure 2.1: Picture of Quality Standards

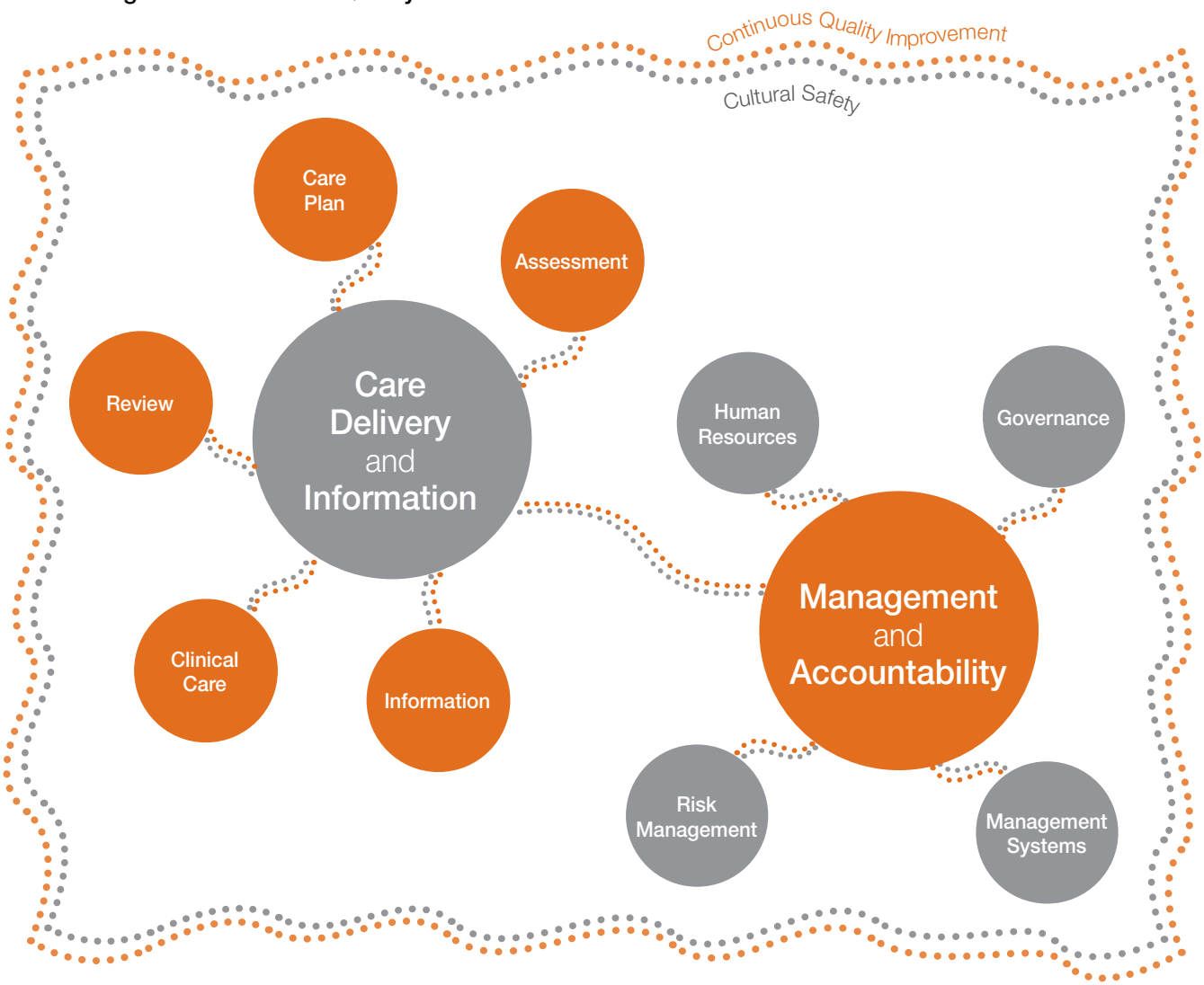


Table 2.1: Standards, Expected Outcomes, Guide to requirements

Standard	Expected Outcome and Guide to requirements
1. Care Delivery and Information *Each service user has access to and receives quality aged care services that meet their needs and respects their dignity and individuality. This is achieved through assessment, planning and regular review of each service user's needs, in consultation with them and their nominated representative/family member/people.* *Each service user is fully informed about service choices and their rights and responsibilities as a service user. This information is provided in a format appropriate to their needs and communicated in a way that is culturally acceptable to each service user.*	**1.1 Assessment** Each service user is supported to actively participate in an assessment of their care needs. The assessment is conducted by appropriately experienced staff and considers: eligibility, priority of access, independence, physical, social, emotional and cultural care needs and clinical care needs, where applicable and with the agreement of the service user. **Guide to requirements:** The assessment includes each service user's: • life story • medical history • functional, cognitive and sensory status • nutritional status/needs • personal care needs • special care needs • clinical risk factors. and where applicable: • assessment of the resident's ability to smoke safely, including the need for, and level of, supervision **1.2 Care Planning** Each service user has a documented care plan that addresses their identified care needs and preferences. This includes a cultural support plan which describes how assessed needs and service user preferences will be met in a culturally safe way. The care/cultural support plan includes strategies to maintain privacy and dignity, individual interests, customs and beliefs, independence and family connectedness. **Guide to requirements:** The care plan addresses: • all assessed needs and preferences of the service user. • what action is to be taken to meet assessed needs and preferences of the service user in a culturally safe and respectful way. • who is responsible for what care (including family members and/or other providers). • when and where care is to be received (ensuring a culturally safe environment). **1.3 Review** Each service user is monitored to ensure: service delivery occurs as planned, their needs are regularly reassessed and the care plan is updated in consultation with the service user to reflect any change in needs and service user preferences. **Guide to requirements:** The care plan addresses: • occurs at least six monthly and where service user needs change • identifies progress against planned goals/actions • results in any change in needs and preferences being documented in the care plan.

Standard	Expected Outcome and Guide to requirements
1. Care Delivery and Information *Each service user has access to and receives quality aged care services that meet their needs and respects their dignity and individuality. This is achieved through assessment, planning and regular review of each service user's needs, in consultation with them and their nominated representative/family member/people.* *Each service user is fully informed about service choices and their rights and responsibilities as a service user. This information is provided in a format appropriate to their needs and communicated in a way that is culturally acceptable to each service user.*	**1.4 Clinical Care** Each service user's clinical care needs are met. **Guide to requirements:** Each staff member works within their scope of practice. Clinical care needs include, as applicable: • special care needs • safe and effective management and administration of medication • effective assessment, treatment and management of pain • access to specialised palliative care services • access to other specialist health care/allied health services • functional care • cognitive care • sensory care • nutritional care • personal care. *Note: The requirements within this outcome may have limited applicability, or not be applicable to some organisations.* **1.5 Information** Each prospective service user is fully informed about service choices and their rights and responsibilities as a service user. **Guide to requirements:** • information about available services and eligibility to receive services is clearly documented. This information is communicated in a manner that is appropriate in format and culturally acceptable to each prospective service user to support choice and decision making • each service user is offered a service agreement by the service provider which sets out the terms and conditions of the service/s to be received and the service user's rights and responsibilities[1] • the service provider ensures that the content of the service agreement is fully explained to each service user (and/or their representative) in a culturally acceptable way prior to entering into the agreement • a process is in place to enable service users to be represented by an advocate of their choice.

1 As per National Aboriginal and Torres Strait Islander Flexible Aged Care Program Service Provider Guidelines, 5. Care Recipient Rights and Responsibilities and 5.3 A Care Recipient has the right to security of tenure, in particular.

Standard	Expected Outcome and Guide to requirements
2: Management and Accountability *The service provider has implemented systems and processes which ensure the organisation is well managed and services are continually improved.* *This results in the delivery of culturally safe, quality services that are responsive to the needs of each service user, their representatives, staff and other stakeholders.*	**2.1: Governance** The service provider has clear and effective governance processes in place. **Guide to requirements:** • Board/Committee members have appropriate skills, knowledge and experience to carry out their role • Board/Committee members have an understanding of, and promote culturally safe service delivery • the roles and responsibilities of the Board/Committee are documented • meeting minutes and other records evidence that the Board/Committee carry out their roles and meet their responsibilities • planning occurs to set strategic directions and promote the delivery of culturally safe quality aged care services • the service actively engages with and consults the community about the services available and reflects this in service planning.
	2.2: Management Systems The service provider has clear and effective management systems and practices in place. **Guide to requirements:** • the service provider understands and complies with the funding agreement, including the service provider guidelines • the service provider understands and complies with regulatory and relevant legislative requirements • management and staff accountabilities and delegations are documented, relevant to their roles • service planning and development occurs and aligns with the organisation's strategic directions • financial, human and physical resources are allocated and used in ways that support quality care services that are delivered in a culturally safe and comfortable environment • information management systems are in place to ensure the service users' right to privacy, dignity and confidentiality in relation to the use of and collection of personal information • information management systems are in place to ensure the safe and secure storage of documents and records, and enable effective use of information to meet the needs of each service user, staff, management and regulatory bodies • a process to manage positive feedback, complaints and allegations is in place which is effective, accessible, and culturally acceptable to stakeholders • the service provider works in partnership with other organisations to maximise access to services and/or enhance service delivery • a continuous quality improvement program is in place to monitor and improve: > the care and services provided to service users, and > the management systems and practices of the service provider.

Standard	Expected Outcome and Guide to requirements
2: Management and Accountability *The service provider has implemented systems and processes which ensure the organisation is well managed and services are continually improved.* *This results in the delivery of culturally safe, quality services that are responsive to the needs of each service user, their representatives, staff and other stakeholders.*	**2.3: Risk Management** A risk management framework is in place to ensure the safety of service users, staff and other stakeholders, and that quality care services are delivered. **Guide to requirements:** • effective financial management processes are in place to ensure the service is, and remains, financially viable. Financial risks are identified and managed in an appropriate manner • an asset management program is in place • purchased goods and services are of a standard that ensure the delivery of quality aged care services • procedures are in place for the management of emergencies including natural disasters • effective infection control procedures are implemented • procedures are in place to identify and address potential risks associated with: > the physical environment > chemicals or dangerous goods > laundry services > kitchen and food handling > cleaning > fire equipment > open fire supervision • Procedures are in place to identify and manage risk related to service delivery.
	2.4: Human Resources Effective staff recruitment and retention ensure that service users' needs are met. **Guide to requirements:** • recruitment and retention processes ensure sufficient staffing levels are maintained at all times for the delivery of safe services • services are provided by appropriately skilled staff that have an understanding of the cultural needs of the key stakeholders, including service users • all staff and volunteers have a current police check that complies with the funding agreement • staff and volunteers are provided with training and development activities relevant to their role • an effective performance appraisal process is implemented for staff and volunteers.

3. The Quality Improvement Cycle and Review Process

3.1 Introduction

The Quality Improvement Cycle outlines:

- the steps which measure and assess service provider performance against the Standards
- support for service providers to meet and continually improve their quality performance against the Standards.

The design of the review process aims to:

- support capacity building for the service provider
- support continuous quality improvement while addressing accountability through quality assurance processes
- promote development of internal systems and processes.

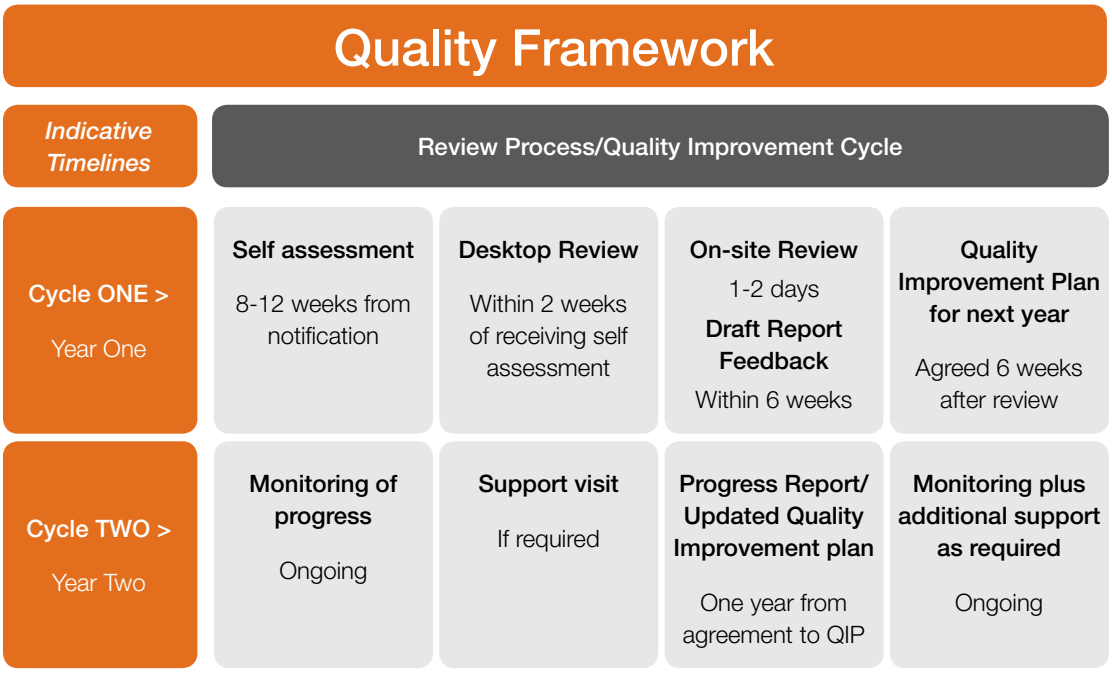
The Quality Improvement cycle is implemented over two years. Figure 3.1 provides a visual outline of the timing of the Review Process and the Quality Improvement Cycle.

The first year includes a formal review against the Quality Standards including self-assessment by the service provider and a site visit by the Quality Review Team. The key output for year one is the agreed Quality Improvement Plan between the Quality Review Team and the service provider.

The service provider is then required to work on actioning the Quality Improvement Plan over the next Calendar year. The service provider's activity is monitored and supported by Program staff and the Quality Review Team.

In the second year, service providers report on their progress in actioning the Quality Improvement Plan and update their Quality Improvement Plan. The Progress Report and Updated Quality Improvement Plan is submitted to the Quality Review Team and is the key output for the second year of the cycle.

Figure 3.1 Overview of the Review Process with key outputs and timelines



3.2 Self-assessment

A letter is generated by the Quality Review Team advising the service provider when the self-assessment is due to be submitted to the Quality Review Team. Service providers should be given 8 to 12 week's notice of the due date for submission of the completed self-assessment.

A self-assessment is completed by each service provider. Self-assessment is usually the beginning point and a critical component of a continuous quality improvement process. Self-assessment involves an organisation looking at how it does things, what it achieves, and how it performs against an agreed set of standards. During the process, an organisation's strengths, weaknesses and opportunities for improvement are identified.

The self-assessment enables a service provider to:

- confirm areas where the service is meeting the Standards
- identify gaps in current systems and processes that do not meet the Standards
- plan action to address any identified gaps in systems and processes, prior to the on-site review being conducted
- identify additional opportunities for improvement, even where the Standards are met, to support continuous improvement.

The self-assessment tool records the things an organisation is currently doing, and information about the systems they have in place. It enables the service provider to identify where there are gaps in their systems and processes. During the self-assessment process there may be opportunities to address these gaps, such as writing a policy or procedure to describe practice.

Once completed, the self-assessment forms the basis of the desk top review and is used to inform the on-site review.

The *Service Provider Self-assessment tool* is included at ***Appendix 1***. The Self-assessment tool includes:

- an Assessment Matrix
- a self-assessment rating against each Expected Outcome of the two Quality Framework Standards and Quality Improvement Actions
- a Checklist.

The **Assessment Matrix** is in the first section of the tool. The Assessment Matrix is a summary of the findings of the self-assessment and allows services to identify their organisation's overall performance against the Standards.

The Assessment Matrix is completed at the end of the self-assessment. Completing the matrix requires the service to insert a rating against each expected outcome, reflecting the self-assessment findings. The following ratings apply:

- **Met:** written and verbal evidence clearly demonstrates that the service provider meets all the requirements of the expected outcome
- **Part Met:** written and verbal evidence clearly demonstrates that the service provider only meets part of the requirements of the expected outcome
- **Not Met:** written and verbal evidence clearly demonstrates that the service provider does not meet the requirements of the expected outcome
- **Not Applicable:** a not applicable rating may apply, for example, where a service does not provide clinical care to service users (refer to expected outcome 1.4).

Once the service has rated each expected outcome, the overall Assessment Result can be determined. The Assessment Result is applied as follows:

- **Met:** all the requirements of each expected outcome have been met
- **Part Met:** the requirements of one or more expected outcomes have not been fully met
- **Not Met:** the requirements of no expected outcomes have been met.

The second section of the tool is designed to enable service providers to work through each of the expected outcomes in the two Standards and document the following information into the tool:

- evidence examples: lists evidence that the service can provide to demonstrate compliance with each expected outcome and its requirements
- self-assessment findings: provides a brief summary of findings that describes why the service meets the expected outcome or describes the identified gap where the expected outcome is part met or not met
- self-assessment ratings: rate the services performance against the expected outcome as met, part met, not met, or not applicable
- quality improvement actions: identified where a service decides that it does not fully meet an outcome.

Ideally, service providers will try to address any actions they identify as being necessary to achieve full compliance with the Standards prior to the on-site review occurring. Examples of the type of improvement actions that may be required are:

- develop and introduce new or additional policies and/or procedures
- review current policies and/or procedures
- change orientation and/or staff training programs
- further develop written information for service users
- introduce new or additional quality improvement processes, for example:
  - > develop an internal audit schedule
  - > increase opportunities for stakeholders to provide feedback
  - > improve processes for analysing, reporting and acting upon service user feedback.

Service providers are also encouraged to document any opportunities for improvement that they identify even where the outcome is fully met. These are considered to be *optional actions* to promote continuous quality improvement and should also be documented in the Self-assessment Tool.

A **Checklist** is included at the back of the self-assessment tool to assist service providers in reviewing the completed self-assessment prior to submitting it to the Quality Review Team.

Examples of completed *Service Provider Self-assessments* are included at **Appendix 2**.

3.3 Desk Top Review

Within **two weeks** of receiving the completed Service Provider Self-Assessment the Quality Review Team will undertake the desk top review.

The desk top review assists in prioritising areas for focus at the on-site review and examines other information such as records of previous review findings and/or other relevant information provided in the Service Provider self-assessment. Any other relevant information, for example information about compliance with requirements for submission of Financial Activity Reports or Service Activity Reports may also be considered at the desk top review.

Reviewers must complete a Desk Top Review Record for each review conducted. The *Desk Top Review Record* is an itemised checklist incorporating notation of any required actions/follow up where any concerns with the completed self-assessment are identified.

Indicators raising concern about readiness for the on-site visit may include submission of an incomplete self-assessment or a self-assessment with limited relevant information. If necessary, the reviewers will make contact with the service provider for additional information or request that the self-assessment be resubmitted.

Service providers will be notified of the outcome of the desk top review and subsequent plans for the On-Site Review in writing.

The *Desk Top Review Record Template* is at **Appendix 3**.

3.4 On-site Review

Following the desk top review, the on-site review will be scheduled and conducted by at least two reviewers, normally lasting between one and two days, depending on the service types delivered. The Quality Review Team would generally allow one day for on-site review of community care providers, and up to two days for residential and mixed service type providers. Large residential service providers may require two full days for on-site review.

Prior to an on-site visit, the Quality Review Team will liaise with the Service Provider to make the necessary arrangements, for example:

- confirming the date, time and duration of the visit
- discussing the proposed schedule
- checking if any permits or departmental identification cards are required
- checking if an interpreter is required
- asking the Service Provider to notify staff and care recipients that the visit will be taking place and that a reviewer might talk to them about their experience at the service
- discussing travel and accommodation options (if necessary).

All of these details will be confirmed in writing by the Quality Review Team prior to the On-Site Review. On-site review planning tools and templates are at **Appendix 4.**

The On-Site Review is a quality assurance process which assesses how the service provider meets the Standards. Reviewers will use the service provider's most recent self-assessment and the Desk Top Review Record to guide them in conducting the on-site review.

The visit will be collaborative in approach and focus on acknowledging good practice and encouraging the development of sustainable quality systems. The On-Site Review will include the following steps:

- entry meeting
- tour of the site
- document review
- review a sample of service user records
- review a sample of staff, carer and volunteer records
- stakeholder interviews
- exit meeting.

The ***Entry Meeting*** is held on the first morning of the on-site review and involves the review team and key service provider staff. The entry meeting provides the opportunity to:

- introduce key staff
- discuss purpose of the visit
- provide acknowledgement of the self-assessment
- explain the on-site review process
- confirm the proposed agenda and timeframes for the visit including interviews with managers, staff, volunteers and service users (where applicable)

- discuss sampling methods
- demonstrate open and transparent approach
- discuss confidentiality
- gain an overview of the services operations
- respond to any questions
- plan a tour of the service.

A ***Tour of the Site*** is conducted to observe the physical environment from which services are run and can be used to confirm verbal and written evidence.

Document review includes a review of any documented evidence to demonstrate if the Expected Outcomes are being met.

Reviewers will generally work independently on-site to assess expected outcomes in a timely manner. Quality reviewer meetings are important to share information, corroborate information and discuss any issues or concerns that may arise. These should be scheduled throughout the day and factored into the on-site visit schedule.

Quality reviewers need to plan who will be reviewing what documentation to reduce the likelihood of both quality reviewers looking in detail at the same information during the on-site visit.

The review of ***service user*** records and ***staff, carer*** and ***volunteer*** records to demonstrate if the Expected Outcomes are being met. Service providers will be required to ensure a sample of records is made available to the reviewers. The formula to calculate the sample size of records to be reviewed will be determined by DoHA. The service provider will be notified of the sample size prior to the on-site review. A common formula utilised by many quality review processes is the square root plus one (√+1), for example for a service with 16 care recipients the sample size would be 5.

Quality Reviewers must ensure that they manage the use of personal and cultural information appropriately and in accordance with the *Privacy Act 1988* and National Privacy Principles.

Stakeholder interviews are conducted with willing participants to confirm written evidence or observations made by the reviewers.

The ***Exit Meeting*** is held on the final day of the on-site review. The purpose of the exit interview is to:

- provide verbal confirmation of the review findings
- advise of ratings against the Standards
- discuss areas where action is required to fully meet the Standards
- discuss areas where opportunities for continuous quality improvement have been identified
- explain the reporting process and associated timeframes
- address any additional concerns
- inform the service provider of the complaints process.

Quality Reviewer tools and templates are at **Appendix 5**.

3.5 Draft Report and Feedback

Within **two weeks** of the visit a draft report of the on-site review is submitted to the service provider. The On-site Review Report will use the same format as the self-assessment report completed by service providers and will include:

- an Executive Summary
- an Assessment Matrix
- evidence examples sighted during the visit to demonstrate compliance with each expected outcome
- review findings detailing the reasons for the reviewers' rating for each expected outcome and the applicable rating
- Quality Improvement Plan to address any identified gaps against each Expected Outcome of the Quality Standards and/or plans to support continuous quality improvement, where applicable.

The report will clearly document what needs to be done to meet the Standards and optional actions to support continuous quality improvement. These actions form the basis of the Quality Improvement Plan.

The service provider will have **four weeks** to work through the draft Report and return their feedback to the Quality Review Team. Feedback may include any service provider comments and factual errors in the draft Report, as well as completing the Quality Improvement Plan, that will include who will be responsible for each action and the due date for completing actions. Feedback may be provided verbally, electronically via email or in a letter. Feedback may include any errors, omissions or requested changes to the draft Report.

Where the service provider disagrees with content in the draft report, the Quality Review Team requires the following information:

- specific detail about the part/s of the draft report that are in dispute
- the evidence the service provider is relying on to substantiate the requested change.

Where agreement on the content of the draft Report cannot be reached, the matter should be referred to the Quality Review Team Manager for review.

The *On-site Review Report* template is at **Appendix 5** and the *Quality Improvement Plan* template is at **Appendix 6**.

3.6 Quality Improvement Plan for next year

The Quality Review Team has **two weeks** to finalise the draft On-site Review Report and the Quality Improvement Plan with the service provider. The service provider is responsible for completing the plan with:

- name/position of the person responsible within their organisation for completing the action
- timeframe within which the action is to be completed.

The return of the final agreed Review Report and Quality Improvement Plan for the next year to the service provider by the Quality Review Team is a key output of Cycle One.

3.7 Monitoring Progress of Quality Improvement Plan

- ***Monitoring Progress of Quality Improvement Plan:*** the service provider will use the Quality Improvement Plan to schedule, monitor and report on the planned actions required to meet the expected outcomes of the Quality Standards.

  The Quality Review Team and Program staff will use the Quality Improvement Plan to monitor the service's progress in implementing the planned actions. The plan will assist to identify any additional support that the service provider may need, including assistance from the Service Development Assistance Panel.

  If serious matters relating to health, safety and well being of care recipients arise, the issue will be referred to the Quality Review Team to manage in consultation with the Program manager and further assessment by the Quality Review Team may be necessary.

3.8 Support Visit to achieve Quality Improvement Plan

To monitor progress of the Quality Improvement Plan, Program staff and/or the Quality Review Team, must include at least one support visit to the service provider following the On-site Review. The timing of this will depend on the support required by the service provider and their progress in implementing their Quality Improvement Plan.

3.9 Progress Report / Quality Improvement Plan for next year

In order to maintain the momentum of Continuous Quality Improvement, service providers will be required to submit a Progress Report against the agreed Quality Improvement Plan a year after that plan has been agreed. Service providers will also update their Quality Improvement Plan for the next calendar year.

The *Progress Report* - template is at **Appendix 6.**

3.10 Complaints

A service provider may make a complaint about any aspect of the quality review process or the conduct of a Quality Reviewer at any time. In the first instance, service providers are encouraged to discuss their complaint with the Quality Review Team Manager, who may be able to resolve the issue. Alternatively, the service provider may prefer to put their complaint in writing via email or letter to the Quality Review Team Manager.

The following information is required from the service provider:

- specific detail about the nature of the complaint
- the evidence the service provider is relying on in making the complaint
- confirmation the service provider's nominated representative (and contact details) with whom DoHA should liaise during the management of the complaint.

DoHA will investigate the complaint and respond to the service provider as soon as practicable.

3.11 Mutual recognition

Where an Aboriginal and Torres Strait Islander Flexible Aged Care service is funded separately to provide Home and Community Care Services, the service provider will also participate in reviews under the Community Care Common Standards (CCCS) and may report on some of the same information required under this Quality Framework (or visa versa).

In this event, the quality reviewers and the service provider will liaise to identify any relevant information common to both processes that can potentially be shared between reviewers, to avoid a duplication of effort. It will however, be important for the quality reviewers to determine that the information is current and relevant to the expected outcome of the particular standard.

This will need to be on a case-by-case basis in consultation with the service provider and the relevant areas of DoHA.

4. Reviewer Methodology

4.1 Reviewer Approach

The Quality Framework is a quality assurance process designed to monitor service providers' performance against the Standards and assist service providers to continuously improve their services.

The focus of the review process is also to include supporting capacity building for providers and promoting development of internal systems and processes.

The review team is responsible for gathering and analysing information and evidence to establish if service providers are meeting the Standards. Evidence is usually more reliable when it can be confirmed by more than one process or piece of information.

Before making any decision about whether the service provider is meeting the Standards, the review team must ensure they have considered enough evidence and that the evidence reviewed is relevant to each expected outcome being assessed.

To ensure the process is fair, equitable and transparent reviewers *must* keep the service provider or their nominated personnel informed about the progress of the review. You will note in the previous section of the Guide concerning the purpose of the exit meeting, the first dot point advises it is to "provide verbal *confirmation* of the review findings."

Unless there are exceptional circumstances, the findings reported to the service provider at the exit meeting should not be 'new' information but instead a summary of the information that reviewers have communicated throughout the course of the review.

In keeping with a collaborative and supportive approach, if the review team identify that an expected outcome is likely to be Part Met or Not Met the service provider should be informed of this *as soon as possible*.

This is to ensure that the service provider understands the rationale for the review team's findings and has adequate opportunity to provide additional/alternative evidence to the review team.

4.2 Collecting Evidence – Potential Sources

Evidence is information that confirms or proves something. Evidence can include something that is written, something that is seen or something that is heard.

The evidence that services have will differ and may depend upon the size and structure of the organisation, the services provided and the staff and service user group. However, to just say that something is done, or describe a system or process that is in place, is not enough evidence to show that a Standard is met.

While it is important that staff and service users can talk about systems and processes during an on-site review, the review team must look for evidence from more than one source to verify any information they are given.

When on-site, the ***three key evidence sources*** available to reviewers are: documentation, interview and observation.

Documentation

Service providers can present any written information to the review team that they believe show they meet the Standards. This documentation might include:

- stakeholder information such as: brochures, pamphlets or other written material given to service users or other stakeholders, newsletters photographs or posters
- documents read by staff such as: policies, procedures, guidelines, work instructions, meeting minutes, memos, newsletters forms and other tools used by staff: referrals, intake and assessment tools, care plans, attendance records, feedback and complaint, improvement forms
- records: service user records, staff records, training records, feedback, complaint and incident/accident records, Quality Improvement Plans
- reports: quality activities, quality reviews, financial reports, annual reports, reports to the Board/Committee.

Interviews

Interviews enable information to be obtained verbally from a range of relevant stakeholders. Interviews can be used to confirm written evidence. Interviewees could include: managers, Board/Committee members, staff, service users, their representatives, community members and other service providers.

Interviewing a range of stakeholders enables the review team to gain information about the service and its operations from different, viewpoints. Stakeholder interviews are a useful way to check that there are feedback mechanisms in place that are understood, accessible and responsive to stakeholder input. Hearing about stakeholder experiences assists in assessing the effectiveness of the services systems and processes.

Some people being interviewed by reviewers will feel worried or anxious to some extent about the interview process. Interviewees may be concerned about saying the “wrong thing” and the consequences of this, or “not knowing” the answer to the reviewers questions. It is therefore essential that reviewers anticipate this and use a friendly and collaborative approach at all times.

When planning interviews reviewers should use a flexible approach, ensuring the location and timing of the interview is acceptable to the interviewee. This should include the option of the interviewee having others present.

Good interpersonal skills are extremely important for an interview to be effective and for the interviewee to feel safe and comfortable. Reviewers should at all times be aware of their verbal and non-verbal communication with the interviewee. This includes a reviewer monitoring the language they use, their tone of voice and body language. It is also important that reviewers do not make assumptions about interviewees reactions based on their own communication style. Reviewers should consider for example, that:

- minimal eye contact may be preferred by some interviewees
- the interviewee may be more relaxed talking outside rather than within the facility/office
- using open questions may assist in getting a response
- the interviewee should be made aware that there is no right or wrong answer

- an interviewees silence may indicate that they are not comfortable sharing the information that is being sought rather than them not understanding or knowing the answer to the question
- if this occurs, ask the interviewee if they have a problem with the question and consider using a more subtle line of questioning around the issue/s being discussed
- the interviewee should be reassured that if they prefer, the information they provide will not be recorded.

Accepted good practice on the interviewer's part would include commencing the interview by:

- explaining the aim of the interview
- outlining the information to be covered
- confirming how much of the interviewees time is required
- asking the interviewee to explain their role and responsibilities, training and education.

The latter is important to ensure the interview questions are appropriate and not outside the scope of knowledge of the interviewee.

Always advise staff that if they need to attend to urgent matters, the interview can be rescheduled. You may not be able to ensure the confidentiality of the information provided by staff, however, you can reassure staff that they will not be referred to by name in the quality review report or to other staff or management in providing feedback.

Staff may feel more comfortable talking in a group. The on-site visit schedule provides time for a service delivery staff group meeting. This allows the group to be interviewed about their general work practices, but quality reviewers must also make time to speak to staff individually throughout the review process to ensure that information is corroborated.

Sometimes staff may provide the quality reviewers with their personal opinions or concerns with the organisation's management. Quality reviewers need to be mindful of this and manage this situation appropriately while considering the information if necessary.

Where reviewers are seeking an explanation or trying to elicit information about a particular system or process it is appropriate to use an open questioning technique. Open questions invite descriptive information. For example, the reviewer might ask:

"How do you go about making sure that each service users' clinical care needs are reviewed regularly"? or

"How are new Board/Committee members recruited"?

However, at times it may be appropriate to use a closed questioning technique. This is particularly relevant if the reviewer is having difficulty confirming information. Closed questions do not invite descriptive information. They seek a 'Yes' or 'No' response. For example:

"Did you have training in Occupational Health and Safety during orientation?" or

"Do you have a Conflict of Interest policy and procedure?"

Effective interview techniques also include attentive listening and not interrupting the interviewee when responding. It is important that reviewers do not make any assumptions and clarify any responses that they are unsure about with the interviewee. It can be helpful to repeat your understanding of what has been said back to the interviewee. This provides an opportunity for clarification and/or confirmation.

Observation

Observation can be used to confirm written and/or verbal evidence. Observation of the physical environment can be useful in gaining information about:

- accessibility
- service user and other stakeholder safety and security
- staff occupational health and safety
- the state of facilities and equipment
- general maintenance
- privacy and confidentiality
- staff interactions with stakeholders
- service user activities.

The extent to which observation can be used as an evidence source may depend on the nature and location of the service/s provided. For example, services may largely be provided off site and the opportunity for observation may therefore be limited.

4.3 Analysing Evidence

Reviewers must collect, review and analyse all evidence provided to assess each service provider's performance against the Standards. Reviewers will be able to utilise the service providers completed self-assessment to assist in this process.

Reviewers must ensure that adequate relevant evidence has been reviewed and evaluated before making any decision about whether a service provider meets or does not meet each expected outcome.

There are three key considerations for reviewers when analysing evidence and rating performance against an expected outcome:

- is there adequate evidence to rate the service provider's performance?
- is the evidence relevant to the expected outcome being assessed?
- is the evidence from a reliable source?

Reviewers should seek to confirm evidence from more than one source where possible, to ensure adequate evidence is considered. For example, information about documented evidence such as a policy or procedure can be confirmed at interview and/or where possible, by observing staff practices. One piece of evidence, not confirmed by another source, would generally not be considered enough evidence for a reviewer to base a decision on about whether an expected outcome is met.

Reviewers must also be satisfied that the evidence being considered is relevant to the expected outcome and the question being asked. To be considered as valid evidence the information provided should clearly relate to the requirement being assessed. If the information is not considered to be relevant, the service provider should be informed and given an opportunity to provide alternative evidence before making any decision about whether a service provider meets or does not meet an expected outcome.

Reviewers must also be satisfied as to the reliability of the evidence that has been provided. Documented evidence would usually be thought to be more reliable than verbal evidence. For example, seeing records of completed service user file audits would be considered as being more reliable evidence than a staff member talking about the file audit process.

First hand observation of a process or activity by a reviewer would also be considered as more reliable evidence than being given a verbal description of a process or activity.

Reviewers must also consider the reliability of the source providing verbal evidence and be satisfied that the person providing the information has the relevant knowledge and/or experience in that area and is the right person to do so. As mentioned previously, it is good practice to establish the role and responsibilities of each person at commencement of any interview.

Once a reviewer has considered these key factors against the evidence provided they have responsibility for making a decision about whether a service provider meets or does not meet each expected outcome.

Reviewers are accountable for their decision making and must at all times be satisfied that their analysis of the evidence gathered clearly supports the rationale for their finding.

Evidence examples for each expected outcome are set out on the following pages. The evidence examples are categorised with reference to the related evidence source (document review, interview and/or observation), as applicable.

These evidence examples are intended as a guide only to assist reviewers in their approach to reviewing and analysing evidence. They are not a list of prescribed evidence that service providers must have to meet the Standards.

4.4 The Standards, Expected Outcomes and Evidence Examples

Standard 1. Care Delivery and Information

Each service user has access to and receives quality aged care services that meet their needs and respects their dignity and individuality. This is achieved through assessment, planning and regular review of each service user's needs, in consultation with them and their nominated representative/family member/ people.

Each service user is fully informed about service choices and their rights and responsibilities as a service user. This information is provided in a format appropriate to their needs and communicated in a way that is culturally acceptable to each service user.

Expected Outcome and Guide to requirements	Evidence Examples
1.1 Assessment Each service user is supported to actively participate in an assessment of their care needs. The assessment is conducted by appropriately experienced staff and considers: eligibility, priority of access, independence, physical, social, emotional and cultural care needs and clinical care needs, where applicable and with the agreement of the service user. **Guide to requirements:** The assessment includes each service user's: • life story • medical history • functional, cognitive and sensory status • nutritional status/needs • personal care needs • special care needs • clinical risk factors and where applicable: • assessment of the resident's ability to smoke safely, including the need for, and level of, supervision.	**Policies and procedures could include:** The assessment includes each service user's: • eligibility • priority of access • waiting lists • service user assessment including who is responsible for assessment • identifying the service users representative/s, where applicable • refusing or ending a service • receiving and making referrals • cultural safety – assessment • service quality and continuous quality improvement.

Expected Outcome and Guide to requirements	Evidence Examples
1.1 Assessment (continued)	**Other documentation could include:** • forms, checklists or other paperwork that is filled out from the time of enquiry or referral and shows how eligibility and priority of access is established • completed assessment tools that include the information listed under the Guide to requirements • forms, checklists or other paperwork that evidence the assessment occurred in consultation with the service user and/or their representative • records showing that staff who assess service users have the necessary experience • records of quality activities such as: > service user file audit results > feedback from service users about their entry to the service. **Evidence at interview could include:** • staff responsible for intake and assessment explaining these processes from the time of enquiry or referral. This could include talking about: > how a prospective service user accesses the service > intake processes > how and when an assessment is arranged > what the service user is told about assessment > who participates in the assessment > how staff go about making sure each service user's independence, physical, social, emotional, clinical and cultural care needs are identified in a culturally safe way > how and when service users are told about the outcome of the assessment > what service users are told about when service will commence.

Expected Outcome and Guide to requirements	Evidence Examples
1.2 Care Planning Each service user has a documented care plan that addresses their identified care needs and preferences. The care plan will be developed in partnership with the service user and/or his or her representative. This will include a cultural support plan which describes how assessed needs and service user preferences will be met in a culturally safe way. The care/cultural support plan includes strategies to maintain privacy and dignity, individual interests, customs and beliefs, independence and family connectedness, at the choice of the service user. **Guide to requirements:** Each service user has a copy of the care plan which addresses: • all assessed needs and preferences of the service user • what action is to be taken to meet assessed needs and preferences of the service user in a culturally safe and respectful way • who is responsible for what care (staff with the necessary skills and qualifications, family members and/or other providers) • when and where care is to be received (ensuring a culturally safe environment).	**Policies and procedures could include:** • service user care planning including who is responsible for care planning • service user involvement in planning • identifying the service users representative/s, where applicable • cultural safety - care plans and cultural support plans • service quality and continuous improvement. **Other documentation could include:** • the care plan and cultural support plan tool used by the service • completed care plans that include all information listed under the Guide to requirements • forms, checklists or other paperwork that evidence the care plan has been developed in consultation with the service user and that they have agreed to the plan and received a copy of the plan • records that show staff who develop service user care plans have the necessary experience • records of quality activities such as: > service user file audit results > feedback from service users about their involvement in care planning and their level of satisfaction with the service/s provided. **Evidence at interview could include:** • staff responsible for developing care plans and cultural support plans explaining these processes. This could include talking about: > expected timeframes between assessment and development of a care plan > what the service user is told about care planning > who is involved in care planning > how staff go about making sure that each service user has a care plan that includes a cultural support plan.

Expected Outcome and Guide to requirements	Evidence Examples
1.3 Review Each service user is monitored to ensure: service delivery occurs as planned, their needs are regularly reassessed and the care plan is updated in consultation with the service user to reflect any change in needs and service user preferences. **Guide to requirements:** Service user and care plan review: • occurs at least six monthly and where service user needs change • identifies progress against planned goals/actions • results in any change in needs and preferences being documented in the care plan.	**Policies and procedures could include:** • service user care plan review including who is responsible for the reviews and how often they occur • service user involvement in care plan review • identifying the service users representative/s, where applicable • cultural safety – review of care plans and cultural support plans • service quality and continuous quality improvement. **Other documentation could include:** • the care plan and cultural support plan tool used by the service which has the provision to record when review is due and has occurred • completed care plans that show review is regularly scheduled and has occurred • forms, checklists or other paperwork that evidence the care plan has been reviewed in consultation with the service user and that they have agreed to the reviewed plan and received a copy of the plan • records that show staff who review service user care plans have the necessary experience • records of quality activities such as: > service user file audit results > feedback from service users about their involvement in care plan reviews. **Evidence at interview could include:** • staff responsible for the review of care plans and cultural support plans explaining these processes. This could include talking about: > how often care plan review occurs > what the service user is told about care plan reviews > who is involved in care plan reviews > how staff go about making sure that each service users care plan is reviewed regularly in a culturally safe way > how staff go about making sure that the reviewed care plan/cultural support plan addresses all identified needs relating to independence, physical, social, emotional, clinical and cultural care > processes to evidence that the service user agrees with the reviewed care plan > processes to evidence that the service user receives a copy of the reviewed care plan.

Expected Outcome and Guide to requirements	Evidence Examples
1.4 Clinical Care Each service user's clinical care needs are met. **Guide to requirements:** Each staff member works within their scope of practice. Clinical care needs include, as applicable: • special care needs • safe and effective management and administration of medication • effective assessment, treatment and management of pain • access to specialised palliative care services • access to other specialist health care/ allied health services • functional care • cognitive care • sensory care • nutritional care • personal care. *Note: The requirements within this outcome may have limited applicability or not be applicable to some organisations, depending upon the services provided to service users.*	**Policies and procedures could include:** • working within scope of practice • what is clinical care • planning clinical care • who is responsible for delivering clinical care • service user involvement in clinical care • family or representative involvement in clinical care • identifying the service users representative/s, where applicable • cultural safety - care plans and cultural support plans: delivering culturally safe clinical care. **Other documentation could include:** • the care plan used by the service has the provision to record all areas of clinical care needs as listed in the Guide to requirements • completed care plans include all relevant clinical care needs • forms, checklists or other paperwork that evidence that clinical care is planned and delivered in consultation with the service user • records that show staff who plan and deliver clinical care have the necessary experience • records of quality activities such as: > service user file audit results > feedback from service users about the clinical care they receive. **Evidence at interview could include:** • staff responsible for planning and delivering clinical care explaining these processes. This could include talking about: > scope of practice > how clinical care planning occurs > who is involved in planning and delivering clinical care > what the service user is told about clinical care > how staff go about making sure that the care plan addresses all identified clinical care needs in a culturally safe way > how staff go about making sure that each service users clinical care needs are reviewed regularly > processes to evidence that the service user agrees with the reviewed care plan > processes to evidence that the service user receives a copy of the reviewed care plan.

Expected Outcome and Guide to requirements	Evidence Examples
1.5 Information Each prospective service user is fully informed about service choices and their rights and responsibilities as a service user. **Guide to requirements:** • information about available services and eligibility to receive services is clearly documented. This information is communicated in a manner that is appropriate in format and culturally acceptable to each prospective service user to support choice and decision making • each service user is offered a service agreement by the service provider which sets out the terms and conditions of the service/s to be received and the service user's rights and responsibilities[2] • the service provider ensures that the content of the service agreement is fully explained to each service user (and/or their representative) in a culturally acceptable way prior to entering into the agreement • a process is in place to enable service users to be represented by an advocate of their choice.	**Policies and procedures could include:** • eligibility • priority of access • waiting lists • assessment • offering service • refusing or ending a service • using an interpreter • information to be given to prospective service users • rights and responsibilities • identifying the service users representative/s, where applicable • service agreements • cultural safety - communicating in a culturally safe way • service quality and continuous improvement. **Other documentation could include:** • information about the service is recorded in a culturally acceptable way • the information provided to service users includes all information listed under the Guide to requirements • forms, checklists or other paperwork that evidence that information about the service is provided and explained to each service user in a culturally acceptable way • records of interpreter use.

2 As per National Aboriginal and Torres Strait Islander Flexible Aged Care Program Service Provider Guidelines, 5. Care Recipient Rights and Responsibilities and 5.3 A Care Recipient has the right to security of tenure, in particular.

Expected Outcome and Guide to requirements	Evidence Examples
1.5 Information (continued)	**Other documentation could include:** • the service agreement which sets out: > the service/s to be received (emergency/planned respite, low/high care or other) > the duration of the service (permanent or short term) > the frequency of service > where services will be provided (residential or community based) > who will deliver the service > the date services will commence > he agreed fees payable and how these charges are determined > the care plan > the circumstances under which: - either party can terminate the agreement - the service provider can reallocate the service user's place - the service provider must help the service user to access alternative care - the service user may choose to suspend the provision of care > service user rights and responsibilities including: - the right to make decisions about the care to be received - information and consultation - protection of privacy and confidentiality - comments and complaints - advocacy - other rights and responsibilities as a service user • records of quality activities such as: > service user file audit results > feedback from service users about the content and appropriateness of the information they have been given and general communication by the service.

Expected Outcome and Guide to requirements	Evidence Examples
1.5 Information (continued)	**Evidence at interview could include:** • staff responsible for providing information to prospective service users explaining these processes. This could include talking about: > what information is provided > when this information is provided > who receives this information > what format this information is provided in > service user rights and responsibilities > how staff go about making sure that each service user and/or their representative understands this information > under what circumstances an interpreter is used > how an interpreter service is organised > how service user consent is obtained to use an interpreter > how interpreter use is recorded > processes to evidence that all service users have received all required information > processes to evidence that all service users have been offered a service agreement > processes to evidence that all service users have received a copy of the service agreement. **Observation of evidence could include:** • Looking at displays of posters, brochures, forms or other information at the service in an appropriate format informing service users about: > services provided > their rights and responsibilities > interpreter use.

Standard 2. Management and Accountability

The service provider has implemented systems and processes which ensure the organisation is well managed and services are continually improved. This results in the delivery of culturally safe, quality services that are responsive to the needs of each service user, their representatives, staff and other stakeholders.

Expected Outcome and Guide to requirements	Evidence Examples
2.1 Governance The service provider has clear and effective governance processes in place. **Guide to requirements:** • Board/Committee members have appropriate skills, knowledge and experience to carry out their role • Board/Committee members have an understanding of, and promote culturally safe service delivery • the roles and responsibilities of the Board/Committee are documented • meeting minutes and other records evidence that the Board/Committee carry out their roles and meet their responsibilities • planning occurs to set strategic directions and promote the delivery of culturally safe quality aged care services • the service actively engages with and consults the community about the services available and reflects this in service planning.	**Policies and procedures could include:** • the organisation's Mission and Vision • selection, recruitment and appointment of Board/ Committee members • induction and training of Board/Committee members • Board/Committee members Code of Conduct/Ethics • Board/Committee members roles and responsibilities • Board/Committee subcommittees • Board/Committee member evaluation • strategic, business and operational planning including development and review of plans • stakeholder consultation • compliance with funding agreements • financial management and reporting • risk management • fraud • conflict of interest • delegation of authority • cultural safety – providing a culturally safe service • service quality and continuous improvement • document control. **Other documentation could include:** • the organisation's Mission and Vision • records evidencing that Board/Committee members have the required skills and a commitment to cultural safety • Board/Committee member selection, recruitment and induction records • Board/Committee member police checks • records of Board/Committee member training in governance and management • the organisation's constitution • organisational chart • Board/committee meeting schedule, agenda, meeting minutes

Expected Outcome and Guide to requirements	Evidence Examples
2.1 Governance (continued)	• information for stakeholders about the Board/Committees role • Board/Committee reports • records of planning activities including stakeholder consultation • demographic data about the community and current service users • strategic and business plans • reports against organisational plans, targets and goals • budget, financial records and reports including acquittals to funding bodies • financial audit records • insurances • a risk register • Quality Improvement Plan • records of quality activities such as: > Board/Committee member file audit results > Board/Committee member evaluations > Stakeholder feedback about governance of the organisation. **Evidence at interview could include:** • Board members talking about: > their skills and understanding of cultural safety > their selection and recruitment to the Board/Committee > the organisation's Mission and Vision > induction and access to other training > Board/Committee roles and responsibilities > service quality and continuous quality improvement > management roles and responsibilities > Board/Committee policies and procedures > processes for policy development, authorisation and review > strategic and business planning > their knowledge of the community and service user demographic > financial management and reporting > risk management.

Expected Outcome and Guide to requirements	Evidence Examples
2.2 Management Systems The service provider has clear and effective management systems and practices in place. **Guide to requirements:** • the service provider understands and complies with the funding agreement, including the Service Provider Guidelines • the service provider understands and complies with regulatory and relevant legislative requirements • management and staff accountabilities and delegations are documented, relevant to their roles • service planning and development occurs and aligns with the organisation's strategic directions • financial, human and physical resources are allocated and used in ways that support quality care services that are delivered in a culturally safe and comfortable environment • information management systems are in place to ensure the service users' right to privacy, dignity and confidentiality in relation to the use of and collection of personal information • information management systems are in place to ensure the safe and secure storage of documents and records, and enable effective use of information to meet the needs of each service user, staff, management and regulatory bodies • a process to manage positive feedback, complaints and allegations is in place which is effective, accessible, and culturally acceptable to stakeholders • the service provider works in partnership with other organisations to maximise access to services and/or enhance service delivery • a continuous quality improvement program is in place to monitor and improve: > the care and services provided to service users, and > the management systems and practices of the service provider.	**Policies and procedures could include:** • the organisation's Mission and Vision • Code of Conduct/Ethics • selection, recruitment and appointment of staff • induction and training of staff • position descriptions • delegation of authority • legislative compliance • compliance with funding agreements • strategic, business and operational planning including development and review of plans • internal reporting • financial management and reporting • risk management • subcontracting • Memorandums of Understanding • purchasing goods and services • asset management • stakeholder consultation • privacy, dignity and confidentiality • information management systems • document control • feedback, complaints and allegations • staff grievances • working with other service providers • cultural safety - providing a culturally safe service • service quality and continuous quality improvement. **Other documentation could include:** • organisational chart • position descriptions • records evidencing that management/staff members have the required skills and a commitment to cultural safety • management/staff member selection, recruitment and induction records • management/staff training records • management/staff meeting schedule, agenda and meeting minutes • management reports to the Board/Committee • records of business/operational/program planning activities including stakeholder consultation

Expected Outcome and Guide to requirements	Evidence Examples
2.2 Management Systems (continued)	• demographic data about the community and current service users • reports against organisational plans, targets and goals • budget, financial records and reports including acquittals to funding bodies • Quality Improvement Plan • Records of quality activities such as: > management file audit results > management appraisals > stakeholder feedback about management of the organisation. **Evidence at interview could include:** • Management/staff talking about: > the organisation's Mission and Vision > their skills and understanding of cultural safety > their selection and recruitment > induction and access to other training > their roles and responsibilities > organisational structure – lines of reporting > policies and procedures > strategic and business/operational planning > their knowledge of/access to relevant legislation and updates their knowledge of the community and service user demographic > program funding, budget and targets > financial management and reporting > risk management > service quality and continuous quality improvement > cultural safety - providing a culturally safe service > maintaining privacy, dignity and confidentiality in relation to information management with reference to the relevant legislation > management of feedback and complaints > management of staff grievances. **Observation of evidence could include:** • Looking at: > file storage areas within the service > displays of posters, brochures, forms or other information in an appropriate format informing service users about: - privacy, dignity and confidentiality - service quality and continuous quality improvement - feedback and complaint processes.

Expected Outcome and Guide to requirements	Evidence Examples
2.3 Risk Management A risk management framework is in place to ensure the safety of service users, staff and other stakeholders, and that quality care services are delivered. **Guide to requirements:** • effective financial management processes are in place to ensure the service is, and remains, financially viable. Financial risks are identified and managed in an appropriate manner • an asset management program is in place • purchased goods and services are of a standard that ensure the delivery of quality aged care services • procedures are in place to identify and address potential risks associated with the physical environment, chemicals or dangerous goods, and work practices • procedures are in place for the management of natural disasters and other emergency events • effective infection control procedures are implemented • procedures are in place to identify and manage risk associated with: > laundry services > kitchen and food handling > cleaning > fire equipment > open fire supervision > resident smoking • procedures are in place to identify and manage risk related to service delivery.	**Policies and procedures could include:** • risk management, including clinical risk management • financial management and reporting • insurances • delegations of authority • internal reporting • conflict of interest • fraud • legislative compliance • information management • compliance with funding agreements • purchasing goods and services • asset management • occupational health and safety (OH&S) including: > staff training in OH&S > environmental risk assessment and reporting > fire safety and equipment including open fire supervision > handling and storing chemicals or dangerous goods > hazard identification and reporting > incident and accident reporting > managing natural disasters and other emergencies > infection control > cleaning > food safety and food preparation > safe work practices > travel > maintenance (including building, equipment and vehicles) > OH&S representatives and/or committee, as applicable. • cultural safety – cultural safety and risk management • service quality and continuous quality improvement.

Expected Outcome and Guide to requirements	Evidence Examples
2.3 Risk Management (continued)	**Other documentation could include:** • Board/Committee reports • risk management plan/risk register • management reports to the Board/Committee reports against organisational plans, targets and goals • asset register • records evidencing that management/staff members have the required skills and a commitment to cultural safety • management/staff training records: fire safety and general OH&S • management/staff meeting schedules, agendas and meeting minutes • forms, checklists or other paperwork that evidence that: > all work sites have a regular safety assessment that is documented and reported > staff have received training in fire safety > fire safety equipment complies with the required standard/regulations > preventative maintenance occurs > hazards are identified, documented reported and addressed > incidents and accidents are documented, reported and action taken as necessary > infections are monitored and reported > all of the above are monitored to ensure any emerging trends are identified and addressed • Quality Improvement Plan • records of quality activities such as: > analysis of work site safety assessments > analysis of incidents/accidents, infections > stakeholder feedback about the safety/appropriateness of equipment.

Expected Outcome and Guide to requirements	Evidence Examples
2.3 Risk Management (continued)	**Evidence at interview could include:** • Board/Committee, Management or staff, as appropriate, talking about: > the organisation's risk management framework > their roles and responsibilities > organisational structure – lines of reporting > policies and procedures > strategic and business/operational planning > their knowledge of/access to relevant legislation and updates > financial management and reporting program funding, budget and targets > service quality and continuous quality improvement > cultural safety – cultural safety and risk management: choice and decision making and risk > management of emergencies > OH&S policies, procedures and practices > preventative maintenance. **Observation of evidence could include:** • Looking at: > access to the building > entry and exit points > safety and security measures > facilities and equipment > fire safety equipment > evacuation plans > storage and handling of chemicals > infection control processes > cleaning processes > laundering processes > catering processes, where applicable.

Expected Outcome and Guide to requirements	Evidence Examples
2.4 Human Resources Effective staff recruitment and retention ensure that service users' needs are met. **Guide to requirements:** • recruitment and retention processes ensure sufficient staffing levels are maintained at all times for the delivery of safe services • services are provided by appropriately skilled staff that have an understanding of the cultural needs of the key stakeholders, including service users • all staff and volunteers have a current police check that complies with the funding agreement • staff and volunteers are provided with training and development activities relevant to their role • an effective performance appraisal process is implemented for staff and volunteers.	**Policies and procedures could include:** • selection and recruitment of staff including: > advertising > applications > short listing > interviewing > notifying applicants > referee checks > sighting qualifications > police checks > staff contracts/agreements • induction • Code of Conduct • Occupational Health and Safety • privacy, dignity and confidentiality • service quality and continuous improvement • cultural safety – providing a culturally safe service • equal employment opportunity • workplace bullying and harassment • workforce planning/staff retention • training and development • staff appraisal. **Other documentation could include:** • recruitment advertisements • position descriptions • interview questions • induction agenda, program or handbook • forms, checklists or other paperwork that evidence: > staff applications > interview processes > staff qualifications > reference checks > police checks > staff contracts/agreements > completion of induction > ongoing training > appraisal > workforce planning, rostering, allocation

Expected Outcome and Guide to requirements	Evidence Examples
2.4 Human Resources (continued)	• training budget • Quality Improvement Plan • records of quality activities such as: > staff file audits to verify all required information is recorded > the selection and recruitment process is completed in line with the services policy and procedure > staff feedback about their selection recruitment and induction experience > staff feedback about training and support, appraisal and working in the organisation. **Evidence at interview could include:** • Board/Committee, Management or staff, as appropriate, talking about: > selection and recruitment > screening processes > induction > training and support > appraisal > their roles and responsibilities > organisational structure – lines of reporting > OH&S policies, procedures and practices > management of emergencies > service quality and continuous quality improvement > cultural safety – cultural safety and risk management: choice and decision making and risk.

APPENDIX

one

Self-Assessment Tool

National Aboriginal and Torres Strait Islander Flexible Aged Care Program

SERVICE PROVIDER SELF-ASSESSMENT

SERVICE NAME

SERVICE PROVIDER	
SERVICE ID	
SITE ADDRESS	
CONTACT NAME	
DUE DATE	
DATE SUBMITTED	
SUBMITTED TO	

EXPECTED OUTCOMES	ASSESSMENT MATRIX				
	Place a tick (✓) in the appropriate box:	Met	Part Met	Not Met	Not Applicable
	Standard 1: Care Delivery and Information				
	1.1 Assessment	❑	❑	❑	❑
	1.2 Care Planning	❑	❑	❑	❑
	1.3 Review	❑	❑	❑	❑
	1.4 Clinical Care	❑	❑	❑	❑
	1.5 Information	❑	❑	❑	❑
	Standard 2: Management and Accountability				
	2.1 Governance	❑	❑	❑	❑
	2.2 Management Systems	❑	❑	❑	❑
	2.3 Risk Management	❑	❑	❑	❑
	2.4 Human Resources	❑	❑	❑	❑
	ASSESSMENT RESULT:				

The Assessment Matrix is a summary of the findings of the self-assessment, and allows services to identify their organisation's overall performance against the standards. The Assessment Matrix should be completed at the end of the self-assessment. Completing the matrix requires you to first insert the rating against each expected outcome, reflecting the self-assessment findings. The following ratings apply:

- **Met:** written and verbal evidence clearly demonstrates that the service provider meets all the requirements of the expected outcome
- **Part Met:** written and verbal evidence clearly demonstrates that the service provider only meets part of the requirements of the expected outcome
- **Not Met:** written and verbal evidence clearly demonstrates that the service provider does not meet the requirements of the expected outcome
- **Not Applicable:** a not applicable rating may apply, for example, where a service does not provide clinical care to service users (refer to expected outcome 1.4).

Once each expected outcome has been rated, the overall Assessment Result can be determined. The Assessment Result is applied as follows:

- **Met:** all the requirements of each expected outcome have been met
- **Part Met:** the requirements of one or more expected outcomes have not been fully met
- **Not Met:** the requirements of no expected outcomes have been met.

Standard 1: Care Delivery and Information
Expected Outcome 1.1: Assessment
Evidence Examples
Self-assessment Findings
SELF-ASSESSMENT RATING:
Quality Improvement Actions
Action required to meet the Expected Outcome:
Optional action to support Continuous Quality Improvement:

Standard 1: Care Delivery and Information
Expected Outcome 1.2: Care Planning
Evidence Examples
Self-assessment Findings
SELF-ASSESSMENT RATING:
Quality Improvement Actions
Action required to meet the Expected Outcome:
Optional action to support Continuous Quality Improvement:

Standard 1: Care Delivery and Information
Expected Outcome 1.3: Review
Evidence Examples
Self-assessment Findings
SELF-ASSESSMENT RATING:
Quality Improvement Actions
Action required to meet the Expected Outcome:
Optional action to support Continuous Quality Improvement:

Standard 1: Care Delivery and Information
Expected Outcome 1.4: Clinical Care
Evidence Examples
Self-assessment Findings
SELF-ASSESSMENT RATING:
Quality Improvement Actions
Action required to meet the Expected Outcome:
Optional action to support Continuous Quality Improvement:

Standard 1: Care Delivery and Information
Expected Outcome 1.5: Information
Evidence Examples
Self-assessment Findings
SELF-ASSESSMENT RATING:
Quality Improvement Actions
Action required to meet the Expected Outcome:
Optional action to support Continuous Quality Improvement:

Standard 2: Management and Accountability
Expected Outcome 2.1: Governance
Evidence Examples
Self-assessment Findings
SELF-ASSESSMENT RATING:
Quality Improvement Actions
Action required to meet the Expected Outcome:
Optional action to support Continuous Quality Improvement:

Standard 2: Management and Accountability
Expected Outcome 2.2: Management Systems
Evidence Examples
Self-assessment Findings
SELF-ASSESSMENT RATING:
Quality Improvement Actions
Action required to meet the Expected Outcome:
Optional action to support Continuous Quality Improvement:

Standard 2: Management and Accountability
Expected Outcome 2.3: Risk Management
Evidence Examples
Self-assessment Findings
SELF-ASSESSMENT RATING:
Quality Improvement Actions
Action required to meet the Expected Outcome:
Optional action to support Continuous Quality Improvement:

Standard 2: Management and Accountability
Expected Outcome 2.4: Human Resources
Evidence Examples
Self-assessment Findings
SELF-ASSESSMENT RATING:
Quality Improvement Actions
Action required to meet the Expected Outcome:
Optional action to support Continuous Quality Improvement:

Self-assessment Checklist	
Please ensure you have completed the following information before submitting your self-assessment.	
Your service provider details	❑
The Assessment Matrix	❑
Your Evidence Examples for each applicable Expected Outcome (Please save your actual Evidence Examples for the on-site review)	❑
Self-assessment Findings for each applicable Expected Outcome	❑
A Self-assessment Rating for each applicable Expected Outcome	
The Quality Improvement 'Actions Required to meet the Expected Outcome' where you have rated an expected outcome as Part Met or Not Met.	❑
The Quality Improvement Plan 'Optional Action to support Continuous Quality Improvement' where you have rated an expected outcome as Met, but identified improvement opportunities.	❑

APPENDIX

two

Examples Completed Self-Assessments

Example of a completed Assessment Matrix

	ASSESSMENT MATRIX				
EXPECTED OUTCOMES	**Place a tick (✓) in the appropriate box:**	**Met**	**Part Met**	**Not Met**	**Not Applicable**
	Standard 1: Care Delivery and Information				
	1.1 Assessment	✓			
	1.2 Care Planning	✓			
	1.3 Review	✓			
	1.4 Clinical Care				✓
	1.5 Information		✓		
	Standard 2: Management and Accountability				
	2.1 Governance	✓			
	2.2 Management Systems	✓			
	2.3 Risk Management	✓			
	2.4 Human Resources			✓	
	ASSESSMENT RESULT:	Part Met			

In the example above, the service provider has achieved an overall Assessment Result of Part Met.

The Part Met rating applies because the requirements of one or more expected outcomes have not been fully met. In this instance, expected outcome 1.5 Information has been rated as Part Met and expected outcome 2.4 Human Resources has been rated as Not Met.

Some examples of expected outcomes rated at self-assessment are provided on the next few pages. When completing the self-assessment it is not necessary to include lengthy information about policies and procedures or other types of evidence. It is acceptable to just list the *name or number* of the policy and procedure or other documents that you have as evidence and can provide to the reviewers.

Similarly, the purpose of the Assessment Findings sections is to provide a *brief* summary as to why your service have self-assessed as Met, Part met, Not Met or Not Applicable.

The following examples also demonstrate different approaches to documenting the Evidence Examples section.

Example of a completed Expected Outcome self-assessed as 'Met'

Standard 1: Care Delivery and Information

The following examples also demonstrate different approaches to documenting the Evidence Examples section.

Expected Outcome 1.2: Care Planning
Evidence Examples
• service user care planning policy and procedure • service user involvement in planning policy and procedure • service user's representative policy and procedure • cultural safety: care plans and cultural support plans policy and procedure • service quality and continuous improvement policy and procedure • care plan and cultural support plan tools • service user completed care plans and cultural support plans • service user file audit results • service user survey results • staff files (qualifications and training) Other information: Management and staff responsible for care planning will be available for interview.
Self-assessment Findings
We conduct regular service user file audit results which show that all service users have a current care plan and cultural support plan that is based on assessed needs and preferences. Our care plans and cultural support plans detail the all action to be taken, who is responsible for care and when and where care is to be received. We have records to show that service users are involved in care planning and that a copy of the care plan is always offered. However we have identified an opportunity for improvement in this area. (See Quality Improvement Plan).
SELF-ASSESSMENT RATING: **Met**
Quality Improvement Actions
Action required to meet the Expected Outcome:
Optional action to support Continuous Quality Improvement:
Include room in the care plan to note when a service user and/or their representative refuse the offer of a copy of the care plan.

Example of a completed Expected Outcome self-assessed as 'Part Met'

Standard 1: Care Delivery and Information
Expected Outcome 1.5: Information
Evidence Examples
We have the following policies and procedures that relate to this expected outcome: Eligibility, priority of access and entry to the service, Giving service user information, Communicating with stakeholders and cultural safety, When to use an interpreter, service user rights and responsibilities and service agreements. Information Pack: all new service users and/or their representatives receive the Information Pack. This includes all aspects of service user's rights and responsibilities. We have this information in several formats to meet the needs of our stakeholders. Our staff always explains this information verbally as well. We will use an interpreter when necessary. Our intake and assessment staff will be available to talk about these processes. We can show you copies of service user's service agreements in their files.
Self-assessment Findings
We checked a sample of service user's files and found none of the files had any evidence that the Information Pack was explained or given to those service users. Yet we are confident that our staff always do this.
SELF-ASSESSMENT RATING: **Part Met**
Quality Improvement Actions
Action required to meet the Expected Outcome:
Make sure the staff giving and explaining the Information Pack know that they must note that they have done this in the service user's file. The entry should always be signed and dated by the staff member. Add this requirement to our procedure. Audit files in two months to check progress.
Optional action to support Continuous Quality Improvement:

Example of a completed Expected Outcome self-assessed as 'Not Met'

Standard 2: Management and Accountability
Expected Outcome 2.4: Human Resources
Evidence Examples
Human resources policies and procedures. Staff files. Our new HR manager will be available to explain our processes and current situation.
Self-assessment Findings
Our staff records do not currently have information about our selection and recruitment, screening, training or appraisal processes. The HR Manager has recently left and we are unsure whether the appropriate records have not been kept or have been misplaced. We have plans to implement a system to address this as soon as possible. Our new HR Manager will be starting in three weeks. We have recently had a number of other staff leave and have had to suspend services to some community based care recipients/service users. We have recently commenced a staff recruitment strategy.
SELF-ASSESSMENT RATING: **Not Met**
Quality Improvement Actions
Action required to meet the Expected Outcome:
Implement a human resources records management system to evidence: • recruitment and retention processes that ensure sufficient staffing levels are maintained • services are provided by appropriately skilled staff • police records checks for all staff and volunteers at commencement • training and development activities • an appraisal process is in place and appraisal occur as scheduled
Optional action to support Continuous Quality Improvement:

APPENDIX

three

Quality Reviewer Desk Top Review Record

Purpose: The following tool is to support Quality Reviewers to undertake the Desk Top Review Record of the Service Provider Self Assessment.

Template 1: Desk Top Review Record Tool

National Aboriginal and Torres Strait Islander Flexible Aged Care Program

DESK TOP REVIEW RECORD

Service Name	

SERVICE PROVIDER	
SERVICE ID	
SITE ADDRESS	
CONTACT NAME	
POSITION	
DUE DATE	
DATE SUBMITTED	
COMPLETED BY	

DESK TOP REVIEW RECORD

Self Assessment Report	✓	✗	Comments
Has the Assessment Matrix been completed?			
Are evidence examples included for each applicable expected outcome?			
Is the self assessment finding completed for each applicable expected outcome?			
Is the self assessment rating completed for each applicable expected outcome?			
Has any supporting documentation been submitted with the self assessment report? (If so, please list in the space provided on the next page).			
Has the self assessment report been satisfactorily completed?			
Is additional information required?			
Has additional information been requested? (If so, please note what information has been requested and the due date for submission in the comments section).			
Departmental Records Reviewed	**✓**	**✗**	**Comments**
Service Provider Service Agreement			
Annual returns			
Compliance history (as applicable)			
Complaints' history			
Previous self assessment report/s			
Previous on-site review report/s and/or quality improvement plans			
Other information			
Summary of findings of Desk Top Review (including any further action required/pending):			
Findings of the Desk Top Review have been reported to: **Name of Person completing the Desk Top Record:** **Signature:** **Date:**			

DESK TOP REVIEW RECORD

Supporting Documentation Submitted	Comments

Quality Reviewer Tools

APPENDIX

four

On-Site Review Planning Templates

Purpose: The following templates are used by the Quality Review Team to plan an On-Site Review.

Template 1: On-Site Review Checklist

Template 2: Entry Meeting Agenda

Template 3: Entry/Exit Meeting Attendance Record

Template 4: Exit Meeting Agenda

Template 5: Examples On-Site Review Schedules

National Aboriginal and Torres Strait Islander Flexible Aged Care Program Quality Framework On-site Review

This list is provided as a starting point to the type of documents the on-site reviewer will ask to see at the on-site visit. The list is a guide only - the reviewer may ask for other documentation or your service may have other types of records and information which are relevant. Please prepare for the on-site visit by having these documents ready for reviewers at the start of the on-site visit.

ORGANISATION

- ❑ 1. Policy and Procedures manuals
- ❑ 2. Organisational structure/staffing chart
- ❑ 3. Insurance certificates
- ❑ 4. Funding Agreement with DoHA
- ❑ 5. Details of any sub-contracting arrangements
- ❑ 6. Police Checks

CLIENT DOCUMENTATION

- ❑ 1. Information given to clients on admission
- ❑ 2. Assessment tool(s) used
- ❑ 3. Informed consent documents
- ❑ 4. Admission records
- ❑ 5. Referral records
- ❑ 6. Complaints register
- ❑ 7. Care Plans

STAFF WHO WORK WITH CLIENTS

- ❑ 1. List of staff including their qualifications
- ❑ 2. Staff education / training program and attendance records
- ❑ 3. Typical staff plan or roster

OTHER RECORDS

- ❑ 1. Financial accounts and budgets
- ❑ 2. Strategic operating plans
- ❑ 3. Asset register

National Aboriginal and Torres Strait Islander Flexible Aged Care Program Quality Framework On-site Review

Entry Meeting Agenda

1. Introductions

2. Explanation of reviewer methodology: document review, interview and observation (*use of interpreter where appropriate*)

3. Interview: overview of the organisation (governance, size, structure, sites, service delivery)

4. Confirm the proposed review agenda (including scheduling of interviews and the exit meeting)

5. Questions

6. Site tour

National Aboriginal and Torres Strait Islander Flexible Aged Care Program Quality Framework On-site Review

Entry/Exit Meeting Attendance Record

Organisation:

Date:

Name	Position	Entry Meeting	Exit Meeting

National Aboriginal and Torres Strait Islander Flexible Aged Care Program Quality Framework On-site Review

Exit Meeting Agenda

1. Confirm review findings (including reviewer ratings)

2. Explanation of reporting processes and timeframes

3. Draft and final reports and feedback process

4. Development of Quality Improvement Plans

5. Complaints process

6. Questions

Example: ONE DAY on-site visit schedule

8.30-9.30am	Entry meeting with management representatives, including: • introductions • explanation of reviewer methodology • request for an overview of the organisation (governance, size, structure, sites, service delivery) • confirmation of the proposed review agenda (including scheduling of interviews and the exit meeting) • questions
9.30 -12.15	Tour of site Reviewers' examination of documentation Client interviews Staff interviews
12.15-1.00pm	Lunch
1.00-3.30	File audits Reviewers' examination of documentation
3.30 -4.30 pm	Exit Meeting, including: • confirm review findings (including reviewer ratings) • explanation of reporting processes and timeframes • draft and final reports and feedback process • development of Quality Improvement Plan • complaints

Example: ONE and ONE HALF DAY on-site visit schedule

Day One	On arrival, am	Entry meeting with management representatives, including: • introductions • explanation of reviewer methodology • request for an overview of the organisation (governance, size, structure, sites, service delivery) • confirmation of the proposed review agenda (including scheduling of interviews and the exit meeting) • questions
	10-12.15	Tour of site Reviewers' examination of documentation* Client interviews
	12.15-1.00pm	Lunch
	1.00-3.00	Staff interviews File audits
	3.00-5.00pm	Reviewers' examination of documentation
Day Two	9.00 am	Remaining file audits and staff / client interviews completed Reviewers' examination of documentation
	Time to be confirmed at on-site visit	Exit Meeting, including: • confirm review findings (including reviewer ratings) • explanation of reporting processes and timeframes • draft and final reports and feedback process • development of Quality Improvement Plan • complaints process

Example: TWO DAY on-site visit schedule

Day One	9.00-10.00am	Entry meeting with management representatives, including: • introductions • explanation of reviewer methodology • request for an overview of the organisation (governance, size, structure, sites, service delivery) • confirmation of the proposed review agenda (including scheduling of interviews and the exit meeting) • questions
	10-12.15	Tour of site Reviewers' examination of documentation Client interviews
	12.15-1.00pm	Lunch
	1.00-3.00	Staff interviews File audits
	3.00-5.00pm	Reviewers' examination of documentation
Day Two	9.00-11.00am	Remaining file audits and staff /client interviews completed
	11.00 -12.00	Reviewers' examination of documentation
	12.15-1.00pm	Lunch
	Times to be Confirmed on-site	Exit Meeting, including: • confirm review findings (including reviewer ratings) • explanation of reporting processes and timeframes • draft and final reports and feedback process • development of Quality Improvement Plan • complaints process

APPENDIX

five

On-Site Review Tools and Templates

Purpose: The following tools and template are to support Quality Reviewers to undertake the On-Site Review and develop a Review Report. At the conclusion of the review, the draft Review Report will be provided to the Service Provider.

Template 1: Reviewer Audit Tool – Staff Files

Template 2: Reviewer Audit Tool – Service User Files

Template 3: On-Site Review Report Template

National Aboriginal and Torres Strait Islander Flexible Aged Care Program

Reviewer Audit Tool: Staff files

Service Name	

SERVICE PROVIDER	
SERVICE ID	
SITE ADDRESS	
CONTACT NAME	
POSITION	
COMPLETED BY	
DATE	

National Aboriginal and Torres Strait Islander Flexible Aged Care Program Quality Framework On-site Review

Reviewer Audit Tool: Staff files

Service Provider:	Date:									
File Contents	In Staff file or Other Record (✓, ✗ orNA)									
	1	2	3	4	5	6	7	8	9	10
Job description **(2.3)**										
Application/resume/interview record shows suitable experience for the role and responsibilities **(2.4)**										
Copies of qualifications, where applicable **(2.4)**										
Reference checks **(2.4)**										
Police records check **(2.4)**										
Employment contract/agreement **(2.4)**										
Induction record: • Occupational Health & Safety • Emergency procedures **(2.3)**										
Training/professional development records **(2.4)**										
Performance appraisals **(2.4)**										
Comments										
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

Key:
✓ = Yes
✗ = No
NA = Not Applicable

Note to reviewers: The bracketed reference following each item relates to the corresponding Expected Outcome/Guide to requirements. No identifying information is to be recorded by reviewers. The file number (1-10) should be used if recording information in the comments section.

National Aboriginal and Torres Strait Islander Flexible Aged Care Program

Reviewer Audit Tool: Service User Files

Service Name	

SERVICE PROVIDER	
SERVICE ID	
SITE ADDRESS	
CONTACT NAME	
POSITION	
COMPLETED BY	
DATE	

National Aboriginal and Torres Strait Islander Flexible Aged Care Program Quality Framework On-site Review

Reviewer Audit Tool: Service User Files

Service Provider:	Date:									
File Contents	In Staff file or Other Record (✓, ✗ or NA)									
	1	2	3	4	5	6	7	8	9	10
Evidence of eligibility **(1.1)**										
Process to establish priority of access **(1.1)**										
Completed assessment which considers: • independence • physical needs • social needs • emotional needs • cultural needs • clinical care needs, where applicable **(1.1)**										
Evidence of service user and/or their representatives participation in assessment **(1.1)**										
Completed care plan which: • addresses all assessed needs/preferences • documents the action to be taken • documents who is responsible for what care • documents where and when care is to be received • includes a cultural support plan that: > includes strategies to maintain privacy and dignity > individual interests > customs and beliefs > independence > family connectedness **(1.2)**										
Evidence of service user and/or their representatives participation in care planning **(1.2)**										
Evidence that the service user and/or their representative has received a copy of the care plan **(1.2)**										

National Aboriginal and Torres Strait Islander Flexible Aged Care Program Quality Framework On-site Review

Reviewer Audit Tool: Service User Files

Service Provider:	Date:									
File Contents	**In Staff file or Other Record (✓, ✗ orNA)**									
	1	2	3	4	5	6	7	8	9	10
Care plan review: • occurs at least six monthly and where needs change • identifies progress against planned goals/ actions • results in any change in needs and preferences being documented in the care plan.**(1.3)**										
Clinical care needs are documented, **as applicable:** • special care needs • safe and effective management and administration of medication • effective assessment, treatment and management of pain • access to specialised palliative care services • access to other specialist health care/allied health services • functional care • cognitive care • sensory care • nutritional care • personal care. **(1.4)** *Note: The requirements within this outcome may have limited applicability or not be applicable to some organisations, depending upon the services provided to service users.*										
Evidence that the service user and/or their representative has received information about available services and eligibility to receive services in a manner that is appropriate in format and culturally acceptable. **(1.5)**										
Evidence that consent to share information has been obtained **(1.5)**										

National Aboriginal and Torres Strait Islander Flexible Aged Care Program Quality Framework On-site Review

Reviewer Audit Tool: Service User Files

Service Provider:	Date:									
File Contents	**In Staff file or Other Record (✓, ✗ or NA)**									
	1	2	3	4	5	6	7	8	9	10
Evidence that: • the service user has been offered a service agreement[1] • the service agreement sets out the terms and conditions of the service/s to be received and the service user's rights and responsibilities • the content of the service agreement has been fully explained to each service user (and/or their representative) in a culturally acceptable way prior to entering into the agreement • a process is in place to enable service users to be represented by an advocate of their choice **(1.5)**										
Comments										
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

Key:
✓ = Yes
✗ = No
NA = Not Applicable

Note to reviewers: The bracketed reference following each item relates to the corresponding Expected Outcome/Guide to requirements. No identifying information is to be recorded by reviewers. The file number (1-10) should be used if recording information in the comments section.

1 The information required in the service user service agreement is set out at section 5.7 'Care recipient agreement' of the *National Aboriginal and Torres Strait Islander Flexible Aged Care Program Service Provider Guidelines*.

National Aboriginal and Torres Strait Islander Flexible Aged Care Program

On-site Review Report

Service Name	

SERVICE PROVIDER	
SERVICE ID	
SITE ADDRESS	
CONTACT NAME	
REVIEWER NAMES	
REVIEW DATE/S	
DATE OF REPORT	

Executive Summary

The Review Team inserts information about the following:

- background/history of the organisation
- size, location/s, structure of the organisation
- services provided
- service user group/s and the community
- a summary of the organisation's strengths, weaknesses and opportunities for improvement identified by the reviewers with reference to the overall Review Result and number of expected outcomes that have been Met, Part Met or Not Met
- other relevant information impacting on the review.

	ASSESSMENT MATRIX				
EXPECTED OUTCOMES	Place a tick (✓) in the appropriate box:	Met	Part Met	Not Met	Not Applicable
	Standard 1: Care Delivery and Information				
	1.1 Assessment				
	1.2 Care Planning				
	1.3 Review				
	1.4 Clinical Care				
	1.5 Information				
	Standard 2: Management and Accountability				
	2.1 Governance				
	2.2 Management Systems				
	2.3 Risk Management				
	2.4 Human Resources				
	ASSESSMENT RESULT:				

The **Assessment Matrix** is a summary of the findings of the on-site review and represents the organisation's overall performance against the Standards. The Review Team has rated your organisations performance against each expected outcome, by applying the following ratings:

- **Met:** written and verbal evidence clearly demonstrates that the service provider meets all the requirements of the expected outcome
- **Part Met:** written and verbal evidence clearly demonstrates that the service provider only meets part of the requirements of the expected outcome
- **Not Met:** written and verbal evidence clearly demonstrates that the service provider does not meet the requirements of the expected outcome
- **Not Applicable:** a not applicable rating may apply, for example, where a service does not provide clinical care to service users (refer to expected outcome 1.4).

Once each expected outcome has been rated, the overall **Review Result** can be determined. The Review Result has been determined by applying the following:

- **Met:** all the requirements of each expected outcome have been met
- **Part Met:** the requirements of one or more expected outcomes have not been fully met
- **Not Met:** the requirements of no expected outcomes have been met.

Standard 1: Care Delivery and Information	
Expected Outcome 1.1: Assessment	
Evidence Examples	
Reviewer Findings	
REVIEWER RATING:	
Quality Improvement Actions	
Action required to meet the Expected Outcome:	
Optional action to support Continuous Quality Improvement:	

Standard 1: Care Delivery and Information	
Expected Outcome 1.2: Care Planning	
Evidence Examples	
Reviewer Findings	
REVIEWER RATING:	
Quality Improvement Actions	
Action required to meet the Expected Outcome:	
Optional action to support Continuous Quality Improvement:	

Standard 1: Care Delivery and Information	
Expected Outcome 1.3: Review	
Evidence Examples	
Reviewer Findings	
REVIEWER RATING:	
Quality Improvement Actions	
Action required to meet the Expected Outcome:	
Optional action to support Continuous Quality Improvement:	

Standard 1: Care Delivery and Information	
Expected Outcome 1.4: Clinical Care	
Evidence Examples	
Reviewer Findings	
REVIEWER RATING:	
Quality Improvement Actions	
Action required to meet the Expected Outcome:	
Optional action to support Continuous Quality Improvement:	

Standard 1: Care Delivery and Information	
Expected Outcome 1.5: Information	
Evidence Examples	
Reviewer Findings	
REVIEWER RATING:	
Quality Improvement Actions	
Action required to meet the Expected Outcome:	
Optional action to support Continuous Quality Improvement:	

Standard 2: Management and Accountability	
Expected Outcome 2.1: Governance	
Evidence Examples	
Reviewer Findings	
REVIEWER RATING:	
Quality Improvement Actions	
Action required to meet the Expected Outcome:	
Optional action to support Continuous Quality Improvement:	

Standard 2: Management and Accountability	
Expected Outcome 2.2: Management Systems	
Evidence Examples	
Reviewer Findings	
REVIEWER RATING:	
Quality Improvement Actions	
Action required to meet the Expected Outcome:	
Optional action to support Continuous Quality Improvement:	

Standard 2: Management and Accountability	
Expected Outcome 2.3: Risk Management	
Evidence Examples	
Reviewer Findings	
REVIEWER RATING:	
Quality Improvement Actions	
Action required to meet the Expected Outcome:	
Optional action to support Continuous Quality Improvement:	

Standard 2: Management and Accountability	
Expected Outcome 2.4: Human Resources	
Evidence Examples	
Reviewer Findings	
REVIEWER RATING:	
Quality Improvement Actions	
Action required to meet the Expected Outcome:	
Optional action to support Continuous Quality Improvement:	

APPENDIX

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Quality Improvement Plan and Progress Report templates

Purpose: The Quality Improvement Plan template is for use by Quality Reviewers to develop a draft Quality Improvement Plan, following the On-Site Review, which will be finalised in consultation with the Service Provider.

The Progress Report template will be used by the Service Provider to report on progress made in implementing actions. Service providers will also update their Quality Improvement Plan for the next year.

Template 1: Quality Improvement Plan

Template 2: Progress Report

National Aboriginal and Torres Strait Islander Flexible Aged Care Program

Service Name	
Quality Improvement Plan (Year)	

SERVICE PROVIDER	
SERVICE ID	
SITE ADDRESS	
CONTACT NAME	
POSTION	
DUE DATE	
DATE SUBMITTED	
SUBMITTED TO	

Quality Improvement Plan

Standard 1: Care Delivery and Information				
Expected Outcome 1.1: Assessment				
Quality Improvement Plan				
Planned action	Who is responsible	Due Date	Date completed	Comments
Action required to meet the Expected Outcome:				
E.g: The initial and any ongoing assessment process does not include the resident's life story.	E.g: Mary, admissions officer will lead. Shane, Board Member on Quality Committee to assist.	30th March 2012		
Optional action to support Continuous Quality Improvement:				

Quality Improvement Plan

Standard 1: Care Delivery and Information				
Expected Outcome 1.2: Care Planning				
Quality Improvement Plan				
Planned action	Who is responsible	Due Date	Date completed	Comments
Action required to meet the Expected Outcome:				
Optional action to support Continuous Quality Improvement:				

Quality Improvement Plan

Standard 1: Care Delivery and Information				
Expected Outcome 1.3: Review				
Quality Improvement Plan				
Planned action	Who is responsible	Due Date	Date completed	Comments
Action required to meet the Expected Outcome:				
Optional action to support Continuous Quality Improvement:				

Quality Improvement Plan

Standard 1: Care Delivery and Information				
Expected Outcome 1.4: Clinical Care				
Quality Improvement Plan				
Planned action	Who is responsible	Due Date	Date completed	Comments
Action required to meet the Expected Outcome:				
Optional action to support Continuous Quality Improvement:				

Quality Improvement Plan

Standard 1: Care Delivery and Information				
Expected Outcome 1.5: Information				
Quality Improvement Plan				
Planned action	Who is responsible	Due Date	Date completed	Comments
Action required to meet the Expected Outcome:				
Optional action to support Continuous Quality Improvement:				

Quality Improvement Plan

Standard 2: Management and Accountability				
Expected Outcome 2.1: Governance				
Quality Improvement Plan				
Planned action	Who is responsible	Due Date	Date completed	Comments
Action required to meet the Expected Outcome:				
Optional action to support Continuous Quality Improvement:				

Quality Improvement Plan

Standard 2: Management and Accountability				
Expected Outcome 2.2: Management Systems				
Quality Improvement Plan				
Planned action	Who is responsible	Due Date	Date completed	Comments
Action required to meet the Expected Outcome:				
Optional action to support Continuous Quality Improvement:				

Quality Improvement Plan

Standard 2: Management and Accountability				
Expected Outcome 2.3: Risk Management				
Quality Improvement Plan				
Planned action	Who is responsible	Due Date	Date completed	Comments
Action required to meet the Expected Outcome:				
Optional action to support Continuous Quality Improvement:				

Quality Improvement Plan

Standard 2: Management and Accountability				
Expected Outcome 2.4: Human Resources				
Quality Improvement Plan				
Planned action	Who is responsible	Due Date	Date completed	Comments
Action required to meet the Expected Outcome:				
Optional action to support Continuous Quality Improvement:				

National Aboriginal and Torres Strait Islander Flexible Aged Care Program

QUALITY IMPROVEMENT PLAN [year] - PROGRESS REPORT

Service Name	

SERVICE PROVIDER	
SERVICE ID	
SITE ADDRESS	
CONTACT NAME	
POSTION	
DUE DATE	
DATE SUBMITTED	
SUBMITTED TO	

Progress Report

Standard 1: Care Delivery and Information				
Expected Outcome 1.1: Assessment				
Quality Improvement Plan (Insert Year) - Progress Report				
Planned action	Who is responsible	Due Date	Date completed	Describe progress to date/action taken (as applicable) and List any evidence being submitted with this report
Action required to meet the Expected Outcome:				
Eg: The initial and any ongoing assessment process does not include the resident's life story.	Eg: Mary, admissions officer will lead. Shane, Board Member on Quality Committee to assist.	30th March 2012	15 March 2012	Eg: The assessment tool has been amended to include a section to record the resident's life story. A copy of the revised assessment tool is attached
Optional action to support Continuous Quality Improvement:				

Progress Report

Standard 1: Care Delivery and Information				
Expected Outcome 1.2: Care Planning				
Quality Improvement Plan (Insert Year) - Progress Report				
Planned action	Who is responsible	Due Date	Date completed	Describe progress to date/action taken (as applicable) and List any evidence being submitted with this report
Action required to meet the Expected Outcome:				
Optional action to support Continuous Quality Improvement:				

Progress Report

Standard 1: Care Delivery and Information				
Expected Outcome 1.3: Review				
Quality Improvement Plan (Insert Year) - Progress Report				
Planned action	Who is responsible	Due Date	Date completed	Describe progress to date/action taken (as applicable) and List any evidence being submitted with this report
Action required to meet the Expected Outcome:				
Optional action to support Continuous Quality Improvement:				

Progress Report

Standard 1: Care Delivery and Information				
Expected Outcome 1.4: Clinical Care				
Quality Improvement Plan (Insert Year) - Progress Report				
Planned action	Who is responsible	Due Date	Date completed	Describe progress to date/action taken (as applicable) and List any evidence being submitted with this report
Action required to meet the Expected Outcome:				
Optional action to support Continuous Quality Improvement:				

Progress Report

Standard 1: Care Delivery and Information				
Expected Outcome 1.5: Information				
Quality Improvement Plan (Insert Year) - Progress Report				
Planned action	Who is responsible	Due Date	Date completed	Describe progress to date/action taken (as applicable) and List any evidence being submitted with this report
Action required to meet the Expected Outcome:				
Optional action to support Continuous Quality Improvement:				

Progress Report

Standard 2: Management and Accountability				
Expected Outcome 2.1: Governance				
Quality Improvement Plan (Insert Year) - Progress Report				
Planned action	Who is responsible	Due Date	Date completed	Describe progress to date/action taken (as applicable) and List any evidence being submitted with this report
Action required to meet the Expected Outcome:				
Optional action to support Continuous Quality Improvement:				

Progress Report

Standard 2: Management and Accountability				
Expected Outcome 2.2: Management Systems				
Quality Improvement Plan (Insert Year) - Progress Report				
Planned action	Who is responsible	Due Date	Date completed	Describe progress to date/action taken (as applicable) and List any evidence being submitted with this report
Action required to meet the Expected Outcome:				
Optional action to support Continuous Quality Improvement:				

Progress Report

Standard 2: Management and Accountability				
Expected Outcome 2.3: Risk Management				
Quality Improvement Plan (Insert Year) - Progress Report				
Planned action	Who is responsible	Due Date	Date completed	Describe progress to date/action taken (as applicable) and List any evidence being submitted with this report
Action required to meet the Expected Outcome:				
Optional action to support Continuous Quality Improvement:				

Progress Report

Standard 2: Management and Accountability				
Expected Outcome 2.4: Human Resources				
Quality Improvement Plan (Insert Year) - Progress Report				
Planned action	Who is responsible	Due Date	Date completed	Describe progress to date/action taken (as applicable) and List any evidence being submitted with this report
Action required to meet the Expected Outcome:				
Optional action to support Continuous Quality Improvement:				

APPENDIX

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Acronyms and Glossary

The following terms and abbreviations are used in this document:

Accountability	Being answerable and responsible for your actions.
Advocacy	The process of speaking out on behalf of an individual or group to protect and promote their rights and interests.
Assessment	A process of holistically identifying individualised care or service needs. This can include determining eligibility and priority of access. The comprehensiveness of the assessment must reflect the program or service type being delivered.
Board/Committee	Representatives or officials responsible for governance of an organisation.
Care/service plan	A document reflecting the individualised service to be provided. This plan will be based upon assessed need/s and service user's choice.
Carer	A person such as a family member, friend or neighbour, who provides regular and sustained care and assistance to another person without payment for their caring role other than a pension or benefit. **Primary Carer** - The person who provides the most informal assistance to the care recipient.
Collaboration	To work jointly or cooperate with others.
Complainant	Individual lodging a complaint.
Complaint	An expression of dissatisfaction or concern. May be expressed orally or in writing through a formal process or as part of other feedback.
Consent	To give permission or agree.
Continuous Quality Improvement	A documented system used by service providers to continuously review their processes and activities and implement changes to improve the way they provide services to service users.
CQI	Continuous Quality Improvement
Cultural Safety	Recognising, respecting and nurturing the unique cultural identity of Aboriginal and Torres Strait Islander people and meeting their needs, expectations and rights.
Documented	Recorded information - may be on a variety of media, i.e. written, on a database, recorded.
DoHA or Department	Australian Government Department of Health and Ageing
Evidence	Something that provides proof or an example.
Expected Outcome/s	Results to be achieved.
Goal orientated	Identifies aims/objectives to be achieved.

Governance	A system by which an organisation is controlled and operates. It is a mechanism by which an organisation and its people are held to account. It documents the organisation's ethics, approaches to risk management, compliance, financial management and administration of all elements of service delivery.
HACC	Home and Community Care
Outcome based	Focuses on results (achievement of goals).
Partnership	To work or collaborate with other organisations.
Policies	Statements of intent providing guidance related to the expected standard to be achieved based on regulatory and contemporary practice. Policies should address the rule, rather than how to implement the rule.
Process	Incorporates the steps, people and materials to complete an activity or task.
Procedures	Provide the guiding steps for the action to be taken to implement a policy. Procedures explain how to perform activities or tasks, specifying who does what, when and with what equipment or tools.
Prospective service user	An individual who has made an enquiry regarding receiving services and/or is considering receiving services or care from a service provider.
Reassessment	Process to re-examine, holistically, an individual's care or service needs.
Representative	An individual acting on the service user's behalf at the request of the care recipient/service user and with the service user's permission.
Review	Process to ensure that service provision is responsive to the service user's current and emerging needs.
Risk	The chance of something happening that will have a negative impact. It is measured in terms of consequences and likelihood.
Service agreement	An agreement or contract between the service user and service provider.
Service provider	Includes organisations funded or approved to provide services under the Program covered by these Standards.
Service user	Any individual accessing services, this may include a carer, if they are the person receiving the service/care.
Stakeholder	Any person or organisation that the service provider is involved with. This includes other service providers; service users; their carers or families; government departments; suppliers; the local community.
System	A number of interrelated processes.
Timeframe	A time period during which something takes place or is projected to occur.