FOCUS CONNECT AGED CARE POLICIES AND PROCEDURES ALIGNED TO THE STRENGTHENED AGED CARE QUALITY STANDARDS 1-5

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FOCUS connect

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Sources:

- Standards 1-5 of the Strengthened Aged Care Quality Standards, February 2025
- Federal Register of Legislation - Aged Care Act 2024
- The Code of Conduct
- New Aged Care Act Rules consultation – Release 1 – Service list November 2024
- Support at Home program handbook December 2024
- New Aged Care Act Rules consultation – Release 2a – Funding for Support at Home program December 2024
- New Aged Care Act Rules consultation – Release 2b – Consolidated Draft Rules Relating to Funding – Supporting Document February 2025
- New Aged Care Act Rules consultation – Release 3 – Provider Obligations February 2025
- Support at Home Program Provider Transition Guide | Australian Government Department of Health and Aged Care February 2025
- Support at Home Manual | Australian Government Department of Health and Aged Care March 2025
- Support at Home: Claims and Payments Business Rules Guidance February 2025

Policy: Person-Centred Care

Standard 1: The Person

Outcome 1.1: Person Centred Care

Policy Statement

FOCUS Connect is committed to delivering person-centred care that upholds the rights, dignity, and autonomy of each older person. In alignment with Outcome 1.1: Person-Centred Care of the Strengthened Aged Care Quality Standards (February 2025) and relevant legislative and regulatory requirements, our organisation ensures that:

- Care and services are co-designed with the older person and their representatives to respect and reflect their identity, culture, life experiences, and personal values.
- Each person's independence, well-being, and quality of life are promoted by respecting their rights to choice and control.
- The workforce is trained and supported to provide care that is inclusive, culturally safe, trauma-aware, and adaptable to changing needs.

Purpose

This policy ensures that:

1. All staff, volunteers, and contractors uphold the rights of older people to express choice and exercise control over their care and services.
2. Care and services are co-designed and tailored to each individual's needs, preferences, and goals.
3. A partnership approach is embedded in all aspects of service provision, ensuring older people are included in all decision-making about their care.

Scope

This policy applies to all FOCUS Connect staff, volunteers, and contractors involved in the planning, provision, and administration of care and services.

Definitions

- Partnership: A collaborative relationship where older people, their families, and representatives actively engage in planning, designing, and making decisions about their care.
- Person-Centred Care: A rights-based approach to care that ensures individuality, dignity, and responsiveness to an older person's needs, goals, and values. This includes:
    - Co-designing care and services with older people.
    - Supporting decision-making to ensure their voice is heard.
    - Recognising and valuing diversity, ensuring care is tailored to cultural, linguistic, and personal backgrounds.
- Quality Care: Care and services that:
    - Keep older people safe from preventable harm.
    - Are responsive to holistic needs (physical, emotional, social, cultural, and spiritual).
    - Are inclusive and trauma-informed.
    - Ensure coordination between all involved in a person's care.

Procedures

1. Person-Centred Care Principles

FOCUS Connect will apply the following principles to all care and services:

- Respect for Individuality: Older people are recognised as unique individuals with diverse needs, identities, and values.
- Choice and Control: Older people have the right to make decisions about their care and services, with support for decision-making when needed.
- Co-Design and Engagement: Older people actively participate in designing their care plans and have a genuine say in how services are delivered.
- Holistic and Inclusive Approach: Services consider the whole person, including physical, emotional, social, cultural, and spiritual needs.
- Cultural Safety and Trauma Awareness: Care is culturally inclusive, safe, and sensitive to past trauma and life experiences.
- Continuous Improvement: Person-centred care is monitored, reviewed, and continuously improved through feedback from older people, families, and staff.

2. Person-Centred Care in Practice

Assessment & Planning

- Older people and their representatives participate in a comprehensive, strengths-based assessment that considers personal goals, background, and aspirations.
- Care planning is co-designed, reflecting personalised care goals that evolve as needs change.

Flexible & Responsive Care

- Services adapt to changing needs, ensuring that care remains aligned with individual preferences.
- Older people can adjust their care plans at any time.

Supported Decision-Making

- Staff support older people in making informed decisions about their care, ensuring they understand their options.
- Where required, decision-making supports (e.g., advocates or interpreters) are provided.

Communication & Transparency

- Accessible communication is maintained with older people, families, and representatives.
- Older people are fully informed about care options and any changes that may affect them.

Workforce Training & Capability

- Staff receive ongoing training in person-centred care, cultural competence, trauma-informed care, and supported decision-making.
- Role expectations include applying person-centred care principles in daily practice.

Continuous Quality Improvement

- Regular feedback and audits ensure services remain aligned with the principles of person-centred care.
- Client experience data is used to refine service delivery and address gaps in care.

Responsibilities

Role	Responsibilities
Aged Care Manager	Ensures person-centred care is upheld across all service areas.
Human Resources	Embeds person-centred care principles in job descriptions and mandatory training.
All Staff, Volunteers, and Contractors	Apply person-centred care principles in daily practice.

Compliance and Enforcement

Failure to comply with this policy may constitute a breach of job role expectations and could result in performance management or disciplinary action.

Regulatory Alignment

This policy aligns with:

- Aged Care Act 2024
- Aged Care Statement of Rights 2024
- The Code of Conduct for Aged Care
    - Element A: Respect for autonomy and self-determination
    - Element B: Treating people with dignity and respect
    - Element C: Respecting privacy
- Support at Home Program Provider Obligations
- Support at Home Claims and Payments Business Rules

Related Policies

- Assessment and Care Planning Policy
- Choice, Independence, and Quality of Life Policy
- Cultural Safety and Inclusion Policy
- Dementia and Cognitive Impairment Policy
- Advanced Care Planning Policy
- Palliative and End-of-Life Care Policy

Policy: Abuse, Neglect, and Discrimination

Standard 1: The Person

Outcome 1.2: Dignity, Respect and Privacy

Policy Statement
FOCUS Connect is committed to fostering a culture of safety, dignity, and respect, ensuring that all individuals receiving care are protected from abuse, neglect, and discrimination. This policy aligns with the Aged Care Act 2024, the Aged Care Statement of Rights 2024, and the Strengthened Aged Care Quality Standards (February 2025), Outcome 1.2: Dignity, Respect, and Privacy.

Our organisation applies a zero-tolerance approach to abuse, neglect, and discrimination, with robust prevention, recognition, response, and reporting mechanisms in place to safeguard older people's well-being, autonomy, and human rights.

Purpose
This policy ensures that:

1. Older people are protected from all forms of violence, exploitation, discrimination, neglect, and abuse, in accordance with the Aged Care Code of Conduct (Elements G & H).
2. Staff, volunteers, and contractors understand their responsibilities in preventing, recognising, and responding to abuse, neglect, and discrimination.
3. A culture of dignity, respect, privacy, and inclusion is embedded in service delivery, fostering safety, autonomy, and individual choice.

Scope
This policy applies to all FOCUS Connect staff, volunteers, and contractors involved in the planning, provision, and administration of care and services.

Definitions

- Abuse: Elder abuse is any act (or failure to act) that results in harm, distress, or exploitation of an older person, occurring within a relationship of trust. This may include physical, emotional, psychological, financial, sexual, or social abuse.
- Neglect: A failure to meet an older person's basic needs, which may be intentional or unintentional. Neglect includes:
    - Failure to provide appropriate care (e.g., nutrition, hygiene, medical attention).
    - Systemic neglect, where ongoing failures in service delivery compromise an older person's well-being.
- Discrimination: Treating a person unfairly or less favourably due to their age, gender, culture, language, disability, or other personal attributes.

Procedures
1. Prevention and Recognition

- Staff, volunteers, and contractors must uphold the dignity, privacy, and autonomy of older people at all times.

- All care and services must be free from discrimination, abuse, and neglect and delivered in a culturally safe and inclusive manner.
- Staff receive mandatory training on recognising physical, psychological, financial, and social indicators of abuse, neglect, and discrimination.
- Regular risk assessments are conducted to proactively identify, mitigate, and prevent risks to older people.
- Organisational culture is monitored and reinforced to ensure a zero-tolerance stance on abuse, neglect, and discrimination.

2. Reporting and Disclosure
- All concerns, suspicions, or disclosures of abuse, neglect, or discrimination must be reported immediately to a supervisor, safeguarding officer, or through the designated incident management system.
- Accessible and confidential reporting mechanisms are available for older people, staff, families, and the public, including anonymous reporting options.
- All reports of abuse, neglect, or discrimination will be treated seriously, promptly investigated, and appropriately acted upon.

3. Response and Investigation
- Affected individuals will receive immediate support, including access to health, legal, and counselling services.
- The organisation will ensure:
    - Immediate safety measures are implemented to protect the older person.
    - If applicable, authorities such as the Aged Care Quality and Safety Commission, police, or other relevant agencies are notified.
    - Comprehensive investigations are conducted in alignment with the Aged Care Act 2024 and provider obligations.
- Outcomes from investigations will inform continuous improvement initiatives to prevent future incidents.

4. Training and Workforce Expectations
- Mandatory workforce training will be provided on:
    - Recognising, reporting, and responding to abuse, neglect, and discrimination.
    - Respecting privacy, dignity, and autonomy under Outcome 1.2 of the Strengthened Standards.
    - Cultural competence and trauma-informed care.
    - Supported decision-making and the rights of older people.
- Organisational policies and procedures will be regularly reinforced through professional development and training sessions.

5. Continuous Monitoring and Quality Improvement
- The organisation will:
    - Conduct regular audits to ensure compliance with legislation, standards, and best practices.
    - Seek feedback from older people, families, and staff to improve service delivery.

- Ensure that risk management and quality assurance processes prevent future incidents.

Responsibilities

Role	Responsibilities
Executive Management	Oversees compliance with legal and regulatory obligations and ensures accountability for abuse prevention.
Quality, Risk and Compliance Officer	Leads investigations, monitors compliance, and supports affected individuals.
Human Resources	Ensures all staff are trained in abuse prevention, response, and reporting.
All Staff, Volunteers, and Contractors	Must recognise, report, and respond to any suspected or actual abuse, neglect, or discrimination.

Compliance and Enforcement

Failure to comply with this policy may result in performance management, disciplinary action, or regulatory reporting to the Aged Care Quality and Safety Commission.

Regulatory Alignment

This policy aligns with:

- Aged Care Act 2024
- Aged Care Statement of Rights 2024
- Strengthened Aged Care Quality Standards (February 2025) – Outcome 1.2: Dignity, Respect, and Privacy
- The Code of Conduct for Aged Care
  - Element G: Provide care, free from violence, exploitation, neglect, abuse, and discrimination.
  - Element H: Take all reasonable steps to prevent and respond to all forms of abuse and neglect.
- Support at Home Program Provider Obligations
- Support at Home Claims and Payments Business Rules

Related Policies and Documents

- Incident Reporting Procedures
- Workforce Training Policy
- Diversity and Inclusion Policy
- Confidentiality and Privacy Policy
- Open Disclosure Policy
- Risk Management Policy
- Continuous Improvement Plan
- Feedback and Complaints Policy
- Incident Management System

Policy: Kindness, Dignity, Respect & Privacy

Standard 1: The Person

Outcome 1.2: Dignity, Respect and Privacy

Policy Statement
FOCUS Connect is committed to upholding the dignity, respect, and privacy of all individuals receiving care by fostering an environment where these principles are embedded in all interactions, service delivery, and care practices.

In alignment with Outcome 1.2: Dignity, Respect, and Privacy of the Strengthened Aged Care Quality Standards (February 2025), we ensure that:

- Older people are treated with kindness, respect, and compassion at all times.
- Cultural safety and diversity are acknowledged and upheld in all aspects of care.
- Privacy and confidentiality are protected in personal interactions, service delivery, and information management.

Purpose
This policy ensures that:

1. All staff, volunteers, and contractors demonstrate respect, kindness, and dignity in all interactions with older people.
2. Care and services are delivered in ways that prioritise autonomy, personal choice, and privacy.
3. Organisational processes and workforce practices protect confidentiality, promote cultural awareness, and foster inclusivity.

Scope
This policy applies to all FOCUS Connect employees, volunteers, and contractors involved in the provision and administration of care and services.

Definitions

- Kindness: Treating older people with compassion, warmth, and empathy, actively listening to their concerns, and engaging without judgment.
- Dignity: Recognising and respecting an individual's worth, independence, and right to self-determination, ensuring they feel valued and respected in all interactions.
- Respect: Acknowledging cultural identity, personal background, and diversity in care planning and service delivery, ensuring inclusive and person-centred approaches.
- Privacy: Respecting an individual's physical, emotional, and personal space, ensuring confidentiality in conversations, care interactions, and information management.

Procedures
1. Upholding Dignity and Respect in Care

- All staff, volunteers, and contractors must:
    - Treat older people with kindness, compassion, and consideration.
    - Communicate in a respectful, culturally appropriate, and inclusive manner.

- Ensure decision-making processes respect autonomy, including for people with cognitive impairments or diverse communication needs.
- Be aware of and respect cultural, linguistic, and spiritual differences when providing care.

2. Protecting Privacy and Confidentiality

- Physical privacy must be upheld during personal care activities, including dressing, bathing, and medical procedures.
- Confidentiality must be maintained in all conversations, record-keeping, and information sharing, ensuring compliance with privacy laws and consent protocols.
- Staff must ensure that:
  - Personal information is securely stored and only accessed by authorised personnel.
  - Conversations of a personal nature occur in private, respectful settings.
  - Electronic data and documentation follow strict privacy protection protocols.

3. Partnering with Families and Carers

- Older people's preferences regarding family involvement in care decisions must be respected.
- Staff must seek informed consent before sharing any personal or medical information with family members, carers, or external service providers.
- Families and carers should be:
  - Engaged in care planning, where appropriate, to support decision-making.
  - Provided with clear communication and relevant updates, in line with consent agreements.

4. Culturally Safe and Inclusive Practices

- Care and services must be delivered in a culturally responsive manner, ensuring:
  - Recognition of diverse cultural and linguistic needs.
  - Respect for spiritual beliefs and values.
  - Inclusive approaches for LGBTQIA+ and other diverse communities.
- Trauma-informed practices must be implemented, ensuring sensitivity to individuals who have experienced trauma or distress in their past.

5. Workforce Training and Responsibilities

- Mandatory training will be provided on:
  - Kindness, dignity, respect, and privacy principles.
  - Cultural awareness and trauma-informed care.
  - Privacy and confidentiality obligations.
  - Effective communication and de-escalation techniques.
- Regular refresher training will ensure all staff maintain knowledge of privacy laws, cultural competence, and dignity-respecting care.

6. Continuous Improvement and Feedback Mechanisms

- The organisation will conduct regular audits and assessments to evaluate the effectiveness of dignity, respect, and privacy practices.

- Feedback from older people, families, and staff will be collected through:
    - Surveys and consultations to assess lived experiences.
    - Complaints and grievance mechanisms to identify areas for improvement.
    - Incident reviews to ensure best practices are upheld.
- Outcomes from feedback will inform continuous improvement initiatives and policy updates.

Responsibilities

Role	Responsibilities
Executive Management	Ensures dignity, respect, and privacy are upheld as core principles of service delivery.
Quality, Risk & Compliance Officer	Oversees privacy compliance, investigates breaches, and ensures adherence to privacy laws.
Human Resources	Embeds training on dignity, respect, and privacy into all workforce development programs.
All Staff, Volunteers, and Contractors	Must actively uphold dignity, respect, and privacy in all interactions and care practices.

Compliance and Enforcement

Failure to comply with this policy may result in performance management, disciplinary action, or regulatory reporting to the Aged Care Quality and Safety Commission.

Regulatory Alignment

This policy aligns with:

- Aged Care Act 2024
- Aged Care Statement of Rights 2024
- Strengthened Aged Care Quality Standards (February 2025) – Outcome 1.2: Dignity, Respect, and Privacy
- The Code of Conduct for Aged Care
    - Element B: Treating people with dignity and respect, and valuing diversity.
    - Element C: Acting with respect for privacy.
- Support at Home Program Provider Obligations

Related Policies and Documents

- Privacy and Confidentiality Policy
- Person-Centred Care Policy
- Assessment & Care Planning Policy
- Cultural Safety and Inclusion Policy
- Diversity and Inclusion Policy
- Feedback and Complaints Policy
- Incident Management and Open Disclosure Policy
- Stakeholder Communication Plan
- Continuous Improvement Plan

Policy: Choice, Independence & Quality of Life

Standard 1: The Person

Outcome1.3: Choice, Independence and Quality of Life

Policy Statement
FOCUS Connect is committed to promoting and upholding the autonomy, independence, and quality of life of all individuals receiving care. We ensure that older people are empowered to exercise choice, make decisions about their care and services, and maintain control over their lives.

In alignment with Outcome 1.3: Choice, Independence, and Quality of Life of the Strengthened Aged Care Quality Standards (February 2025), our organisation ensures that:

- Older people are supported to make informed choices about their care, lifestyle, and daily activities.
- Independence is fostered, ensuring individuals retain control over their own lives for as long as possible.
- A reablement and wellness approach is embedded in service provision to enhance overall quality of life and meaningful engagement.

Purpose
This policy ensures that:

1. Older people's rights to choice, independence, and self-determination are respected in all aspects of care.
2. Information is provided in a way that supports informed decision-making and enables older people to exercise control over their care and services.
3. Care and services are designed to enhance independence, using a reablement and strengths-based approach to promote continued engagement in daily life.

Scope
This policy applies to all FOCUS Connect employees, volunteers, and contractors involved in the planning, provision, and administration of care and services.

Definitions

- Choice: The right of an older person to make decisions about their care, services, and lifestyle based on their needs, goals, and preferences. Genuine options must be provided, and decisions must be respected and supported.
- Independence: The ability to maintain autonomy, perform daily activities, and engage in meaningful experiences with minimal assistance while receiving necessary support to ensure well-being and safety.
- Quality of Life: An individual's overall well-being, encompassing physical, emotional, social, and spiritual dimensions, influenced by their environment, preferences, and life experiences.

Procedures

1. Facilitating Informed Choice

- Older people will be actively involved in developing and reviewing their care plans to ensure their choices and preferences are central to decision-making.
- Staff will provide timely, clear, and accessible information to enable informed decision-making, including alternative options where available.
- Where decision-making support is needed, older people will be assisted through:
    - Supported decision-making frameworks.
    - Family involvement or independent advocates, where appropriate.
    - Communication supports, including interpreters or assistive technology.
- Care planning will incorporate personal preferences, including:
    - Daily routines, cultural or religious practices, dietary choices, and activities.
    - Preferences regarding how services are provided, including gender preferences for personal care staff.
    - End-of-life care preferences where applicable.

2. Promoting Independence Through a Reablement Approach

- Staff will support self-care and independence by:
    - Encouraging and assisting older people to complete daily activities on their own where possible.
    - Providing mobility aids and assistive technology to enhance functional ability.
    - Offering rehabilitation services, including physiotherapy and occupational therapy, to restore or maintain independence.
- A wellness and reablement approach will be embedded in care planning, ensuring that older people:
    - Have opportunities to set personal goals and work towards maintaining autonomy.
    - Are encouraged to remain physically, socially, and cognitively active.
    - Receive adaptable care plans that focus on what they can do rather than what they cannot do.

3. Enhancing Quality of Life and Meaningful Engagement

- Older people will be supported to engage in activities that bring them joy, meaning, and purpose, including:
    - Community involvement and social participation.
    - Cultural, recreational, and spiritual activities.
    - Hobbies and personal interests that enhance emotional well-being.
- Emotional and mental well-being will be actively supported, with access to:
    - Mental health support, counselling, or peer networks.
    - Grief, loss, and trauma-informed care for those experiencing life transitions.
- Care and services will reflect a holistic approach, ensuring that social, emotional, physical, and spiritual needs are met.

4. Ongoing Monitoring, Feedback, and Continuous Improvement

- Regular care plan reviews will be conducted to ensure evolving needs, preferences, and independence levels are accommodated.
- Feedback mechanisms will be provided to assess satisfaction with choice, independence, and quality of life, including:
    - Client satisfaction surveys.
    - Family and carer engagement sessions.
    - Regular reviews of complaints and feedback reports.
- Outcomes from feedback will inform continuous improvement strategies and ensure that older people's choices and independence are consistently prioritised.

Workforce Training and Responsibilities

Role	Responsibilities
Executive Management	Ensures choice, independence, and quality of life principles are upheld in service provision.
Care Coordinators	Support older people in making informed decisions and developing personalised care plans.
Frontline Care Staff	Provide care that respects autonomy, promotes independence, and enhances well-being.
Human Resources	Ensures staff receive training on informed choice, reablement, and cultural competency.

Workforce Development and Training

- All staff will receive training on:
    - Supporting choice and independence in daily care practices.
    - Applying reablement and strengths-based approaches in care delivery.
    - Recognising and upholding decision-making rights.
    - Culturally safe and trauma-informed approaches to support individual autonomy.
- Training will be reinforced through professional development programs and annual refreshers.

Compliance and Enforcement

Failure to comply with this policy may result in performance management, disciplinary action, or regulatory reporting to the Aged Care Quality and Safety Commission.

Regulatory Alignment

This policy aligns with:

- Aged Care Act 2024
- Aged Care Statement of Rights 2024
- Strengthened Aged Care Quality Standards (February 2025) – Outcome 1.3: Choice, Independence, and Quality of Life
- The Code of Conduct for Aged Care
    - Element A: Act with respect for people's rights to freedom of expression, self-determination, and decision-making.
- Support at Home Program Provider Obligations

Related Policies and Documents

- Person-Centred Care Policy
- Assessment & Care Planning Policy
- Reablement and Wellness Policy
- Cultural Safety and Inclusion Policy
- Privacy and Confidentiality Policy
- Feedback and Complaints Policy
- Risk Management and Continuous Improvement Plan

Policy: Participant Agreements

Standard 1: The Person **Outcome1.4: Transparency and Agreements**

Policy Statement
FOCUS Connect is committed to transparent communication, informed decision-making, and clear agreements with older persons about their care and services. Our organisation ensures that all individuals receiving home care services:

- Receive clear, accurate, and timely information regarding their care agreements.
- Are supported to understand their Home Care Agreement (HCA), including their rights, responsibilities, and financial obligations.
- Have ample opportunity to ask questions, seek external advice, and provide informed consent before agreeing to services.

In alignment with Outcome 1.4: Transparency and Agreements of the Strengthened Aged Care Quality Standards (February 2025), our organisation ensures that Home Care Agreements are:

- Easy to understand, using plain language and accessible formats.
- Fair and transparent, outlining participant contributions and available services in a way that promotes informed choice.
- Regularly reviewed and updated, ensuring that older people remain informed of any changes and can negotiate terms where necessary.

Purpose
This policy ensures that:

1. All older people are provided with a formal Home Care Agreement that sets out the terms and conditions of their care services.
2. Older people have sufficient time, information, and support to understand their agreement before providing consent.
3. Home Care Agreements remain up to date, fair, and compliant, reflecting changes in services, individual needs, or regulations.

Scope
This policy applies to all FOCUS Connect employees involved in the provision, administration, and review of Home Care Agreements.

Definitions

- Standard Home Care Agreement (Support at Home and Commonwealth Home Support Program Service Agreement): A template service agreement used as the basis for Support at Home and Commonwealth Home Support Programs.
- Individual Home Care Agreement (Support at Home and Commonwealth Home Support Program): A tailored agreement created for a specific older person, based on their care needs, preferences, and funding eligibility.
- Representative: A legally appointed individual or organisation acting on behalf of an older person (e.g., guardian, power of attorney, advocate).

Procedures

1. Home Care Agreement Content and Structure

Each individual Home Care Agreement will include:

- Care recipient details and organisation details.
- Scope of care and services, including level of care and when services will commence.
- Rights and responsibilities of the older person and the organisation.
- Service schedules, pricing, and fee structures, including a breakdown of:
    - Maximum Participant Contributions
    - Government contributions and any out-of-pocket expenses.
- Participant -directed care approach, confirming that services will be tailored to the older person's needs.
- Processes for making complaints or providing feedback.
- Leave entitlements and applicable charges.
- Conditions for changing or terminating the agreement.
- Provision of a care plan, individualised budget, and monthly statements.
- A copy of the Aged Care Statement of Rights and an offer to sign.

All agreements will be presented in plain language and be available in multiple formats (large print, digital, translated versions, Easy Read) to ensure accessibility.

2. Offering the Home Care Agreement (HCA)

- Each older person (or their representative) must be offered a Home Care Agreement before services commence.
- The Care Coordinator will:
    - Provide verbal and written explanations of the agreement.
    - Offer translation and interpreting services where required (e.g., TIS National).
    - Allow at least 14 days for review and external advice before requiring a response.
- If the older person does not understand or agree to any terms, further discussions and negotiations will be undertaken.

Agreement Finalisation

Once an older person has agreed to their Home Care Agreement:

- A finalised copy will be provided before services commence.
- The older person must sign the agreement,
- Documentation of all discussions, consent, and agreement status must be recorded in the individual's file.

3. Reviewing and Updating Home Care Agreements

- Standard Home Care Agreements will be reviewed annually to ensure they remain compliant with regulations.
- Individual Home Care Agreements will be reviewed:
    - Whenever the older person's care needs change (e.g., after a care plan review).
    - When any fee structures, service terms, or funding rules change.
    - At the older person's request.

The Aged Care Manager is responsible for reviewing standard HCAs, while the Care Coordinator reviews individual agreements.

4. Making Changes to a Home Care Agreement

If changes to a Home Care Agreement are required:

1. The older person must be informed in writing of the proposed changes.
2. They must be given at least 14 days to review and seek advice unless urgent changes are needed.
3. If the older person disagrees, further negotiation will take place to reach an agreement.

Once agreement is reached:

- A revised Home Care Agreement will be issued before services commence under the new terms.
- The older person must either:
    - Sign the revised agreement, OR
    - Provide verbal confirmation that they understand and accept the changes.
- All discussions, negotiations, and final consent status must be documented in the older person's file.

Workforce Responsibilities

Role	Responsibilities
Aged Care Manager	Ensures compliance with Support at Home and Commonwealth Home Support Program regulatory requirements.
Care Coordinator	Prepares individual agreements, provides explanations, facilitates understanding, and documents all discussions.
Frontline Care Staff	Supports informed decision-making and refers agreement-related concerns to Care Coordinator s.

Compliance and Enforcement

Failure to comply with this policy may result in performance management, disciplinary action, or regulatory reporting to the Aged Care Quality and Safety Commission.

Regulatory Alignment

This policy aligns with:

- Aged Care Act 2024
- Aged Care Statement of Rights 2024
- Strengthened Aged Care Quality Standards (February 2025) – Outcome 1.4: Transparency and Agreements
- The Code of Conduct for Aged Care
    - Element C: Act with integrity, honesty, and transparency.
- Support at Home Program Provider Obligations

Related Policies and Documents

- CHSP and Support at Home Service Agreement Template
- Participant Rights and Informed Consent Policy
- Assessment & Care Planning Policy
- Financial Transparency and Pricing Policy
- Feedback and Complaints Policy
- Cultural Safety and Inclusion Policy
- Incident Management and Open Disclosure Policy

Policy: Pricing Transparency

Standard 1: The Person

Outcome1.4: Transparency and Agreements

Policy Statement

FOCUS Connect is committed to ensuring transparent, accurate, and accessible pricing information for all older persons receiving care and services. The organisation will:

- Provide clear, itemised pricing in plain language.
- Ensure older persons and their representatives are fully informed of any required contributions or additional charges before services commence.
- Seek informed consent for all contributions and changes to pricing.
- Align all pricing with the Department of Health and Aged Care's Support at Home Funding Rules, Pricing Schedule, and Pricing Definitions.

In accordance with Outcome 1.4 of the Strengthened Aged Care Quality Standards (February 2025), all pricing information:

- Will be made publicly available and regularly reviewed.
- Will support informed decision-making through accessible and appropriate communication.
- Will include justification for all contributions and charges to ensure fairness and accountability.

Purpose

This policy ensures that:

1. Older persons receive transparent, timely, and understandable information about costs.
2. All contributions and fees are reasonable, justified, and aligned with the latest funding and pricing rules.
3. Older persons can review and provide informed consent before agreeing to contributions.

Scope

This policy applies to all FOCUS Connect employees involved in providing, administering, or reviewing pricing information for Support at Home services.

Definitions

- **Support at Home Pricing Schedule:** The Department-published list of fees and contributions applicable to support services.
- **Participant Contributions:** Contributions set by Services Australia based on income assessments, in collaboration with providers.
- **Fee Schedule:** The organisation's breakdown of service rates, inclusive of cancellation fees and contractor pricing.
- **Informed Consent:** Explicit agreement by the older person after understanding proposed costs and implications.
- **Financial Hardship:** Circumstances where the older person is unable to meet contribution requirements and may need an adjusted plan.

Procedures

1. Publishing Pricing Information
    - FOCUS Connect will publish the full Pricing Schedule on the My Aged Care portal and its website.
    - The schedule will:
        - Use the Department's standard pricing format and definitions.
        - Include service charges, estimated delivery hours, contractor pricing ranges, and staff travel costs.
        - Display the date the prices take effect and the most recent review date.
    - Pricing will be reviewed and updated at least annually or when program rules change.

2. Participant Contributions: Setting and Review
    - Services Australia will assess income to determine required contributions.
    - The provider will work collaboratively with the older person to agree on the final contribution.
    - Where specific needs or preferences require a deviation from standard fees, a negotiated contribution may be documented with informed consent.
    - Contribution reviews will be conducted annually or following changes in income, funding rules, or contractor pricing.
    - All changes to contributions require documented consent before implementation.

3. Care Management Fee Structure
    - Care Management fees will:
        - Be fixed, transparent, and listed in the organisation's Fee Schedule.
        - Be capped at 10% of the participant's budget, in accordance with the pooled funding allocation for Care Management.
        - Reflect the actual care management functions delivered.
        - Be reviewed regularly to ensure proportionality to services provided.

4. Contractor Fees and Administration
    - Contractor services will be listed as inclusive of all charges (no additional administration fees).
    - Minimum and maximum ranges will be displayed in the Pricing Schedule.
    - Where participant preferences require a specific contractor with unique pricing, this will be negotiated, justified, and documented.
    - Informed consent will be obtained prior to engaging services at a non-standard rate.

5. Financial Hardship and Contribution Waivers
    - The organisation will work with older persons experiencing financial hardship to explore solutions such as:
        - Contribution reductions.
        - Payment instalment plans.
        - Financial counselling referrals.
    - Where hardship is confirmed and Services Australia waives contributions, the provider will assume responsibility for delivering services within the allocated budget.

- Documentation and agreement of any waivers must be maintained.

6. Communication and Consent for Contributions

- The organisation will:
  - Provide a clear Participant Contribution Schedule with proposed pricing.
  - Notify participants at least 14 days prior to any pricing changes.
  - Allow participants time to review, discuss, or seek advice before confirming agreement.
  - Record either written or verbal acceptance, and retain documentation.
- Language and format accessibility will be supported through bilingual staff or interpreters as required.

Monthly Statements under Support at Home

Purpose

Monthly statements ensure older persons have visibility over their budget, spending, and available funds to support informed planning.

Contents

1. **Recipient and Provider Details:** Name, reference number, and package level.
2. **Budget Summary:** Funding received, contributions, carryovers, and forecast.
3. **Service Use:** Itemised services, dates, hours, unit costs, and totals.
4. **Charges:** Participant and government contributions, reimbursements, or adjustments.
5. **Goods and Equipment:** Assistive tech, purchases, rentals, and funding sources.
6. **Forecast:** Remaining funds and any planning recommendations.
7. **Additional Info:** Billing notes, dispute process, advocacy contacts.

Accessibility and Delivery

- Statements will be sent monthly, within 14 days of the end of each billing cycle.
- Formats may include: email, hard copy, large print, translated versions, or audio.
- A Care Coordinator or Finance Officer will be available to clarify statements upon request.

Disputes and Adjustments

Older persons can:

- Request clarification or changes.
- Lodge a formal dispute within 5 business days for resolution.
- Escalate unresolved matters to:
  - Aged Care Quality and Safety Commission
  - Commonwealth Ombudsman
  - Independent advocacy services such as OPAN

Compliance

Non-compliance with this policy may result in performance management, internal investigation, or reporting to relevant authorities.

Regulatory Alignment

This policy aligns with:

- Aged Care Act 2024
- Support at Home Program Manual (March 2025)
- Strengthened Aged Care Quality Standards (February 2025) – Outcome 1.4
- Code of Conduct for Aged Care – Element C: Integrity, Honesty, Transparency

Policy: Partnering with Older People

Standard 2: The Organisation

Outcome 2.1: Partnering with Older People

Policy Statement

FOCUS Connect is committed to fostering a culture of partnership, shared decision-making, and respect for the autonomy of older people. We recognise that older people must be at the centre of their care decisions, and we support their active participation in shaping their care and the services they receive.

This commitment includes:

- Genuine engagement with older people in decision-making about their care and the organisation's service delivery.
- Respect for diversity, ensuring care and services are culturally safe, inclusive, and responsive to each individual's background, values, and preferences.
- Transparent communication, ensuring clear, accessible, and meaningful information is provided to support informed decision-making.
- Ongoing feedback mechanisms, ensuring older people can influence continuous improvements in service quality.

This policy aligns with Outcome 2.1: Partnering with Older People of the Strengthened Aged Care Quality Standards (February 2025) and ensures that older people are treated as equal partners in their care experience.

Purpose

The purpose of this policy is to ensure that:

1. Older people are actively involved in decisions about their care, services, and organisational improvements.
2. Services are designed, delivered, and reviewed in partnership with older people, promoting choice, independence, and self-determination.
3. Older people's diverse identities, experiences, and preferences are recognised and respected in all interactions.
4. Aged care services uphold the rights of older people and align with the principles of Participant -directed care and shared decision-making.

Scope

This policy applies to:

- All staff, volunteers, and contractors involved in the provision, administration, and management of aged care services.
- All older persons receiving care and support services from Insert organisation name.
- Family members, carers, advocates, and appointed representatives of older people where applicable.

Definitions

- Diversity: The varied characteristics and life experiences of older people, including but not limited to cultural, linguistic, religious, spiritual, psychological, medical, gender, and sexual identity factors.
- Partnership: A collaborative relationship where older people are actively involved in shaping decisions about their care and influencing organisational practices.
- Shared Decision-Making: A structured process ensuring older people understand their care options and make informed choices, supported by evidence-based information.

Procedures

1. Engagement and Communication

FOCUS Connect will:

- Enable older people to actively participate in setting priorities and shaping strategic directions for their care through:
    - Participant advisory groups, co-design initiatives, and care plan discussions.
    - Regular Participant forums, feedback sessions, and satisfaction surveys.
- Actively seek representation from diverse groups, ensuring inclusion of:
    - Aboriginal and Torres Strait Islander peoples.
    - Culturally and linguistically diverse (CALD) communities.
    - LGBTQIA+ older people.
    - Older people with disabilities or specific health conditions.
- Ensure information is clear, accessible, and culturally appropriate, by:
    - Using plain language, translated materials, interpreters, and assistive technologies.
    - Providing verbal and visual explanations of care options for those with cognitive or literacy challenges.
    - Allowing sufficient time and support for older people to make decisions.
- Support independent advocacy by facilitating access to aged care advocates and external advisory services when requested.

2. Supporting Informed Decision-Making

FOCUS Connect will ensure that:

- Older people have access to unbiased, evidence-based information about their care and service options.
- Decisions are guided by the older person's preferences, goals, and autonomy, with staff ensuring:
    - Respect for personal choices, even where they involve risks.
    - Supported decision-making is available for those requiring additional assistance.
    - Decisions are free from coercion or provider-led influence.
- Regular care plan reviews are conducted, allowing older people to adjust services based on changing needs and circumstances.

3.Continuous Feedback and Quality Improvement

- FOCUS Connect will implement robust feedback systems that allow older people to:
    - Provide real-time feedback on their care experience.
    - Raise concerns, suggest improvements, and co-design services.

    - Participate in advisory committees and service planning meetings.
- Feedback will be used to:
    - Enhance service delivery, organisational policies, and staff training.
    - Improve inclusivity and accessibility in service provision.
    - Inform quality improvement and compliance activities.
- Older people will receive regular updates on how their feedback has led to meaningful change.

4.Cultural Safety and Inclusion

FOCUS Connect is committed to ensuring:

- Staff, volunteers, and contractors receive ongoing cultural competency training to provide:
    - Culturally appropriate care for Aboriginal and Torres Strait Islander peoples and CALD communities.
    - LGBTQIA+ inclusive care that respects gender and sexual identities.
    - Trauma-informed care approaches for those with lived experiences of trauma.
- Organisational policies and practices reflect the rights and dignity of all older people, ensuring they feel safe, respected, and valued.
- Older people can access care that aligns with their cultural, spiritual, and personal preferences.

5.Monitoring and Evaluation

To ensure continuous improvement in Participant engagement, FOCUS Connect will:

- Conduct periodic evaluations of engagement strategies, ensuring older people's perspectives actively shape service improvements.
- Collect and analyse data on Participant participation, identifying areas for enhanced engagement.
- Use independent assessments and external Participant advisory panels to evaluate performance.
- Communicate evaluation results to older people, demonstrating transparency and accountability.

Compliance and Enforcement

Failure to comply with this policy may result in:

- Performance management or disciplinary action for staff, volunteers, or contractors.
- Regulatory review or intervention by the Aged Care Quality and Safety Commission.
- Corrective actions to address non-compliance, ensuring adherence to best practice standards.

Regulatory Alignment

This policy aligns with:

- Aged Care Act 2024
- Strengthened Aged Care Quality Standards (February 2025) – Standard 2.1: Partnering with Older People
- Aged Care Statement of Rights 2024
- The Code of Conduct for Aged Care

- Element A: Act with respect for people's rights to freedom of expression, self-determination, and decision-making.
- Element B: Act in a way that treats people with dignity and respect and values their diversity.

Related Documents

- Participant Engagement and Co-Design Framework
- Cultural Safety and Inclusion Policy
- Feedback and Complaints Management Policy
- Workforce Cultural Competency Training Guidelines
- Supported Decision-Making Toolkit
- Information Accessibility and Communication Strategy

Policy: Quality and Safety Culture

Standard 2: The Organisation

Outcome 2.2: Quality and Safety Culture

Policy Statement

FOCUS Connect is committed to establishing and maintaining a robust culture of quality and safety, ensuring that:

- Older people receive safe, high-quality, and person-centred care that meets their needs, goals, and preferences.
- The workforce operates within a supportive, accountable, and risk-aware environment, where quality and safety are embedded in everyday practice.
- Continuous improvement, transparency, and inclusivity drive all decisions and actions.
- Diversity and cultural safety are upheld, ensuring that care is accessible and appropriate for people with specific needs and diverse backgrounds, including Aboriginal and Torres Strait Islander peoples, individuals from culturally and linguistically diverse (CALD) communities, and people living with dementia.

This policy is guided by Outcome 2.2: Quality and Safety Culture of the Strengthened Aged Care Quality Standards (February 2025) and supports compliance with the Aged Care Act 2024, the Aged Care Code of Conduct, and best practice governance principles.

Purpose

This policy ensures that:

1. A strong, organisation-wide commitment to quality and safety is embedded in all aspects of care and service delivery.
2. Leaders actively foster a culture of safety, transparency, accountability, and continuous improvement.
3. Older people, their families, and the workforce are engaged in quality improvement and risk management processes.
4. Staff, volunteers, and contractors are trained and supported to uphold quality and safety principles in their daily roles.

Scope

This policy applies to:

- All staff, volunteers, and contractors involved in aged care service provision, administration, and management.
- All older people receiving care and services from Insert organisation name.
- Governance and leadership teams responsible for setting quality and safety priorities.

Definitions

- Organisational Culture: The shared values, beliefs, and behaviours that define how an organisation operates, prioritises quality and safety, and engages with older people and the workforce.

- Quality and Safety Culture: A culture where safety and quality are embedded in all aspects of service delivery, and where continuous improvement, accountability, and risk awareness drive decision-making.
- Continuous Improvement: A structured approach that identifies, implements, and evaluates changes to enhance the quality and safety of care and services.
- Open Disclosure: A transparent communication process with older people, their families, and representatives when incidents or risks occur, ensuring honesty, accountability, and resolution.

Procedures

1. Leadership Commitment to Quality and Safety

- The Board, senior leadership, and management teams will actively:
    - Demonstrate and promote a quality and safety culture through their actions, policies, and engagement.
    - Support an open, no-blame environment, where concerns, incidents, and risks are openly discussed and addressed.
    - Prioritise the safety, health, and wellbeing of older people and the workforce in all strategic decisions.
    - Ensure resources are allocated for quality and safety improvements, including staff training, risk management, and compliance monitoring.
    - Encourage staff and Participant s to contribute to service enhancements through structured engagement mechanisms.

2. Strategic and Business Planning for Quality and Safety

- FOCUS Connect will:
    - Integrate quality and safety priorities into strategic and business planning.
    - Develop quality indicators and performance measures to track care and service outcomes.
    - Conduct regular organisational risk assessments, identifying emerging quality and safety concerns.
    - Use data and evidence-based research to guide continuous improvement efforts.

3. Workforce Training, Development, and Support

- All staff, volunteers, and contractors will:
    - Receive mandatory training on quality, safety, and incident reporting at induction and through regular refresher courses.
    - Be provided with practical tools and resources to support safe and effective care delivery.
    - Be encouraged to report quality and safety concerns without fear of retaliation, supporting a culture of continuous learning and accountability.
    - Participate in quality improvement initiatives, ensuring Participant feedback is embedded into daily practice.

4. Continuous Improvement and Feedback Mechanisms

- FOCUS Connect will maintain a structured continuous improvement framework, ensuring that:
    - Participant feedback, complaints, and incidents are actively collected, analysed, and used to inform service enhancements.
    - Trends in quality and safety performance are regularly reviewed, with corrective actions taken as needed.
    - Older people, their families, and representatives are engaged in quality improvement discussions, ensuring their perspectives shape decisions.
    - Lessons from incidents, complaints, and audits are shared across the workforce, supporting sector-wide learning and best practice.

5. Diversity, Inclusion, and Cultural Safety

- FOCUS Connect is committed to ensuring care is inclusive, culturally responsive, and safe by:
    - Embedding cultural competency training for staff, ensuring respect for Aboriginal and Torres Strait Islander peoples, CALD communities, and LGBTQIA+ older people.
    - Developing engagement strategies that enable older people from diverse backgrounds to influence service delivery.
    - Regularly reviewing policies and procedures to reflect the needs of people with diverse linguistic, religious, spiritual, and personal identities.

6. Open Disclosure and Transparency

- FOCUS Connect will:
    - Implement an open disclosure policy, ensuring that older people and their families are fully informed when incidents occur.
    - Encourage proactive conversations about risks and safety, ensuring Participant s are empowered to make informed decisions.
    - Provide regular updates on improvements made in response to Participant feedback.

7. Risk Management and Accountability

- A comprehensive risk management system will be maintained, ensuring:
    - Regular identification, assessment, and mitigation of risks affecting older people and the workforce.
    - Immediate response mechanisms to address and rectify safety concerns.
    - Clear escalation pathways for staff to report risks and incidents without fear of reprisal.
    - Annual reviews of governance and accountability structures to ensure compliance with aged care quality standards and regulatory obligations.

Compliance and Enforcement

Failure to comply with this policy may result in:

- Performance management or disciplinary action for staff, volunteers, or contractors.
- Regulatory review or intervention by the Aged Care Quality and Safety Commission.

- Corrective actions to address non-compliance, ensuring adherence to best practice standards.

Regulatory Alignment

This policy aligns with:

- Aged Care Act 2024
- Strengthened Aged Care Quality Standards (February 2025) – Standard 2.2: Quality and Safety Culture
- Aged Care Statement of Rights 2024
- The Code of Conduct for Aged Care
    - Element F: Take responsibility for quality care and services.
    - Element G: Provide care, supports, and services free from violence, discrimination, exploitation, neglect, and abuse.

Related Documents

- Abuse and Neglect Prevention Policy
- Continuous Improvement Framework
- Incident and Complaints Management Policy
- Participant Rights and Feedback Policy
- Risk Management Strategy
- Workforce Training and Development Policy

Policy: Accountability and Quality System

Standard 2: The Organisation

Outcome 2.3: Accountability and Quality System

Policy Statement

FOCUS Connect is committed to ensuring transparency, accountability, and continuous improvement in the delivery of safe, high-quality, and person-centred care and services. This policy establishes a robust quality system that ensures compliance with regulatory requirements, supports informed decision-making, and fosters a culture of openness, learning, and improvement.

Through governance oversight, workforce engagement, and data-driven improvements, FOCUS Connect will:

- Ensure strong governance and leadership that monitors service quality and risk management.
- Promote a culture of accountability and continuous improvement, ensuring that care and services remain safe, effective, and responsive to the needs of older people.
- Use evidence-based decision-making, incorporating feedback, quality indicator data, and benchmarking against industry standards.
- Maintain transparency with older people, their families, and the workforce regarding organisational performance, risks, and areas for improvement.

This policy aligns with Outcome 2.3: Accountability and Quality System of the Strengthened Aged Care Quality Standards (February 2025) and ensures compliance with the Aged Care Act 2024 and the Code of Conduct for Aged Care.

Purpose

The purpose of this policy is to:

1. Establish a structured framework for quality governance, performance monitoring, and compliance.
2. Ensure all staff, volunteers, and contractors understand and uphold their accountability in providing safe and high-quality care.
3. Support continuous improvement initiatives that enhance the quality, safety, and effectiveness of care and services.
4. Enable open disclosure and transparent communication about care quality, risks, and outcomes.

Scope

This policy applies to:

- All staff, volunteers, and contractors responsible for providing and administering care and services.
- The governing body and senior management, ensuring accountability for strategic and operational decision-making.

- Older people, their families, and representatives, who will have access to information regarding service quality and continuous improvement efforts.

Definitions

- Accountability: The responsibility of individuals and the organisation to monitor, report, and improve the quality and safety of care, ensuring compliance with regulatory requirements.
- Quality System: A structured framework that includes policies, procedures, monitoring, evaluation, and reporting mechanisms to ensure that care is safe, effective, and person-centred.
- Continuous Improvement: A structured approach to evaluating, refining, and enhancing service delivery through ongoing feedback, audits, and best practice implementation.
- Governance Oversight: The leadership responsibility to monitor, manage risks, and ensure quality service provision across all levels of care.
- Open Disclosure: A transparent communication process with older people, their families, and representatives when adverse events, risks, or quality concerns arise.

Procedures

1. Implementation of a Quality System

- FOCUS Connect will establish a comprehensive quality system that:
    - Defines clear accountabilities and responsibilities for all levels of staff.
    - Monitors care quality, safety, and effectiveness through data collection, performance reviews, and Participant feedback.
    - Ensures compliance with aged care standards, funding requirements, and legislative obligations.
    - Supports the governing body in monitoring service performance based on real-time insights and risk analysis.
- The quality system will be aligned with strategic priorities and operational goals to ensure care is accessible, equitable, and responsive to Participant needs.

2. Continuous Improvement Framework

- Continuous improvement will be achieved by:
    - Regular audits, risk assessments, and service reviews to identify areas for enhancement.
    - Benchmarking against national quality indicators, identifying trends and setting targets for improvement.
    - Utilising Participant feedback, complaints, and incident reports to drive service enhancements.
    - Embedding a culture of learning, ensuring findings from adverse events or safety concerns inform best practices.
- The governing body will review improvement initiatives quarterly, ensuring that corrective actions lead to tangible service enhancements.

3. Open Disclosure and Transparency

- FOCUS Connect will ensure open, honest, and timely communication with:

  - Older people, their families, and carers, providing them with clear information on risks, incidents, and improvement measures.
  - The workforce, ensuring they understand their role in reporting risks and participating in quality improvements.
  - Regulatory bodies, where required, to meet compliance obligations and demonstrate commitment to transparency.
- When an incident occurs, staff must:
  - Acknowledge and communicate what happened.
  - Apologise where appropriate and outline corrective actions.
  - Provide opportunities for Participant s to engage in decision-making regarding their care adjustments.

4. Governance and Oversight
- The governing body will:
  - Oversee strategic quality initiatives and compliance performance.
  - Review quality and safety data regularly, ensuring risks are identified and managed proactively.
  - Maintain accountability for the delivery of high-quality care, ensuring compliance with aged care regulatory requirements.
  - Support workforce engagement in quality governance through structured reporting and improvement mechanisms.
- The governing body will receive regular quality reports, covering:
  - Risk trends and mitigation strategies.
  - Complaints, incidents, and key performance indicators.
  - Findings from audits and Participant feedback surveys.

5. Policy and Procedure Management
- Policies and procedures will be:
  - Regularly reviewed and updated to reflect regulatory changes, best practice, and sector developments.
  - Easily accessible to staff and workforce members, ensuring they understand compliance obligations.
  - Integrated into induction and ongoing training to ensure consistent application across all levels of service delivery.

6. Strategic and Operational Planning
- Strategic and operational planning will be evidence-based and data-driven, ensuring that:
  - Workforce consultation informs quality priorities and planning.
  - Investment in quality and safety initiatives aligns with strategic objectives.
  - Participant feedback is embedded in all planning efforts, ensuring person-centred care remains a priority.

Compliance and Enforcement

Failure to comply with this policy may result in:
- Performance management or disciplinary action for staff, volunteers, or contractors.

- Regulatory review or intervention by the Aged Care Quality and Safety Commission.
- Corrective actions to address non-compliance, ensuring adherence to best practice standards.

Regulatory Alignment

This policy aligns with:

- Aged Care Act 2024
- Strengthened Aged Care Quality Standards (February 2025) – Standard 2.3: Accountability and Quality System
- Aged Care Statement of Rights 2024
- The Code of Conduct for Aged Care
    - Element D: Take responsibility for delivering safe and quality care.
    - Element E: Act within the best interests of older people.

Related Documents

- Clinical Governance Policy
- Feedback and Complaints Management Policy
- Incident and Risk Management Framework
- Participant Engagement and Co-Design Policy
- Strategic and Business Planning Guidelines
- Workforce Training and Development Policy

Policy: Risk Management

Standard 2: The Organisation

Outcome 2.4: Risk Management

Policy Statement

FOCUS Connect is committed to establishing and maintaining a comprehensive risk management framework that ensures the safety, health, and wellbeing of older people, staff, volunteers, contractors, and the organisation as a whole.

This policy ensures that:

- Risks are identified, assessed, controlled, and monitored systematically.
- A proactive, rather than reactive, approach is taken to mitigate risks and enhance service quality.
- Aged care service risks, including clinical, operational, environmental, and financial risks, are managed in compliance with regulatory requirements.
- Risk management is embedded into governance, decision-making, workforce training, and day-to-day operations.

This policy aligns with Outcome 2.4: Risk Management of the Strengthened Aged Care Quality Standards (February 2025) and ensures compliance with the Aged Care Act 2024 and the Code of Conduct for Aged Care.

Purpose

The purpose of this policy is to:

1. Establish a structured and systematic approach to risk identification, assessment, mitigation, and review.
2. Ensure that all staff understand their role in managing and reporting risks to create a culture of safety and accountability.
3. Enable continuous improvement in risk management practices by analysing feedback, incidents, and data trends.
4. Maintain compliance with legal and regulatory requirements and align with best practice risk management frameworks in aged care.

Scope

This policy applies to:

- All staff, volunteers, and contractors involved in aged care service provision, administration, and management.
- The governing body and senior leadership, who oversee risk governance and compliance.
- Older people, their families, and representatives, ensuring transparency in risk-related decision-making.

Definitions

- Risk Management: A structured process of identifying, assessing, mitigating, and monitoring risks to minimise harm and ensure quality service delivery.

- Risk Assessment: The process of evaluating the likelihood and impact of risks, determining appropriate controls, and prioritising action.
- Mitigation Strategies: Actions taken to prevent, reduce, or eliminate risks, ensuring a safe environment for older people, staff, and stakeholders.
- Incident and Near-Miss Reporting: A mandatory process where staff must report incidents, hazards, and near-misses to support learning and improvement.
- Business Continuity Planning: Ensuring continuity of care and operations in the event of disruptions, emergencies, or disasters.

Procedures

1. Risk Management System Implementation

- FOCUS Connect will implement a comprehensive risk management system, which includes:
    - Clear roles and responsibilities for risk identification and mitigation.
    - Integration of risk management into governance, strategic planning, and service delivery.
    - Compliance monitoring, ensuring all staff, volunteers, and contractors adhere to risk management policies.
    - Emergency preparedness and response planning, including infectious disease management, cyber threats, and financial risks.
- The system will be continuously reviewed and refined, ensuring risks are actively managed rather than just monitored.

2. Risk Identification and Assessment

- FOCUS Connect will identify, assess, and document risks in the following areas:
    - Older person safety and wellbeing, including mobility risks, medication management, falls, transportation, home safety, and social isolation.
    - Workforce risks, including manual handling, workplace violence, stress, fatigue, and compliance risks.
    - Service delivery risks, including continuity of care, workforce shortages, and funding risks.
    - Operational and financial risks, including budgetary constraints, fraudulent activities, and reputational risks.
    - Emerging risks, including climate-related emergencies, cyber security threats, and pandemics.
- Risk assessments will be conducted regularly, ensuring that:
    - Likelihood and severity of risks are evaluated.
    - Preventative and corrective actions are developed and implemented.
    - Escalation pathways are in place for new or emerging risks.

3. Risk Mitigation and Management Strategies

- To effectively manage and mitigate risks, FOCUS Connect will:
    - Develop action plans for high-priority risks, ensuring timely responses and accountability.
    - Use evidence-based risk control measures, including engineering, administrative, and personal protective controls.

    - Integrate risk management into individual care planning, ensuring older people's needs, preferences, and circumstances are considered.
    - Monitor and adjust policies, procedures, and processes in response to identified risks.
- For high-impact risks, emergency response procedures will be activated, including:
    - Immediate intervention for life-threatening situations.
    - Engagement with emergency services where required.
    - Implementation of business continuity plans for service disruptions.

4. Risk Monitoring and Continuous Improvement
- FOCUS Connect will ensure continuous monitoring and review of risks through:
    - Regular audits and safety inspections, identifying trends and weaknesses.
    - Analysis of incident reports, complaints, and feedback, ensuring lessons learned are implemented.
    - Use of performance data, including quality indicators, to assess risk trends and effectiveness of controls.
    - Annual organisational risk reviews, ensuring a proactive approach to risk mitigation.
- The governing body will receive quarterly risk management reports, outlining:
    - Risk trends and areas of concern.
    - Effectiveness of mitigation strategies.
    - Recommended changes to policies or processes.

5. Workforce Training and Risk Communication
- All staff, volunteers, and contractors will:
    - Receive mandatory risk management training at induction and through regular refresher courses.
    - Understand their role in identifying, reporting, and managing risks.
    - Be encouraged to report hazards and near-misses, supporting a culture of transparency and improvement.
- Risk management policies will be clearly communicated to all stakeholders, including older people and their families, ensuring:
    - They understand potential risks related to their care.
    - They are empowered to participate in risk-related decisions.
    - Their feedback is actively incorporated into risk assessments and improvement plans.

6. Reporting and Accountability
- A structured incident and risk reporting system will be in place, ensuring:
    - Immediate documentation of incidents, hazards, and near-misses.
    - Clear escalation pathways for unresolved or high-priority risks.
    - Accountability assigned at all levels, from frontline staff to the governing body.
    - Compliance with legislative reporting requirements, including mandatory notifications to the Aged Care Quality and Safety Commission where required.

Compliance and Enforcement

Failure to comply with this policy may result in:

- Performance management or disciplinary action for staff, volunteers, or contractors.
- Regulatory review or intervention by the Aged Care Quality and Safety Commission.
- Implementation of corrective actions to address risk-related non-compliance.

Regulatory Alignment

This policy aligns with:

- Aged Care Act 2024
- Strengthened Aged Care Quality Standards (February 2025) – Standard 2.4: Risk Management
- Aged Care Statement of Rights 2024
- The Code of Conduct for Aged Care
    - Element G: Take all reasonable steps to prevent and respond to risks.
    - Element H: Provide care and services free from harm and neglect.

Related Documents

- Incident and Risk Management Framework
- Emergency and Disaster Management Policy
- Workplace Health and Safety Policy
- Continuous Improvement Strategy
- Strategic and Business Planning Guidelines

FOCUS connect

Policy: Incident Management

Standard 2: The Organisation

Outcome 2.5: Incident Management

Policy Statement

FOCUS Connect is committed to maintaining a safe, transparent, and accountable environment for older people, staff, volunteers, and contractors by implementing an effective, structured, and compliant incident management system.

This policy ensures that:

- All incidents and near-misses are reported, investigated, and resolved in a timely manner.
- Continuous learning and quality improvement strategies are implemented to prevent reoccurrence.
- A culture of open disclosure, transparency, and accountability is embedded across the organisation.
- Older people, their families, and carers are supported in reporting incidents and actively involved in their resolution.

This policy aligns with Outcome 2.5: Incident Management of the Strengthened Aged Care Quality Standards (February 2025) and ensures compliance with the Aged Care Act 2024 and the Code of Conduct for Aged Care.

Purpose

The purpose of this policy is to:

1. Establish a structured and systematic incident management system that ensures:
    - Prompt identification and response to incidents and near-misses.
    - Thorough investigations and implementation of corrective actions.
    - A strong focus on learning, transparency, and continuous improvement.
2. Ensure compliance with regulatory requirements, including mandatory reporting obligations under the Aged Care Act 2024.
3. Support a culture of open disclosure, ensuring older people and their representatives are informed when an incident occurs.
4. Promote staff accountability and workforce capability, ensuring all workers are trained and understand their roles in incident prevention and management.

Scope

This policy applies to:

- All staff, volunteers, and contractors providing or administering care and services.
- The governing body and senior leadership, ensuring oversight and accountability for incident management.
- Older people, their families, and representatives, ensuring their involvement in incident reporting and resolution.

This policy covers all incidents and near-misses within the scope of aged care service delivery, including but not limited to:

- Care-related incidents, such as medication errors, falls, or infections.
- Workplace health and safety incidents, including staff injuries and manual handling risks.
- Abuse, neglect, or breaches of dignity and respect.
- Operational and environmental incidents, such as equipment failure or service disruption.

Definitions

- Incident Management: A structured process for identifying, recording, investigating, and resolving incidents and near-misses. This includes immediate response actions, ongoing review, and continuous quality improvement.
- Near-Miss: An event that did not result in harm but had the potential to do so.
- Open Disclosure: A transparent communication process with older people and their families when an incident occurs, ensuring they receive information about what happened, the impact, and the actions taken to prevent recurrence.
- Mandatory Reporting: A legal obligation under the Aged Care Act 2024 to report specific incidents to the Aged Care Quality and Safety Commission, including serious injury, abuse, neglect, or systemic failures.

Procedures

1. Incident Management System Implementation

- FOCUS Connect will implement a comprehensive incident management system, which includes:
    - Clear roles and responsibilities for incident prevention, response, and resolution.
    - A documented process for recording, investigating, and escalating incidents.
    - Regular evaluation of the incident management system to ensure effectiveness.
    - Integration with quality and safety governance to identify trends and drive improvement.
    - Compliance with all mandatory reporting requirements under the Aged Care Act 2024.

2. Incident Reporting and Immediate Response

- All staff, volunteers, contractors, older people, families, and carers are encouraged and supported to report incidents.
- Reporting mechanisms will be accessible, confidential, and easy to use, including:
    - Verbal and written reporting options.
    - Digital or online incident reporting platforms.
    - Anonymous reporting channels for sensitive issues.
- Immediate response actions will be taken to address risks, including:
    - Providing first aid or medical assistance if required.
    - Ensuring the safety and wellbeing of affected individuals.
    - Escalating high-risk incidents to senior management and regulatory bodies.
- Mandatory reporting obligations apply to serious incidents, including:
    - Unexplained serious injury or abuse (physical, sexual, emotional, or financial).
    - Neglect, inappropriate use of restrictive practices, or unlawful conduct.

- Any incident resulting in a significant adverse outcome for an older person.

3. Incident Recording and Investigation

- All incidents must be recorded in an incident register with:
  - A detailed description of the incident (nature, date, time, individuals involved).
  - Immediate response actions taken.
  - Preliminary risk assessment and escalation pathway.
- Investigation procedures will:
  - Identify root causes using evidence-based analysis.
  - Determine whether policy, practice, or process failures contributed to the incident.
  - Involve multidisciplinary teams, including management, clinical staff, and quality assurance personnel, if necessary.

4. Incident Response, Resolution, and Prevention

- Based on investigation findings, FOCUS Connect will:
  - Implement corrective actions immediately to reduce risk.
  - Develop long-term prevention strategies informed by quality data.
  - Monitor effectiveness of changes and make necessary adjustments.
  - Provide support to affected individuals and staff, including debriefing and counselling if needed.

5. Monitoring, Review, and Continuous Improvement

- Incident data will be regularly reviewed to identify trends, system failures, and opportunities for improvement.
- Findings from incident investigations will be used to refine policies, procedures, and training.
- The governing body will receive quarterly reports summarising:
  - Incident frequency and type.
  - Risk patterns and emerging concerns.
  - Corrective actions taken and their effectiveness.

6. Workforce Training and Risk Communication

- All staff, volunteers, and contractors must complete mandatory training on incident management, including:
  - How to identify and report incidents and near-misses.
  - The role of open disclosure in supporting older people and families.
  - Legislative and regulatory requirements, including mandatory reporting obligations.
- Incident management policies will be clearly communicated to older people and families, ensuring:
  - They understand their rights regarding incident reporting and resolution.
  - They receive timely and transparent information when an incident occurs.

7. Open Disclosure and Transparency

- Open disclosure will be practised for all reportable incidents, ensuring:

    - Affected individuals and their families are informed of what occurred.
    - A clear explanation is provided about the actions taken to prevent recurrence.
    - Opportunities for discussion and support are offered.
- FOCUS Connect will:
    - Foster a culture of trust and accountability by encouraging staff to be open about incidents.
    - Ensure no staff are penalised for reporting incidents in good faith.

Compliance and Enforcement
Failure to comply with this policy may result in:

- Performance management or disciplinary action for staff, volunteers, or contractors.
- Regulatory investigation and enforcement action by the Aged Care Quality and Safety Commission.
- Implementation of corrective actions and increased monitoring of non-compliant areas.

Regulatory Alignment
This policy aligns with:

- Aged Care Act 2024
- Strengthened Aged Care Quality Standards (February 2025) – Standard 2.5: Incident Management
- Aged Care Statement of Rights 2024

Related Documents

- Incident Management Reporting Form
- Open Disclosure Policy and Procedure
- Workplace Health and Safety Policy
- Emergency and Disaster Management Policy

Policy: Feedback and Complaints Management

Standard 2: The Organisation **Outcome 2.6: Feedback and Complaints Management**

Policy Statement
FOCUS Connect is committed to creating an environment where feedback and complaints are welcomed, valued, and used as a foundation for continuous improvement.

This policy ensures that:

- Older people, their families, carers, and staff are empowered to provide feedback and make complaints without fear of retribution.
- All feedback and complaints are handled promptly, fairly, and transparently.
- Outcomes are communicated clearly and effectively to complainants.
- Feedback and complaint data is systematically used to improve services and prevent future issues.

- A culture of open disclosure and continuous improvement is embedded across the organisation.

This policy aligns with Outcome 2.6: Feedback and Complaints Management of the Strengthened Aged Care Quality Standards (February 2025) and ensures compliance with the Aged Care Act 2024 and the Code of Conduct for Aged Care.

Purpose

The purpose of this policy is to:

1. Provide a structured, accessible, and transparent system for individuals to give feedback and make complaints.
2. Ensure all concerns are addressed promptly, investigated thoroughly, and resolved fairly.
3. Protect the rights of older people by fostering a culture of openness, respect, and accountability.
4. Ensure compliance with legislative and regulatory requirements, including mandatory reporting obligations.
5. Promote learning and continuous improvement through the use of feedback and complaints data.

Scope

This policy applies to:

- All staff, volunteers, and contractors providing or administering care and services.
- Older people, their families, and representatives, ensuring they have accessible ways to provide feedback or lodge complaints.
- The governing body and senior leadership, ensuring oversight and accountability for complaints management.

This policy applies to all forms of feedback and complaints, including:

- Service quality concerns, including delays, poor communication, or lack of responsiveness.
- Allegations of abuse, neglect, or disrespectful treatment.
- Concerns about staff conduct or competency.
- Suggestions for service improvement.

Definitions

- Feedback: Information provided by older people, their families, carers, or staff about their experiences with care and services, including compliments, suggestions, and complaints.
- Complaint: A formal or informal expression of dissatisfaction with care, services, staff, volunteers, contractors, or organisational processes, where a response or resolution is expected.
- Anonymous Complaint: A complaint lodged without the complainant revealing their identity.

- Open Disclosure: A transparent communication process with older people and their families about issues that arise, ensuring they are informed of what occurred, why, and what is being done to prevent recurrence.

Procedures

1. Feedback and Complaints Submission

- FOCUS Connect will provide multiple, accessible ways for individuals to provide feedback or make complaints, including:
  - Phone, email, website forms, written correspondence, and in-person discussions.
  - Anonymously, where preferred.
- Older people, their families, and carers will be encouraged and supported to provide feedback, ensuring they understand their right to do so without fear of retaliation.
- All complaints and feedback will be acknowledged within two (2) business days, informing the complainant of next steps and expected resolution timeframes.
- Feedback and complaints will be handled confidentially, following the organisation's Information Management and Privacy Policy.

2. Recording and Tracking Feedback and Complaints

- All feedback and complaints will be logged in a centralised Feedback and Complaints Register, including:
  - Nature and details of the complaint.
  - Date received and method of submission.
  - Individuals involved (if applicable).
  - Actions taken, investigation outcomes, and resolution status.
- A tracking system will be used to monitor progress and ensure timely resolution.
- Escalation pathways will be in place for high-risk or unresolved complaints, including:
  - Referral to senior management or external authorities (e.g., Aged Care Quality and Safety Commission).

3. Investigating and Resolving Complaints

- All complaints will be investigated impartially, thoroughly, and in a timely manner.
- Investigations will be led by appropriately qualified personnel, ensuring:
  - Root cause analysis is conducted.
  - Interviews or discussions are held with relevant individuals.
  - Findings are documented, and corrective actions are identified.
- Complainants will receive a formal response outlining findings and resolutions within 20 business days.
- If the complainant is not satisfied with the resolution, they will be advised of external escalation options, including:
  - Aged Care Quality and Safety Commission.
  - Older Persons Advocacy Network (OPAN).

4. Monitoring, Review, and Continuous Improvement

- FOCUS Connect will:
  - Regularly review feedback and complaints data to identify patterns and trends.

    - Conduct periodic audits to assess compliance with complaints management processes.
    - Ensure learnings from complaints are used to inform service improvements.
- Older people and their families will be engaged in reviewing complaints processes to ensure continuous improvement.

5. Staff Training and Awareness
- All staff, volunteers, and contractors must complete training on feedback and complaints management, including:
    - How to encourage and respond to feedback appropriately.
    - Handling complaints with empathy and professionalism.
    - Open disclosure and legal obligations regarding complaints resolution.
- Regular refresher training will be provided, with a focus on continuous improvement in communication and resolution skills.

6. Open Disclosure and Transparency
- Open disclosure will be practised for all complaints, ensuring:
    - Affected individuals and their families are informed of complaint outcomes.
    - Actions taken to prevent recurrence are communicated clearly.
    - Opportunities for discussion and support are provided.
- Anonymity and confidentiality will be respected where requested.

Compliance and Enforcement
Failure to comply with this policy may result in:
- Performance management or disciplinary action for staff, volunteers, or contractors.
- Regulatory investigation and enforcement action by the Aged Care Quality and Safety Commission.
- Implementation of corrective actions and increased monitoring of non-compliant areas.

Regulatory Alignment
This policy aligns with:
- Aged Care Act 2024
- Strengthened Aged Care Quality Standards (February 2025) – Standard 2.6: Feedback and Complaints Management
- Aged Care Statement of Rights 2024

Related Documents
- Feedback and Complaints Register
- Tracking and Escalation Template
- Complaint Acknowledgement and Resolution Form
- Stakeholder Communication Plan
- Continuous Improvement Plan
- Open Disclosure Policy
- Confidentiality and Information Management Policies

Policy: Information Management

Standard 2: The Organisation

Outcome 2.7: Information Management

Policy Statement

FOCUS Connect is committed to ensuring that all information related to individuals receiving care, staff, volunteers, contractors, and organisational operations is managed securely, accurately, and efficiently. This policy ensures that:

- Client and organisational information is protected, accessible, and used appropriately to support high-quality, safe, and effective care.
- All information management practices comply with the Aged Care Act 2024, the Code of Conduct for Aged Care, and the Strengthened Aged Care Quality Standards (February 2025).
- Confidentiality and privacy are maintained, ensuring informed consent for the collection, storage, and sharing of personal data.
- A culture of continuous improvement is embedded in the organisation's information management practices.

This policy aligns with Outcome 2.7: Information Management of the Strengthened Aged Care Quality Standards (February 2025) and ensures compliance with all regulatory and legislative requirements.

Purpose

This policy and related procedures outline FOCUS Connect'sapproach to information management, privacy, security, and accessibility to:

1. Ensure the effective, safe, and secure collection, storage, use, and disposal of information.
2. Support staff, volunteers, and contractors to manage information efficiently while maintaining confidentiality.
3. Enable older people and their representatives to access their information and make informed decisions about their care.
4. Ensure compliance with relevant regulatory and legislative obligations.
5. Support a culture of continuous improvement in information management practices.

Scope

This policy applies to:

- All staff, volunteers, and contractors who handle information as part of their roles.
- All individuals receiving care, ensuring they understand their rights regarding the use, access, and security of their personal information.
- The governing body and senior leadership, ensuring oversight and accountability for information management.

It covers all forms of information, including:

- Personal and sensitive client information (e.g., care records, health information, financial records).
- Operational and administrative data (e.g., policies, procedures, incident reports, risk management documentation).
- Workforce records (e.g., employment contracts, training records, staff incident reports).

Definitions

- Information Management System: A structured system (digital or physical) that enables an organisation to securely create, store, access, share, and dispose of information.
- Confidentiality: The obligation to protect private information, ensuring it is only accessed and used by authorised individuals.
- Informed Consent: A client's voluntary decision to agree to a process, service, or disclosure of information after being provided with relevant details about risks, benefits, and alternatives.
- Data Integrity: Ensuring that information is accurate, complete, and up-to-date throughout its lifecycle.
- Access Control: Measures that ensure only authorised personnel can access specific types of information.

Procedures

1. Information Management System

- FOCUS Connect maintains a secure and structured information management system that ensures:
    - Accurate and up-to-date records are maintained.
    - Client and operational data is stored securely and is only accessible to authorised personnel.
    - Integrated information-sharing mechanisms are in place, ensuring that relevant stakeholders can access necessary information while maintaining privacy protections.
    - Regular system reviews and audits are conducted to verify compliance with current best practices and regulatory standards.

2. Confidentiality and Access Control

- All client, workforce, and operational data is classified as confidential and is protected from unauthorised access.
- Access is granted on a need-to-know basis, ensuring that only staff, volunteers, or contractors with a legitimate purpose can view or use specific information.
- Older people are informed of their right to access and correct their personal information, and they may withdraw consent for its use at any time.
- When information is shared externally (e.g., with health professionals, family members, or regulatory bodies), explicit client consent is required unless mandated by law.
- Third-party access is strictly controlled, and contractual agreements must be in place before any external service provider accesses client data.

3. Accuracy, Integrity, and Record-Keeping

- All staff, volunteers, and contractors are responsible for ensuring information is accurate, up-to-date, and complete.
- Data entry timeframes must be adhered to, with client records updated within [insert timeframe, e.g., 24-48 hours] of care interactions.
- Regular audits will be conducted to review data accuracy, ensuring records reflect real-time updates on care plans, progress notes, and other critical information.
- Outdated or incorrect information will be rectified promptly, with clear version control and tracking mechanisms.

4. Informed Consent and Client Rights
- Older people must provide informed consent before their personal information is collected, used, or shared.
- Information must be presented in a way that is understandable to the client, using plain language and accessible formats (e.g., translated materials, verbal explanations).
- Clients have the right to request corrections to their personal information, ensuring accuracy and alignment with their care needs.
- Clients can withdraw consent for information sharing, except where disclosure is required by law (e.g., mandatory reporting obligations).

5. Security, Storage, and Disposal
- All electronic records are stored securely, with encryption, password protection, and firewall protections in place.
- Physical records are stored in locked, access-controlled areas, with clear documentation of who accesses records.
- Data retention and disposal policies are in place, ensuring that:
    - Client records are securely maintained for the legally required period.
    - Sensitive data is permanently deleted or destroyed when no longer required.
    - Disposal of records is conducted following legal and regulatory standards.

6. Continuous Improvement and Compliance
- The information management system will be regularly reviewed to ensure compliance with best practices and legislative changes.
- Staff feedback on information management processes will be encouraged to identify areas for improvement.
- Training will be provided to all relevant personnel on information security, confidentiality, and informed consent procedures.
- Findings from audits and compliance reviews will be used to strengthen information management policies and processes.

Compliance and Enforcement

Failure to comply with this policy may result in:
- Performance management or disciplinary action for staff, volunteers, or contractors who breach confidentiality or fail to follow information management procedures.
- Regulatory penalties for non-compliance with privacy and information security requirements.
- Corrective action measures, including retraining, system updates, or process revisions.

Regulatory Alignment

This policy aligns with:

- Aged Care Act 2024
- Strengthened Aged Care Quality Standards (February 2025) – Standard 2.7: Information Management
- Aged Care Statement of Rights 2024

Related Documents

- Information Management and Privacy Policy
- Data Security and Access Control Guidelines
- Client Consent Form for Information Sharing
- Feedback and Complaints Policy
- Incident Management Policy
- Workforce Training Records for Data Security
- Document storage, access request forms, and disposal policies

Policy: Workforce Planning

Standard 2: The Organisation

Outcome 2.8: Workforce Planning

Policy Statement

FOCUS Connect is committed to ensuring that its workforce is sufficient, skilled, and well-supported to deliver high-quality, person-centred care that meets the needs of individuals receiving in-home aged care. This policy ensures that:

- The workforce strategy aligns with regulatory requirements and contemporary best practices.
- Workforce planning is proactive, ensuring that staffing levels meet service demand.
- Workforce skills, competencies, and qualifications match the needs of older people receiving care.
- Workforce engagement, retention, and well-being are prioritised to enhance service quality.
- Diversity, inclusion, and cultural safety are embedded in workforce planning.

This policy aligns with Outcome 2.8: Workforce Planning of the Strengthened Aged Care Quality Standards (February 2025) and ensures compliance with all regulatory and legislative requirements.

Purpose

This policy and related procedures outline FOCUS Connect's approach to strategic workforce planning, recruitment, training, and retention to:

1. Ensure that the organisation has an appropriately skilled workforce to provide high-quality, person-centred care.
2. Maintain compliance with minimum staffing requirements and workforce capabilities.
3. Support workforce satisfaction, psychological safety, and retention.
4. Implement contingency planning to address workforce shortages and service continuity risks.
5. Foster a culture of continuous learning and improvement in workforce management.

Scope

This policy applies to:

- All staff, volunteers, and contractors involved in direct care, administration, and management.
- The governing body and senior leadership, ensuring oversight and accountability for workforce planning.
- All workforce-related activities, including recruitment, training, performance management, and workforce satisfaction.

It covers all employment models, including:

- Direct employees
- Contracted and agency workers

- Allied health professionals engaged under service agreements
- Volunteers involved in client care or support roles

Definitions

- Workforce: The total number of people (employees, contractors, and volunteers) engaged by an organisation to deliver and support aged care services.
- Workforce Planning: A structured approach to ensuring the right number of workers, with the right skills, are in place to meet current and future care demands.
- Competency: The combination of knowledge, skills, and experience required for a worker to perform their role effectively and safely.
- Direct Employment: Engaging staff directly rather than relying on contractors or agency workers to enhance continuity of care and organisational alignment.
- Contingency Planning: Strategies to mitigate workforce risks, ensuring service continuity during staff shortages, emergencies, or increased demand.

Procedures

1. Workforce Strategy and Planning

- FOCUS Connect develops and implements a workforce strategy that ensures:
    - The right number and mix of staff to meet service delivery needs.
    - Clear succession planning to prepare for workforce changes.
    - Proactive workforce monitoring and forecasting to anticipate future staffing needs.
- The workforce strategy is reviewed at least annually and adjusted as necessary.

2. Recruitment and Retention

- Recruitment processes ensure all workers meet the competency requirements for their roles.
- Direct employment is prioritised where possible to improve continuity of care and service consistency.
- Job descriptions and position requirements are regularly reviewed to align with evolving care models.
- Recruitment strategies actively promote diversity and cultural safety, ensuring that Aboriginal and Torres Strait Islander peoples and those from culturally and linguistically diverse backgrounds are represented in the workforce.
- Workforce retention strategies focus on:
    - Competitive remuneration and working conditions.
    - Career development opportunities.
    - Recognition and reward programs for staff contributions.

3. Skills and Competency Management

- All workers must demonstrate competency in their roles, assessed through:
    - Qualification and credential checks before employment.
    - Ongoing competency assessments to ensure skills remain current.
- Workforce capabilities must align with the health conditions and support needs of individuals receiving care.
- A continuous learning and professional development program is implemented to:

    - Ensure staff skills align with best practices and emerging care models.
    - Support career progression within the aged care sector.
- Training covers core competency areas, including:
    - Person-centred care
    - Cultural competency and trauma-informed care
    - Dementia care and reablement approaches
    - Emergency response and risk management

4. Workforce Satisfaction and Psychological Safety
- Strategies are implemented to support workforce well-being, engagement, and job satisfaction, including:
    - Regular staff engagement surveys and feedback mechanisms.
    - Mental health and well-being support programs.
    - Supervision and peer support networks.
- Staff are encouraged to provide feedback on workplace conditions and report safety concerns without fear of reprisal.
- Flexible work arrangements are offered where feasible to support staff well-being.

5. Contingency Planning for Workforce Shortages
- FOCUS Connect maintains workforce contingency plans to address:
    - Unplanned staff absences.
    - Short-term workforce shortages due to increased demand.
    - Emergency scenarios, including pandemics or natural disasters.
- Strategies include:
    - Maintaining a pool of casual or on-call staff.
    - Formal agreements with recruitment agencies for urgent workforce needs.
    - Cross-skilling staff to enable role flexibility.
    - Technology-enabled care models (e.g., telehealth, remote support options).

6. Continuous Improvement and Monitoring
- Workforce planning and performance data are regularly reviewed to identify areas for improvement.
- Workforce feedback and quality indicator data inform ongoing adjustments to staffing strategies.
- The workforce strategy is updated annually to ensure it aligns with changing regulations and sector needs.

Compliance and Enforcement

Failure to comply with this policy may result in:
- Performance management or disciplinary action for non-compliance with staffing, training, or competency requirements.
- Corrective action measures to address workforce shortages or skills gaps.
- Regulatory penalties if staffing levels or competency standards do not meet Aged Care Quality Standards.

Regulatory Alignment

This policy aligns with:

- Aged Care Act 2024
- Strengthened Aged Care Quality Standards (February 2025) – Standard 2.8: Workforce Planning
- Aged Care Statement of Rights 2024
- The Code of Conduct for Aged Care

Related Documents

- Workforce Planning Strategy
- Training and Professional Development Policy
- Diversity and Inclusion Policy
- Staff Recruitment and Retention Policy
- Emergency Workforce Contingency Plan
- Workforce Performance and Competency Assessment Forms

Policy: Human Resource Management

Standard 2: The Organisation

Outcome 2.9: Human Resource Management

Policy Statement

FOCUS Connect is committed to ensuring that its staff, volunteers, and contractors are competent, skilled, and supported to deliver high-quality, safe, and person-centred care in accordance with aged care regulatory and quality standards. This policy ensures that:

- Recruitment and onboarding processes attract skilled workers with the right qualifications and values.
- Training and development programs ensure the workforce remains competent and responsive to evolving care needs.
- Supervision and performance management processes support staff, volunteers, and contractors in achieving excellence.
- A positive, culturally safe, and inclusive work environment is maintained.
- Workforce planning and human resource practices align with the Strengthened Aged Care Quality Standards (February 2025), Outcome 2.9: Human Resource Management.

Purpose

This policy and related procedures outline FOCUS Connect's approach to human resource management, workforce development, and performance monitoring to:

1. Ensure the organisation has an appropriately skilled and competent workforce.
2. Maintain compliance with aged care regulatory requirements.
3. Support the continuous improvement of workforce capabilities.
4. Foster a workplace culture that promotes staff well-being and satisfaction.
5. Ensure all staff, volunteers, and contractors understand and fulfil their responsibilities in delivering safe, high-quality care.

Scope

This policy applies to:

- All staff, volunteers, and contractors involved in providing and administering care and services.
- The governing body and senior leadership, ensuring oversight and accountability for human resource practices.
- All workforce-related activities, including recruitment, training, supervision, performance management, and professional development.

It covers all employment models, including:

- Direct employees
- Contracted and agency workers
- Allied health professionals engaged under service agreements
- Volunteers involved in client care or support roles

Definitions

- Human Resource Management: The process of recruiting, training, supervising, and managing an organisation's workforce to ensure staff competency, performance, and well-being.
- Competence: The ability of a staff member to demonstrate and apply the necessary skills, knowledge, and behaviours to perform their role effectively.
- Supervision: A structured process to provide support, guidance, and professional development for staff, volunteers, and contractors.
- Performance Management: A systematic approach to assessing and improving workforce performance, including training, feedback, and corrective action where needed.
- Cultural Safety: Ensuring that care is delivered in a way that is respectful of, and responsive to, diverse cultural backgrounds, particularly Aboriginal and Torres Strait Islander peoples and CALD communities.

Procedures

1.Recruitment and Onboarding

- The organisation ensures transparent, equitable, and merit-based recruitment processes.
- Recruitment practices prioritise values-based hiring to attract individuals committed to person-centred care.
- Pre-employment checks include:
    - Verification of qualifications, certifications, and experience.
    - Reference checks from previous employers.
    - Police checks or NDIS Worker Screening Check, where required.
    - Aged Care register of banning orders
    - Visa and right-to-work eligibility checks, if applicable.
- A comprehensive onboarding program ensures all new staff:
    - Are introduced to the organisation's culture, policies, and quality expectations.
    - Receive mandatory training in aged care quality standards, person-centred care, and Code of Conduct requirements.

2.Training and Development

- All staff, volunteers, and contractors participate in mandatory training and competency-based learning aligned with their roles.
- Training programs cover:
    - Person-centred and culturally safe care
    - Dementia care and palliative care
    - Infection control and medication safety
    - Recognising and responding to abuse, neglect, and discrimination
    - Emergency preparedness and disaster response
    - Digital and assistive technology literacy for supporting care delivery
- Training is responsive to feedback, complaints, and incidents, ensuring emerging risks are addressed.
- Annual competency assessments ensure that all staff remain up to date with best practices and regulatory changes.

- The organisation supports professional development, including:
    - Scholarships and study assistance programs for further education.
    - Leadership development programs for career progression.
    - External training opportunities, such as aged care conferences and workshops.

3.Supervision and Workforce Support

- All staff, volunteers, and contractors have access to regular supervision and professional guidance.
- Supervision includes:
    - Regular one-on-one check-ins between staff and supervisors.
    - Group or team meetings for peer learning and shared problem-solving.
    - Access to mentoring and coaching programs.
- Staff have access to well-being and mental health support services, ensuring they feel valued and supported in their roles.

4.Performance Management

- A structured performance management system ensures staff:
    - Understand their roles, responsibilities, and performance expectations.
    - Receive regular performance reviews and constructive feedback.
    - Have opportunities to address any areas for improvement.
- If performance concerns are identified, the organisation will:
    - Develop improvement plans with clear goals, timelines, and additional support.
    - Provide additional training and mentoring, where necessary.
    - Take corrective action or disciplinary measures, if required.
- Performance records are maintained for all staff to track progress and inform future workforce planning.

5.Workforce Well-being and Cultural Safety

- Workforce well-being strategies include:
    - Flexible working arrangements, where possible.
    - Access to Employee Assistance Programs (EAPs).
    - Recognition and reward initiatives for staff achievements.
- The organisation promotes an inclusive workplace culture, ensuring that:
    - Diversity and equity are prioritised in workforce recruitment and retention strategies.
    - Cultural awareness training is provided to all staff.
    - Aboriginal and Torres Strait Islander and CALD workforce representation is actively supported.

6.Workforce Planning and Continuous Improvement

- Human resource management processes are regularly reviewed and updated to reflect:
    - Workforce needs and service demands.
    - Feedback from staff and care recipients.

    - Changes in aged care regulations and quality standards.
- Workforce data is monitored to identify trends, risks, and opportunities for workforce improvements.
- HR policies align with the broader workforce planning strategy, ensuring long-term sustainability in service delivery.

Compliance and Enforcement
Failure to comply with this policy may result in:

- Performance management or disciplinary action for breaches of HR policies.
- Corrective action measures to address competency gaps or misconduct.
- Regulatory action if workforce management does not meet Aged Care Quality Standards.

Regulatory Alignment
This policy aligns with:

- Aged Care Act 2024
- Strengthened Aged Care Quality Standards (February 2025) – Standard 2.9: Human Resource Management
- Aged Care Statement of Rights 2024
- The Code of Conduct for Aged Care

Related Documents

- Workforce Planning Policy
- Training and Professional Development Policy
- Staff Supervision and Performance Management Policy
- Diversity and Inclusion Policy
- Recruitment and Retention Guidelines
- HR Compliance and Employment Records Policy

Policy: Emergency and Disaster Management

Standard 2: The Organisation **Outcome 2.10: Emergency and Disaster Management**

Policy Statement
FOCUS Connect is committed to ensuring the safety, health, and wellbeing of clients, staff, volunteers, and contractors by implementing a comprehensive emergency and disaster management framework that:

- Identifies, assesses, and mitigates risks associated with emergencies and disasters.
- Ensures preparedness through planning, staff training, and stakeholder engagement.
- Maintains continuity of care during and after emergency events.
- Establishes clear communication and coordination mechanisms with emergency services, government agencies, and community networks.

This policy aligns with the Aged Care Act 2024, the Strengthened Aged Care Quality Standards (February 2025), and emergency preparedness guidelines from relevant government authorities.

Purpose

This policy outlines FOCUS Connect's approach to emergency and disaster preparedness, response, and recovery to:

1. Ensure clients continue receiving safe and effective care during and after an emergency.
2. Protect staff, volunteers, and contractors from risks associated with emergency events.
3. Support compliance with legal and regulatory obligations related to emergency and disaster management.
4. Promote a culture of risk awareness, preparedness, and resilience.

Scope

This policy applies to:

- All staff, volunteers, and contractors involved in providing and administering care and services.
- Clients, their families, and carers who may be impacted by emergencies and disasters.
- Governing body and senior leadership responsible for organisational risk management.

It encompasses all emergency scenarios that could impact care and service delivery, including:

- Natural disasters (e.g., floods, bushfires, extreme heatwaves).
- Health-related emergencies (e.g., pandemics, infectious disease outbreaks).
- Utility failures (e.g., power outages, water shortages, IT system failures).
- Security incidents (e.g., cyber-attacks, intruder threats, violent incidents).

Definitions

- Emergency: A sudden, urgent event that requires an immediate response to protect life, health, and safety.
- Disaster: A large-scale event that significantly disrupts community functioning, requiring external resources for response and recovery.
- Emergency and Disaster Management: The organisation's structured approach to planning, responding to, and recovering from emergencies to minimise risks and ensure business continuity.
- Continuity of Care: Ensuring essential aged care services continue during and after an emergency, with minimal disruption to clients.

Procedures

1.Emergency and Disaster Management Planning

- The organisation maintains a formal Emergency and Disaster Management Plan, outlining:
    - Roles and responsibilities of staff, volunteers, and contractors.
    - Emergency response procedures for different types of incidents.
    - Evacuation and shelter-in-place protocols.
    - Continuity of care arrangements, ensuring clients still receive essential services.

    - Communication protocols for informing staff, clients, families, and external stakeholders.
    - Collaboration arrangements with local emergency services, government bodies, and community organisations.
- Emergency plans are reviewed and updated annually or after a major emergency event.

2.Training and Preparedness

- All staff, volunteers, and contractors receive mandatory training on emergency procedures, including:
    - Identifying and reporting potential hazards and risks.
    - Implementing evacuation, shelter, and lockdown procedures.
    - Supporting clients during emergencies, including those with mobility limitations, cognitive impairments, or medical dependencies.
    - Using emergency equipment, such as fire extinguishers and first aid supplies.
- The organisation conducts annual emergency drills and simulations, including:
    - Fire drills
    - Severe weather response exercises
    - Business continuity scenario planning

3.Risk Management and Business Continuity

- A risk assessment is conducted at least annually to identify potential emergency threats and develop mitigation strategies.
- The organisation implements preventative measures, including:
    - Backup power sources (e.g., generators, battery packs).
    - Redundant communication systems (e.g., mobile networks, satellite phones).
    - Stockpiling of critical supplies (e.g., food, water, medications, PPE).
- A Business Continuity Plan (BCP) ensures the continuation of critical aged care services, including:
    - Client prioritisation strategies (identifying high-risk clients needing urgent care).
    - Alternative care arrangements if usual service locations are unavailable.
    - Remote workforce mobilisation, if necessary.

4.Communication and Coordination

- The organisation maintains emergency contact lists for:
    - Staff, clients, families, and carers.
    - Emergency services, local authorities, and healthcare providers.
- Emergency notifications are issued via multiple channels, including:
    - SMS, phone calls, and email alerts.
    - Website and social media updates.
    - In-person briefings for affected clients.
- Clients and their families receive clear guidance on:
    - What to expect during an emergency.

- Who to contact for assistance.
- How to access continued care and support.

5.Response and Recovery

Immediate Response Actions

- When an emergency occurs, staff follow the Emergency and Disaster Response Plan, which includes:
  - Ensuring client safety (assessing immediate risks, evacuating if necessary).
  - Activating emergency communication protocols.
  - Coordinating with external emergency responders (police, fire, ambulance).
  - Documenting all actions and decisions taken.

Post-Emergency Recovery

- After an emergency, the organisation:
  - Conducts a debriefing session with staff to review response effectiveness.
  - Assesses physical damage and service disruptions.
  - Supports affected clients, families, and staff (e.g., counselling, financial assistance referrals).
  - Implements corrective actions to improve future preparedness.

Compliance and Enforcement

Failure to comply with this policy may result in:

- Performance management or disciplinary action for breaches of emergency procedures.
- Regulatory sanctions if emergency preparedness does not meet aged care quality and safety standards.
- Increased organisational liability in the event of preventable harm.

Regulatory Alignment

This policy aligns with:

- Aged Care Act 2024
- Aged Care Statement of Rights 2024
- Strengthened Aged Care Quality Standards (February 2025) – Standard 2.10: Emergency and Disaster Management
- Emergency Management Frameworks (Australian Government & State Emergency Services)
- The Code of Conduct for Aged Care

Related Documents

- Risk Management Policy
- Incident Management Policy
- Business Continuity Plan
- Workforce Planning Policy
- Infection Prevention and Control Policy
- Client Evacuation and Shelter Protocols

Policy: Assessment & Care Planning

Standard 3: The Care & Services

Outcome 3.1: Assessment and Planning

Policy Statement

FOCUS Connect is committed to delivering person-centred, evidence-informed care that supports each older person's independence, health, and wellbeing.

Assessment and care planning are inclusive, holistic, and responsive, ensuring that services are tailored to each individual's goals, risks, and preferences. Our approach incorporates and supports the Australian Government's Single Point of Assessment model and the use of the Integrated Assessment Tool (IAT) as part of the aged care reforms under the Support at Home Program.

We ensure that:

- Comprehensive assessments are conducted using nationally consistent assessment information from the IAT.
- Planning is collaborative, with active involvement of the older person and their representatives.
- Risk identification and mitigation are embedded in planning processes.
- Assessments and care plans are regularly reviewed to reflect the older person's evolving needs.

This policy is informed by the Aged Care Act 2024, Strengthened Aged Care Quality Standards (2025), and the Support at Home Program Manual (March 2025).

Purpose

To establish a consistent approach to assessment and care planning that ensures:

1. Older persons receive high-quality, individualised support.
2. Assessment and planning are transparent, collaborative, and culturally responsive.
3. The organisation complements the national assessment system and acts on classification outcomes.
4. Risk is proactively managed and reviewed.
5. Care plans are responsive to change and support informed decision-making.

Scope

This policy applies to:

- All employees, contractors, and volunteers responsible for coordinating or delivering care.
- Older persons receiving services, and their families, carers, or nominated representatives.
- Governance, management, and quality teams overseeing compliance with aged care obligations.

Note: Entry assessment and classification into the Support at Home Program is conducted by authorised independent assessors under the Single Point of Assessment model using the Integrated Assessment Tool (IAT). This policy applies to post-entry assessment and care planning undertaken by Insert organisation name.

Definitions

- Single Point of Assessment: The national gateway for assessing eligibility and classification into aged care programs, replacing the former RAS/ACAT systems.
- Integrated Assessment Tool (IAT): A nationally consistent tool used by assessment organisations to assess care needs, risks, goals, and assign classification levels.
- Assessment (post-entry): An ongoing, structured evaluation of a client's needs, strengths, and risks by the service provider, to support effective service delivery.
- Care and Services Plan: A documented, co-developed plan outlining services and supports that reflect the person's needs, goals, and agreed care approach.
- Shared Decision-Making: A process where the older person, their representatives, and professionals collaborate on planning and decision-making.
- Validated Tools: Clinical and functional tools used post-entry by the provider to assess changes and inform care planning (e.g., nutrition, mobility, cognitive screeners).

Procedures

1. Using National Assessment Outcomes (Program Entry)
    - All clients entering the Support at Home Program will have their eligibility and classification determined through the government's Single Point of Assessment, conducted by independent assessment organisations using the IAT.
    - FOCUS Connect will:
        - Review IAT outputs to understand the person's classification, risks, and care needs.
        - Use this information to inform the development of an initial Care and Services Plan.
        - Ensure that planning is consistent with the person's classification and funding allocation.
2. Comprehensive Post-Entry Assessment
    - Following program entry, FOCUS Connect will:
        - Conduct a provider-based assessment to confirm service preferences, environmental factors, and lifestyle priorities.
        - Reassess aspects not captured during the national assessment (e.g., service-specific logistics, carer preferences, cultural or religious practices).
        - Involve the older person and/or their representative in all discussions.
        - Use validated tools as appropriate to monitor changes over time (e.g., pain scales, mobility assessments, mood screens).
        - Screen for risks including clinical (falls, nutrition), psychosocial (isolation), and environmental (hazards at home).
3. Development of a Care and Services Plan
    - A Care and Services Plan will be co-designed with the older person, their family, and other relevant parties, and will:
        - Reflect the older person's goals, values, and support needs.
        - Detail the types, frequency, and delivery methods of services.
        - Include culturally appropriate considerations and reasonable adjustments.
        - Specify risk mitigation strategies and escalation protocols.
        - Be consistent with the classification level and funding allocation from the IAT.

- The plan must be agreed upon, signed or verbally accepted by the older person, and shared in a suitable format.

4. Documentation and Communication
   - All assessment findings and plans will be:
     - Recorded in the organisation's secure care management system.
     - Accessible to all relevant staff involved in service delivery.
     - Provided to the older person and/or their representative in their preferred format (e.g., translated, large print, Easy Read).
   - Any changes to the plan must be documented and communicated in a timely manner.
5. Ongoing Review and Reassessment
   - Care and Services Plans will be reviewed:
     - At least annually.
     - When requested by the older person or their representative.
     - After significant life events, changes in health, or following incidents (e.g., hospitalisation, fall).
   - The review process will:
     - Ensure that services remain aligned with evolving goals and needs.
     - Reassess risks and make necessary adjustments.
     - Involve the older person and their care team in decision-making.
     - Result in an updated plan with documented agreement.
6. Risk Management
   - Risk identification and mitigation are embedded throughout the assessment and planning process.
   - Risks considered include:
     - Clinical: Medication safety, nutrition, pressure injuries.
     - Psychosocial: Cognitive decline, depression, carer burden.
     - Environmental: Home access, hygiene, trip hazards.
   - Targeted interventions are implemented, and high-risk individuals may require more frequent monitoring or escalation.
7. Continuous Improvement
   - This policy and related processes will be:
     - Reviewed annually or as required due to regulatory change.
     - Informed by client feedback, complaints, incidents, and audit findings.
     - Benchmarked against national standards and best practice.
   - Staff training and internal audits will monitor policy implementation effectiveness.

Compliance and Enforcement

Non-compliance with this policy may result in:

- Performance management for staff.
- Regulatory non-compliance issues.
- Client dissatisfaction or safety risks.
- Escalation to the Aged Care Quality and Safety Commission if required.

Regulatory Alignment

This policy is aligned with:

- Aged Care Act 2024

- Aged Care Statement of Rights 2024
- Strengthened Aged Care Quality Standards (February 2025) – Standard 3, Outcome 3.1
- Support at Home Program Manual (March 2025)
- Code of Conduct for Aged Care – especially regarding acting with care, respect, and transparency

Related Documents

- Person-Centred Care Policy
- Cultural Safety and Inclusion Policy
- Risk and Clinical Governance Policy
- Incident Management Policy
- Advance Care Planning Policy
- Restrictive Practices Policy
- Quality and Safety Framework
- Client Rights and Feedback Policy

Policy: Review and Monitoring

Standard 3: The Care & Services **Outcome 3.1: Assessment and Planning**

Policy Statement

FOCUS Connect is committed to ensuring that client care and service plans remain relevant, effective, and responsive to changing needs, goals, and preferences.

This is achieved through:

- Regular and proactive reviews of care and services plans.
- A systematic, evidence-based approach to monitoring client outcomes.
- Timely updates based on client feedback, risk identification, incidents, and service effectiveness.
- Collaborative engagement with clients, carers, families, and multidisciplinary teams to ensure plans remain person-centred and goal-oriented.
- Compliance with all legislative and regulatory requirements, including the Aged Care Act 2024 and the Support at Home Program guidelines.

Purpose

This policy outlines FOCUS Connect's approach to review and monitoring, ensuring:

1. Care and service plans are regularly assessed and updated to reflect the client's evolving needs.
2. Clients and their representatives remain actively involved in reviewing their care.
3. Emerging risks, health deteriorations, or changes in social circumstances trigger timely reassessments.
4. Care and services remain person-centred, safe, and aligned with best practices.
5. Continuous improvement in service planning and delivery through structured feedback and data analysis.

Scope

This policy applies to:

- All staff, volunteers, and contractors involved in providing, managing, or coordinating care and services.
- Clients, their families, carers, and appointed representatives.
- Governing body and leadership team responsible for overseeing quality compliance and continuous improvement.

Definitions

- Assessment: A structured process to evaluate a client's care needs, goals, risks, and preferences using standardised and validated tools.
- Care and Services Plan: A documented plan outlining the client's assessed needs, goals, services, and care interventions. It includes clinical, personal, and social support services and aligns with person-centred principles.
- Person-Centred Care: A holistic, partnership-driven approach that prioritises client choice, autonomy, and self-determination in service planning.
- Validated Assessment Tool: A reliable and standardised tool used for clinical decision-making and reassessment of client needs.
- Triggers for Review: Events or circumstances that indicate the need to reassess and update the care plan to maintain its relevance and effectiveness.

Procedures

1.Triggers for Review of Care and Services Plans

A review of the care and services plan is required when any of the following occur:

Client-Driven Changes

- Changes in Preferences or Goals: The client expresses a desire to modify their care plan.
- Concerns Raised by the Client, Family, or Carer: The client or their representative reports dissatisfaction or requests changes.

Health-Related Triggers

- Deterioration in Function: Decline in mobility, cognition, mental health, or ability to perform daily activities.
- Improvement in Function: The client regains abilities and no longer requires certain services.
- Emerging Health Risks: New diagnoses, medication changes, or increased support needs.

- Incident-Driven Review: Falls, hospitalisations, near-misses, or any significant event impacting the client's health or safety.

Environmental and Social Triggers

- Change in Family or Carer Support: The client's primary carer becomes unavailable, or their support needs change.
- Relocation or Transition: The client moves to a different care setting or experiences a significant lifestyle adjustment.
- Community or External Factors: Changes in service availability, funding adjustments, or emergency situations affecting service provision.

2.Review Process

Step	Description
1. Initiate Review	A review is triggered by one of the above events, and a designated staff member initiates the process.
2. Consultation	Engage the client, family, carers, and relevant healthcare professionals in a structured discussion about the client's evolving needs.
3. Reassessment	Use validated assessment tools to evaluate new risks, care needs, preferences, and service effectiveness.
4. Update Care Plan	Modify the care and services plan based on reassessment findings and ensure alignment with person-centred care principles.
5. Documentation	Record changes in the client's digital or physical care file, ensuring all updates are clearly documented and time stamped.
6. Communication	Notify all relevant staff, volunteers, contractors, and family/carers about the updated plan and ensure they understand any new responsibilities.
7. Implementation	Adjust service provision to reflect the updated plan, ensuring prompt and effective implementation.
8. Continuous Monitoring	Track client outcomes post-review, ensuring any further adjustments are made promptly based on feedback and observation.

3.Continuous Monitoring and Quality Assurance

- Clients are continuously monitored for ongoing suitability of their care plan.
- Service delivery is regularly reviewed to ensure care and support remain appropriate, effective, and culturally responsive.
- Systematic audits and case reviews are conducted to evaluate compliance with best practices and regulatory requirements.
- Client and workforce feedback informs ongoing improvements, ensuring the review and monitoring process remains effective and aligned with person-centred care principles.

Compliance and Enforcement

Failure to comply with this policy may result in:

- Performance management or disciplinary action for staff.
- Regulatory non-compliance issues, affecting accreditation and funding.
- Compromised client safety and quality of care.

Regulatory Alignment

This policy aligns with:

- Aged Care Act 2024
- Aged Care Statement of Rights 2024
- Strengthened Aged Care Quality Standards (February 2025) – Standard 3.1.5: Review and Monitoring
- Support at Home Program guidelines
- The Code of Conduct for Aged Care

Related Documents

- Assessment & Care Planning Policy
- Advanced Care Planning Policy
- Clinical Governance Policy
- Communicating for Safety & Quality Policy
- Incident Management Policy
- Person-Centred Care Policy
- Risk Management Policy
- Restrictive Practices Policy
- Review and Monitoring Policy
- Others added by organisation

Policy: Advanced Care Planning

Standard 3: The Care & Services

Outcome 3.1: Assessment and Planning

Policy Statement

FOCUS Connect is committed to respecting and upholding clients' rights, values, and preferences regarding future medical treatment and care through a structured and person-centred approach to advanced care planning (ACP).

This commitment includes:

- Encouraging proactive discussions about future care planning early in the care relationship.
- Supporting clients in documenting their wishes, ensuring informed decision-making.
- Ensuring ACP documents are accessible to all relevant personnel while maintaining confidentiality.
- Regularly reviewing and updating ACPs to reflect changes in health, preferences, or circumstances.
- Integrating spiritual and psychosocial support, recognising the holistic nature of end-of-life care.
- Complying with all legislative and regulatory requirements, including the Aged Care Act 2024 and Support at Home Program guidelines.

Purpose

This policy outlines FOCUS Connect's approach to Advanced Care Planning (ACP), ensuring:

1. Clients have the opportunity to express, document, and update their future care preferences.
2. ACP is embedded as part of routine care planning and service delivery.
3. Clients, carers, and families understand the importance of ACP and are supported in making informed decisions.
4. A structured process for reviewing and implementing ACP directives is in place.
5. Staff are trained to uphold and respect ACP in all care decisions, especially when clients lose decision-making capacity.

Scope

This policy applies to:

- All staff, volunteers, and contractors involved in providing, managing, or coordinating care and services.
- Clients, their families, carers, and appointed representatives.
- Governing body and leadership team responsible for oversight and compliance with ACP regulations.

Definitions

- Advanced Care Planning (ACP): A voluntary, ongoing process that enables a person to document their values, beliefs, and future healthcare preferences if they lose decision-making capacity. ACP is not a one-time event but should be regularly revisited.

- Advance Care Directive (ACD): A legally binding document that records a person's preferences for future healthcare, including medical treatments they wish to receive or refuse.
- Substitute Decision-Maker (SDM): A legally appointed individual who makes healthcare decisions on behalf of a person who lacks capacity. The SDM is bound by the individual's ACP and legal obligations.
- Person-Centred Care: A collaborative approach that ensures care is respectful of and responsive to the individual's preferences, needs, and values.
- Spiritual Care: Holistic support that recognises the need for meaning, purpose, and emotional well-being in end-of-life decision-making.

Procedures

1.Initiating Advanced Care Planning

- ACP discussions are introduced at the start of service provision and revisited regularly.
- Clients, their families, and carers are encouraged to participate in ACP discussions.
- Staff are trained to facilitate ACP discussions sensitively, using clear and accessible language.
- Clients are supported with resources (e.g., fact sheets, decision-making guides) to make informed choices.
- If a client lacks capacity, an appointed Substitute Decision-Maker (SDM) is engaged in the process.

2.Documenting Advanced Care Plans

- ACP documents should include:
  - Client's values, beliefs, and care preferences.
  - Decisions about life-sustaining treatments, pain management, and palliative care.
  - Appointment of a Substitute Decision-Maker (if applicable).
  - Instructions for end-of-life care preferences, including spiritual and emotional needs.
- ACP documents must be securely stored in the client's care record and information management system.
- All relevant care personnel must have access to the ACP to ensure it informs clinical decisions.

3.Reviewing and Updating Advanced Care Plans

ACP is not a static document and should be reviewed in response to:

- Significant changes in the client's health, cognitive function, or medical condition.
- Changes in personal values, goals, or preferences.
- Major life transitions, such as relocation or changes in family/carer support.
- Regulatory changes affecting care planning or decision-making processes.
- Client request for modifications.

Step	Action
1. Trigger for Review	A change in the client's health, preferences, or support needs occurs.

2. Consultation	Engage the client, SDM, carers, and healthcare professionals to discuss updates.
3. Update ACP Document	Modify the ACP accordingly and record changes in the client's file.
4. Communication	Notify all relevant staff and service providers of changes.
5. Implementation	Ensure care is provided in accordance with the updated ACP.

4.Respecting and Implementing Advanced Care Plans

- All staff must adhere to the ACP when providing care.
- ACP must guide clinical decisions when the client loses decision-making capacity.
- In case of emergency, staff must refer to the ACP to ensure care aligns with the client's documented wishes.
- If a conflict arises regarding the ACP, consult the Substitute Decision-Maker or legal team.

5.Spiritual and Emotional Support

- ACP discussions should include consideration of spiritual and emotional needs.
- Clients should be offered access to faith-based or spiritual care providers upon request.
- ACP should incorporate psychosocial aspects of care, including end-of-life preferences, cultural considerations, and bereavement support for families.

Communication and Training

- Clients and families receive ongoing education about ACP and their rights.
- Staff undergo regular training in ACP facilitation, ethical decision-making, and cultural sensitivity.
- ACP discussions are embedded in routine care planning conversations.

Compliance and Enforcement

Failure to comply with this policy may result in:

- Performance management or disciplinary action for staff.
- Legal consequences for failing to honour a client's ACP.
- Regulatory non-compliance issues, affecting accreditation and funding.

Regulatory Alignment

This policy aligns with:

- Aged Care Act 2024
- Aged Care Statement of Rights 2024
- Strengthened Aged Care Quality Standards (February 2025) – Standard 3.1.6: Advanced Care Planning
- Support at Home Program guidelines
- The Code of Conduct for Aged Care

Related Documents

- Assessment & Care Planning Policy
- Palliative Care and End-of-Life Policy
- Spiritual Care Policy
- Person-Centred Care Policy

- Risk Management Policy
- Review and Monitoring Policy
- Others added by organisation

Policy: Participant Needs, Goals & Preferences

Standard 3: The Care & Services

Outcome 3.2: Delivery of Care and Services

Policy Statement

FOCUS Connect is committed to ensuring that all care and services provided are tailored to the unique needs, goals, and preferences of each older person receiving support. The organisation applies a person-centred, partnership-based approach that upholds individual choice, dignity, and respect in all aspects of care planning and delivery.

FOCUS Connect ensures that care and services support wellness, reablement, and independence while promoting meaningful engagement and social connections in line with Aged Care Quality Standards Outcome 3.2 and the principles of Participant -directed care.

Purpose

This policy and related procedures describe the steps that FOCUS Connect will take to:

- Identify and document each older person's care needs, goals, and preferences to support their independence, wellbeing, and quality of life.
- Ensure that care and services are delivered in partnership with older people, their carers, families, and relevant stakeholders.
- Facilitate ongoing reviews and adjustments to care plans, ensuring that they remain responsive to the changing needs and preferences of each individual.

Scope

This policy applies to all FOCUS Connect staff, volunteers, and contractors involved in the provision and administration of care and services.

Definitions

Participant (Older Person): An individual who has been assessed as eligible to receive Australian Government-funded aged care services under the Aged Care Act 2024.

Person-Centred Care: A collaborative approach to care planning and service delivery that:

- Recognises that every person is unique and values the older person's voice and choices.
- Supports partnerships between providers, older people, and their carers to co-design care and services.
- Ensures culturally appropriate and spiritually inclusive care that respects an older person's values and identity.
  Reablement and Wellness: An approach that focuses on supporting older people to regain or maintain functional ability, independence, and social participation through targeted, time-limited, or ongoing support.

Procedures

1.Identifying Needs, Goals & Preferences

- Upon initial assessment and regularly thereafter, FOCUS Connect works collaboratively with older people, their families, and their support network to identify their needs, goals, and preferences.
- The assessment considers:
    - Health and functional needs (personal care, mobility, medication management).
    - Wellness and reablement goals (e.g., maintaining physical activity, regaining function).
    - Social, cultural, and emotional needs (community participation, language preferences, religious/spiritual beliefs).
    - Personal care preferences, including how and when services are delivered.
- The older person is encouraged to actively participate in identifying their goals and preferences, and these are clearly documented in their care plan.

2.Integrating Needs, Goals & Preferences into Care Plans

- Each older person's care and services plan is developed with their input and agreement, ensuring that it aligns with their priorities and desired outcomes.
- The care plan:
    - Is flexible and adaptable, allowing for changes in circumstances.
    - Uses plain language and is provided in accessible formats to ensure understanding.
    - Includes specific strategies for supporting independence and achieving wellness and reablement goals.
- Care staff are trained to deliver services in accordance with each older person's plan, ensuring a personalised and culturally safe approach to care.

3.Reviewing and Updating Care Plans

- Care plans are reviewed at regular intervals, as well as:
    - When there is a significant change in the older person's health, functional capacity, or preferences.
    - Following a change in carer arrangements or support networks.
    - After any incident, hospitalisation, or new diagnosis that impacts care needs.
- Older people are given the opportunity to participate in care plan reviews to ensure services remain relevant and meaningful to them.
- Updates to care plans are:
    - Clearly documented and stored securely within the organisation's information management system.
    - Communicated to all relevant staff, volunteers, contractors, and support networks to ensure continuity of care.

4.Ensuring Client Autonomy and Choice

- Older people are supported to make informed decisions about their care and services, with full respect for their rights, choices, and autonomy.
- The organisation ensures that older people:
    - Have access to comprehensive, clear, and unbiased information about their service options.
    - Are provided with support, such as interpreting services, where required.

- Can exercise their preferences even if they differ from provider recommendations, with appropriate risk management strategies in place.

5.Communication and Documentation

- All identified needs, goals, and preferences are clearly recorded in the care plan and updated as required.
- Care plans and assessments are securely stored in line with privacy and confidentiality requirements under the Aged Care Act 2024.
- The organisation maintains accessible documentation and ensures that staff and care recipients have access to updated care plans.

Enforcement

Failure to follow this policy and related procedures may be considered a breach of job role requirements or regulatory compliance and may lead to performance management or disciplinary action.

Related Regulatory Requirements

- Aged Care Act 2024
- Aged Care Statement of Rights 2024
- Aged Care Quality and Safety Commission, Strengthened Aged Care Quality Standards – Final Draft, November 2023, Standard 3, Outcome 3.2, Action 3.2.1.
- Aged Care Quality and Safety Commission, Draft: Standard 3 Care and Services, Guidance Material for the Strengthened Aged Care Quality Standards.
- The Code of Conduct for Aged Care

Related Documents

- Advanced Care Planning Policy
- Assessment & Care Planning Policy
- Choice, Independence and Quality of Life Policy
- Comprehensive Care Policy
- Coordination of Care & Services Policy
- Information Management Policy
- Palliative Care and End of Life Policy
- Partnering with Older People Policy
- Person-Centred Care Policy
- Reablement Policy
- Review and Monitoring Policy
- Spiritual Care Policy
- Others added by organisation

Policy: Reablement

Standard 3: The Care & Services

Outcome 3.2: Delivery of Care and Services

Policy Statement

FOCUS Connect is committed to enabling older people to achieve and maintain their optimal level of independence through a reablement-focused model of care. In alignment with the Support at Home Program Manual (March 2025), reablement is a foundational element of service delivery and must be embedded in every stage of the care process — from assessment to service provision and review.

Reablement under the Support at Home Program is:

- Person-centred and strengths-based, focused on what the individual can do or regain.
- Goal-oriented, addressing both physical and social functioning.
- Time-limited and measurable, with clear expectations for review and progression.
- Adaptable, ensuring support is tailored to cultural, emotional, cognitive, and spiritual needs.

The organisation ensures that all support staff and care coordinators actively promote reablement and integrate it into everyday practice.

Purpose

This policy outlines the approach to delivering reablement interventions across home care services, ensuring consistency with the Support at Home Program's requirements. The goal is to maximise each person's potential for independence, autonomy, and participation in life roles.

Scope

This policy applies to:

- All staff, contractors, and allied health professionals responsible for providing, coordinating, or reviewing care and services.
- Older persons receiving support under the Support at Home Program, and their carers or nominated representatives.
- Governance and management teams overseeing compliance with care planning and service delivery standards.

Definitions

- Reablement: A short-term, goal-directed approach designed to help older people regain or maintain functional ability, reduce dependency, and delay or avoid long-term support. It may include therapy-based services, equipment, assistive technology, and community engagement activities.
- Maintenance of Function: Longer-term strategies aimed at preserving physical, cognitive, and emotional wellbeing to prevent deterioration.
- Support at Home Classification Model: The framework used to determine care needs and funding allocations, guiding reablement intensity and focus.
- Person-Centred Reablement: An inclusive process that prioritises individual values, cultural identity, and life goals in designing and delivering care.

- SMART Goals: Goals that are Specific, Measurable, Achievable, Relevant, and Time-bound — a core requirement for structured reablement planning.

Procedures

1. Identifying Reablement Opportunities
   - During initial assessment and subsequent care plan reviews, the following must be evaluated:
     - Functional status, including mobility, self-care, cognition, and daily living skills.
     - Psychosocial factors such as social isolation, emotional wellbeing, and community participation.
     - The individual's personal goals, preferences, and aspirations for independence.
   - The organisation works with the outputs from the Support at Home Integrated Assessment Tool (IAT) and classification outcomes to identify reablement needs.
   - Clients and their representatives must be actively involved in all reablement-related discussions.
2. Developing Reablement-Focused Care and Service Plans
   - Each plan must:
     - Include SMART goals and expected timelines for achieving them.
     - Incorporate appropriate strategies such as therapy (OT/PT), home modifications, assistive tech, or skill-building support.
     - Address both clinical and non-clinical areas, including community re-engagement, digital literacy, and confidence-building.
     - Be documented clearly and accessible to the care team and the client.
   - Reablement strategies should be prioritised before long-term support unless there is clear clinical justification otherwise (in line with Support at Home guidelines).
3. Monitoring and Review of Reablement Interventions
   - Progress toward reablement goals must be reviewed at least every 3–6 months or sooner if the person's condition changes.
   - The review process must:
     - Include feedback from the older person and their care team.
     - Assess what has been achieved and what requires adjustment.
     - Explore alternatives or longer-term supports where reablement is no longer effective or relevant.
     - Be documented, including any changes to goals or strategies.
   - If goals are achieved early, new goals may be developed collaboratively with the older person.
4. Supporting Motivation, Participation and Inclusion
   - Reablement relies on older people actively participating in their care. The organisation will:
     - Provide education about reablement and its benefits at intake and during reviews.
     - Encourage peer support, role modelling, and client success stories.
     - Support older people to access social, recreational, and community-based activities.
     - Facilitate connections to culturally relevant groups and services.
5. Documentation and Communication

- Reablement goals, strategies, and outcomes must be:
    - Documented in the care and services plan and regularly updated.
    - Communicated clearly to care staff, with instructions for support workers integrated into their daily activity plans.
    - Shared with clients and families in accessible formats and reviewed at each formal care planning checkpoint.

6. Workforce Capability and Training

- Staff must be trained in:
    - Reablement principles and goal-setting techniques.
    - Motivational interviewing and behaviour change support.
    - Monitoring and reporting on functional progress.
    - Adjusting service delivery to reduce over-reliance and foster independence.

Compliance and Enforcement

Failure to adhere to this policy may result in:

- Performance management or retraining.
- Regulatory non-compliance.
- Reduced outcomes for older people and diminished service quality.

Regulatory Alignment

This policy aligns with:

- Aged Care Act 2024
- Aged Care Statement of Rights 2024
- Support at Home Program Manual (March 2025) – Reablement and Maintenance of Function (Chapter 6)
- Strengthened Aged Care Quality Standards (February 2025):
    - Standard 3, Outcome 3.2 – Delivery of Care and Services
    - Outcome 3.2.2 – Maximising Independence and Autonomy
- Code of Conduct for Aged Care – promoting dignity, choice, and active support

Related Documents

- Assessment and Care Planning Policy
- Choice, Independence & Quality of Life Policy
- Person-Centred Care Policy
- Goal-Setting and Outcomes Documentation Guidelines
- Workforce Education and Training Policy
- Coordination of Care & Services Policy
- Service Delivery Manual
- Quality and Continuous Improvement Framework

Policy: Goods, Equipment & Assistive Devices

Standard 3: The Care & Services
Outcome 3.2: Delivery of Care and Services
Standard 4: The Environment
Outcome 4.1a: Environment & Equipment at Home
Outcome 4.1b: Environment & Equipment in a Service Environment

Policy Statement
FOCUS Connect is committed to ensuring that all goods, equipment, and assistive devices used to support the delivery of care and services are safe, suitable, functional, and aligned with the older person's assessed needs and goals. In accordance with the Support at Home Program Manual (March 2025), the organisation ensures that any assistive technology, home modifications, or mobility-related supports:

- Reflect the person's functional needs and funding classification
- Are assessed and prescribed by appropriately qualified professionals
- Support independence, participation, and risk reduction
- Are maintained to safe operational standards in home and service environments

Purpose
To outline the organisation's responsibilities and processes for the assessment, provision, monitoring, and maintenance of goods, equipment, and assistive devices that support service delivery, personal care, and home safety in accordance with:

- Support at Home Program funding rules (including coverage of assistive technology and goods)
- Aged Care Act 2024 and the Aged Care Statement of Rights
- Strengthened Aged Care Quality Standards – particularly Standard 3 (Care and Services) and Standard 4 (Environment)

Scope
This policy applies to all staff, contractors, allied health professionals, and volunteers who are involved in:

- Assessing, prescribing, or supplying assistive devices, home modifications, and other care-related goods
- Delivering services in homes or service-based settings (e.g., day centres)
- Managing safety, compliance, and maintenance of equipment owned or used by the organisation

Definitions

- **Goods, Equipment & Assistive Devices:** Items that support independence, safety, and service delivery for older persons, including but not limited to mobility aids, pressure-relieving mattresses, communication aids, continence products, adaptive utensils, and home modifications (e.g., ramps, rails).

- **Assistive Technology:** Devices, systems, or products used to increase, maintain, or improve the functional capabilities of older persons (e.g., personal alarms, smart devices, low-vision tools).
- **Prescriber:** A qualified allied health professional (e.g., occupational therapist, physiotherapist) who assesses functional needs and prescribes appropriate equipment.
- **Risk Management:** Processes to identify, control, and monitor safety risks associated with equipment use in home or service environments.
- **Support at Home Program Funding Categories:** Defined funding streams under which assistive technology and home modification supports can be claimed, as outlined in the Support at Home Program Manual (March 2025).

Procedures

1. Selection and Procurement

- Equipment and goods are selected based on assessed functional needs, goals, and preferences documented through the **Support at Home classification and care planning process**.
- Only Department-approved or reputable suppliers that comply with Australian standards are used.
- Where appropriate, a **trial period or demonstration** is offered before committing to purchase.
- Considerations include:
    - Clinical and functional appropriateness;
    - Compatibility with the home or service environment;
    - Ongoing maintenance and usability.

2. Assessment, Prescription and Fitting

- Equipment must be **prescribed by a qualified health professional** where clinical or safety risk is involved (e.g., mobility devices, home modifications).
- Prescribers must consider:
    - The individual's classification level and approved funding scope
    - The client's physical, cognitive, and psychosocial context
    - Environmental layout and care setting requirements
- Client and carer preferences are incorporated into decisions, and informed consent is obtained prior to purchase or installation.
- Documentation of assessment outcomes, prescriptions, and fitting requirements must be maintained.

3. Maintenance, Repairs & Cleaning

- Organisation-owned equipment is managed under a **preventative maintenance schedule** that adheres to manufacturer and infection control guidelines.
- Equipment is:
    - Regularly cleaned and disinfected;
    - Inspected for defects, wear, or mechanical failure;
    - Repaired or replaced promptly if found to be unsafe.
- **Emergency backup plans** are documented for essential equipment (e.g., oxygen concentrators, pressure care surfaces).
- Clients using personal or self-purchased devices are given guidance on safe use and maintenance obligations.

4. Risk Management and Safety Monitoring

- Risk assessments are completed before use or installation of any equipment or device.
- Staff and clients are provided with:
    - Safe use instructions and storage requirements;
    - Training on use of higher-risk or electrical equipment.
- Any incidents, near misses, or complaints relating to equipment failure or safety must be reported immediately and investigated.
- Records of equipment servicing, incident investigations, and risk assessments are maintained and monitored for trends.

5. Review and Reassessment

- The suitability of assistive devices and environmental modifications is reviewed:
    - As part of regular care plan reviews (minimum annually or earlier as needs change);
    - Following major health events, environmental changes, or participant feedback.
- Prescribers may be re-engaged if significant changes to mobility, cognition, or care needs are identified.

6. Continuous Improvement and Education

- The organisation will:
    - Review this policy and related procedures annually or following updates to government funding rules;
    - Monitor effectiveness and client satisfaction with assistive devices;
    - Analyse incident data to identify safety or training gaps;
    - Provide training to staff on new equipment and assistive technologies relevant to Support at Home participants.

Compliance and Enforcement

Failure to comply with this policy and its associated procedures may result in:

- Performance or disciplinary action;
- Client safety risks;
- Non-compliance with regulatory standards and funding rules.

Regulatory Alignment

This policy aligns with the following legislation and guidance:

- Aged Care Act 2024
- Aged Care Statement of Rights 2024
- Support at Home Program Manual (March 2025) – Assistive Technology, Goods, Equipment and Home Modifications (Chapter 6)
- Strengthened Aged Care Quality Standards (February 2025) –
    - **Standard 3, Outcome 3.2** – Delivery of Care and Services
    - **Standard 4, Outcome 4.1a** – Environment & Equipment at Home
    - **Standard 4, Outcome 4.1b** – Environment & Equipment in a Service Environment
- Code of Conduct for Aged Care – Acting with care, skill, and safety.

Related Documents

- Assessment & Care Planning Policy

- Support at Home Budget and Pricing Policy
- Home Environment & Safety Policy
- Infection Control Policy
- Incident Management Policy
- Risk and Compliance Framework
- Service Agreements and Client Rights Policy
- Workforce Education and Training Plan

Policy: Referrals

Standard 3: The Care & Services **Outcome 3.2: Delivery of care and services**

Policy Statement
FOCUS Connect is committed to ensuring older people receive timely, appropriate, and coordinated referrals to access the care and services that support their health, well-being, independence, and quality of life. This commitment aligns with the Aged Care Act 2024, the Strengthened Aged Care Quality Standards (Outcome 3.2 – Delivery of Care and Services), the Code of Conduct for Aged Care, and the Support at Home Program requirements.
FOCUS Connect applies a systematic, person-centred approach to managing referrals, ensuring culturally safe, inclusive, and responsive practices when coordinating with health professionals, service providers, and support systems.

Purpose
This policy and related procedures outline how FOCUS Connect will:

- Facilitate timely and appropriate referrals.
- Ensure equitable access to care and services.
- Support choice, control, and dignity in referral processes.
- Integrate monitoring and review mechanisms to track referral effectiveness.

Scope
This policy applies to all staff, volunteers, and contractors responsible for:

- Identifying referral needs for older people.
- Coordinating internal and external referrals.
- Supporting Participant choice and decision-making in the referral process.
- Ensuring compliance with aged care legislation, funding rules, and quality standards.

Definitions

Care and Services Plan: A personalised plan that documents an older person's aged care needs, goals, preferences, and required services, including referrals.

Facilitate Access: The process of ensuring older people can access care and services without barriers, including through referral, advocacy, scheduling, transport arrangements, and follow-up.

Referral: The process of connecting an older person to a service provider to address specific health, care, or support needs.

Procedures

1.Identification of Referral Needs

FOCUS Connect will:

- Conduct regular, person-centred assessments of older people's health, well-being, and social needs.
- Identify the need for referrals based on physical, cognitive, emotional, spiritual, and social changes.
- Ensure culturally appropriate assessments are conducted, recognising diverse backgrounds, languages, and needs.
- Document all identified referral needs in the Care and Services Plan and review these during scheduled care plan reviews.

2.Making and Managing Referrals

When a referral is needed, staff will:

- Engage with the older person and their representatives to explain options, ensure informed consent, and respect their preferences.
- Identify and contact the most appropriate service provider, ensuring they meet the Aged Care Quality Standards and regulatory requirements.
- Ensure alignment with funding and service eligibility under the Support at Home Program (e.g., Home Care Packages, Commonwealth Home Support Program).
- Coordinate with My Aged Care if additional services require assessment or approval.
- Document referral details, including the provider, reason for referral, and expected outcomes, in the Care and Services Plan.

3.Follow-Up, Communication, and Monitoring

To ensure the effectiveness and continuity of referrals, staff will:

- Establish a tracking process to monitor referral outcomes and ensure services commence as planned.
- Proactively communicate with external providers to confirm service initiation.

- Engage in follow-up discussions with the older person and their representatives to review satisfaction, service appropriateness, and any ongoing needs.
- Adjust care and service plans based on feedback and outcomes.

4.Review of Referral Effectiveness
- Regularly review referral data to assess efficiency, accessibility, and Participant satisfaction.
- Conduct post-referral evaluations during care plan reviews to determine service effectiveness and whether additional referrals or modifications are required.
- Incorporate feedback from older people, families, advocates, and health professionals into service improvement strategies.

5.Supporting Staff in the Referral Process
- Provide training to all relevant staff on identifying referral needs, engaging Participant s, liaising with external providers, and tracking referrals.
- Ensure staff understand cultural safety, trauma-informed care, and referral processes for diverse communities, including First Nations, CALD, LGBTQIA+, and neurodiverse individuals.
- Develop clear guidelines and workflows to support timely and accurate referral management.

Enforcement and Compliance

Failure to adhere to this policy may be considered a breach of job role requirements, regulatory obligations, or ethical standards. Non-compliance may lead to performance management or disciplinary action.

Regulatory and Legislative Alignment

This policy aligns with:
- Aged Care Act 2024 (including provider responsibilities, Participant rights, and service access requirements).
- Aged Care Statement of Rights 2024 (ensuring person-centred referral processes).
- Code of Conduct and provider obligations
- Strengthened Aged Care Quality Standards (Outcome 3.2: Delivery of Care and Services).
- Support at Home Program requirements (ensuring funding and service eligibility).

Related Policies and Documents
- Care and Services Planning Policy
- Clinical Governance Policy
- Culturally Inclusive and Trauma-Informed Care Policy
- Participant Needs, Goals & Preferences Policy
- Risk Management and Continuous Improvement Policy
- Monitoring and Compliance Procedures

Policy: Dementia Care

Standard 3: The Care & Services

Outcome 3.2: Delivery of care and services

Policy Statement

FOCUS Connect is committed to providing high-quality, evidence-based, and person-centred dementia care that enhances the cognitive, physical, social, emotional, and spiritual well-being of clients. This approach ensures that care is tailored to each individual's needs, goals, and preferences while incorporating best practices, legal requirements, and contemporary dementia care strategies.

We are dedicated to:

- Ensuring early recognition and timely access to appropriate dementia care services.
- Partnering with families, carers, and health professionals in the care planning process.
- Adopting least-restrictive approaches when managing changed behaviours and ensuring restrictive practices are used only as a last resort and in accordance with legal obligations.
- Providing staff training in contemporary dementia care, cultural competence, and trauma-informed practices.

Purpose

This policy and procedures outline how FOCUS Connect will:

- Ensure early recognition, assessment, and appropriate care for individuals with dementia.
- Deliver safe, inclusive, and culturally appropriate dementia care.
- Comply with aged care legislation, quality standards, and Support at Home Program guidelines.
- Support Participant choice, dignity, and independence in dementia care delivery.

Scope

This policy applies to all staff, volunteers, and contractors responsible for:

- Recognising and assessing cognitive impairment.
- Developing and implementing person-centred dementia care plans.
- Supporting families and carers in the dementia care journey.
- Ensuring compliance with aged care regulatory requirements and ethical obligations.

Definitions

Cognitive Impairment: Deficits in memory, attention, problem-solving, judgment, or communication. This may be temporary or permanent and can result from dementia, delirium, stroke, or other neurological conditions.

Dementia: A collection of symptoms caused by disorders affecting the brain, impacting memory, behaviour, and daily function (Dementia Australia).

Changed Behaviours: Behavioural or psychological symptoms of dementia (BPSD), including agitation, aggression, confusion, wandering, hallucinations, or withdrawal, which can indicate distress or unmet needs.

Behaviour Support Plan: A structured plan used when a person experiences changed behaviours, detailing person-centred strategies, triggers, interventions, and safeguards, including restrictive practice protocols if applicable.

Restrictive Practices: Physical, chemical, environmental, mechanical, or seclusion-based restrictions used to manage risks of harm. Restrictive practices must only be used as a last resort under the Aged Care Act 2024 and with informed consent.

Procedures

1.Recognition and Diagnosis of Dementia

FOCUS Connect will:

- Implement contemporary screening and assessment strategies to identify early signs of dementia.
- Ensure staff are trained to recognise cognitive decline and refer clients for further medical or allied health assessment.
- Support timely diagnosis, specialist intervention, and access to appropriate dementia support services.

2.Individualised Dementia Care Planning

- Develop personalised dementia care plans in collaboration with the client, their family, and health professionals.
- Ensure care plans:
    - Prioritise the person's strengths, skills, and preferences.
    - Respect cultural identity, language, and spiritual needs.
    - Include behaviour support strategies to manage changed behaviours without restrictive practices where possible.
    - Outline communication approaches tailored to cognitive abilities and language needs.
- Review and update care plans regularly or as needs change.

3.Involvement of Families, Carers, and Advocates

- Recognise families and carers as partners in dementia care.
- Ensure families and carers are:
    - Informed and supported in their role.
    - Involved in decision-making, respecting the client's autonomy and choices.
    - Provided with guidance on dementia progression and care strategies.

4.Minimising the Use of Restrictive Practices

Restrictive practices must:

- Only be used as a last resort after all least-restrictive strategies have been exhausted.
- Be clinically justified, proportionate, and time-limited.
- Be used only with informed consent from the client, substitute decision-maker, or guardian.

- Be documented in a Behaviour Support Plan and reviewed regularly.
- Comply with Aged Care Act 2024 regulations, Strengthened Aged Care Quality Standards, and the Support at Home Program requirements.

5.Workforce Training and Development

- Provide ongoing dementia care training to staff, covering:
    - Best-practice dementia support techniques.
    - Trauma-informed and culturally safe approaches.
    - Effective communication and de-escalation strategies.
    - How to recognise and respond to changed behaviours.
    - Legal and ethical requirements in dementia care.

6.Review and Monitoring of Dementia Care

- Regularly review dementia care plans to assess their effectiveness.
- Monitor client well-being, changed behaviours, and service responsiveness.
- Ensure continuous improvement in dementia care practices, guided by Participant feedback, complaints, and quality review processes.

Enforcement and Compliance

Failure to comply with this policy may be considered a breach of:

- Job role responsibilities.
- Aged Care Act 2024 and quality standards.
- Ethical obligations related to dementia care.

Non-compliance may result in performance management, disciplinary action, or regulatory enforcement measures.

Regulatory and Legislative Alignment

This policy aligns with:

- Aged Care Act 2024 (Provider obligations and Participant rights).
- Aged Care Statement of Rights 2024 (Person-centred and culturally responsive care).
- Code of Conduct and provider obligations
- Strengthened Aged Care Quality Standards – Standard 3, Outcome 3.2.6 (Safe and effective dementia care).
- Support at Home Program guidance on cognitive support services and restrictive practice management.

Related Policies and Documents

- Assessment and Care Planning Policy
- Cognitive Impairment and Delirium Policy
- Choice, Independence and Quality of Life Policy
- Co-ordination of Care & Services Policy
- Incident Management Policy
- Kindness, Dignity, Respect and Privacy Policy
- Palliative Care and End of Life Policy
- Restrictive Practices Governance Policy
- Risk Management and Continuous Improvement Policy

Policy: Restrictive Practices

Standard 3: The Care & Services

Outcome 3.2: Delivery of care and services

Policy Statement

FOCUS Connect is committed to providing person-centred, rights-based, and least-restrictive care that upholds the autonomy, dignity, and safety of all clients. Restrictive practices must only be used as a last resort, in the least restrictive form necessary, and for the shortest possible duration.

We ensure that:

- Alternative strategies are always prioritised before restrictive practices are considered.
- Informed consent is obtained from the older person or their legally appointed substitute decision-maker in compliance with State/Territory laws.
- All restrictive practices are documented, monitored, and reviewed regularly.
- Our approach aligns with the Aged Care Act 2024, the Strengthened Aged Care Quality Standards, and the Support at Home Program regulatory framework.

Purpose

This policy and procedures outline how FOCUS Connect will:

- Prevent, minimise, and justify the use of restrictive practices.
- Ensure compliance with all legal, ethical, and clinical obligations.
- Promote person-centred approaches that reduce the need for restrictive practices.

Scope

This policy applies to all staff, volunteers, and contractors responsible for:

- Supporting clients in home care settings.
- Identifying and managing risks associated with restrictive practices.
- Complying with aged care legislation, quality standards, and ethical obligations.

Definitions

- Restrictive Practices: Any intervention or action that restricts a person's rights, freedom of movement, or decision-making. The Aged Care Act 2024 defines restrictive practices as:
    - Chemical Restraint: Use of medication to influence behaviour, not required for a diagnosed medical condition.
    - Environmental Restraint: Restriction of access to an area or items (e.g., locking doors, restricting movement).
    - Mechanical Restraint: Use of a device to restrict movement (e.g., belts, straps, restrictive clothing).
    - Physical Restraint: Use of force to restrict voluntary movement (e.g., holding a person down).
    - Seclusion: Solitary confinement of a person in a locked or inaccessible space.

- Least Restrictive Option: The minimum level of restriction necessary to ensure safety.
- Informed Consent: Legally valid consent obtained from the older person or their substitute decision-maker before a restrictive practice is applied.
- Person-Centred Alternatives: Strategies that eliminate or reduce the need for restrictive practices, including environmental adjustments, behaviour support plans, and de-escalation techniques.

Procedures

1. Prevention and Minimisation of Restrictive Practices

Before using restrictive practices, staff must:

- Identify underlying causes of behaviours and consider alternative strategies.
- Implement evidence-based, least-restrictive approaches, such as:
    - De-escalation techniques (e.g., calming strategies, redirection).
    - Environmental modifications (e.g., noise reduction, improved lighting).
    - Engagement in meaningful activities to prevent distress.
    - Adjustments to care routines based on the older person's needs.
- Document all preventative strategies used before considering restrictive practices.

2. Justification and Authorisation of Restrictive Practices

- Restrictive practices must only be used as a last resort to prevent serious harm.
- Before applying any restrictive practice, staff must:
    - Seek clinical and behavioural support interventions.
    - Confirm the practice is legally compliant with State/Territory requirements.
    - Ensure a Behaviour Support Plan is in place.

3. Informed Consent Requirements

- Consent must be obtained before using any restrictive practice.
- The informed consent process must include:
    - Discussion with the older person (where possible) about the practice and alternatives.
    - Explanation to the substitute decision-maker (if applicable) about the necessity, risks, and expected outcomes.
    - Documented consent, including the date, details, and reviewing authority.
- Consent must be reviewed regularly and withdrawn if restrictive practices are no longer required.

4. Monitoring, Review, and Reporting

- All restrictive practices must be:
    - Monitored continuously to assess their necessity.
    - Reviewed at least every six months (or sooner, if needed).
    - Documented, including the type, duration, reason, and alternatives attempted.
- If restrictive practices are no longer justified, they must be discontinued immediately.
- Any restrictive practice used may be reportable under the Serious Incident Response Scheme (SIRS) and must be escalated to the Aged Care Quality and Safety Commission.

5. Training and Workforce Support

- All staff, volunteers, and contractors must receive regular training on:
    - Least-restrictive care approaches.
    - Behaviour management and de-escalation techniques.
    - Informed consent and legal compliance.

- Reporting obligations under the Aged Care Act 2024.

Enforcement and Compliance
Failure to comply with this policy may be considered a breach of:

- Aged Care Act 2024 obligations.
- Job role responsibilities and professional standards.
- Human rights, ethical obligations, and Participant rights protections.

Non-compliance may result in performance management, disciplinary action, or regulatory enforcement measures.

Regulatory and Legislative Alignment
This policy aligns with:

- Aged Care Act 2024 (Provider obligations and restrictive practice regulations).
- Aged Care Statement of Rights 2024 (Participant rights and least-restrictive care principles).
- Code of Conduct and provider obligations
- Strengthened Aged Care Quality Standards – Standard 3, Outcome 3.2.7 (Safe and ethical use of restrictive practices).
- Support at Home Program guidelines for restrictive practices and incident reporting.

Related Policies and Documents

- Abuse & Neglect Prevention Policy
- Behaviour Support and De-Escalation Policy
- Choice, Independence, and Quality of Life Policy
- Incident Management and SIRS Reporting Policy
- Person-Centred Care and Dignity Policy
- Quality and Safety Culture Policy
- Risk Management and Continuous Improvement Policy

Policy: Support Workers

Standard 3: The Care & Services **Outcome 3.2: Delivery of care and services**

Policy Statement
FOCUS Connect is committed to ensuring that support workers deliver high-quality, person-centred, and culturally responsive care that enhances the health, well-being, and independence of older people.

We apply a systematic and evidence-based approach to workforce planning, ensuring that all support workers:

- Possess the necessary qualifications, skills, and competencies to provide safe, high-quality care.
- Undergo ongoing training in person-centred care, cultural competence, and reablement principles.
- Are equipped to identify and respond to risks, changes in client conditions, and emerging needs.
- Provide care that aligns with clients' preferences, values, and cultural backgrounds.

Purpose

This policy and procedures outline how FOCUS Connect will:

- Ensure support workers are appropriately trained, supported, and supervised.
- Embed person-centred, rights-based, and culturally safe care approaches.
- Align workforce practices with aged care legislation, quality standards, and the Support at Home Program framework.

Scope

This policy applies to all staff, volunteers, and contractors responsible for:

- Delivering care and services in home care settings.
- Ensuring workforce competency, supervision, and ongoing professional development.
- Monitoring and improving workforce capacity to meet the evolving needs of clients.

Definitions

- Support Worker: An individual employed, hired, or contracted to provide care and services to older people in home care settings.
- Person-Centred Care: An approach that respects and responds to an older person's preferences, needs, and values. It involves:
    - Partnering with older people to shape their care.
    - Recognising each individual's unique identity and preferences.
    - Ensuring care decisions align with Participant voice, choice, and dignity.
- Reablement: A care approach that focuses on maintaining or improving an older person's independence, supporting them to continue engaging in meaningful activities and daily life.

Procedures

1. Workforce Planning and Competency Development

FOCUS Connect will:

- Employ an appropriate mix of support workers, ensuring staff have the skills and qualifications necessary to meet diverse care needs, including dementia care and palliative care.
- Provide mandatory training and ongoing professional development, covering:
    - Person-centred care and Participant rights.
    - Cultural safety, trauma-informed care, and diversity awareness (CALD, First Nations, LGBTQIA+ clients).
    - Reablement and functional support.
    - Dementia awareness and effective communication techniques.
    - Workplace safety, risk management, and incident reporting.

- Regularly assess and monitor support worker competencies through supervision, client feedback, and performance evaluations.

2. Client Involvement in Worker Selection

- Clients will be provided with the opportunity to express preferences for support workers, considering:
    - Cultural, linguistic, gender, and personal compatibility factors.
    - Continuity of care and relationship building.
- Where possible, workforce rostering will accommodate client preferences, ensuring trusted and consistent support relationships.

3. Effective Communication and Risk Identification

Support workers must:

- Communicate clearly and effectively, ensuring accessible and inclusive interactions with clients, including those:
    - With cognitive impairments (e.g., dementia, delirium).
    - With limited English proficiency (using interpreters or translated materials where needed).
    - Who require alternative communication methods (e.g., visual aids, assistive technology).
- Identify and report risks or changes in a client's condition, escalating concerns to supervisors, Care Coordinator s, or relevant health professionals as required.

4. Reablement-Focused Care

Support workers must:

- Deliver care that promotes independence and self-care, encouraging clients to engage in daily activities to the fullest extent possible.
- Use reablement-focused approaches, supporting clients to:
    - Develop or regain functional skills.
    - Adapt their environment or routines to enhance independence.
    - Access assistive technologies, community resources, and social connections.
- Ensure care and reablement plans are regularly reviewed and adjusted to reflect clients' evolving needs and preferences.

5. Supervision, Monitoring, and Continuous Improvement

- Conduct regular performance evaluations of support workers to assess:
    - Skill proficiency and adherence to quality standards.
    - Client feedback and satisfaction.
    - Compliance with safety, risk management, and reporting requirements.
- Engage in workforce planning and resourcing reviews to ensure sustainable staffing levels and service responsiveness.

Enforcement and Compliance

Failure to comply with this policy may be considered a breach of:

- Job role responsibilities and professional standards.
- Aged Care Act 2024 and Quality Standards requirements.
- Workplace safety and Participant rights obligations.

Non-compliance may result in performance management, disciplinary action, or regulatory intervention.

Regulatory and Legislative Alignment
This policy aligns with:

- Aged Care Act 2024 (Provider responsibilities and workforce competency requirements).
- Aged Care Statement of Rights 2024 (Participant rights and person-centred workforce expectations).
- Code of Conduct for Aged Care
- Strengthened Aged Care Quality Standards – Standard 3, Outcomes 3.2.5, 3.2.8 – 3.2.9 (Workforce capacity, skills, and service delivery requirements).
- Support at Home Program workforce planning and service delivery guidelines.

Related Policies and Documents

- Assessment and Care Planning Policy
- Culturally Safe and Inclusive Care Policy
- Dementia and Cognitive Support Policy
- Incident Management and Risk Reporting Policy
- Partnering with Older People Policy
- Person-Centred Care and Dignity Policy
- Workforce Planning and Development Policy

Policy: Communicating for Safety & Quality

Standard 3: The Care & Services

Outcome 3.3: Communicating for safety and quality

Policy Statement
FOCUS Connect is committed to ensuring safe, high-quality care and services through structured, timely, and effective communication processes.
Clear, accurate, and person-centred communication is essential to prevent risks, ensure continuity of care, and respond to changes in client needs.
We ensure that:

- Critical information is identified, recorded, and shared in a timely manner between clients, their families, the workforce, and health professionals.
- Escalation pathways are in place for reporting risks, incidents, or changes in client condition.
- Communication supports inclusivity, including culturally safe and accessible approaches for diverse communities.
- Our systems align with the Aged Care Act 2024, Strengthened Aged Care Quality Standards, and Support at Home Program requirements.

Purpose
This policy and procedures outline how FOCUS Connect will:

- Ensure timely, structured, and effective communication of critical client information.
- Support safe transitions of care and risk escalation processes.

- Ensure staff are trained in communication best practices that prioritise Participant safety and quality outcomes.

Scope

This policy applies to all staff, volunteers, and contractors responsible for:

- Sharing and managing critical client information.
- Communicating during transitions, incidents, and care plan changes.
- Ensuring compliance with communication-related regulatory obligations.

Definitions

- Comprehensive Care: A team-based, collaborative approach ensuring all care services are coordinated, communicated, and aligned with an older person's needs, goals, and preferences.
- Continuous Improvement: Ongoing efforts to enhance care quality, using feedback, monitoring, and innovation to improve communication effectiveness.
- Critical Information: Any information that is essential to the safe delivery of care and must be shared immediately (e.g., medical conditions, care preferences, deterioration, incident reports).
- Facilitating Access: Ensuring timely connections to care, services, and equipment, including referrals, follow-ups, and coordination with external providers.
- Quality and Safety Culture: A care environment where safety, trust, transparency, and shared responsibility underpin communication practices.

Procedures

1. Communication of Critical Information

FOCUS Connect will implement structured communication processes to ensure:

- All relevant information is shared between support workers, family, carers, and health professionals.
- Critical information is documented and communicated when:
    - A client starts receiving care.
    - There is a change in the client’s needs, goals, or preferences.
    - A risk, incident, or deterioration in health occurs.
    - The client transitions between services or care settings.

2. Escalation of Risks and Concerns

- Establish clear escalation pathways to report concerns about:
    - Client safety, well-being, or deteriorating health.
    - Errors, near misses, or incidents affecting care quality.
    - Suspected abuse, neglect, or restrictive practices.
- Ensure staff, clients, families, and health professionals have access to structured reporting mechanisms, with concerns addressed promptly and transparently.

3. Client Identification and Matching

- Implement procedures to accurately identify and match clients to the correct care and services.
- Ensure all care and service plans are updated in a secure, centralised information system, with unique client identifiers.

- Verify client identity during service transitions, medication administration, and referrals to prevent errors.

4. Communication During Transitions of Care
   - Ensure all relevant client information is shared when transitioning between:
     - Care providers or settings (e.g., hospital to home care).
     - Different support workers or case managers.
     - Services requiring specialist or multidisciplinary involvement.
   - Use handover tools, checklists, and standardised documentation to ensure information continuity.
5. Inclusive and Culturally Safe Communication
   - Adapt communication methods to support diverse needs, including:
     - CALD communities (use of interpreters, translated materials).
     - First Nations clients (respecting cultural protocols, incorporating family and community).
     - People with cognitive impairments (simplified language, visual aids, assistive technology).
     - LGBTQIA+ individuals (using affirming language and person-centred approaches).
   - Ensure all communication respects participant's dignity, choice, and independence.
6. Workforce Training and Accountability
   - Provide ongoing training for staff on:
     - Effective communication strategies for safety and quality.
     - Handover and escalation processes.
     - Culturally responsive and trauma-informed communication.
     - Use of digital tools for documentation and information sharing.
   - Ensure leadership teams model safe communication practices, fostering a transparent, learning-based culture.

Enforcement and Compliance

Failure to comply with this policy may be considered a breach of:

- Aged Care Act 2024 obligations.
- Participant rights under the Aged Care Statement of Rights 2024.
- Workforce professional and ethical standards.

Non-compliance may result in performance management, disciplinary action, or regulatory intervention.

Regulatory and Legislative Alignment

This policy aligns with:

- Aged Care Act 2024 (Provider obligations and communication-related safety measures).
- Aged Care Statement of Rights 2024 (Ensuring transparency and accessibility in participant communication).
- Code of Conduct for Aged Care
- Strengthened Aged Care Quality Standards – Standard 3, Outcomes 3.3.1 – 3.3.4 (Communicating for safety, effective transitions, risk identification, and escalation).
- Support at Home Program guidance on provider obligations for timely communication.

Related Policies and Documents

- Assessment and Care Planning Policy
- Culturally Safe and Inclusive Care Policy
- Incident Management and Risk Reporting Policy
- Information Management and Digital Documentation Policy
- Partnering with Older People Policy
- Person-Centred Care and Dignity Policy
- Quality and Safety Culture Policy
- Review and Continuous Improvement Policy

Policy: Coordination of Care and Services

Standard 3 - The Care & Services

Outome 3.4: Coordination of care and services

Policy Statement

FOCUS Connect is committed to ensuring seamless, person-centred, and well-coordinated care and services to support the health, well-being, and quality of life of older people.
We adopt a collaborative approach to care coordination, ensuring:

- Continuity of care across multiple providers, carers, and health professionals.
- Safe and planned transitions between services (e.g., hospital to home care).
- Clear, timely communication and documentation to facilitate effective service delivery.
- Participant participation in decision-making to ensure care aligns with personal needs, goals, and preferences.
- Compliance with regulatory requirements, including the Aged Care Act 2024, Strengthened Aged Care Quality Standards, and the Support at Home Program.

Purpose

This policy and procedures outline how FOCUS Connect will:

- Ensure seamless coordination and integration of services.
- Support clients, carers, and providers to maintain continuity of care.
- Facilitate safe, well-managed transitions between care settings.
- Embed clear communication and documentation practices to support high-quality service delivery.

Scope

This policy applies to all staff, volunteers, and contractors responsible for:

- Coordinating and delivering care and services.
- Communicating and documenting care plans, transitions, and updates.
- Ensuring compliance with care coordination requirements under aged care legislation.

Definitions

- Continuity of Care: Ensuring that care services remain consistent, responsive, and well-coordinated over time, even when different providers or settings are involved.
- Quality Care: Care that is:
    - Safe (protects older people from harm).
    - Person-centred (delivered with compassion and tailored to individual needs).
    - Culturally safe (recognising diverse backgrounds, trauma-informed approaches, and inclusive care).
    - Effective (aligned with the client's goals, preferences, and evolving needs).
    - Coordinated (ensuring smooth service delivery among all involved providers).
- Planned Transition of Care: The structured transfer of care responsibility between providers or settings (e.g., hospital to home, CHSP to HCP).

Procedures

1. Identification of Involved Parties

FOCUS Connect will:

- Partner with clients to identify all involved providers, carers, health professionals, and support networks.
- Ensure all parties are informed, involved, and updated about care planning and service coordination.
- Clearly define roles and responsibilities of each involved party to prevent service gaps.

2. Carers as Partners in Care

- Recognise and actively involve carers as partners in the coordination of care.
- Ensure that carers:
    - Have access to relevant information about care arrangements.
    - Are consulted in care planning and decision-making.
    - Receive support, training, and resources to participate in care delivery effectively.

3. Planned Transitions of Care

- Implement structured transition planning when clients:
    - Move between home care and residential care.
    - Transfer from hospital to home care services.
    - Switch between Commonwealth Home Support Program (CHSP) and Home Care Packages (HCP).
    - Change service providers or case managers.
- Ensure all transitions are:
    - Well-documented and effectively communicated.
    - Planned with input from clients, families, and all relevant stakeholders.
    - Monitored for risks, ensuring safety and continuity of services.

4. Communication and Documentation

- Maintain clear communication channels between clients, carers, and service providers.
- Ensure critical care information is shared and updated in real-time, including:
    - Care plans and health assessments.
    - Service changes or updates.
    - Risk or incident reports.
    - Client goals, preferences, and evolving needs.
- Store all documentation securely and systematically in the organisation's information management system to ensure service continuity.

5. Interdisciplinary Collaboration

- Encourage coordination between aged care providers, primary care professionals, and allied health teams.
- Establish referral pathways and case conferencing mechanisms to ensure holistic care planning.
- Facilitate regular care team meetings to review service alignment and effectiveness.

6. Review and Continuous Improvement

- Monitor care coordination processes and evaluate their effectiveness through:
    - Client and carer feedback.
    - Service audits and incident reviews.
    - Staff performance evaluations on care coordination responsibilities.
- Implement continuous improvement strategies based on review findings to enhance care integration and coordination.

Enforcement and Compliance
Failure to comply with this policy may be considered a breach of:

- Aged Care Act 2024 obligations.
- Participant rights under the Aged Care Statement of Rights 2024.
- Professional standards and regulatory requirements.

Non-compliance may result in performance management, disciplinary action, or regulatory enforcement measures.

Regulatory and Legislative Alignment
This policy aligns with:

- Aged Care Act 2024 (Provider responsibilities for care coordination).
- Aged Care Statement of Rights 2024 (Participant rights to seamless and integrated care).
- Code of Conduct for Aged Care
- Strengthened Aged Care Quality Standards – Standard 4, Outcomes 4.1 – 4.3 (Coordination of care and services).
- Support at Home Program guidance on care transitions and service coordination.

Related Policies and Documents

- Communicating for Safety & Quality Policy
- Participant Needs, Goals & Preferences Policy
- Dementia and Cognitive Support Policy
- Kindness, Dignity, Respect and Privacy Policy
- Person-Centred Care Policy
- Referrals and Service Access Policy
- Workforce Training and Competency Policy

Policy: The Home Environment

Standard 4: The Environment

Outcome 4.1a: Environment & Equipment at Home

Policy Statement

FOCUS Connect is committed to ensuring that the home environment where care and services are provided is safe, accessible, and free from avoidable risks for both clients and care providers.

We recognise that:

- All older people have the right to live as they choose, and their preferences regarding their home environment will be respected.
- A structured risk assessment and mitigation approach is essential to maintaining a safe environment.
- Collaboration with clients and their representatives is necessary to balance safety, autonomy, and personal preferences.
- Compliance with aged care regulations, quality standards, and risk management principles ensures safety and quality in care delivery.

Purpose

This policy and procedures outline how FOCUS Connect will:

- Identify and mitigate environmental risks that may affect clients and care providers.
- Support clients to make informed choices about their home environment, balancing safety with personal autonomy.
- Ensure staff are trained to assess and respond to environmental risks effectively.
- Document, monitor, and continuously improve home environment safety.

Scope

This policy applies to all staff, volunteers, and contractors involved in:

- Planning, assessing, and delivering care and services in clients' homes.
- Conducting risk assessments and implementing risk mitigation strategies.
- Ensuring compliance with home environment safety regulations.

Definitions

- Participant 's Home: The primary residence of an older person receiving care and services under FOCUS Connect.
- Environmental Risk: Any factor within a home setting that may compromise safety, accessibility, or quality of care for the client or service providers.
- Risk Elect Form: A document signed by the client or their representative acknowledging awareness of identified risks and the decision to accept or manage them in a way that differs from standard recommendations.
- Home Environment Risk Assessment (HERA): A structured assessment to identify, document, and manage potential home safety hazards.

Procedures

1. Identification of Home Environment Risks

Home environment risks include, but are not limited to:

Risk Category	Examples
Access Issues	Steep pathways, heavy doors, missing ramps, narrow corridors.
Falls & Trip Hazards	Loose rugs, uneven flooring, broken chairs, cluttered spaces.
Mobility Barriers	Inadequate lighting, no handrails, absence of wheelchair access.
Electrical Hazards	Frayed wires, overloaded power points, faulty appliances.
Fire Risks	Lack of smoke detectors, flammable materials, blocked exits.
Hoarding & Clutter	Excessive personal items that increase fall and fire risk.
Security Concerns	Broken locks, unsecured doors or windows.
Health Hazards	Poor ventilation, mould, pest infestations, unsafe chemical storage.
Emergency Preparedness	Lack of emergency contact details, absence of a fire escape plan.

2. Home Environment Risk Assessment

- A Safe Home Visit Checklist and Participant Risk Assessment Profile must be conducted:
    - Before the commencement of in-home care services.
    - Whenever there is a significant change in the home environment.
    - Annually, as part of the care plan review process.
- The Care Coordinator or intake & Assessment Officer will complete the risk assessment, documenting:
    - Identified risks.
    - Agreed mitigation or control measures.
    - Any decisions made by the client regarding risk acceptance or alternative solutions.

3. Risk Mitigation and Client Choice

- All identified risks must be discussed with the client, including:
    - The nature and potential consequences of the risk.
    - Available options for reducing or eliminating the risk.
    - The client's right to make informed decisions, even if they choose to accept a risk.
- If a client elects to accept a risk or choose an alternative risk management approach, they must sign a Risk Elect Form to acknowledge their decision.

4. Documentation and Risk Communication

- All risk assessment records must be:
    - Stored securely in the client's care file.
    - Made available to care staff and relevant health professionals.
    - Reviewed during regular care plan updates.
- Staff delivering care in homes with known risks must:
    - Be informed of risks before each service visit.
    - Have clear instructions on managing risks during service delivery.

    - Escalate new or escalating risks through the Risk Report Form.

5. Response to High-Risk Environments
   - If a home poses an immediate danger to staff or the client, the Care Coordinator has the discretion to:
     - Delay or modify service delivery until risks are mitigated.
     - Work with external agencies (e.g., fire safety, housing services) to resolve issues.
     - Discuss alternative care arrangements if safety concerns cannot be managed.
6. Staff Training & Awareness
   - All staff must complete Risk Awareness Training, covering:
     - Identifying and assessing home environment risks.
     - Balancing safety with client rights and autonomy.
     - Emergency procedures for high-risk situations.
     - Use of risk assessment tools
   - Training is mandatory during induction and refreshed at least every two years.
7. Review and Continuous Improvement
   - The effectiveness of home environment risk management will be reviewed through:
     - Incident reports and client feedback.
     - Regular audits of risk assessments and care plans.
     - Staff feedback on risk training effectiveness.
   - Improvements will be incorporated into policies, staff training, and risk mitigation strategies.

Enforcement and Compliance

Failure to comply with this policy may result in:

- Performance management or disciplinary action.
- Non-compliance penalties under the Aged Care Act 2024.
- Risk to client safety and regulatory action.

Regulatory and Legislative Alignment

This policy aligns with:

- Aged Care Act 2024 (Provider obligations for home safety).
- Aged Care Quality Standard 4 – The Environment, Outcome 4.1a (Safe home environments for care delivery).
- Code of Conduct for Aged Care – Element F (Acting on concerns about care safety).
- Support at Home Program requirements (Home safety assessments and risk management).

Related Policies and Documents

- Participant Assessment Form
- Safe Home Visit Checklist
- Risk Register
- Incident Management & Reporting Policy
- Care Planning and Participant Preferences Policy
- Emergency Preparedness and Response Policy
- Workforce Training and Competency Policy

Policy: The Service Environment

Standard 4: The Environment

Outcome: 4.1b: Environment & Equipment in a Service Environment

Policy Statement

FOCUS Connect is committed to ensuring that all service environments where care and services are provided or administered are safe, inclusive, accessible, and welcoming for clients, staff, volunteers, and contractors.

We undertake to:

- Provide a positive experience for all individuals accessing our services.
- Uphold a duty of care to older people, Participant s, staff, and stakeholders.
- Ensure compliance with regulatory and legislative safety requirements.
- Continuously monitor and improve service environments to promote quality care.

Purpose

This policy and related procedures outline how FOCUS Connect will:

- Ensure the safety and accessibility of service environments.
- Maintain high environmental standards for comfort, inclusion, and functionality.
- Conduct regular audits and risk assessments to identify and mitigate hazards.
- Respond to emergencies effectively to protect all individuals on-site.

Scope

This policy applies to all staff, volunteers, and contractors involved in:

- Managing, planning, and delivering services within organisational sites.
- Assessing and mitigating environmental risks.
- Ensuring compliance with facility safety and maintenance requirements.

External service environments: While this policy does not directly apply to third-party managed sites, FOCUS Connect will ensure that any external sites used for service provision meet safety and quality standards.

Definitions

- Service Environment: The physical locations and built environments controlled by FOCUS Connect where care and services are provided or administered.
- External Site: A site controlled by another entity that is used for service delivery by FOCUS Connect.
- Environmental Risk: Any physical, structural, or safety hazard that may impact service users or staff within a service environment.
- Site Safety Audit: A structured review of site safety and accessibility, including hazards, equipment conditions, and emergency preparedness.

Procedures

1. Environmental Access and Inclusivity

FOCUS Connect will ensure that all service environments:

- Have clear signage at entry points.
- Provide accessible drop-off areas and nearby parking.
- Include step-free access, ramps, and lifts in multi-storey buildings.
- Have wide doorways, clear pathways, and accessible furniture layouts for mobility support.
- Maintain barrier-free navigation for individuals with disabilities.
- Are designed for cultural inclusivity and trauma-informed care.

The Project Officer and Quality, Risk and Compliance Officer is responsible for ensuring all sites meet accessibility and safety requirements.

2. Equipment & Fittings Safety

- All seating must be stable, supportive, and comfortable.
- Adequate heating and cooling will be provided, considering clients with temperature sensitivities.
- Lighting must be sufficient in hallways, staircases, and common areas.
- Equipment and appliances must be maintained in working order, with regular safety checks.
- Fire safety measures (smoke detectors, extinguishers) must be operational.
- Trip hazards (loose rugs, clutter, electrical cords) must be removed.
- Handrails, grab bars, and non-slip flooring must be fitted in key areas (bathrooms, staircases).

The Project Officer and Quality, Risk and Compliance is responsible for overseeing equipment maintenance and hazard mitigation.

3. Work, Health and Safety Inspection checklist

- Safety audits must be conducted at least annually for all service environments.
- The audit process includes:
    - Identifying workplace hazards and risks.
    - Inspecting safety equipment and emergency protocols.
    - Reviewing trip hazards, lighting, and ventilation.
    - Checking structural integrity and facility upkeep.
- Audit outcomes and risk mitigation strategies must be:
    - Documented in the Site Safety Audit Form.
    - Submitted to the Care Coordinator for review.
    - Incorporated into facility management plans.

4. Risk Identification & Mitigation

- All staff and contractors must report hazards using the Risk Report Form.
- If an identified risk remains high after mitigation, it must be added to the Risk Register.
- Immediate action must be taken to address serious safety concerns.
- If a site is deemed unsafe for service provision, care and services may be delayed until the risk is controlled.

5. Site Maintenance

- A Planned Maintenance Schedule will be implemented for:
    - Regular cleaning and sanitation of service environments.
    - Ensuring entrances and exits remain free of hazards.
    - Using non-toxic cleaning products to minimise chemical exposure.

The Care Coordinator, Project Officer and Quality, Risk and Compliance Officer is responsible for ensuring site maintenance compliance.

6. Emergency Preparedness & Response

- Emergency procedures must be clearly displayed at all service environments.
- Emergency plans must cover:
    - Power or water outages.
    - Fires and natural disasters.
    - Medical emergencies.
    - Security threats.
- The Facility/Site Manager is responsible for:
    - Training staff and volunteers on emergency protocols.
    - Ensuring clients are aware of emergency procedures.

Enforcement and Compliance

Failure to comply with this policy may result in:

- Performance management or disciplinary action.
- Non-compliance penalties under the Aged Care Act 2024.
- Risk to client and staff safety, leading to regulatory action.

Regulatory and Legislative Alignment

This policy aligns with:

- Aged Care Act 2024 (Provider obligations for safe service environments).
- Aged Care Quality Standard 4 – The Environment, Outcome 4.1b (Service environment and equipment safety).
- Code of Conduct for Aged Care – Element F (Acting on concerns about safety).
- Support at Home Program requirements (Safe and inclusive service environments).

Related Policies and Documents

- Work, Health and Safety Inspection Checklist
- Risk Register
- Emergency Preparedness and Response Policy
- Facilities and Maintenance Management Policy
- Health and Safety Procedures

Policy: Infection Prevention & Control

Standard 4: The Environment
Outcome: 4.2: Infection Prevention & Control
Standard 5: Clinical Care
Outcome: 5.2 Preventing and controlling infections in clinical care

Policy Statement

FOCUS Connect is committed to protecting the health, safety, and well-being of older persons, staff, volunteers, and contractors by preventing and controlling the transmission of infectious diseases.

Our infection prevention and control measures include:

- Evidence-based infection control practices that align with national and international guidelines.
- Staff training and continuous improvement to support infection prevention strategies.
- Standard and transmission-based precautions to prevent infection spread.
- Ensuring clients understand infection risks and strategies for prevention.
- A structured outbreak management plan to address suspected or confirmed infections.

Purpose

This policy and related procedures outline how FOCUS Connect will:

- Implement and monitor effective infection prevention and control practices.
- Educate and train staff to follow best-practice hygiene and infection control measures.
- Ensure compliance with regulatory standards for infection control.
- Respond effectively to infection risks and outbreaks.

Scope

This policy applies to all staff, volunteers, and contractors involved in:

- Providing or administering aged care services.
- Managing infection risks in the home care environment.
- Monitoring compliance with infection control procedures.

Third-party service providers delivering care on behalf of FOCUS Connect must also comply with this policy or have an equivalent Infection Prevention & Control Policy.

Definitions

- Infection Prevention & Control (IPC): Actions taken to minimise infection transmission risks, maintain hygiene, and prevent outbreaks.
- Outbreak: A sudden increase in the number of cases of an infectious disease that exceeds normal expectations.
- Standard Precautions: Routine infection prevention measures applied to all care interactions to prevent infection transmission.
- Transmission-Based Precautions: Additional measures applied when a known or suspected infection risk exists in a service environment.

- Antimicrobial Stewardship: The responsible use of antimicrobial medications to prevent resistance and optimise treatment.

Procedures

1. Infection Prevention & Control Governance

- Oversight of infection prevention & control is provided by the Care Coordinator and Registered Nurse, who:
  - Ensures infection prevention measures are implemented and monitored.
  - Supports care staff in managing infection risks within the home and service environment.
  - Ensures infection control is included in care planning and risk management.
- Infection prevention will be included in:
  - Assessment and Care Planning (15.01) to identify infection risks.
  - Review & Monitoring (16.01) to track infection-related changes in health status.
  - Emergency and Disaster Management (14.01) for outbreak response planning.

2. Evidence-Based Infection Prevention Practices

- FOCUS Connect follows national and international guidelines, including:
  - Department of Health and Aged Care guidance.
  - Australian Commission on Safety & Quality in Health Care.
  - World Health Organisation infection control protocols.
- The Quality, Risk and Compliance Officer / Registered Nurse is responsible for:
  - Monitoring emerging infection control updates.
  - Updating policies and procedures accordingly.
  - Ensuring staff training reflects best practice.

3. Standard Precautions (Everyday Infection Prevention Measures)

All staff must adhere to standard infection prevention practices, including:

Precaution	Action Required
Hand Hygiene	Wash hands for at least 20 seconds with soap and water or use an alcohol-based hand sanitiser before and after all client interactions.
Environmental Cleaning	Routinely clean high-touch surfaces and equipment using approved disinfectants.
Personal Protective Equipment (PPE)	Use gloves, masks, eye protection, and gowns when required. Dispose of PPE safely.
Respiratory Hygiene & Cough Etiquette	Cover coughs and sneezes with tissues or elbows. Provide tissues and hand sanitiser to clients.
Waste Management	Dispose of medical waste, sharps, and other potentially infectious materials in designated containers.
Aseptic Technique	Use proper sterile techniques for procedures requiring skin penetration or wound care.

4. Transmission-Based Precautions (For Known or Suspected Infections)

If an infection is suspected or confirmed, additional precautions apply:

Precaution Type	Action Required

Contact Precautions	Use gloves and gowns, clean and disinfect shared equipment, limit unnecessary contact.
Droplet Precautions	Wear surgical masks, provide masks to the older person, maintain physical distancing.
Airborne Precautions	Use N95 respirators or PAPR devices, ensure adequate ventilation.
Client Isolation	If feasible, limit client interactions to prevent infection spread.

The Aged Care Coordinator /Clinical Care Coordinator determines when additional precautions are required.

5. Outbreak Management & Response

- In the event of an outbreak, outbreak management protocols will be activated in line with Emergency and Disaster Management (14.01).
- Staff must immediately report suspected outbreaks using the Risk Report Form.
- The Aged Care Coordinator /Emergency Manager is responsible for coordinating:
    - Public health notifications.
    - Staffing adjustments and PPE provisions.
    - Communication with clients, families, and stakeholders.

6. Personal Protective Equipment (PPE) Provision

- PPE will be supplied to:
    - All staff providing direct care.
    - Clients where infection risks are identified.
- The Aged Care Coordinator is responsible for:
    - Managing PPE stock levels in the PPE Register.
    - Ensuring adequate PPE availability for all staff and clients.
- The Human Resource/Training Manager will:
    - Train staff on correct PPE usage and disposal.
    - Monitor compliance through routine staff competency checks.

7. Immunisation & Vaccination

- All staff must comply with mandatory vaccination requirements (e.g., influenza, COVID-19).
- Clients will be supported with information about available vaccinations.
- The Aged Care Coordinator is responsible for:
    - Maintaining a Mandatory Immunisation Register.
    - Tracking immunisation compliance among staff.
    - Communicating public health vaccination updates.

8. Antimicrobial Stewardship

- Inappropriate antibiotic use will be minimised through:
    - Care planning updates when antimicrobials are prescribed.
    - Medication management support to encourage full-course completion.
    - Six-month reviews for prolonged antibiotic prescriptions.
    - Encouraging immunisation to reduce infection risks.
- The Aged Care Coordinator /Clinical Care Coordinator is responsible for:

- Ensuring infection control practices reduce antibiotic reliance.
- Training staff in antimicrobial stewardship principles.

Enforcement & Compliance

Failure to comply with this policy may result in:

- Performance management or disciplinary action.
- Regulatory enforcement under the Aged Care Act 2024.

Regulatory Alignment

This policy aligns with:

- Aged Care Act 2024 (Provider obligations for infection control).
- Aged Care Quality Standard 4 – Outcome 4.2 (Infection prevention & control).
- Aged Care Quality Standard 5 – Outcome 5.2 (Preventing and controlling infections in clinical care).
- Support at Home Program infection control requirements.

Policy: Clinical Governance

Standard 5: Clinical Care

Outcome 5.1: Clinical governance

Policy Statement
FOCUS Connect is committed to ensuring the delivery of safe, high-quality, and person-centred clinical care through the implementation of a structured clinical governance framework.

Clinical governance ensures:

- Accountability for clinical care quality and safety across all levels of the organisation.
- A culture of safety, transparency, and continuous improvement in clinical care.
- Proactive risk management and quality assurance in clinical decision-making.
- Engagement of Participant s, families, and health professionals in care planning and governance.

Purpose
This policy and related procedures outline how FOCUS Connect will:

- Establish and maintain a clinical governance framework that ensures accountability for safe, high-quality care.
- Define roles, responsibilities, and decision-making structures related to clinical care.
- Monitor, evaluate, and improve clinical care through a structured risk management and continuous improvement approach.
- Ensure clinical staff and contractors have the required skills, training, and competency to provide safe, evidence-based care.

Scope
This policy applies to all staff, volunteers, and contractors responsible for:

- Providing or managing clinical care services.
- Monitoring clinical risks and reporting incidents.
- Ensuring compliance with clinical governance requirements.

Third-party health professionals delivering services on behalf of FOCUS Connect must also comply with this policy or have an equivalent Clinical Governance Framework.

Definitions

- Clinical Governance: An integrated leadership and accountability framework ensuring safe, effective, and high-quality clinical care. It supports workforce capability, risk management, and continuous improvement.
- Organisational Culture: The shared values, attitudes, and behaviours that drive a commitment to safety and quality in clinical care.
- Clinical Risk Management: The systematic identification, assessment, and mitigation of risks related to clinical care.
- Participant Engagement: The active involvement of clients and families in clinical care decisions, planning, and evaluation.

Procedures

1. Implementation of a Clinical Governance Framework

FOCUS Connect will:

- Develop and implement a Clinical Governance Framework that includes:
  - Roles and responsibilities for clinical safety at all levels.
  - Processes for risk identification, incident management, and service improvement.
  - Regular clinical audits, compliance checks, and safety reviews.
- Ensure governance structures support accountability for clinical care quality across:
  - Board/Governing Body: Strategic oversight of clinical governance.
  - Senior Leadership & Clinical Managers: Implementation and monitoring of governance policies.
  - Frontline Clinical Workforce: Delivery of safe, evidence-based care.
- Communicate clinical governance priorities to staff, clients, and external health professionals.

2. Monitoring and Clinical Risk Management

- Implement a Clinical Risk Management System, ensuring:
  - Proactive identification and mitigation of risks related to clinical care.
  - Regular monitoring of clinical performance indicators (e.g., infection rates, medication incidents, hospitalisations).
  - Incident reporting and root cause analysis to prevent reoccurrence.
- Ensure all clinical incidents are reported, investigated, and addressed in line with:
  - Incident Management Policy.
  - Risk Management Policy.
  - Continuous Improvement Plan.

3. Workforce Competency and Accountability

- Ensure all clinical staff, volunteers, and contractors:
  - Have the required qualifications, competencies, and clear role descriptions.
  - Receive ongoing professional development in clinical care best practices.
  - Participate in competency assessments and performance reviews.
- Implement mandatory training programs, including:
  - Clinical risk identification and escalation.
  - Infection prevention and control.
  - Medication safety and antimicrobial stewardship.
  - Participant engagement and person-centred clinical decision-making.

4. Continuous Improvement in Clinical Care

- Monitor and evaluate clinical care quality through:
  - Participant feedback, complaints, and satisfaction surveys.
  - Clinical audit reports and benchmarking data.
  - Regular reviews of safety and quality performance indicators.
- Use data to drive evidence-based improvements in clinical care and service delivery.

5. Clinical Information and Documentation

- Ensure accurate, secure, and accessible documentation of clinical care, including:
  - Participant care plans.
  - Medication records.
  - Clinical assessments and progress notes.
  - Incident and risk management reports.
- Implement data security measures to protect clinical information in compliance with privacy and confidentiality regulations.

Enforcement & Compliance

Failure to comply with this policy may result in:

- Performance management or disciplinary action.
- Regulatory enforcement under the Aged Care Act 2024.

Regulatory Alignment

This policy aligns with:

- Aged Care Act 2024 (Provider obligations for clinical governance).
- Aged Care Quality Standard 5 – Outcome 5.1 (Clinical governance responsibilities).
- Aged Care Quality and Safety Commission Rules (Governance requirements for clinical care).
- Support at Home Program provider obligations.

Related Policies and Documents

- Accountability and Quality System Policy
- Assessment and Care Planning Policy
- Incident Management Policy
- Information Management Policy
- Monitoring and Review Policy
- Risk Management Policy
- Workforce Planning Policy

Policy: Safe and Quality Use of Medicines

Standard 5: Clinical Care

Outcome 5.3: Safe and quality use of medicines

Policy Statement
FOCUS Connect is committed to ensuring that all medicines used in the provision of home care services are safe, effective, and aligned with clinical best practices.

Our approach to medication management focuses on:

- Minimising risks and maximising benefits of medicines.
- Ensuring medicines are prescribed, administered, and monitored safely.
- Supporting older persons in medication self-management where appropriate.
- Preventing medicine-related harm, including adverse drug events and medication errors.
- Collaborating with prescribers and pharmacists to optimise medication use.

Purpose
This policy and related procedures outline how FOCUS Connect will:

- Ensure medication management systems support safe and appropriate use of medicines.
- Minimise medication-related risks, particularly with high-risk and psychotropic medicines.
- Provide workforce training on safe medication management.
- Monitor and review medication use for effectiveness and safety.
- Support deprescribing efforts where appropriate to reduce polypharmacy risks.

Scope
This policy applies to all staff, volunteers, and contractors involved in:

- Medication management, administration, monitoring, and review.
- Supporting clients in medication self-management.
- Ensuring compliance with medication safety regulations.

Third-party prescribers and pharmacists providing medication services on behalf of FOCUS Connect must also adhere to this policy or have an equivalent Medication Management Policy.

Definitions

- Medication Management: The systematic selection, prescribing, dispensing, administration, storage, and monitoring of medicines.
- Deprescribing: The process of tapering or stopping medicines to optimise therapy and reduce risks of adverse drug events.
- High-Risk Medicines: Medicines that have a narrow safety margin or a high risk of harm if misused. Examples include anticoagulants, opioids, insulin, and psychotropic medicines.

- Medication Reconciliation: A formal process of ensuring an accurate and up-to-date medication list for each client.
- Medication Review: A comprehensive assessment of a client's medicines to ensure safety, effectiveness, and appropriateness.
- Medicine-Related Adverse Event: An incident where medicine use results in harm or risk of harm.

Procedures

1. Medication Management System

FOCUS Connect will implement a comprehensive medication management system, including:

- Safe prescribing, dispensing, administration, monitoring, and review of medicines.
- Medication reconciliation during client intake, care transitions, and service discharge.
- Ensuring timely and uninterrupted access to prescribed medicines.
- Collaboration with prescribers and pharmacists for medication reviews and deprescribing efforts.
- Medication storage, disposal, and infection control measures to prevent errors and contamination.

The Aged Care Manager / Registered Nurse is responsible for overseeing the safe and quality use of medicines.

2. Administration and Monitoring of Medicines

- Only qualified health professionals may administer medicines.
- Clients assessed as capable may self-administer medicines, with support and oversight as needed.
- Minimise interruptions during medication administration to reduce the risk of errors.
- Document all medication administration details, including client reactions and refusals.
- Monitor high-risk medicines closely for side effects and adverse events.
- Review psychotropic medicines regularly to prevent inappropriate use.

3. Medication Reviews and Reconciliation

- Conduct medication reviews annually or sooner if there are changes in diagnosis or treatment.
- Encourage deprescribing where appropriate, particularly for older persons on multiple medicines (polypharmacy).
- Ensure any changes in medication are communicated to:
    - The client and their carers.
    - The prescribing doctor or pharmacist.
    - The client's care team for care plan updates.

4. Management of High-Risk Medicines

- Implement specific safety protocols for high-risk medicines, including:
    - Anticoagulants (e.g., warfarin) – monitor for bleeding risks.
    - Opioids – assess for signs of dependence and overdose risk.
    - Insulin – ensure correct dosing and monitoring of blood glucose levels.
    - Psychotropic medicines – review for continued need and deprescribing opportunities.

- Provide mandatory workforce training on handling high-risk medicines.

5. Adverse Drug Events and Incident Reporting
- All medicine-related incidents must be reported immediately, including:
    - Adverse drug reactions.
    - Medication administration errors.
    - Client refusal or medication non-compliance.
- Report serious adverse events to the Therapeutic Goods Administration (TGA) and the Aged Care Quality and Safety Commission as required.
- Conduct root cause analysis to prevent medication errors from reoccurring.

6. Client and Workforce Education
- Educate clients and carers about:
    - The purpose, benefits, and risks of their medicines.
    - Medication storage, administration, and disposal.
    - Potential side effects and when to seek medical help.
- All staff involved in medication management must complete:
    - Medication safety training at induction.
    - Annual refresher training on medicine handling, administration, and adverse event response.

7. Continuous Improvement
- Regularly review medication safety practices, including:
    - Analysis of medication incidents and trends.
    - Effectiveness of medication reviews and deprescribing efforts.
    - Participant feedback on medication support.
- Use findings from medication audits and reviews to drive policy improvements.

Enforcement & Compliance

Failure to comply with this policy may result in:
- Performance management or disciplinary action.
- Regulatory enforcement under the Aged Care Act 2024.

Regulatory Alignment

This policy aligns with:
- Aged Care Act 2024 (Provider obligations for safe medication management).
- Aged Care Quality Standard 5 – Outcome 5.3 (Safe and quality use of medicines).
- Code of Conduct for Aged Care (Safe and ethical medication practices).
- Support at Home Program provider obligations.

Related Policies and Documents
- Accountability and Quality System Policy
- Assessment & Care Planning Policy
- Communicating for Safety & Quality Policy
- Incident Management Policy
- Information Management Policy

- Restrictive Practices Policy
- Risk Management Policy

Policy: Comprehensive Care

Standard 5: Clinical Care

Outcome 5.4: Comprehensive care

Policy Statement
FOCUS Connect is committed to delivering comprehensive, person-centred, and high-quality clinical care that meets the holistic needs of each client, while supporting independence, quality of life, and personal preferences.

Comprehensive care involves:

- Integrated, multidisciplinary care coordination.
- Ongoing assessment and monitoring of clinical and personal care needs.
- Timely response to changes in health and well-being.
- Participant and family engagement in care planning and decision-making.
- Access to necessary equipment, aids, and supports.

Purpose
This policy outlines the systems and processes in place to ensure that clients receive comprehensive, coordinated, and safe care in home care services.
It ensures that:

- All aspects of clinical, personal, and functional care are addressed.
- Care teams communicate effectively to support a client's health and well-being.
- Care planning is proactive, goal-oriented, and continuously monitored.
- Clients, families, and carers are empowered to participate in care decisions.

Scope
This policy applies to all staff, volunteers, and contractors responsible for:

- Delivering, coordinating, or monitoring care.
- Conducting clinical assessments.
- Referring clients to health professionals and external services.
- Ensuring compliance with comprehensive care standards.

Third-party service providers delivering clinical care on behalf of FOCUS Connect must also comply with this policy or have an equivalent Comprehensive Care Framework.

Definitions

- Comprehensive Care: A coordinated, multidisciplinary approach to care that addresses clinical, functional, personal, and social needs while supporting client well-being and independence.
- Multidisciplinary Care: Care provided by a team of health professionals from different disciplines to holistically support a client's needs.
- Holistic Care: A care approach that considers the physical, emotional, social, and spiritual well-being of the client.

- Communication Barriers: Factors that prevent a client from understanding or expressing information, such as cognitive impairment, language barriers, or hearing loss.
- Care Coordination: The process of integrating and managing care across multiple providers and services to ensure continuity and quality of care.
- Quality of Life: The client's perception of well-being and life satisfaction, considering health, independence, relationships, and personal goals.

Procedures

1. Comprehensive Clinical Assessment & Care Planning

FOCUS Connect will:

- Conduct a comprehensive clinical assessment at the commencement of care, including:
    - Medical history and current conditions.
    - Functional abilities and limitations.
    - Cognitive and psychological well-being.
    - Communication barriers and cultural considerations.
- Develop goal-oriented care plans that:
    - Are co-designed with the client, family, and relevant health professionals.
    - Reflect client preferences and values.
    - Integrate clinical, personal, and social support needs.
- Regularly review and update care plans to reflect changes in health and well-being.

2. Multidisciplinary Care Coordination

- Establish and maintain partnerships with health professionals (e.g., GPs, specialists, allied health providers, and community support services).
- Ensure timely referrals to external providers when additional clinical support is required.
- Implement a system for sharing care information across disciplines, ensuring that:
    - Client information is communicated accurately and securely.
    - Health professionals involved in care have access to relevant medical history.

3. Early Identification and Response to Changing Needs

- Implement early warning systems to detect deterioration in client health, including:
    - Regular health and functional status monitoring.
    - Staff training to recognise signs of decline.
    - Prompt escalation procedures to medical professionals when required.
- Ensure clients and families have clear escalation pathways for reporting concerns.

4. Communication and Participant Engagement

- Support effective two-way communication by:
    - Addressing language barriers through interpreters, translated materials, or assistive technology.
    - Supporting clients with cognitive impairments by adapting communication methods.
    - Encouraging family and carer involvement in decision-making where appropriate.
- Ensure clients are informed of their care options, rights, and responsibilities.

5. Equipment, Aids, and Assistive Technology

- Facilitate timely access to assistive devices and mobility aids, including:
  - Wheelchairs, walking aids, and transfer equipment.
  - Communication and hearing support devices.
  - Medical equipment such as oxygen or wound care supplies.
- Assess and monitor the effectiveness and appropriateness of equipment and aids.

6. Monitoring, Review, and Continuous Improvement

- Regularly evaluate the effectiveness of comprehensive care strategies, including:
  - Participant feedback and satisfaction surveys.
  - Clinical and functional outcome assessments.
  - Incident and risk management reviews.
- Use data-driven insights to enhance service quality and inform policy improvements.

Enforcement & Compliance

Failure to comply with this policy may result in:

- Performance management or disciplinary action.
- Regulatory enforcement under the Aged Care Act 2024.

Regulatory Alignment

This policy aligns with:

- Aged Care Act 2024 (Provider obligations for comprehensive care).
- Aged Care Quality Standard 5 – Outcome 5.4 (Comprehensive care standards).
- Aged Care Quality and Safety Commission Rules (Care coordination and service delivery obligations).
- Support at Home Program provider requirements.

Related Policies and Documents

- Assessment & Care Planning Policy
- Choice, Independence and Quality of Life Policy
- Participant Needs, Goals & Preferences Policy
- Coordination of Care & Services Policy
- Goods, Equipment & Assistive Devices Policy
- Partnering with Older People Policy
- Review and Monitoring Policy

Policy: Clinical Care Risk Management

Standard 5: Clinical Care

Outcome 5.5: Clinical safety

Policy Statement

FOCUS Connect is committed to ensuring the safety, well-being, and quality of life of clients by implementing a structured clinical risk management framework that:

- Identifies, monitors, and mitigates risks associated with clinical care.
- Supports evidence-based, person-centred care to prevent harm.
- Empowers clients, carers, and health professionals to participate in risk management.
- Ensures compliance with clinical governance principles and regulatory requirements.

Purpose

This policy outlines the systems and processes in place to:

- Proactively assess, document, and manage clinical risks for home care clients.
- Implement structured monitoring and escalation processes for health deterioration.
- Reduce preventable harm, including falls, medication errors, infections, and adverse reactions.
- Ensure staff, contractors, and health professionals have the skills and competencies to manage clinical risks effectively.

Scope

This policy applies to all staff, volunteers, and contractors responsible for:

- Providing, coordinating, or monitoring clinical care.
- Identifying, documenting, and responding to clinical risks.
- Ensuring compliance with clinical safety and governance standards.

Third-party providers delivering clinical care on behalf of FOCUS Connect must comply with this policy or have an equivalent Clinical Risk Management Framework.

Definitions

- Clinical Risk Management: A structured approach to identifying, assessing, mitigating, and reviewing risks associated with clinical care.
- Clinical Care Risks: Risks that may cause harm if not managed effectively, including falls, medication errors, infections, pressure injuries, and choking hazards.
- Early Warning Signs: Observable changes in a client's condition that indicate potential clinical deterioration, requiring prompt response.
- Continuous Improvement: The ongoing evaluation and refinement of risk management strategies, based on data, incident reports, and participant feedback.
- Multidisciplinary Risk Management: A collaborative approach to risk identification and mitigation involving general practitioners, allied health professionals, care workers, and family carers.

Procedures

1. Identification and Assessment of Clinical Risks

- Conduct comprehensive clinical risk assessments at:
  - Intake (commencement of services).
  - Regular care plan reviews.
  - Significant health changes or incidents.
- Use validated clinical risk assessment tools to identify risks related to:
  - Falls and mobility.
  - Medication management errors.
  - Cognitive impairment (e.g., dementia-related risks).
  - Pressure injuries and wound care.
  - Swallowing difficulties (dysphagia and choking risk).
  - Infections and sepsis risk.
- Document all identified risks and mitigation strategies in the client's care plan.

2. Clinical Risk Monitoring and Documentation

- Ongoing monitoring of client health status and early warning signs of deterioration.
- Real-time documentation of clinical risk incidents, including:
  - Falls, medication errors, and infections.
  - Escalation actions taken.
  - Changes in client behaviour, cognitive function, or physical condition.
- Ensure relevant health professionals, family members, and carers have access to up-to-date risk management information.

3. Escalation and Response to Clinical Deterioration

- Implement clear pathways for escalating clinical concerns, including:
  - Urgent escalation to general practitioners or emergency services if required.
  - Referrals to allied health professionals (e.g., physiotherapists for falls prevention).
  - Specialist assessments for cognitive, nutritional, or wound care risks.
- Ensure staff and carers receive training to:
  - Recognise early warning signs of deterioration.
  - Respond appropriately to clinical incidents.
  - Follow established escalation procedures.

4. Risk Prevention Strategies

Falls Prevention and Mobility Support

- Conduct falls risk assessments and implement preventive strategies, including:
  - Home environment modifications (e.g., grab rails, fall-proof flooring).
  - Exercise and strength training programs to improve mobility.
  - Assistive devices (e.g., walking frames, wheelchairs, fall alarms).

Medication Safety and Error Prevention

- Implement medication reconciliation at each care transition.
- Conduct regular medication reviews with prescribers to:
  - Minimise polypharmacy risks.
  - Assess for adverse drug reactions or contraindications.
- Train staff in safe medication administration and documentation.

Infection Control and Antimicrobial Stewardship

- Implement standard and transmission-based infection prevention measures.
- Provide influenza and COVID-19 vaccinations to staff and clients as required.
- Train staff in proper hand hygiene, PPE use, and outbreak response.

Pressure Injury and Skin Integrity Management

- Assess clients at risk of pressure injuries and implement:
    - Regular skin checks and repositioning schedules.
    - Use of pressure-relieving mattresses and cushions.
    - Wound management interventions as required.

Choking and Dysphagia Management

- Conduct swallowing assessments for at-risk clients.
- Ensure dietary modifications and safe eating practices are in place.
- Refer clients to speech pathologists or dietitians where necessary.

5. Incident Reporting, Investigation, and Continuous Improvement

- All clinical incidents must be reported immediately via the organisation's Risk Reporting System.
- Conduct root cause analysis (RCA) of all major incidents, including:
    - Falls resulting in injury.
    - Medication errors leading to harm.
    - Infection outbreaks.
- Implement corrective actions based on incident trends and findings.
- Engage clients and carers in feedback mechanisms to improve risk management processes.

6. Workforce Training and Competency Development

- Ensure mandatory clinical risk training for all care staff, including:
    - Early warning signs of deterioration.
    - Falls prevention and mobility support.
    - Medication safety and high-risk medicine protocols.
    - Infection prevention and wound care best practices.
- Conduct regular competency assessments and refresher training.

Enforcement & Compliance

Failure to comply with this policy may result in:

- Performance management or disciplinary action.
- Regulatory enforcement under the Aged Care Act 2024.

Regulatory Alignment

This policy aligns with:

- Aged Care Act 2024 (Provider obligations for clinical risk management).
- Aged Care Quality Standard 5 – Outcome 5.5 (Clinical safety).
- Aged Care Quality and Safety Commission Rules (Risk management and incident reporting).
- Support at Home Program provider requirements.

Related Policies and Documents

- Assessment & Care Planning Policy
- Clinical Governance Policy
- Communicating for Safety & Quality Policy
- Comprehensive Care Policy
- Incident Management Policy
- Information Management Policy
- Person-Centred Care Policy
- Review and Monitoring Policy
- Risk Management Policy

Policy: Dysphagia (Chewing & Swallowing)

Standard 5: Clinical Care

Outcome 5.5: Clinical safety

Policy Statement

FOCUS Connect is committed to ensuring the safety, dignity, and well-being of clients with dysphagia (chewing and swallowing difficulties) by implementing evidence-based risk management strategies.

We adopt a person-centred approach to managing dysphagia, working with speech pathologists, dietitians, general practitioners, and carers to:

- Minimise the risk of choking, aspiration pneumonia, malnutrition, and dehydration.
- Ensure clients receive safe, nutritious, and appropriately modified food and drink.
- Respect client choice and autonomy, including eating and drinking with acknowledged risk (EDAR).
- Educate staff and carers on the safe preparation and administration of meals for clients with dysphagia.

Purpose

This policy outlines the steps taken to identify, assess, and manage dysphagia risks to:

- Promote safe and dignified eating and drinking experiences.
- Reduce preventable complications from swallowing difficulties.
- Empower clients and families with knowledge and support.

Scope

This policy applies to all staff, volunteers, and contractors responsible for:

- Providing direct support to clients with dysphagia.
- Preparing and serving meals and fluids to clients.
- Monitoring swallowing difficulties and escalating concerns.
- Implementing and reviewing dysphagia care plans.

Third-party service providers delivering meals or health services must comply with this policy or have an equivalent Dysphagia Management Framework.

Definitions

- Dysphagia: A condition where a person has difficulty swallowing food, liquids, or medication, which can increase the risk of choking, aspiration, dehydration, and malnutrition.
- Aspiration: The inhalation of food, liquids, or saliva into the airways or lungs, increasing the risk of aspiration pneumonia.
- Eating and Drinking with Acknowledged Risk (EDAR): A client's informed decision to eat and drink in a way that may pose a higher risk of choking or aspiration, respecting personal choice and dignity.

- Texture-Modified Foods and Fluids: Foods and drinks prepared to reduce the risk of choking, such as pureed, minced, or thickened liquids, following the International Dysphagia Diet Standardisation Initiative (IDDSI) guidelines.
- Speech Pathologist: A health professional who assesses and manages swallowing difficulties and recommends appropriate interventions.
- Dietitian: A health professional who provides nutritional advice and develops meal plans tailored to dysphagia needs.

Procedures

1. Identification and Assessment of Dysphagia
   - Conduct a dysphagia risk screening during initial client assessments and update it:
     - At least annually or more frequently for high-risk clients.
     - If a client experiences choking, weight loss, persistent coughing while eating, or difficulty swallowing medications.
   - Refer clients with suspected swallowing difficulties to a speech pathologist for a formal assessment.
   - Maintain ongoing monitoring and reassessment, particularly after health changes such as strokes, neurological conditions, or cognitive decline.

2. Dysphagia Care Planning and Intervention
   - Develop an individualised dysphagia care plan based on recommendations from speech pathologists and dietitians.
   - Ensure care plans include:
     - Safe swallowing strategies and positioning techniques.
     - Texture-modified food and fluid requirements (aligned with IDDSI standards).
     - Medication modifications (e.g., crushing tablets or alternative liquid forms where appropriate).
     - Staff training requirements to support the client safely.
   - Collaborate with clients and families to explain the risks and benefits of different feeding options, including EDAR where applicable.

3. Training and Support for the Workforce
   - Provide mandatory training for all relevant staff, including:
     - Recognising dysphagia symptoms (e.g., coughing, choking, drooling, prolonged eating times).
     - Correct preparation of texture-modified foods and thickened fluids.
     - Safe feeding techniques and positioning during meals.
     - How to assist clients with eating while respecting dignity and autonomy.
     - How to document and escalate concerns about swallowing difficulties.
   - Ensure ongoing refresher training and practical demonstrations for direct care workers and meal preparation staff.

4. Safe Meal Preparation and Administration
   - All meals and fluids provided to clients with dysphagia must be prepared according to IDDSI standards, including:
     - Pureed (Level 4), Minced & Moist (Level 5), and Soft & Bite-Sized (Level 6) diets.

    - Thickened fluids where required (Level 1-4).
- Ensure meals are appealing and culturally appropriate, maintaining variety and enjoyment.
- Supervise clients at high risk of choking during meals and provide appropriate utensils (e.g., adaptive cutlery, non-slip plates).

5. Monitoring and Incident Management
- Continuously monitor for:
    - Changes in swallowing ability (e.g., increased difficulty swallowing, coughing more frequently, or refusing food).
    - Signs of aspiration pneumonia (e.g., unexplained weight loss, persistent coughing, chest infections).
    - Adverse reactions to texture-modified diets (e.g., refusal to eat, malnutrition risk).
- Document any incidents of choking, aspiration, or refusal to eat, and escalate concerns to:
    - Speech pathologists or dietitians for reassessment.
    - General practitioners if there are signs of serious complications (e.g., pneumonia, dehydration, weight loss).

6. Respecting Client Choice and EDAR
- Support informed decision-making by discussing risks, benefits, and alternatives with clients and families.
- Ensure that clients who choose to eat or drink outside recommended guidelines:
    - Understand the potential risks of choking or aspiration.
    - Have their choices documented in their care plan under EDAR principles.
    - Receive assistance in a way that balances dignity, safety, and autonomy.

Enforcement & Compliance

Failure to comply with this policy may result in:
- Performance management or disciplinary action.
- Regulatory enforcement under the Aged Care Act 2024.

Regulatory Alignment

This policy aligns with:
- Aged Care Act 2024 (Provider obligations for clinical safety and dysphagia management).
- Aged Care Quality Standard 5 – Outcome 5.5 (Clinical safety in swallowing and choking risk).
- Aged Care Quality and Safety Commission Rules (Dysphagia care and EDAR compliance).
- Support at Home Program provider requirements.

Related Policies and Documents
- Choice, Independence and Quality of Life Policy
- Comprehensive Care Policy

- Kindness, Dignity, Respect and Privacy Policy
- Incident Management Policy
- Nutrition and Hydration Policy
- Person-centred Care Policy
- Risk Management Policy

Policy: Continence Care

Standard 5: Clinical Care

Outcome 5.5: Clinical safety

Policy Statement

FOCUS Connect is committed to ensuring that clients experiencing bladder and bowel incontinence receive safe, dignified, and person-centred continence care that promotes comfort, functional independence, and quality of life.

We apply evidence-based continence management strategies in partnership with clients, carers, general practitioners, continence nurses, and other health professionals to:

- Prevent, manage, and reduce the impact of incontinence.
- Promote dignity and autonomy in continence care practices.
- Prevent complications such as infections, skin breakdown, and incontinence-associated dermatitis (IAD).
- Ensure continence support is responsive to individual preferences and cultural needs.
- Educate staff and carers on safe and effective continence management strategies.

Purpose

This policy outlines the steps taken to assess, manage, and support clients with continence care needs, ensuring:

- Comprehensive continence assessment and monitoring.
- Access to appropriate continence aids and products.
- Safe toileting assistance tailored to the client's needs.
- Risk management strategies to protect skin integrity and prevent complications.

Scope

This policy applies to all staff, volunteers, and contractors responsible for:

- Assessing and assisting clients with bladder and bowel management.
- Providing support and guidance on continence care products and aids.
- Monitoring and documenting continence care interventions and outcomes.
- Working in partnership with health professionals for clinical continence management.

Third-party service providers delivering continence-related services must comply with this policy or have an equivalent Continence Management Framework.

Definitions

- Continence: The ability to control bladder and bowel functions.
- Continence Care: A care process that supports individuals in managing bladder and bowel control issues, enhancing comfort, dignity, and quality of life.
- Urinary Incontinence: The involuntary loss of urine (mild to severe), impacting daily activities.
- Faecal Incontinence: The involuntary loss of faeces, which may include liquid or solid stool.

- Incontinence-Associated Dermatitis (IAD): Skin irritation and breakdown caused by prolonged exposure to urine or faeces, leading to redness, inflammation, and infection risk.
- Urinary Catheter: A hollow tube that drains urine directly from the bladder, used for clients with significant urinary retention issues.
- Continence Aids: Products such as absorbent pads, catheters, and toileting equipment that help manage incontinence effectively.

Procedures

1. Person-Centred Continence Care
   - Ensure continence care is tailored to the client's needs, preferences, and dignity.
   - Engage clients in open and respectful discussions about their continence needs, reducing stigma and embarrassment.
   - Involve family members or carers where appropriate, while respecting client privacy and choice.
   - Ensure care plans reflect cultural and individual preferences, including toileting routines and continence product choices.

2. Comprehensive Continence Assessment
   - Conduct a comprehensive continence assessment for all new clients and update it:
     - At least annually, or
     - Whenever there is a change in the client's health or continence needs.
   - Assess:
     - Bladder and bowel function (patterns, frequency, urgency, leakage).
     - Medications that may impact continence.
     - Cognitive and physical abilities affecting toileting independence.
     - Environmental factors that may pose barriers (e.g., inaccessible toilets).
     - Risk of complications (e.g., skin breakdown, urinary tract infections).
   - Refer clients with complex or worsening continence issues to a continence nurse, GP, or specialist for further assessment.

3. Managing Continence and Optimising Dignity
   - Provide discreet and respectful assistance with toileting and continence management.
   - Support clients in maintaining mobility to enable safe and independent toileting.
   - Modify the physical environment to improve access to toilets (e.g., installing grab rails, ensuring adequate lighting).
   - Offer continence aids and assistive products tailored to client needs, including:
     - Absorbent pads and protective underwear.
     - Catheter management support.
     - Bed and chair protectors.
     - Adaptive toileting equipment.

4. Protecting Skin Integrity and Preventing IAD
   - Implement a structured skin care plan for clients with incontinence.
   - Use barrier creams and skin protectants to prevent moisture-related skin damage.
   - Monitor and document any signs of IAD, including:

    - Redness or irritation around the perineal area.
    - Skin breakdown or ulcerations due to prolonged exposure to urine/faeces.
- Encourage frequent changes of continence aids to prevent prolonged skin exposure to moisture.
- Provide education to staff and carers on early detection and prevention of IAD.

5. Continence Product Selection and Management
- Ensure continence products are:
    - Clinically appropriate based on assessment findings.
    - Comfortable and discreet, promoting dignity and independence.
    - Regularly reviewed and adjusted to meet changing needs.
- Assist clients in accessing funding support for continence products through government programs (e.g., Continence Aids Payment Scheme - CAPS).
- Ensure staff are trained in correct product use, including disposal and infection prevention measures.

6. Monitoring and Incident Reporting
- Monitor continence care effectiveness through regular reviews and reassessments.
- Document any adverse events, including:
    - Urinary tract infections (UTIs).
    - Skin integrity concerns (e.g., IAD, pressure injuries).
    - Choking or swallowing issues related to continence medications.
- Use incident reporting systems to track continence-related complications and implement corrective actions where necessary.
- Engage in continuous improvement initiatives, using client feedback and clinical data to refine continence care practices.

Enforcement & Compliance

Failure to comply with this policy may result in:
- Performance management or disciplinary action.
- Regulatory enforcement under the Aged Care Act 2024.

Regulatory Alignment

This policy aligns with:
- Aged Care Act 2024 (Provider obligations for clinical safety and continence management).
- Aged Care Quality Standard 5 – Outcome 5.5 (Clinical safety in bladder and bowel management).
- Aged Care Quality and Safety Commission Rules (Continence care, skin integrity, and risk prevention).
- Support at Home Program provider requirements.

Related Policies and Documents
- Choice, Independence and Quality of Life Policy
- Comprehensive Care Policy
- Goods, Equipment & Assistive Devices Policy

- Incident Management Policy
- Kindness, Dignity, Respect and Privacy Policy
- Pressure Injuries & Wounds Policy
- Risk Management Policy

Policy: Falls Prevention and Management

Standard 5: Clinical Care

Outcome 5.5: Clinical safety

Policy Statement

FOCUS Connect is committed to reducing the risk of falls and fall-related injuries among clients by implementing proactive assessment, prevention, intervention, and post-fall care strategies. Falls prevention is integrated into the organisation's person-centred care model, ensuring that clients receive individualised support that enhances safety, mobility, independence, and quality of life.

We apply evidence-based falls prevention measures, working in collaboration with clients, carers, physiotherapists, occupational therapists, and other health professionals to:

- Identify and assess fall risks early.
- Implement personalised fall prevention strategies.
- Promote mobility and strength-building activities.
- Reduce environmental hazards in the client's home.
- Ensure appropriate post-fall care and monitoring.
- Continuously evaluate and improve falls prevention initiatives.

Purpose

This policy outlines the approach to falls risk assessment, prevention, and management, ensuring:

- Comprehensive falls risk screening and regular reassessment.
- Access to appropriate mobility supports, assistive devices, and home modifications.
- Safe and evidence-based post-fall care and follow-up.
- Continuous improvement of falls prevention strategies based on data and feedback.

Scope

This policy applies to all staff, volunteers, and contractors responsible for:

- Assessing fall risks and implementing prevention strategies.
- Providing care and services to clients at risk of falls.
- Responding to, documenting, and reviewing fall incidents.
- Working in partnership with health professionals for falls prevention.

Third-party service providers delivering falls prevention or rehabilitation services must comply with this policy or have an equivalent Falls Management Framework.

Definitions

- Fall: An event where a person unintentionally comes to rest on the ground, floor, or a lower level.
- Falls Risk: The likelihood of a client experiencing a fall due to reduced mobility, cognitive impairment, frailty, or environmental hazards.
- Post-Fall Care: The immediate and ongoing care provided after a fall, including assessment, monitoring, and updates to the client's care plan.

- Functional Decline: A reduction in physical or cognitive abilities, increasing the risk of falls.
- Clinical Frailty: A state of increased vulnerability to stressors, making clients more prone to falls, injuries, and other adverse health outcomes.
- Mobility and Exercise Support: Supervised exercise programs and physiotherapy interventions designed to enhance balance, strength, and stability to reduce fall risks.

Procedures

1. Falls Risk Assessment and Monitoring
   - Conduct a comprehensive falls risk assessment for all clients upon entry into the service and update at least annually or sooner if:
     - The client experiences a fall.
     - There is a change in mobility, medication, or cognitive function.
     - The client reports new concerns about balance or stability.
   - Use validated risk assessment tools to evaluate:
     - History of previous falls.
     - Muscle weakness and mobility limitations.
     - Use of assistive devices or mobility aids.
     - Medication side effects that may increase fall risks.
     - Cognitive impairments affecting awareness and decision-making.
     - Environmental factors, including home safety hazards.
   - Refer high-risk clients to physiotherapists, occupational therapists, or specialist falls clinics for further assessment.

2. Personalised Falls Prevention Strategies
   - Develop a personalised fall prevention plan based on individual risk factors and care goals.
   - Ensure the plan includes:
     - Exercise programs tailored to the client's needs.
     - Home modifications to reduce fall risks (e.g., installing grab rails, removing trip hazards).
     - Review of footwear and assistive devices.
     - Continence management strategies to reduce night-time falls.
     - Medication review for drugs that may increase dizziness or postural hypotension.
   - Encourage clients and carers to participate in falls prevention education.
   - Provide referrals to allied health professionals for balance training and mobility support.

3. Mobility and Exercise Support
   - Encourage regular, supervised physical activity to improve strength, flexibility, and coordination.
   - Refer clients with mobility limitations to physiotherapists, exercise physiologists, or rehabilitation specialists.
   - Provide access to walking aids, transfer supports, and other mobility equipment as required.
   - Ensure staff are trained in safe manual handling and mobility assistance.

4. Home Safety and Environmental Modifications
- Conduct a home environment risk assessment to:
    - Identify trip hazards (e.g., loose rugs, cluttered walkways).
    - Assess lighting and visibility in high-risk areas.
    - Recommend grab bars, ramps, and appropriate seating.
    - Ensure bathrooms and bedrooms are optimised for safe movement.
- Work with occupational therapists and home modification specialists to enhance home safety.

5. Post-Fall Care and Incident Management
- Provide immediate post-fall assessment and support, ensuring:
    - The client's condition is stabilised.
    - Any injuries are identified and treated.
    - The care plan is reviewed and updated based on findings.
- If the client is injured, arrange for medical review and follow-up.
- Monitor the client for delayed complications, including:
    - Undetected fractures.
    - Head injuries (especially in clients on anticoagulants).
    - Psychological impacts, such as fear of falling.
- Conduct a post-fall review involving:
    - Staff and carers who were present.
    - Health professionals involved in the client's care.
    - The client and their representatives to identify contributing factors.
- Update the falls prevention plan with any necessary adjustments.

6. Data Collection and Continuous Improvement
- Use the incident management system to track fall-related events and analyse trends.
- Review falls incident reports to identify patterns and areas for improvement.
- Conduct periodic audits of falls risk assessments and prevention strategies.
- Use client and carer feedback to enhance falls prevention education and intervention programs.

Enforcement & Compliance

Failure to comply with this policy may result in:
- Performance management or disciplinary action.
- Regulatory enforcement under the Aged Care Act 2024.

Regulatory Alignment

This policy aligns with:
- Aged Care Act 2024 (Provider obligations for falls prevention and safety).
- Aged Care Quality Standard 5 – Outcome 5.5 (Falls prevention and clinical safety).
- Aged Care Quality and Safety Commission Rules (Falls prevention, mobility support, and risk prevention).
- Support at Home Program provider requirements.

Related Policies and Documents

- Choice, Independence and Quality of Life Policy
- Clinical Governance Policy
- Comprehensive Care Policy
- Incident Management Policy
- Mobility and Exercise Support Policy
- Risk Management Policy

Policy: Nutrition & Hydration

Standard 5: Clinical Care

Outcome 5.5: Clinical Safety

Policy Statement

FOCUS Connect is committed to ensuring all clients receive adequate nutrition and hydration to maintain their health, well-being, and dignity, in alignment with the Aged Care Act 2024, the Strengthened Aged Care Quality Standards (Standard 5: Clinical Care – Outcome 5.5 Clinical Safety), and the Support at Home Program.

This policy outlines evidence-based practices for monitoring, assessing, and responding to risks of malnutrition and dehydration, ensuring person-centred care that respects client preferences, cultural needs, and clinical conditions.

Purpose

The purpose of this policy is to:

- Establish a framework to prevent and manage malnutrition and dehydration through early detection, intervention, and escalation.
- Ensure that nutrition and hydration planning is client-centred, culturally responsive, and clinically appropriate.
- Promote multi-disciplinary collaboration with dietitians, speech pathologists, and healthcare professionals to optimise care.
- Ensure compliance with legal and regulatory requirements under the Aged Care Act 2024 and associated rules and standards.

Scope

This policy applies to all employees, volunteers, and contractors involved in the provision of home care services under the Support at Home Program and other aged care programs.

Definitions

- Dehydration: A condition resulting from excessive loss of body fluids, leading to impaired health and bodily function.
- Hydration: The maintenance of adequate fluid balance to support physiological functions, including nutrient transportation and waste elimination.
- Nutrition: The process of obtaining and utilizing essential nutrients for health, energy, and cognitive function.
- Malnutrition: A condition arising from inadequate intake, absorption, or metabolism of essential nutrients, leading to poor health outcomes.

Procedure

1. Screening and Assessment

- Conduct malnutrition and hydration risk screenings during initial assessment, care plan reviews, and significant changes in health status using validated assessment tools

- Identify clients at risk of dysphagia, malnutrition, or dehydration and ensure referral to a dietitian, speech pathologist, or other relevant health professional.
- Document all assessments in the client's care plan and update them regularly based on changes in health, dietary needs, or preferences.

2. Care Planning and Delivery
- Develop individualised nutrition and hydration care plans, considering:
    - Dietary preferences, cultural and religious needs.
    - Texture-modified diets for dysphagia.
    - Medical conditions (e.g., diabetes, kidney disease, cardiovascular issues).
- Ensure access to nutritionally adequate meals and fluids, incorporating recommendations from dietitians where applicable.
- For clients with swallowing difficulties, implement evidence-based dysphagia management strategies, including thickened fluids, feeding support, and adaptive utensils.

3. Managing Risk and Escalation
- Identify and implement early interventions for clients at risk, including:
    - High-protein, high-energy diets for underweight clients.
    - Supplementary nutrition products where clinically indicated.
    - Supervised fluid intake for clients with dehydration risks.
- Escalate concerns to health professionals and primary care providers when there are signs of:
    - Unexplained weight loss (>5% in 3 months).
    - Signs of malnutrition (e.g., muscle wasting, fatigue, cognitive decline).
    - Severe dehydration (e.g., confusion, dizziness, low blood pressure).

4. Monitoring and Documentation
- Record and monitor nutritional intake, hydration status, and weight changes in the client's care plan.
- Ensure staff document any changes in appetite, ability to eat/drink, or signs of malnutrition/dehydration.
- Conduct monthly care reviews with dietitians and update care plans accordingly.

5. Client and Family Engagement
- Educate clients and families on nutrition, hydration, and dietary modifications.
- Encourage client participation in meal selection and preparation to enhance autonomy.
- Ensure informed consent before making changes to dietary intake, supplements, or interventions.

Compliance and Enforcement
Failure to comply with this policy may result in disciplinary action and reporting under the Serious Incident Response Scheme (SIRS) if malnutrition or dehydration results from neglect.

Regulatory Alignment and References
- Aged Care Act 2024.

- The Code of Conduct for Aged Care.
- Aged Care Quality Standards (February 2025) – Standard 5: Clinical Care – Outcome 5.5 Clinical Safety.
- Support at Home Program Provider Transition Guide & Handbook.
- Support at Home Claims and Payments Business Rules Guidance.
- New Aged Care Act Rules Consultation – Tranche 1 (Service List) and Tranche 2b (Funding Rules).

Related Organisational Documents

- Comprehensive Care Policy
- Clinical Care Risk Management Policy
- Dysphagia Management Policy
- Oral Health Policy
- Incident Management Policy
- Risk Management Policy
- Feedback and Complaints Policy

Policy: Mental Health

Standard 5: Clinical Care

Outcome 5.5: Clinical Safety

Policy Statement
FOCUS Connect is committed to supporting the mental health, emotional well-being, and resilience of all clients receiving home care services. This policy aligns with the Aged Care Act 2024, the Strengthened Aged Care Quality Standards (February 2025), and the Support at Home Program requirements, ensuring that mental health is prioritised as part of holistic, person-centred care.

Recognising that mental illness is not a normal part of ageing, this policy aims to promote early identification, proactive intervention, and access to appropriate support services for clients experiencing mental health concerns, distress, or psychological decline.

Purpose
The purpose of this policy is to:

- Ensure that clients receive timely, evidence-based mental health care and support.
- Facilitate early identification, intervention, and referral pathways for clients at risk of psychological distress or mental illness.
- Establish mental health crisis management protocols to protect the safety and dignity of clients.
- Ensure workforce training and competency in recognising and managing mental health issues.
- Promote collaborative care planning involving general practitioners, psychologists, psychiatrists, faith representatives, and other mental health professionals.
- Maintain compliance with legal, ethical, and regulatory requirements under the Aged Care Act 2024 and the Strengthened Aged Care Quality Standards (Outcome 5.5.6 Clinical Safety: Mental Health Support).

Scope
This policy applies to all employees, volunteers, and contractors delivering care and services under home care programs, including the Support at Home Program.

Definitions

- Mental Health: A state of psychological, emotional, and social well-being that allows individuals to cope with life's stressors and engage in meaningful activities.
- Mental Illness: A diagnosed condition that significantly impacts a person's thoughts, emotions, and behaviours (e.g., depression, anxiety, schizophrenia, bipolar disorder).
- Psychosocial Well-being: A holistic state that includes emotional, social, and spiritual factors influencing a person's mental health.
- Mental Health Crisis: A situation in which an individual experiences acute distress, severe psychological symptoms, or suicidal thoughts requiring immediate intervention.

Procedure

1. Mental Health Screening and Assessment
    - Conduct mental health screenings at intake and regular intervals using validated screening tools
    - Identify risk factors such as social isolation, grief, cognitive decline, and chronic illness that may contribute to poor mental health.
    - Ensure referral pathways to psychologists, psychiatrists, or mental health services for clients with emerging or worsening symptoms.

2. Mental Health Care Planning and Support
    - Develop individualised mental health care plans incorporating:
        - Psychological, emotional, and social needs.
        - Spiritual and cultural considerations.
        - Risk mitigation strategies for clients with a history of mental illness.
    - Ensure regular review of care plans with input from multidisciplinary teams.
    - Support client engagement in meaningful activities that promote well-being, such as social programs, creative arts, music therapy, and mindfulness practices.

3. Mental Health Crisis Management
    - Implement a clear crisis response protocol, including:
        - Recognising and assessing distress (e.g., panic attacks, suicidal thoughts, severe anxiety).
        - De-escalation techniques to provide immediate psychological support.
        - Emergency intervention procedures, including contacting crisis teams, GPs, or emergency services.
        - Post-crisis follow-up to ensure ongoing support and risk mitigation.

4. Access to Mental Health Services
    - Facilitate referrals to mental health professionals, including psychologists, psychiatrists, social workers, and grief counsellors.
    - Provide mental health literacy education to clients and families, helping them recognise symptoms and seek timely support.
    - Ensure access to culturally appropriate mental health services, particularly for CALD and Indigenous clients.

5. Workforce Training and Support
    - Provide annual mental health training for all staff, volunteers, and contractors on:
        - Recognising and responding to mental health symptoms in older adults.
        - Suicide prevention and crisis intervention strategies.
        - Culturally safe and trauma-informed approaches to mental health care.
        - Self-care and resilience-building for aged care workers managing client distress.
    - Establish formal reporting pathways for staff to escalate concerns about client mental health.
    - Offer debriefing and counselling services for staff after handling complex mental health cases.

6. Monitoring, Documentation, and Feedback
- Regularly review client mental health status and update care plans accordingly.
- Document all mental health incidents and crisis responses in the incident management system.
- Collect feedback from clients, carers, and staff to improve mental health service delivery.

Compliance and Enforcement
Failure to comply with this policy may result in disciplinary action and potential reporting under the Serious Incident Response Scheme (SIRS) if mental health neglect results in harm to a client.

Regulatory Alignment and References
- Aged Care Act 2024.
- Aged Care Statement of Rights 2024.
- The Code of Conduct for Aged Care.
- Strengthened Aged Care Quality Standards (February 2025) – Standard 5, Outcome 5.5.6 Clinical Safety: Mental Health Support.
- Support at Home Program Provider Transition Guide & Handbook.
- Support at Home Claims and Payments Business Rules Guidance.
- New Aged Care Act Rules Consultation – Tranche 1 (Service List) and Tranche 2b (Funding Rules).

Related Organisational Documents
- Comprehensive Care Policy
- Assessment and Care Planning Policy
- Dementia Care Policy
- Participant Needs, Goals & Preferences Policy
- Co-ordination of Care & Services Policy
- Incident Management Policy
- Spiritual Care Policy
- Risk Management Policy
- Referrals Policy

Policy: Oral Health

Standard 5: Clinical Care **Outcome 5.5: Clinical Safety**

Policy Statement
FOCUS Connect is committed to promoting and maintaining optimal oral health for all clients receiving home care services. Oral health is intrinsically linked to overall well-being, and poor

oral hygiene can lead to pain, malnutrition, infections, cardiovascular disease, and reduced quality of life.

This policy ensures that oral health care is embedded into person-centred care planning and that clients have access to appropriate oral health services, preventive care, and treatment interventions in accordance with the Aged Care Act 2024 and the Strengthened Aged Care Quality Standards (Outcome 5.5.7 Clinical Safety: Oral Health).

Purpose

The purpose of this policy is to:

- Ensure proactive and comprehensive oral health care for all clients.
- Identify and address oral health risks, pain, and deterioration early.
- Ensure that oral care is integrated into broader health and well-being planning.
- Promote access to professional dental care services, including timely referrals.
- Provide staff with training and resources to support effective oral hygiene practices.
- Align with legislative and regulatory requirements, including the Aged Care Act 2024 and the Support at Home Program provider obligations.

Scope

This policy applies to all staff, volunteers, and contractors involved in assisting clients with oral care and ensuring their oral health needs are met in home care services.

Definitions

- Oral Health: The condition of a person's teeth, gums, tongue, and oral tissues, including their ability to chew, swallow, and speak comfortably.
- Oral Hygiene: The practice of keeping the mouth clean and free from disease, including brushing, flossing, and denture care.
- Preventive Oral Care: Practices that reduce the risk of oral health deterioration, such as regular dental check-ups, healthy nutrition, and hygiene maintenance.
- Oral Health Deterioration: Conditions such as gum disease, tooth decay, oral infections, and difficulty chewing or swallowing that impact overall health and quality of life.

Procedure

1. Oral Health Screening and Assessment

- Conduct an oral health assessment for each client upon intake and at regular care plan reviews.
- Use a validated oral health assessment tool to identify gum disease, cavities, dry mouth, ill-fitting dentures, oral infections, and signs of pain.
- Assess and document:
    - Oral hygiene practices (e.g., ability to brush, floss, use mouthwash).
    - Presence of natural teeth, dentures, or implants.
    - Signs of discomfort, inflammation, or difficulty eating.
    - Medical conditions affecting oral health (e.g., diabetes, stroke, dementia, Parkinson's disease).
- Ensure that oral health assessments inform individual care plans and that updates are made when new concerns arise.

2. Individualised Oral Care Planning
- Develop a personalised oral care plan that:
    - Reflects the client's abilities, preferences, and specific oral health risks.
    - Includes daily oral hygiene routines, such as brushing, flossing, and denture care.
    - Incorporates nutritional advice to support oral health (e.g., reducing sugary foods and acidic drinks).
    - Ensures appropriate assistive devices are available for clients with mobility impairments.
    - Supports clients with dementia or cognitive decline by tailoring oral care approaches to their needs.
- Ensure oral care is part of comprehensive care planning in collaboration with health professionals, including general practitioners and dentists.

3. Preventive Oral Hygiene and Education
- Encourage and support daily oral hygiene practices, ensuring that clients:
    - Brush teeth at least twice daily with fluoride toothpaste.
    - Floss or use interdental brushes as required.
    - Clean and soak dentures overnight to prevent infections.
    - Rinse the mouth with water or prescribed mouthwash if needed.
- Educate clients and families on:
    - The importance of oral hygiene in preventing systemic diseases.
    - Signs of oral health decline (e.g., bleeding gums, persistent bad breath, difficulty eating).
    - The impact of chronic conditions (e.g., diabetes, osteoporosis) on oral health.
- Provide access to community dental programs, mobile dental services, or referral pathways for regular check-ups.

4. Management of Oral Health Issues
- Monitor for early signs of oral health deterioration, including:
    - Tooth decay, gum disease, ulcers, fungal infections, or abscesses.
    - Persistent bad breath, dry mouth, difficulty chewing, or speaking.
    - Changes in eating patterns due to oral discomfort.
- Refer clients to dental professionals when concerns arise. Ensure that:
    - Emergency dental care is sought for acute pain, infection, or tooth fractures.
    - Treatment recommendations are integrated into the client's care plan.
    - Clients with complex needs (e.g., cognitive impairment, physical disabilities) receive specialist oral health services.

5. Workforce Training and Support
- Provide annual staff training on:
    - The link between oral health and systemic conditions.
    - Recognising signs of oral health deterioration.
    - Best practices in assisting clients with oral hygiene.
    - Procedures for handling dental emergencies and referrals.

- Ensure staff are aware of oral health referral pathways and how to escalate concerns.

6. Documentation, Monitoring, and Continuous Improvement
   - Maintain detailed records of oral health assessments, care plans, and referrals.
   - Review oral health status during case reviews and update care plans as needed.
   - Gather client and carer feedback to evaluate the effectiveness of oral health services.
   - Regularly review the effectiveness of oral care training programs and update as needed.

Compliance and Enforcement

Failure to comply with this policy may result in disciplinary action and potential reporting under the Serious Incident Response Scheme (SIRS) if oral health neglect results in harm to a client.

Regulatory Alignment and References

- Aged Care Act 2024.
- Aged Care Statement of Rights 2024.
- 10The Code of Conduct for Aged Care.
- Strengthened Aged Care Quality Standards (February 2025) – Standard 5, Outcome 5.5.7 Clinical Safety: Oral Health.
- Support at Home Program Provider Transition Guide & Handbook.
- Support at Home Claims and Payments Business Rules Guidance.
- New Aged Care Act Rules Consultation – Tranche 1 (Service List) and Tranche 2b (Funding Rules).

Related Organisational Documents

- Comprehensive Care Policy
- Assessment and Care Planning Policy
- Incident Management Policy
- Nutrition and Hydration Policy
- Dementia Care Policy
- Pain Management Policy
- Person-centred Care Policy
- Risk Management Policy

FOCUS connect

Policy: Pain Management

Standard 5: Clinical Care

Outcome 5.5: Clinical Safety

Policy Statement
FOCUS Connect is committed to delivering comprehensive, person-centred pain management that considers the physical, psychological, social, and spiritual aspects of pain. Effective pain management is integral to enhancing comfort, dignity, and quality of life for clients receiving home care services.

This policy aligns with the Aged Care Act 2024, the Strengthened Aged Care Quality Standards (Outcome 5.5.8 Clinical Safety: Pain Management), and the Support at Home Program provider obligations, ensuring pain management practices are evidence-based, holistic, and responsive to individual needs.

Purpose
The purpose of this policy is to:

- Ensure early identification, assessment, and effective management of pain.
- Provide holistic pain management strategies that address physical, psychological, social, and spiritual factors contributing to pain.
- Ensure pain management is integrated into individualised care planning.
- Promote collaboration with healthcare professionals, including general practitioners, pain specialists, mental health professionals, and spiritual care providers.
- Ensure compliance with legislative, ethical, and regulatory requirements, including the Aged Care Act 2024 and Strengthened Aged Care Quality Standards.

Scope
This policy applies to all employees, volunteers, and contractors responsible for pain management within home care services.

Definitions

- Pain: An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage (International Association for the Study of Pain).
- Pain Management: A structured process that includes pain identification, assessment, intervention, monitoring, and evaluation (Pain Management Guide Toolkit for Aged Care, 2nd Edition).
- Chronic Pain: Persistent pain lasting longer than three months, often requiring multidisciplinary management.
- Pain-Related Communication Barriers: Challenges in expressing or identifying pain due to cognitive impairment, communication difficulties, or cultural beliefs about pain.
- Spiritual Care: Holistic care that supports meaning, purpose, and emotional resilience, recognising the role of spirituality in coping with pain (Meaningful Ageing Australia).

Procedure

1. Pain Identification and Assessment

- Conduct comprehensive pain assessments upon intake and at regular intervals, particularly when there are changes in health status.
- Use validated pain assessment tools tailored to client communication abilities and cognitive function
- Assess pain across multiple domains, including:
    - Physical symptoms (e.g., location, intensity, duration).
    - Psychological distress (e.g., anxiety, depression).
    - Social factors (e.g., isolation, lack of support).
    - Spiritual concerns (e.g., existential distress).
- Document pain assessments in the client's care plan, ensuring prompt referral to appropriate health professionals if pain is persistent or unmanaged.

2. Individualised Pain Management Planning

- Develop personalised pain management plans that:
    - Address physical, psychological, social, and spiritual factors contributing to pain.
    - Incorporate input from multidisciplinary teams, including GPs, pain specialists, psychologists, and faith-based support providers.
    - Ensure access to appropriate assistive devices (e.g., mobility aids, pressure-relieving cushions).
- Review pain management plans regularly and update them following significant health changes.

3. Multimodal Pain Management Interventions

- Pharmacological Approaches:
    - Administer analgesics as prescribed, ensuring clients are educated about proper use, risks, and side effects.
    - Work with healthcare providers to adjust medication regimens based on effectiveness and side effects.
- Non-Pharmacological Approaches:
    - Physical therapies (e.g., massage, heat/cold therapy, mobility exercises).
    - Psychological support (e.g., counselling, relaxation techniques, mindfulness).
    - Social engagement activities to reduce pain-related isolation.
    - Spiritual support (e.g., chaplaincy, meditation, guided reflection).

4. Psychological, Social, and Spiritual Support

- Recognise the impact of emotional distress, grief, and social isolation on pain perception.
- Facilitate mental health support services, including:
    - Access to psychologists, grief counsellors, and social workers.
    - Referrals to community support programs to enhance social connectedness.
- Provide spiritual care services for clients experiencing spiritual or existential distress related to their pain.

5. Monitoring and Continuous Review
- Conduct ongoing monitoring of pain symptoms and evaluate treatment effectiveness through:
    - Regular pain reassessments during care plan reviews.
    - Family and client feedback on pain relief measures.
    - Care team collaboration to adjust interventions as needed.
- Escalate unmanaged pain to healthcare professionals and specialist pain services.

6. Workforce Training and Capability Building
- Provide annual pain management training for all staff, volunteers, and contractors, covering:
    - Pain identification and assessment techniques.
    - Recognising non-verbal pain indicators in clients with dementia.
    - Multidimensional pain management approaches.
    - Strategies for supporting clients with psychological and spiritual distress related to pain.
- Ensure staff have access to clinical guidelines, referral pathways, and decision-making support tools.

7. Documentation, Compliance, and Reporting
- Maintain accurate documentation of pain assessments, interventions, and reviews.
- Report and investigate incidents of unmanaged pain or inadequate pain relief through the incident management system.
- Ensure compliance with the Serious Incident Response Scheme (SIRS) for cases of pain-related neglect.

Compliance and Enforcement

Failure to comply with this policy may result in disciplinary action and reporting under the Serious Incident Response Scheme (SIRS) if pain management neglect leads to harm.

Regulatory Alignment and References
- Aged Care Act 2024.
- Aged Care Statement of Rights 2024.
- The Code of Conduct for Aged Care.
- Strengthened Aged Care Quality Standards (February 2025) – Standard 5, Outcome 5.5.8 Clinical Safety: Pain Management.
- Support at Home Program Provider Transition Guide & Handbook.
- Support at Home Claims and Payments Business Rules Guidance.
- New Aged Care Act Rules Consultation – Tranche 1 (Service List) and Tranche 2b (Funding Rules).

Related Organisational Documents
- Comprehensive Care Policy
- Assessment and Care Planning Policy
- Dysphagia (Chewing & Swallowing) Policy

- Goods, Equipment & Assistive Devices Policy
- Incident Management Policy
- Mental Health Support Policy
- Oral Health Policy
- Pressure Injuries and Wounds Policy
- Spiritual Care Policy

Policy: Pressure Injuries & Wounds

Standard 5: Clinical Care

Outcome 5.5: Clinical Safety

Policy Statement

FOCUS Connect is committed to preventing, assessing, and managing pressure injuries and wounds to promote client safety, comfort, and quality of life. Pressure injuries and wounds can lead to serious complications, infections, and reduced mobility, impacting a client's physical, psychological, and emotional well-being.

This policy ensures evidence-based, person-centred, and multidisciplinary wound care that aligns with the Aged Care Act 2024, Strengthened Aged Care Quality Standards (Outcome 5.5.9 Clinical Safety: Pressure Injuries and Wounds), and the Support at Home Program requirements.

Purpose

The purpose of this policy is to:

- Implement best-practice strategies to prevent, assess, treat, and monitor pressure injuries and wounds.
- Ensure early identification and timely intervention to reduce complications.
- Promote collaboration with healthcare professionals, including general practitioners, wound care specialists, and allied health providers.
- Provide education and resources to clients, carers, and staff on pressure injury prevention and wound management.
- Ensure compliance with legislative, ethical, and regulatory requirements, including the Aged Care Act 2024 and Strengthened Aged Care Quality Standards.

Scope

This policy applies to all employees, volunteers, and contractors involved in the prevention, assessment, and management of pressure injuries and wounds in home care services.

Definitions

- Pressure Injury (Pressure Ulcer): A localized injury to the skin and underlying tissue, typically over a bony prominence, caused by unrelieved pressure, shear, or friction (NSQHS Standards).
- Wound Care Management: A structured approach to prevent, assess, and treat wounds using appropriate dressings, infection control measures, and pain management strategies.
- Risk Factors for Pressure Injuries: Limited mobility, poor nutrition, dehydration, incontinence, cognitive impairment, and chronic conditions (e.g., diabetes, vascular disease).
- Preventive Equipment: Pressure-relieving mattresses, seat cushions, mobility aids, and skin protection strategies.

Procedure

1. Pressure Injury Risk Assessment and Prevention

- Conduct comprehensive skin and pressure injury risk assessments at:
  - Initial care planning and routine reviews.
  - When there is a change in the client's condition or mobility.
- Use validated assessment tools to determine risk levels.
- Develop individualised prevention strategies, including:
  - Regular repositioning schedules for clients with limited mobility.
  - Encouragement of mobility and physical activity, where appropriate.
  - Use of pressure-relieving devices, such as cushions, mattresses, and heel protectors.
  - Ensuring proper skin hygiene and hydration to maintain skin integrity.
  - Nutritional assessments to support wound healing and prevent pressure injuries.
- Educate clients and carers on:
  - The importance of repositioning, skin hygiene, and nutrition.
  - Recognising early signs of skin breakdown.

2. Wound Identification and Documentation

- Upon identification of a pressure injury or wound, staff must:
  - Document the wound location, size, depth, and appearance.
  - Report the injury immediately to the designated clinical professional.
  - Initiate a wound care plan in collaboration with a registered nurse, GP, or wound care specialist.
- Use a standard wound assessment tool, such as:
  - TIME (Tissue, Infection/Inflammation, Moisture balance, and Edge of wound assessment).
  - National Pressure Injury Advisory Panel (NPIAP) classification system.

3. Individualised Wound Care Planning

- Develop a personalised wound care plan, including:
  - Type of wound and appropriate dressing selection.
  - Cleansing and infection control protocols.
  - Pain management strategies.
  - Frequency of wound assessments and dressing changes.
  - Psychosocial and emotional support for clients experiencing pain or distress.
- Ensure that clients at risk of pressure injuries have access to necessary medical equipment and that staff and carers are trained to use these devices correctly.

4. Wound Management and Monitoring

- Implement evidence-based wound care in alignment with clinical best practices, including:
  - Use of aseptic technique for wound dressing changes.
  - Appropriate selection of dressings based on wound type and stage.
  - Application of pain relief measures as required.

    - Ongoing hydration, nutrition, and mobility support to promote healing.
- Regularly monitor wounds for changes in size, depth, exudate, or infection.
- Escalate non-healing wounds to wound care specialists, general practitioners, or hospital services as required.
- Ensure all monitoring and interventions are accurately documented in the client's care plan.

5. Infection Prevention and Control
- Follow strict infection prevention measures to reduce wound-related complications:
    - Hand hygiene protocols before and after wound care.
    - Aseptic dressing techniques to minimise infection risks.
    - Safe disposal of contaminated materials.
    - Use of personal protective equipment (PPE) where applicable.
- Report and document any suspected infections, ensuring timely medical intervention.

6. Staff Training and Capability Development
- Provide annual wound care and pressure injury prevention training covering:
    - Early detection and assessment of wounds and pressure injuries.
    - Wound dressing selection and care.
    - Infection control and hygiene best practices.
    - Use of preventive equipment and repositioning techniques.
- Ensure staff have access to clinical guidelines and referral pathways for wound care management.

7. Documentation, Compliance, and Continuous Improvement
- Maintain detailed records of wound assessments, interventions, and outcomes.
- Conduct regular audits of wound care practices to ensure compliance with clinical guidelines.
- Gather client and carer feedback to identify opportunities for quality improvement.
- Ensure all non-healing wounds or pressure injuries leading to significant harm are reported under the Serious Incident Response Scheme (SIRS).

Compliance and Enforcement
Failure to comply with this policy may result in disciplinary action and reporting under the Serious Incident Response Scheme (SIRS) if pressure injury neglect leads to harm.

Regulatory Alignment and References
- Aged Care Act 2024.
- Aged Care Statement of Rights 2024.
- The Code of Conduct for Aged Care.
- Strengthened Aged Care Quality Standards (February 2025) – Standard 5, Outcome 5.5.9 Clinical Safety: Pressure Injuries and Wounds.
- Support at Home Program Provider Transition Guide & Handbook.
- Support at Home Claims and Payments Business Rules Guidance.
- New Aged Care Act Rules Consultation – Tranche 1 (Service List) and Tranche 2b (Funding Rules).

Related Organisational Documents

- Comprehensive Care Policy
- Assessment and Care Planning Policy
- Goods, Equipment & Assistive Devices Policy
- Incident Management Policy
- Pain Policy
- Referrals Policy

Policy: Sensory Impairment

Standard 5: Clinical Care

Outcome 5.5: Clinical Safety

Policy Statement
FOCUS Connect is committed to ensuring that clients with sensory impairments receive high-quality, person-centred care that upholds their dignity, independence, and overall well-being. Sensory impairment can significantly impact an individual's ability to communicate, engage socially, and navigate daily activities, and can contribute to isolation, anxiety, and reduced quality of life.

This policy ensures that clients with hearing, vision, tactile, balance, or multi-sensory impairments receive tailored support, assistive technologies, and environmental adaptations, in alignment with the Aged Care Act 2024, Strengthened Aged Care Quality Standards (Outcome 5.5.10 Clinical Safety: Sensory Impairment), and the Support at Home Program requirements.

Purpose
The purpose of this policy is to:

- Provide comprehensive, person-centred support for clients with sensory impairments.
- Ensure early identification and assessment of sensory loss and its impact on communication, safety, mobility, and well-being.
- Enable access to appropriate assistive technologies, therapies, and environmental modifications to enhance quality of life.
- Offer social, emotional, and spiritual support to mitigate the psychological impact of sensory impairment.
- Ensure compliance with legislative, ethical, and regulatory requirements, including the Aged Care Act 2024 and Strengthened Aged Care Quality Standards.

Scope
This policy applies to all employees, volunteers, and contractors involved in assessing, supporting, and managing sensory impairments within home care services.

Definitions

- Sensory Impairment: A partial or complete loss of one or more senses, including hearing, vision, touch, balance, and spatial awareness.
- Assistive Technology: Devices or tools used to support clients with sensory loss, such as hearing aids, magnifiers, braille devices, and tactile equipment.
- Holistic Care: A comprehensive approach that addresses physical, psychological, social, and spiritual well-being in sensory impairment management.
- Social Inclusion: Ensuring that clients with sensory loss can actively participate in social, cultural, and recreational activities to promote emotional well-being.

Procedure

1. Assessment and Identification of Sensory Impairment
   - Conduct comprehensive sensory screenings at:
     - Initial care planning and routine reviews.
     - When changes in hearing, vision, or sensory function are observed.
   - Use validated assessment tools to evaluate:
     - Hearing loss
     - Visual impairment
     - Balance and spatial awareness issues
     - The impact of sensory impairment on communication, safety, and mental health

   - Develop individualised care plans tailored to client preferences, safety requirements, and social engagement needs.

2. Access to Assistive Technology and Environmental Adaptations
   - Provide or facilitate access to assistive devices, including:
     - Hearing aids, cochlear implants, and amplified phones for hearing loss.
     - Magnifiers, high-contrast materials, and screen readers for vision loss.
     - Tactile signage, braille resources, and vibration alert systems for multi-sensory impairments.
     - Walking aids, handrails, and anti-slip flooring for balance disorders.
   - Ensure clients and carers receive training in correct device usage and maintenance.
   - Modify home environments to support sensory impairments, including:
     - Adequate lighting, high-contrast furniture placement, and colour-coded objects for clients with vision impairment.
     - Reduction of background noise, provision of sound amplification, and clear communication spaces for clients with hearing impairment.

3. Communication and Social Inclusion Support
   - Train staff in effective communication strategies, such as:
     - Speaking clearly and facing clients with hearing loss.
     - Using written, visual, and non-verbal communication methods.
     - Employing tactile communication techniques for clients with combined vision and hearing loss.
   - Encourage social connection and participation by:
     - Facilitating access to sign language interpreters or captioned services.
     - Promoting engagement in support groups, hobby activities, and community programs.
     - Ensuring opportunities for digital connectivity through assistive technologies.

4. Emotional and Psychological Well-being
   - Recognise the emotional impact of sensory impairment, including:
     - Social withdrawal and isolation.
     - Frustration and anxiety related to communication barriers.
     - Grief and loss associated with progressive sensory decline.
   - Provide access to:
     - Mental health professionals, including counsellors and psychologists.

- Support groups for clients and their families.
- Culturally and spiritually appropriate services.

5. Spiritual Care and Well-being

- Support clients in maintaining spiritual and religious connections through:
  - Faith-based discussion groups, audio religious materials, and accessible worship settings.
  - Emotional support from chaplains or culturally aligned spiritual caregivers.
- Recognise the role of spiritual care in coping with sensory loss and provide access to:
  - Guided reflection, mindfulness, and relaxation techniques.
  - Life story projects and reminiscence activities.

6. Monitoring and Continuous Review

- Conduct regular reviews of:
  - Sensory impairment assessments.
  - Assistive device functionality and client satisfaction.
  - Changes in the client's ability to communicate or participate in activities.
- Escalate concerns to audiologists, optometrists, occupational therapists, or relevant specialists when sensory impairments impact daily living.

7. Workforce Training and Capability Development

- Provide annual staff training covering:
  - Sensory impairment identification and assessment techniques.
  - Use of assistive devices and communication methods.
  - Strategies for engaging clients with vision, hearing, or tactile impairments.
  - Psychosocial and spiritual aspects of sensory loss.
- Ensure staff have access to clinical guidelines, referral pathways, and ongoing professional development.

8. Documentation, Compliance, and Continuous Improvement

- Maintain detailed records of:
  - Sensory impairment assessments and interventions.
  - Assistive technology provisions and home modifications.
  - Training completion and workforce competency.
- Collect client feedback to enhance service quality.
- Conduct regular audits and evaluations to ensure adherence to best practices.

Compliance and Enforcement

Failure to comply with this policy may result in disciplinary action and reporting under the Serious Incident Response Scheme (SIRS) if failure to support sensory impairment results in avoidable harm or distress.

Regulatory Alignment and References

- Aged Care Act 2024.
- Aged Care Statement of Rights 2024.
- The Code of Conduct for Aged Care.

- Strengthened Aged Care Quality Standards (February 2025) – Standard 5, Outcome 5.5.10 Clinical Safety: Sensory Impairment.
- Support at Home Program Provider Transition Guide & Handbook.
- Support at Home Claims and Payments Business Rules Guidance.
- New Aged Care Act Rules Consultation – Tranche 1 (Service List) and Tranche 2b (Funding Rules).

Related Organisational Documents

- Comprehensive Care Policy
- Assessment and Care Planning Policy
- Incident Management Policy
- Mental Health Support Policy
- Referrals Policy

Policy: Cognitive Impairment

Standard 5: Clinical Care

Outcome 5.6: Cognitive Impairment

Policy Statement
FOCUS Connect is committed to delivering high-quality, compassionate, and person-centred care to clients with cognitive impairments, ensuring that their dignity, autonomy, and well-being are respected at all times. Cognitive impairment can significantly impact a person's ability to communicate, make decisions, and manage daily activities, often leading to emotional distress, social withdrawal, and behavioural changes.

This policy ensures that clients experiencing dementia, delirium, or other cognitive impairments receive individualised support, risk management interventions, and environmental modifications to enhance safety, quality of life, and social engagement, in alignment with the Aged Care Act 2024, Strengthened Aged Care Quality Standards (Outcome 5.6 Clinical Safety: Cognitive Impairment), and the Support at Home Program requirements.

Purpose
The purpose of this policy is to:

- Provide early identification, assessment, and care planning for clients with cognitive impairments.
- Ensure that care is person-centred, responsive, and considers emotional, social, and spiritual well-being.
- Support families, carers, and staff in managing cognitive decline and behavioural changes.
- Ensure that care environments are safe, structured, and adapted to meet cognitive needs.
- Ensure compliance with legislative, ethical, and regulatory requirements, including the Aged Care Act 2024 and Strengthened Aged Care Quality Standards.

Scope
This policy applies to all employees, volunteers, and contractors involved in the assessment, care, and management of clients with cognitive impairments in home care settings.

Definitions

- Cognitive Impairment: A decline in memory, communication, attention, reasoning, or judgment, which can be temporary or permanent, impacting a person's ability to perform daily activities and engage socially.
- Changed Behaviours: Alterations in a person's responses, emotions, or actions due to cognitive impairment, often linked to distress, unmet needs, or environmental factors (Dementia Support Australia).
- Functional Decline: A deterioration in a person's cognitive or physical abilities, reducing their independence and engagement in daily activities.

- Supported Decision-Making: A framework that enables individuals with cognitive impairment to make their own choices with appropriate support from caregivers and legal representatives.
- Pain-Related Communication Barriers: Difficulty expressing pain due to cognitive or communication impairments, requiring observational pain assessment methods.

Procedure

1. Cognitive Assessment and Care Planning
   - Conduct comprehensive cognitive assessments at:
     - Initial service commencement.
     - Routine care reviews.
     - When changes in behaviour or cognitive function are observed.
   - Use validated cognitive screening tools
   - Develop individualised care plans that:
     - Address cognitive function, emotional well-being, and social needs.
     - Incorporate feedback from families and supported decision-makers.
     - Outline strategies for managing changed behaviours using non-pharmacological interventions.
     - Include risk mitigation plans for wandering, falls, and disorientation.

2. Managing Changed Behaviours and Psychological Symptoms
   - Use person-centred approaches to address behavioural and psychological symptoms of cognitive impairment, including:
     - Therapeutic communication techniques to reduce distress.
     - Environmental modifications to create familiar, calming spaces.
     - Engagement in structured, meaningful activities tailored to cognitive abilities.
   - Implement de-escalation strategies for clients experiencing:
     - Agitation, aggression, or confusion.
     - Delusions or hallucinations.
     - Increased anxiety, withdrawal, or restlessness.
   - Ensure that medications for behavioural symptoms are used only when clinically indicated, with regular reviews to prevent overuse.

3. Safe and Supportive Environments
   - Modify home care environments to enhance safety and cognitive orientation, including:
     - Clear signage, visual cues, and familiar objects.
     - Minimising noise and clutter to reduce sensory overload.
     - Establishing structured routines to maintain consistency.
   - Ensure access to assistive technologies and memory aids, such as:
     - GPS tracking devices and alert systems for clients at risk of wandering.
     - Medication reminders and automatic dispensers.
     - Personalised visual or audio prompts for daily activities.

4. Emotional, Social, and Spiritual Well-being
   - Encourage social engagement and cognitive stimulation through:
     - Music therapy, reminiscence therapy, and creative activities.

    - Social outings and peer interactions.
    - Structured daily routines to maintain familiarity and comfort.
- Provide access to spiritual and emotional support, including:
    - Faith-based groups, meditation sessions, or counselling services.
    - Opportunities for life story recording and reminiscence activities.
    - Support groups for families and carers coping with cognitive decline.

5. Monitoring and Escalation of Cognitive Decline
- Conduct ongoing monitoring of cognitive function through:
    - Routine assessments and behavioural observations.
    - Family and carer feedback on changes in client behaviour.
    - Multidisciplinary case reviews involving geriatricians, psychologists, and allied health professionals.
- Escalate cases to specialist healthcare providers when:
    - Sudden cognitive deterioration occurs.
    - Severe distress, aggression, or behavioural challenges persist.
    - Clients require medication adjustments or additional therapeutic interventions.

6. Workforce Training and Capability Building
- Provide annual cognitive impairment training for all staff, volunteers, and contractors, covering:
    - Early identification of cognitive decline.
    - Strategies for managing changed behaviours in dementia and delirium.
    - Person-centred communication techniques.
    - Legal and ethical considerations, including supported decision-making.
    - Recognising and managing pain-related communication barriers.
- Ensure staff have access to clinical guidelines, referral pathways, and ongoing professional development.

7. Documentation, Compliance, and Continuous Improvement
- Maintain detailed records of cognitive assessments, care plans, and interventions.
- Conduct regular audits and evaluations to ensure:
    - Adherence to best-practice dementia care guidelines.
    - Implementation of risk management strategies for cognitive impairment.
    - Compliance with regulatory requirements.
- Gather client and carer feedback to enhance service quality and improve cognitive impairment support programs.

Compliance and Enforcement
Failure to comply with this policy may result in disciplinary action and reporting under the Serious Incident Response Scheme (SIRS) if failure to manage cognitive impairment results in avoidable harm, neglect, or abuse.

Regulatory Alignment and References
- Aged Care Act 2024.
- Aged Care Statement of Rights 2024.

- The Code of Conduct for Aged Care.
- Strengthened Aged Care Quality Standards (February 2025) – Standard 5, Outcome 5.6 Clinical Safety: Cognitive Impairment.
- Support at Home Program Provider Transition Guide & Handbook.
- Support at Home Claims and Payments Business Rules Guidance.
- New Aged Care Act Rules Consultation – Tranche 1 (Service List) and Tranche 2b (Funding Rules).

FOCUS connect

Policy: Palliative Care & End-of-Life Care

Standard 5: Clinical Care

Outcome 5.7: Palliative Care and End-of-Life Care

Policy Statement

FOCUS Connect is committed to delivering high-quality, compassionate, and person-centred palliative and end-of-life care that supports the holistic wellbeing of older people with life-limiting conditions. In accordance with the Support at Home Program Manual (March 2025) and Strengthened Aged Care Quality Standards (2025), this policy ensures that clients' comfort, autonomy, cultural needs, and preferences are upheld during the final phase of life.
Palliative care is not limited to the final days but is part of a broader, goal-aligned, anticipatory care model that is responsive to the changing needs of older people and their carers over time.

Purpose

This policy ensures the delivery of safe, ethical, and culturally respectful palliative and end-of-life care that:

- Aligns with clients' values, advance care plans, and preferred place of care.
- Ensures early identification of palliative needs and timely access to care.
- Promotes dignity, comfort, and quality of life.
- Supports carers and families before, during, and after the end-of-life period.
- Fulfils obligations under aged care legislation and clinical standards.

Scope

This policy applies to all staff, contractors, and volunteers who:

- Provide or coordinate clinical, emotional, or spiritual care to clients with palliative care needs;
- Support families or carers of individuals receiving palliative or end-of-life care in a home or community setting;
- Collaborate with external providers (e.g., GPs, palliative care teams, hospices).

Definitions

- Palliative Care: An approach that improves the quality of life of people facing life-limiting illness by addressing physical, psychological, social, and spiritual needs (National Palliative Care Strategy 2018).
- End-of-Life Care: The support and medical care given during the final weeks or days of life, prioritising comfort, dignity, and choice.
- Advance Care Planning (ACP): A voluntary process through which individuals communicate their care values, goals, and preferences for future care.
- Advance Care Directive (ACD): A legally binding document that outlines a person's wishes for future medical treatment, including consent/refusal of care.
- Multidisciplinary Care: A coordinated approach involving various professionals (e.g., nurses, GPs, allied health, pastoral care) to meet client needs.
- Spiritual Care: Support that addresses a person's need for meaning, belonging, and transcendence, especially at end-of-life.

Procedures

1. Identification and Assessment
    - Identify potential palliative care needs as early as possible using validated tools and classification outputs from the Support at Home assessment process.
    - Reassess at key transition points (e.g., post-hospitalisation, disease progression).
    - Include discussions about prognosis, goals, and care options during care plan reviews.
2. Individualised Palliative and End-of-Life Care Planning
    - Develop and document a Palliative and End-of-Life Care Plan in consultation with:
        - The client (where possible),
        - Family/nominated representative,
        - Clinical and allied health professionals.
    - Plans must include:
        - Pain and symptom management strategies,
        - Preferred place of care and death,
        - Cultural, religious, and spiritual preferences,
        - Legal documentation (ACD, enduring guardianship, etc.),
        - Support arrangements for carers and families.
    - Plans must be reviewed regularly, particularly if the person's condition or preferences change.
3. Advance Care Planning and Legal Documentation
    - Facilitate structured ACP conversations and provide access to translated or Easy Read formats where appropriate.
    - Ensure:
        - ACDs and substitute decision-makers are clearly recorded and honoured,
        - All staff involved in care delivery are aware of and act in accordance with these directives,
        - Documentation is stored securely and is accessible when required (including during emergencies).
4. Pain and Symptom Management
    - Implement both pharmacological and non-pharmacological strategies for:
        - Pain relief,
        - Dyspnoea (breathlessness),
        - Fatigue,
        - Nausea,
        - Delirium and agitation.
    - Collaborate with the person's GP and/or external palliative specialists for complex symptom control.
    - Ensure that medications are administered and monitored according to clinical best practice and scope of practice.
5. Psychosocial and Spiritual Support
    - Offer emotional and psychological support, including:
        - Grief counselling,
        - Referral to mental health professionals if needed.
    - Facilitate spiritual care based on client preference, including:
        - Rituals, prayer, life review activities, or contact with religious leaders.

- Provide opportunities for legacy building or reminiscence work.

6. Client Dignity, Choice and Autonomy
   - Ensure decisions reflect the person's values, goals, and care preferences, particularly concerning:
     - Place of care (e.g., home, hospice, residential facility),
     - Medical interventions (e.g., resuscitation, artificial feeding),
     - Presence of family or community members.
   - Provide culturally safe care, recognising and supporting diverse end-of-life traditions, beliefs, and ceremonies.
7. Carer and Family Support
   - Provide families and carers with:
     - Education on what to expect during the palliative and dying process,
     - Guidance on managing care needs at home (e.g., positioning, administering medications),
     - Access to emotional support and respite options.
   - Following death:
     - Offer bereavement care (e.g., referral to grief counsellors, funeral planning support),
     - Conduct follow-up contact with the family.
8. Coordination and External Partnerships
   - Establish communication pathways with:
     - GPs, community nursing, and specialist palliative care services,
     - Hospital-based teams and hospices as needed.
   - Ensure continuity of care through:
     - Shared documentation,
     - Case conferencing,
     - Escalation pathways for complex needs.
9. Documentation and Communication
   - All palliative and end-of-life care decisions, interventions, and reviews must be:
     - Documented in the client's care management system,
     - Communicated to relevant staff, family, and stakeholders in a timely manner.
   - Use standardised care plan templates and symptom monitoring tools (e.g., pain scales).

Compliance and Enforcement

Failure to comply with this policy and procedures may result in:

- Internal performance management or disciplinary action;
- Notification under the Serious Incident Response Scheme (SIRS) if neglect or substandard care results in preventable harm or distress;
- Review by the Aged Care Quality and Safety Commission.

Regulatory Alignment and References

- Aged Care Act 2024
- Aged Care Statement of Rights 2024
- Support at Home Program Manual (March 2025) – Clinical Care, Palliative & End-of-Life Supports
- Strengthened Aged Care Quality Standards (February 2025)

    - Standard 5: Clinical Care
    - Outcome 5.7: Palliative Care and End-of-Life Care
- The Code of Conduct for Aged Care
- Support at Home Funding and Service List Rules – Tranche 2b Consultation Draft
- National Palliative Care Strategy 2018

Related Organisational Documents

- Advance Care Planning Policy
- Assessment and Care Planning Policy
- Spiritual and Cultural Support Policy
- Bereavement and Grief Support Guidelines
- Risk and Incident Management Policy
- Coordination of Care and Clinical Escalation Pathway
- Service Environment and Equipment Policy
- Communication and Documentation Protocols

Policy: Spiritual Care

Standard 5: Clinical Care **Outcome 5.7: Palliative Care and End-of-Life Care**

Policy Statement

FOCUS Connect is committed to delivering holistic, person-centred care that recognises and supports the spiritual needs of clients as an essential component of their overall well-being. Spirituality plays a fundamental role in how individuals find meaning, purpose, and comfort, particularly during times of illness, aging, or end-of-life care.

This policy ensures that spiritual care is integrated into all aspects of care planning, regardless of a person's religious beliefs, cultural background, or personal spiritual practices, in alignment with the Aged Care Act 2024, Strengthened Aged Care Quality Standards (Standard 1: The Person & Standard 3: Care and Services), and the Support at Home Program requirements.

Purpose

The purpose of this policy is to:

- Ensure that spiritual care is provided respectfully, inclusively, and compassionately as part of a client's holistic well-being.
- Support clients, families, and carers in expressing and integrating their spiritual or religious practices into daily care.
- Facilitate access to spiritual care services through trained professionals, community organisations, and faith representatives.
- Provide workforce training to ensure that staff understand and support the role of spirituality in health and aged care.
- Promote compliance with legislative, ethical, and regulatory requirements, including the Aged Care Act 2024 and Strengthened Aged Care Quality Standards.

Scope

This policy applies to all employees, volunteers, and contractors involved in the assessment, provision, and facilitation of spiritual care within home care services.

Definitions

- Spiritual Care: A holistic approach to caring for the mind, body, and spirit, supporting clients in finding meaning, purpose, and hope, especially in the context of aging, illness, grief, and end-of-life (Meaningful Ageing Australia).
- Well-being: A positive state of physical, emotional, mental, and spiritual health that gives a person a sense of meaning and purpose.
- Holistic Care: Person-centred care that considers an individual's spiritual, emotional, physical, and social well-being.
- Advance Care Planning (ACP): A voluntary process where clients document their spiritual preferences, values, and beliefs in relation to future care and end-of-life decisions.
- Culturally Safe Care: A model of care that respects and upholds the religious, cultural, and spiritual traditions of diverse clients.

Procedure

1. Spiritual Needs Assessment and Care Planning

- Conduct spiritual assessments upon:
  - Initial intake and care planning.
  - Routine care plan reviews.
  - Significant life events, health changes, or end-of-life transitions.
- The spiritual needs assessment should:
  - Explore the client's spiritual beliefs, values, or religious practices.
  - Identify any rituals, traditions, or personal practices important to the client.
  - Determine whether the client would like access to spiritual care services.
- Incorporate spiritual care into the client's individualised care plan, ensuring:
  - Access to spiritual or religious practices is facilitated.
  - Cultural and religious preferences are respected in daily care.
  - Clients and families are informed of available spiritual care services.

- Regularly review and update spiritual care plans to reflect changes in preferences or needs.

2. Facilitating Spiritual Care Services
- Clients will have access to spiritual care providers, including:
  - Chaplains, clergy, religious representatives, or spiritual leaders.
  - Counsellors trained in spiritual and emotional support.
  - Community-based spiritual care organisations.
- The organisation will make reasonable accommodations to support:
  - Prayer, meditation, and religious observances.
  - Access to sacred texts, religious music, and ceremonial objects.
  - Space for spiritual reflection or quiet time.
- Clients will be supported to engage in spiritual and social activities, such as:
  - Religious services, cultural ceremonies, or group reflections.
  - Life story projects, legacy writing, or reminiscence therapy.

3. Culturally Safe and Inclusive Spiritual Care
- All spiritual and religious practices will be respected, ensuring:
  - Clients from all backgrounds feel safe and supported.
  - Staff, volunteers, and contractors provide non-judgmental, inclusive care.
- Care plans will reflect diverse cultural and religious traditions, including:
  - Indigenous Australian spiritual practices.
  - Multifaith approaches to care.
  - Support for non-religious clients exploring meaning and purpose.

4. Workforce Training and Capability Development
- Provide annual training for all staff, volunteers, and contractors, covering:
  - Recognising and responding to spiritual needs in aged care.
  - Cultural competency and interfaith awareness.
  - Communication strategies for discussing spiritual concerns.
  - Facilitating access to spiritual care providers.
- Support staff in having respectful, compassionate spiritual care conversations.

5. Spiritual Care in Palliative and End-of-Life Support
- Prioritise spiritual care for clients receiving palliative or end-of-life care, ensuring:
  - Spiritual guidance, rituals, or faith-based services are available.
  - Last rites, prayers, or other meaningful observances are facilitated.
  - Clients and families receive grief and bereavement support.
- Families and carers will be offered:
  - Access to spiritual or religious leaders.
  - Counselling services to navigate loss and grief.
  - Post-bereavement support programs.

6. Monitoring and Continuous Improvement
- Regularly review and assess the effectiveness of spiritual care services through:
  - Client and family feedback surveys.

    - Care plan audits to ensure spiritual preferences are honoured.
    - Engagement with faith and community leaders to improve spiritual support.
- Update spiritual care policies and training based on evolving client needs.

Compliance and Enforcement

Failure to comply with this policy may result in disciplinary action and reporting under the Serious Incident Response Scheme (SIRS) if a failure to provide spiritual care contributes to distress, cultural harm, or neglect of end-of-life preferences.

Regulatory Alignment and References

- Aged Care Act 2024.
- Aged Care Statement of Rights 2024.
- Code of Conduct for Aged Care.
- Strengthened Aged Care Quality Standards (February 2025) – Standard 1: The Person & Standard 3: Care and Services.
- Support at Home Program Provider Transition Guide & Handbook.
- New Aged Care Act Rules Consultation – Tranche 1 (Service List) and Tranche 2b (Funding Rules).

Related Organisational Documents

- Advance Care Planning Policy
- Comprehensive Care Policy
- Palliative Care and End-of-Life Care Policy
- Cognitive Impairment Policy
- Mental Health Support Policy
- Sensory Impairment Policy

Date	Version	Created by	Reviewed by	Description of change	Approved by
26/06/2025	Draft	Lorraine Poulos and Associate ©		Draft document created	
01/07/2025	1.0		QRC Officer – Tajudeen Fawehinmi	Reviewed and updated to meet FOCUS Connect internal processes and operational structure	Lee-Ann Brynes