LINK HEALTH AND COMMUNITY LIMITED RECERTIFICATION ASSESSMENT REPORT

DATE OF VISIT	15 – 16 August 2018
DATE OF DRAFT REPORT	30 August 2018
DATE OF FINAL REPORT	7 September 2018
INITIAL CERTIFICATION DATE	HSS and NSQHSS – 19 November 2015
ASSESSMENT COMPLETED WITH	Link Health and Community Limited, 1 Jackson's Road, Mulgrave, Victoria 3170
CERTIFICATE REGISTRATION NUMBER	509VHS
STANDARD ASSESSED	• Human Services Standards • National Safety & Quality Health Service Standards (2011) (Standards 1 to 6)
ASSESSORS	Cheryl de Blaquiere – Lead Assessor Chris Coombs – Support Assessor
REVIEWER	David Hamer – Principal
ASSESSMENT PROVIDED BY	HDAA Australia Pty Ltd, PO Box 365, North Lakes, QLD 4509. ABN: 40 134 482 625; ACN: 134 482 625

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The information contained in this report and associated assessment evidence records relates to Link Health and Community Limited's compliance with the Human Services Standards and the National Safety & Quality Health Service Standards as at 7 September 2018. Nothing in this report pertains to Link Health and Community Limited's compliance or otherwise with the relevant laws or regulations applicable to Link Health and Community Limited and the responsibility of compliance with the relevant laws or regulations applicable to Link Health and Community Limited remains the responsibility of Link Health and Community Limited.

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- Except where it is required by legislation or through its accreditation, we will treat information about the organisation that is acquired in the course of any work conducted for the organisation, as confidential and proprietary to the organisation.
- We shall treat all confidential information about the organisation, clients, and associated persons (including documentation, records, and data, either in hard copy or electronic format, or verbal information) in accordance with relevant privacy legislation.
- We shall not disclose information about a particular person which identifies him or her directly or indirectly, except where required by law or as required by the Department of Health and Human Services for a Notifiable Issue. In this case, information may be disclosed without the consent of the person or the person's authorised representative.
- We shall not use information about people or organisation personnel for any purpose other than the assessment of conformity with the standards.

- We shall provide the Department of Health and Human Services with a copy of the final assessment report. If we are required through our accreditation to disclose information about the organisation to the Department of Health and Human Services, we aim to inform the organisation prior to doing so.
- If necessary, we may ask that files and records be de-identified to allow sampling.
- Where the following requirements are a condition of our deed of agreement and or accreditation we may: (a) issue a copy of the review reports and findings to authorised persons, (b) contact a relevant authority if any health, safety or abuse risks, professional misconduct, financial improprieties is found or suspected during the assessment, (c) disclose information to a relevant authority after we have notified the organisation and this may be without the organisations' consent, and (e) maintain a register of its certified organisations that is up to date.
- If during any assessment, evidence is found or allegations are made regarding a Notifiable Issue, we will report this to the Department of Health and Human Services. A Notifiable Issue is where we find evidence or allegations of significant harm to a person accessing a service; risk of abuse; serious health, safety or, financial impropriety; potential insolvency and or professional misconduct. If we are required to notify an issue, we shall inform the relevant service senior manager. We shall record the Notifiable Issue and this shall be reported immediately to the relevant authority. We are not responsible for resolving a Notifiable Issue, but Certification will not proceed until we are advised by the Department that the issue has been resolved.

ACKNOWLEDGEMENT

HDAA would like to thank the Quality Manager, Audrey Ellis for coordinating and guiding the assessment. We also thank staff and others for their support during the assessment visit.

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This report includes the following:

1. INTRODUCTION

HDAA conducted an assessment for certification in relation to the Human Services Standards (gazetted as the Department of Health and Human Services Standards - HSS) and the National Safety & Quality Health Service Standards [Standards 1 to 6 (NSQHSS)] on 15 – 16 August 2018 with Link Health and Community Limited (Link Health and Community).

A skilled and experienced assessment team was identified to work with Link Health and Community. The assessment team has considerable experience in assessing human services in Victoria.

The purpose of the assessment is to evaluate the implementation, including effectiveness, of the service's quality management system.

During this assessment, the assessors reviewed documentation and assessed its implementation and delivery of services in relation to the Human Services Standards and NSQHSS. The assessors also talked to people who use the service, management, staff and other persons associated with service delivery.

What follows is a detailed report describing Link Health and Community's quality management system and documentation, and its implementation in relation to the HSS and NSQHSS.

The service is provided with a workbook that accompanies this report. This includes an improvement action planning worksheet (refer "HSSImprovements"). This worksheet should be used by Link Health and Community to plan those actions necessary to implement improvements identified in the assessment. HDAA has completed the findings section of the template. The service should complete the "Organisation Planned Improvements", "Person Responsible" and "Planned Completion Date" parts of the table, and where action has occurred, identify the "Date of Completion" section.

The workbook also includes an observations worksheet (refer "HSSObservations" and "NSQHSSObservations"). Responding to observations is discretionary and can be considered as part of the service's on-going program of continuous improvement. The observations worksheet can be used by Link Health and Community to plan those actions that would support the service's on-going development.

The assessment evidence records are included in the workbook that accompanies this report (refer to worksheet: "HSSEvidence" and "NSQHSSEvidence"). The assessment evidence records identify evidence that demonstrates achievement of the requirements of each indicator assessed. The evidence record is supported by file assessment tools for staff and people who access the service.

Further details of the HDAA assessment system are included in the worksheet titled "Overview" in the excel assessment that accompanies this report.

2. KEY POINTS

2.1 ASSESSMENT OVERVIEW

A two day onsite assessment for certification was completed on 15 – 16 August 2018 to ascertain how Link Health and Community is functioning in relation to the Human Services Standards and the National Safety & Quality Health Service Standards (Standards 1 to 6).

Discussions with people accessing the service (including related persons), staff, management, and senior management and others occurred. The assessment also reviewed the quality management system framework and its implementation.

Assessment summary

Legal Entity Name: Link Health and Community Limited

Certification decision and date:

- Certification to occur after the non-conforming criteria are determined to be fully conforming prior to 18 November 2018

Assessment type: Recertification Assessment

Assessors: Cheryl de Blaquiere – Lead Assessor, Chris Coombs – Support Assessor

Certificate provided:

- A certificate shall be issued after the conditions are met

Service streams assessed:

- Child Protection and Family Services

Progress with previous assessed improvements:

Reference Number	Closed out
HSS 3.5	HSS 3.5

Current improvements:

Reference Number	Not closed out at the final report
HSS 1.1, 3.5, and 4.4	HSS 1.1, 3.5, and 4.4

2.2 SUMMARY OF ATTAINMENT

HUMAN SERVICES STANDARDS				
Criteria	**On-site attainment**	**Final report attainment**	**Observations**	**Standards rating**
1.1	**Non-conforming**	**Non-conforming**	**Observation**	**Standard 1 Non-conforming**
1.2	Conforming	Conforming	Nil	
2.1	Conforming	Conforming	Nil	**Standard 2** Conforming
2.2	Conforming	Conforming	Nil	
2.3	Conforming	Conforming	Nil	

HUMAN SERVICES STANDARDS				
Criteria	On-site attainment	Final report attainment	Observations	Standards rating
3.1	Conforming	Conforming	Nil	Standard 3 Non-conforming
3.2	Conforming	Conforming	Nil	
3.3	Conforming	Conforming	Nil	
3.4	Conforming	Conforming	Nil	
3.5	Non-conforming	Non-conforming	Observation	
4.1	Conforming	Conforming	Observation	Standard 4 Non-conforming
4.2	Conforming	Conforming	Nil	
4.3	Conforming	Conforming	Nil	
4.4	Non-conforming	Non-conforming	Nil	
4.5	Conforming	Conforming	Nil	
4.6	Conforming	Conforming	Nil	

NATIONAL SAFETY & QUALITY HEALTH SERVICE STANDARDS				
Criteria	On-site attainment	Final report attainment	Observations	Standards rating
1.1	Met	Met	Nil	Standard 1 Met
1.2	Met	Met	Nil	
1.3	Met	Met	Nil	
1.4	Met	Met	Nil	
1.5	Met	Met	Nil	
1.6	Met	Met	Nil	
1.7	Met	Met	Nil	
1.8	Met	Met	Nil	
1.9	Met	Met	Nil	
1.10	Met	Met	Nil	
1.11	Met	Met	Nil	
1.12	Met	Met	Nil	
1.13	Met	Met	Nil	
1.14	Met	Met	Nil	
1.15	Met	Met	Nil	

NATIONAL SAFETY & QUALITY HEALTH SERVICE STANDARDS				
Criteria	On-site attainment	Final report attainment	Observations	Standards rating
1.16	Met	Met	Nil	
1.17	Met	Met	Nil	
1.18	Met	Met	Nil	
1.19	Met	Met	Nil	
1.20	Met	Met	Nil	
2.1	Met	Met	Nil	Standard 2 Met
2.2	Met	Met	Nil	
2.3	Met	Met	Nil	
2.4	Met	Met	Nil	
2.5	Met	Met	Nil	
2.6	Met	Met	Nil	
2.7	Met	Met	Nil	
2.8	Met	Met	Nil	
2.9	Met	Met	Nil	
3.1	Met	Met	Nil	Standard 3 Met
3.2	Met	Met	Nil	
3.3	Met	Met	Nil	
3.4	Met	Met	Nil	
3.5	Met	Met	Nil	
3.6	Met	Met	Nil	
3.7	Met	Met	Nil	
3.8	Met	Met	Nil	
3.9	Met	Met	Nil	
3.10	Met	Met	Nil	
3.11	Met	Met	Nil	
3.12	Met	Met	Nil	
3.13	Met	Met	Nil	
3.14	Met	Met	Nil	
3.15	Met	Met	Nil	

NATIONAL SAFETY & QUALITY HEALTH SERVICE STANDARDS				
Criteria	On-site attainment	Final report attainment	Observations	Standards rating
3.16	Met	Met	Nil	
3.17	Met	Met	Nil	
3.18	Met	Met	Nil	
3.19	Met	Met	Nil	
4.1	Met	Met	Nil	
4.2	Met	Met	Nil	
4.3	Met	Met	Nil	
4.4	Met	Met	Nil	
4.5	Met	Met	Nil	
4.6	Met	Met	Nil	
4.7	Met	Met	Nil	
4.8	Not applicable	Not applicable	Nil	**Standard 4** Met
4.9	Met	Met	Nil	
4.10	Met	Met	Nil	
4.11	Met	Met	Nil	
4.12	Not applicable	Not applicable	Nil	
4.13	Met	Met	Nil	
4.14	Not applicable	Not applicable	Nil	
4.15	Not applicable	Not applicable	Nil	
5.1	Met	Met	Nil	
5.2	Met	Met	Nil	
5.3	Not applicable	Not applicable	Nil	**Standard 5** Met
5.4	Met	Met	Nil	
5.5	Met	Met	Nil	
6.1	Met	Met	Nil	
6.2	Met	Met	Nil	
6.3	Met	Met	Nil	**Standard 6** Met
6.4	Met	Met	Nil	
6.5	Met	Met	Nil	

2.3 SUMMARY OF IMPROVEMENTS

Criteria	Summary of HSS improvements
1.1	A standardised process that documents that clients have received relevant information should be developed and implemented.
3.5	Staff training on abuse and neglect should be provided and records of this should be retained.
4.4	(a) Cultural competency education for staff should be provided. (b) An organisational procedure should be developed for working with Aboriginal or Torres Strait Islander people.
Summary of NSQHSS improvements	
The assessors have identified that all assessed criteria are met and consequently there are no improvement actions.	

2.4 SUMMARY OF OBSERVATIONS

Criteria	Summary of HSS observations
1.1	Client information packs could be reviewed for: (a) Consistency of contents; (b) Strengthening of information relating to the right to be free from abuse and neglect; and (c) Strengthening information relating to the complaints management process.
3.5	(a) Toy cleaning could be reviewed and cleaning could be documented for infection control purposes (b) Duress alarms could be stored away from reception benches to avoid unintended access. (Oakleigh office). (c) Recording of staff participation in fire drills and similar safety activities could be strengthened.
4.1	Alternate formats for information provision to clients could be considered.
Summary of NSQHSS observations	
There are no assessor observations.	

2.5 EXECUTIVE SUMMARY

OVERVIEW

This re-certification assessment of Link Health and Community has also identified that three actions are required to fully meet the requirements of the Human Service Standards (HSS). The assessment also identifies that the organisation has fully met the requirements of the National Standards for Safety and Quality in Health Care for dental services.

The above conclusion has been determined by a review of documented information; file samples of staff and clients/patients; discussions with managers, staff, clients/families; site inspections and general observations during the onsite assessment

The organisation was able to evidence compliance with all of the NSQHSS requirements and feedback from patients indicate high levels of satisfaction with the services provided.

The HSS improvements relate to:

- Having evidence that people have receive information packs (HSS 1.1);
- Ensuring that staff complete training on abuse and neglect (HSS 3.5); and
- Ensuring that cultural competency training is provided for staff who are working with Aboriginal and Torres Strait Islander people (HSS 4.4).

Observations were also made in relation to people being aware of their rights and responsibilities (HSS 1.1) and provision of a safe environment for service delivery (HSS 3.5).

Many service strengths were evident to the assessment team as a result of discussions with people across many reporting levels within the organisation. Staff who participated in discussions demonstrated high levels of commitment and aim to ensure clients receive the high-quality outcomes; for instance, from a dental visit to participating in men's behaviour change program within the family violence arena.

Documentation review also indicates that there has been active review of processes, some of which are still in progress, and additional resourcing from management levels including current recruitment for an HR/Learning and Development Officer to strengthen this area of management.

Since the time of the previous assessment a decision has been made, following consultation with DHHS, to change the service model in Integrated Family Services to one of outreach and case management focus. This new model has been embraced by staff and discussions indicate that some procedures are still in the process of being finalised, or fine-tuned, to reflect the new practices.

Safety in outreach was advised as being a key focus for both staff and clients with risk assessments being undertaken for each client and initial visits being completed by two staff members. Staff indicated that systems for monitoring their safety have been reviewed and strengthened to align with the new service model. Safety is also a central component for family violence programs with men's behaviour change groups being held in an evening time slot to avoid attendance of perpetrators and victims on site at the same time. Other programs are delivered at sites where counselling is provided which provides discrete access for people, as relevant.

The demonstrated levels of commitment by all staff and managers have a direct link to the organisation's culture and published mission, vision and value statements, as noted below:

- Vision: *Healthier people participating in their communities.*
- Mission: *To provide integrated health and community services in the east and south-east of Melbourne and eastern Victoria.*
- Values: *Care for people who use services; listen to people and advocate for our community; provide accessible, innovative and high-quality services and programs; partner with other organisations for better services and be a sustainable organisation, financially, socially and environmentally.*

The structure of the organisation's quality management system has been reviewed to align the clinical quality objectives to the vision, mission and values for Link Health and Community

There is a reporting calendar of quality and audit activities for reporting to senior executive on safety and quality indicators and data. Safety and quality indicators and reports are on the agendas of the Board and Board subcommittees, plus the Quality and Clinical Safety committee.

There is a coherent, planned and systematic schedule of audits of clinical and organisational systems, and reliable processes to capture findings and implement necessary improvements. There are few complaints however, those reviewed demonstrate effective and transparent management consistent with best practice complaints management. Feedback is provided to all staff regarding complaints management.

Link Health and Community uses the data from the incident reporting system to recommend and prioritise quality improvement activities. All incidents are reviewed by all clinical committees and senior management, with aggregated data being reviewed at Board level. Should there be an incident, appropriate systems are in place to analyse, review and communicate to the members of the service. Incident management is Incorporated into the audit program. Evidence of regular review found in the Board Minutes and papers 2018, Safety and Clinical Governance committees 2018 and Quality and Safety Committee.

The Risk Management and Compliance Policy (07) provides guidance to the organisation in relation to consideration of risks in organisational decision-making and the application of a systematic process of identification, reduction, management and reporting of risks is vital to the achievement of strategic objectives.

The Risk Register for the Oral Wellbeing program 2018 consists of both strategic, operational and clinical risks. These are all risk rated and have mitigation or control strategies aligned to each item.

The quality schedule and plan 2018 incorporate aspects of infection control.

An extensive consultation has been completed to drive the safety and quality issues in relation to safety and quality for infection prevention and control. There is an organisation-wide definition of the elements of quality for clinical services in relation to effectiveness, safety and consumer experience.

Discussions with clients took place during the course of the onsite assessment with a summary of themes, and some direct quotes, noted below:

- Varied levels of awareness of information provision about complaints processes and timelines for addressing complaints;
- Confirmation of goal-centred plans and ongoing review of goals to ensure they remain current;
- Appreciation for safety plans which are developed and discussed at length when it is not safe for the client to take a hard copy of the plan home with them;
- ‘Staff are professional and non-judgemental at all times’;
- ‘They do a fantastic job providing support but it must be hard for them to keep going at times, taking on board all of my stuff’;
- ‘They have the skill to make people feel comfortable enough in a group setting to share personal information’; and
- ‘Having both a male and female facilitator at the group is excellent to keep us balanced’ (men’s behaviour change group).

HUMAN SERVICES STANDARDS OVERVIEW

Standard One - Empowerment

An improvement has been identified for this standard as it was not possible to evidence from client file review that people had received information provision. Discussion with clients indicate that this practice is carried out, and this will be strengthened through the development of a standardised approach for evidencing this practice.

There are also varied levels of understanding as to what the complaints management process entails and how long it takes for people to be contacted by Link Health if they wished to lodge a complaint.

Standard Two - Access and engagement

Eligibility for service access is defined, and information brochures provide additional resources for people wishing to access programs. There is ongoing review of policy and procedures to ensure that service delivery is adequately maintained. A change of service model has been introduced for Integrated Family Services to one of outreach and case management. The organisation is currently able to provide services to meet demand.

Standard Three - Wellbeing

Program staff provided examples of strengths based, capacity building and person-centred approaches used to assist client participation in community-based activities, acknowledging safety and risk components as relevant. Clients verified supports provided to plan for and to enact strategies to achieve stated goals. An improvement has been identified to ensure that staff receive training in neglect and abuse, and that training attendance is documented including for updates when relevant.

Standard Four - Participation

The organisation participates in relevant service provider networks with the Inner East Family Services Alliance and relevant Family Violence networks being predominant. Staff advised of very low client numbers where people have identified as Aboriginal or Torres Strait Islander.

An improvement has been identifed to provide Aboriginal cultural competency to staff and develop a procedure for working with Aboriginal or Torres Strait Islander people. Staff discussed ways in which they support people to develop, sustain and strengthen independent life skills through the individualised support planning process as well as group and/or individual counselling.

NATIONAL SAFETY AND QUALITY HEALTH SERVICE STANDARDS OVERVIEW

Link Health and Community provides a range of general and specialist dental services both public and private at the Clayton site and a number of innovative outreach programs.

Services that are provided include the following:

- General Dental;
- Orthodontics;
- Endodontics;
- Specialist Special Needs;
- Outreach;
- Education; and
- Oral Health Promotion.

Link Health Oral Wellbeing Service meets the requirements of the National Safety and Quality Health Service Standards. This conclusion is supported by evidence obtained from a review of a sample of documents and records as well as discussions with management, staff and people who access the service and a review of service delivery sites. It was apparent that Link Health Oral Wellbeing Service executive and workforce are striving for excellence in the standard of care provided. A definite focus on providing safe and quality services and improving performance is evident. Effective progress has been made in the implementation of the National Safety and Quality Health Service.

HUMAN SERVICES STANDARDS OVERVIEW

Progress in relation to the assessed HSS is as follows:

STANDARD 1

EMPOWERMENT - People's rights are promoted and upheld.

Overview

1.1	People understand their rights and responsibilities.

Client information pack review, site inspection and discussion with managers and clients indicate that whilst overall, people understand their rights and responsibilities, there is a need to review how information provision is documented. Client file review could not evidence for 9 files out of 10 that information has been provided, however, general client discussions were able to verify that this does take place. It is acknowledged that there have been a number of new staff within program areas as well as other changes within quality and management areas. It has also been noted that this lack of clarity was identified at the previous assessment. Link Health should develop a standardised process for how receipt of information by clients will be evidenced. An improvement opportunity has been identified.

1.2	People exercise their rights and responsibilities.

Managers, staff and client discussions indicate that people exercise their rights and responsibilities. CRAF assessments are undertaken to ensure the most appropriate supports are in place for each individual. Staff spoke of the Child Safety policy which includes mandatory reporting requirements. Link Health is not funded for Disability Services and as such, is not required to be registered for RIDS nor report to the OPP. Policy is in place to provide guidance on this area should clients have a behaviour support plan. Incident reporting is monitored and reported through Risk Man. The organisation has an exemption from CIMS registration for twelve months effective from the commencement date of CIMS implementation by DHHS. Staff and managers demonstrated high levels of awareness of the Healthcare Charter of Rights and the programs' respective client catchment areas. Managers spoke of liaison with VACCA or Boondawan Willam Aboriginal Healing Centre when this has been relevant. Clients who participated in interviews indicated that they are satisfied with the quality of support they receive and believe their privacy and dignity are maintained, however, there were varied responses in relation to knowledge of the complaints and feedback management process. Refer improvement opportunity standard 1.1.

Improvement action

Criteria 1.1 does not meet the requirements of the HSS and Link Health and Community should take action in relation to this.

Observations

An observation has been made in relation to 1.1 and Link Health and Community could respond to this. Responding to observations is discretionary and is identified for continual improvement purposes.

STANDARD 2

ACCESS AND ENGAGEMENT - People's rights to access transparent, equitable and integrated services are promoted and upheld.

Overview

2.1	Services have a clear and accessible point of contact.

Discussion with managers, review of client information packs, policy and procedure and site inspections indicate that people's rights to access transparent, equitable and integrated services are promoted and upheld. Service delivery hours are displayed and the move to an outreach-based case management approach from Integrated Family Services program allows for service delivery at a location which best suits the needs of the individual. Men's Family Violence group programs are conducted in the evening and scheduling of appointments in general allows for safety of women attending at times that differ from those of the perpetrator, as relevant. Procedural guidelines are in place relating to access and engagement. Service sites are physically accessible and information posters and brochures are displayed. Resources and symbols are visually evident in relation to recognition of both CALD and Aboriginal or Torres Strait Islander backgrounds as well as information being age appropriate, as relevant. Services are provided in venues which also cater for other programs such as dental and/or allied health which provides a discrete pathway access for people who may be receiving individual counselling. Lifts are available where services are located on the first floor.

2.2	Services are delivered in a fair, equitable and transparent manner.

Review of documents, procedures, records, and client information packs indicate that services are delivered in a fair, equitable and transparent manner. Procedural guidelines are in place relating to access and engagement. The Inner East Family Services Alliance Operations Manual April 2017; Link Integrated Family Services Manual 2018; Family Violence Information Sharing Guidelines; Person Centred Care Policy; Access and Coordination Policy; Fees Policy and FV Men's Behaviour Change Manual are key resource documents. Information provided to clients includes any entry and exit rules; conditions that may apply to services being provided; and fees if attending the men's family violence group. There is currently no waiting list and referrals from the Alliance provide the organisation with relevant criteria that may have determined priority of access for services. Client information packs provide people with information on a range of programs available within Link Health and people may be referred to other organisations where this has been identified as being in the client's best interests for required needs and outcomes.

2.3	People access services most appropriate to their needs through timely, responsive service integration and referral.

Review of documented information, and discussions with managers indicate that people access services most appropriate to their needs through timely, responsive service integration and referral. Managers spoke of participation in the Family Services Alliance and Family Violence networks as well as the role of the Alliance in undertaking the initial screening of client needs prior to referral/allocation to Alliance organisations. Referrals to Child FIRST and VACCA were discussed as well as court orders for men participating in the family violence group. Managers and staff advised that people can be referred to other programs within Link Health or to external agencies if this is the best fit for the client's individual needs. There are currently no waiting lists for programs. Staff are supported through group supervision in IFS and external supervision, as relevant, within family violence programs to ensure that staff are supported to maintain response levels to referrals and requests. People may also self-refer. Procedural guidelines are in place relating to referrals.

Improvement action

Link Health and Community meets the requirements of Standard 2 and because Standard 2 is fully conforming there are no improvement actions.

STANDARD 3

WELLBEING - People's right to wellbeing and safety is promoted and upheld.

Overview

3.1	Services adopt a strengths-based and early intervention approach to service delivery that enhances people's wellbeing.

Staff and manager discussions together with a review of client records indicate that Link Health adopts a strengths-based and early intervention approach to service delivery that enhances people's wellbeing. Staff demonstrated high levels of awareness of the importance for people to be empowered to make decisions and identify their strengths. Staff are guided through the Person Centred Care Policy. Client file reviews indicate that both IFS and FV programs undertake comprehensive risk assessments when working with people to identify their strengths and build capacity within their families, where this is safe to do so, or to increase confidence and independence in situations where the family setting provides greater risk from perpetrators. Group and individual sessions provide opportunity for people to reflect, identify active engagement strategies and change strategies as often as is needed.

3.2	People actively participate in an assessment of their strengths, risks, wants and needs.

Review of documented information including client files and discussions with staff and managers indicate that people actively participate in an assessment of their strengths, risks, wants and needs. Client file review also indicates that there is active involvement with other health professionals, or agencies, as required as part of the assessment process. Staff are guided by procedural documents such as: The Inner East Family Services Alliance Operations Manual April 2017; Link Integrated Family Services Manual 2018; Family Violence Information Sharing Guidelines; Assessment and planning templates across programs; and Integrated Family Services Cheat Sheets; and Person-Centred Care Policy. Assessments take people's cultural, religious, spiritual, language, and age into consideration to ensure that the assessment process optimises the best outcomes for each individual situation. Staff spoke of the need for safety to be paramount, particularly in the family violence programs, which enables clients to decline taking a copy of any assessment documents given the escalated risk this may impose. IFS clients receive a copy of all assessment and planning documents which was evidenced in the client file review.

3.3	People have a goal oriented plan documented and implemented. This plan includes strategies to achieve stated goals.

Policy, procedure, client records review together with client, staff and manager discussions indicate that people have a goal-oriented plan documented and implemented which includes strategies to achieve stated goals. Key resource documents such as The Inner East Family Services Alliance Operations Manual April 2017 ensures that programs are operating according to relevant legislation, departmental policies and sector frameworks. Family violence staff have an operational manual which is still in development, in part, and all programs have access to the Link Health Person Centred Care Policy. Goal centred plans were evidenced in client files with goals showing as being identified through active participation in discussion by the client at each point of the implementation process. Each discussion held indicated that client safety is the priority at all times which means that, as such, there will be times when the client chooses to not receive a copy of their plan or any updated versions, given the risk to safety that could occur by taking the plan with them. Client discussions verified that this practice is in place, however, each person who had declined a copy of their plan were familiar with their goals and strategies as this is discussed at length by staff to ensure that client understanding and awareness has been achieved. IFS clients receive a Family Action Plan with clearly defined goals and strategies which is signed off by the client at the time of plan development.

3.4	Each person's assessments and plans are regularly reviewed, evaluated and updated. Exit/transition planning occurs as appropriate.

Policy, procedure, client records review together with client, staff and manager discussions indicate that each person's assessment and plans are regularly reviewed, evaluated and updated whilst exit/transition planning occurs as appropriate. Reviews consider the client's current situation, risk assessments, age, ability, gender, sexual identity, culture, religion or spirituality. Each client is asked if they identify as Aboriginal or Torres Strait Islander background. Health and wellbeing is also addressed for each individual, including children, where relevant. Client file review indicates that reviews of goals and strategies take place in an ongoing manner with updated case notes reflecting each session's outcomes and discussions where goals have either been met or need to be adjusted, depending on the client's current safety levels. Family Action Plans are reviewed in accordance with timeframes determined by the FS Alliance with more frequent cases notes indicating that plans are 'living' documents. Clients who were interviewed indicated that they are happy with the support provided to them to be able to reach their goals and identify strategies for ongoing sustainability in the long term. Closure letters are provided in accordance with Case Closure guidelines.

3.5	Services are delivered in a safe environment for all people free from abuse, neglect, violence and/or preventable injury.

Policy, procedure, process and staff file review together with staff discussion and site review indicates that the organisation has need to strengthen existing processes in relation to staff awareness surrounding abuse, neglect, violence and/or preventable injury. There is a Child Safety Procedure in place which mentions zero tolerance and mandatory reporting obligations, however, staff discussions did not indicate a thorough awareness of the procedure contents. Managers advised that a Child Safe Code of Conduct is a work in progress. Other procedures are in place in relation to safety. Staff record review could not evidence that training has been undertaken to ensure that people are safe from abuse, neglect, violence and preventable injury, in service environments. Whilst programs have a focus on client safety by nature of the programs themselves staff who participated in discussions could not confirm that training has been provided. An improvement opportunity has been identifed. There is a mixed understanding from staff discussions of the organisation's progress in relation to the implementation of Child Safe Standards.

Service sites are physically accessible and well maintained, both in leased and owned premises. Systems are in place for maintenance, fire and evacuation, first aid kits, fleet vehicles, OHS and general wellbeing. Discussions indicate that these systems are being managed effectively. A new position is currently being recruited for a central OHS officer who will be responsible for Work Safe liaison and will participate in the Safe Link OHS Committee. Some observations have been made from walk throughs at various sites. Refer also to observation at clause 1.1 in relation to strengthening information provision to clients on safety from abuse and neglect. Other systems include hazard and incident reporting; root cause analysis; risk register report; OHS quarterly site inspections and site manager positions; hand hygiene audits; CPR training; CRAF assessment tool; and site injury registers.

<u>Improvement action</u>

Criteria 3.5 does not meet the requirements of the HSS and Link Health and Community should take action in relation to this.

Observations

An observation has been made in relation to criteria 3.5 and Link Health and Community could respond to this. Responding to observations is discretionary and is identified for continual improvement purposes.

STANDARD 4

PARTICIPATION - People actively participate in their community by identifying goals and pursuing opportunities including those related to health, education, training and employment.

Overview

4.1	People exercise choice and control in service delivery and life decisions, where appropriate.

Review of policy, procedure and process together with client and staff discussions indicate that people exercise choice and control in service delivery and life decision, where appropriate. Key documentation to guide staff include Person Centred Care Policy; Access and Coordination Procedure; Feedback and Complaints Procedure; Planning and Participation in Care Procedure and Rights and Responsibilities Procedure. The client information pack also advises on the option for an advocate if this is the person's choice. Client discussions verified that people are happy with the choices they are provided, and are able to identify their strengths and goals. Participants in the Family Violence Men's Behaviour Change Program also commented on the value of the program acknowledging that they do not choose the topics/themes contained in the program. Information is provided to people on the programs they are coming to as well as the other options available to them through Link Health. Information is provided in standard text form, or translated into other languages. It could be helpful to review client communication needs for the value of easy read or pictorial information provision in some instances. An observation has been made. Staff provided examples of working with people to ensure that dignity of risk is respected within client decision making.

4.2	People actively participate in their community by identifying goals and pursuing opportunities including those related to health, education, training and employment.

Client record review, and staff discussions indicate that people actively participate in their community by identifying goals and pursuing relevant associated opportunities. Client plans and goal setting documented in files indicate a wide variety of engagement is considered and encouraged, depending on the individual needs of the person, including children, as well as safety factors within the family violence program settings. Staff discussions provided examples of working with people to help them identify safe networks and access community facilities and resources. Strategies are identified to ensure that any possible barriers which may restrict their participation are taken into consideration, and as barriers arise throughout session discussions, these barriers are addressed for the way forward. Family Violence has an after-hours response, white ribbon events are acknowledged within Link Health, and active support is given to the South Sudanese Peer Leadership Program in partnership with Community Engagement Link, to strengthen this CALD group within local communities. Staff also indicates that the organisation has low representation of clients who identify as Aboriginal or Torres Strait Islander background, however, there is an awareness of VACCA for secondary consultations and support.

4.3	People maintain connections with family and friends, as appropriate.

Discussion with staff and clients indicate that people maintain connections with family and friends, as appropriate. Staff advised that clients are encouraged to establish community networks through programs within Link Health as well as the broader community which will also help to strengthen their parenting capacity. Family Action Plans are developed to help people maintain and strengthen connections with family and friends. Family Violence programs support people to identify safe networks of people. Aboriginal and Torres Strait Islander people would be asked if they wish to connect to their local community and extended family. Client discussions indicated that they have received support in working towards stronger family connections and identifying trusted friend networks.

4.4	People maintain and strengthen connection to their Aboriginal and Torres Strait Islander culture and community.

Senior manager discussion indicates that the organisation does not currently provide Aboriginal and Torres Strait Islander cultural competency training for staff, which was verified through staff file review. Managers also spoke of low numbers of clients who identify as Aboriginal or Torres Strait Islander, however, clients who do identify may not necessarily be supported in a culturally appropriate manner given the lack of training and awareness by staff. The Person-Centred Care Policy has a broad statement encompassing diversity as a whole, however, there is no specific procedure relating to working with Aboriginal and Torres Strait Islander people. Improvement opportunities have been identified.

4.5	People maintain and strengthen their cultural, spiritual and language connections.

Client information pack review and discussion with managers and staff indicate that people maintain and strengthen their cultural, spiritual and language connections. Information can be provided in main community languages which was verified during site inspections with posters and brochures easily accessible as well as within information packs if language has been identified as a need. Managers and staff were able to describe working with interpreters and mentioned the specific Interpreting Use Procedure which all staff have access to. There was a demonstrated knowledge of local cultural communities and managers also spoke of multi lingual staff employed to assist clients when accessing services.

4.6	People develop, sustain and strengthen independent life skills.

Staff discussions indicate that people develop, sustain and strengthen independent life skills. Examples were provided of how people are supported to achieve sustainable positive changes in their circumstances, which often includes greater parenting skills being employed. Age and developmental stage is considered when working with children and young people. Safety and self-care skills are an integral focus of family violence programs and men's behaviour change programs aim to support men to work with issues such as anger management so as to empower them with life skills which can positively impact their family and relationship settings.

Improvement action

Criteria 4.4 does not meet the requirements of the HSS and Link Health and Community should take action in relation to this.

Observations

An observation has been made in relation to criteria 4.1 and Link Health and Community could respond to this. Responding to observations is discretionary and is identified for continual improvement purposes.

NATIONAL SAFETY AND QUALITY HEALTH SERVICE STANDARDS

Progress in relation to the assessed NSQHSS is as follows:

STANDARD 1

Overview

Governance for Safety and Quality in Health Service Organisations

The policy register which includes Number, policy name, procedure name, document status, approval responsibility, currency status, next review and notes.

Changes to practice, legislation, regulations are received via the DHVS and Australian Dental Council.

Notifications to changes to policy and practice are managed through email broadcast and team meetings and a daily huddle

A copy of the incident logs for the preceding 12 months evidenced effective use of the incident system to inform and improve practice

Link Health Community and Dental strategic and business planning processes are directed toward ensuring patient and staff safety and provision of a quality service. The quality plan is in place and supports the strategic plan.

The Link Health and Community Oral health Care Plan 2017-2020 and the minutes and Board papers April and June 2018 confirm that quality and safety is embedded in business practices.

Workforce planning is ongoing and used to align the needs and priorities of the Link Oral Health to its workforce to ensure it can meet its legislative, regulatory, service requirements and organisational objectives.

Other documents include: Audit schedule, results and improvements spreadsheet, audit reports, OWB Business Plan, morning communication meeting minutes 2017," Monthly Bites' and staff meeting minutes

There is a reporting calendar of quality and audit activities for reporting to senior executive on safety and quality indicators and data. Safety and quality indicators and reports are on the agendas of the Board and Board subcommittees, plus the Quality and Clinical Safety committee.

Indicator reports and actions taken are noted on the minutes and Quality and Safety Committee Minutes and Agendas February-June 2018, Board Minutes January - June 2018 and Clinical Governance & Health Promotion Committee Meeting June 2018.

Information for patients is reviewed at the Marketing & Publications Reference Group which has consumer representation.

The Link Health and Community newsletter has a section "Quality Account" which describes quality initiatives and outcomes under the banners of "we care, we are accessible and we partner".

There is a suite of reports required by DHSV in relation to performance. Any issues are reported back to the service when an action plan is required. The majority of reports reviewed at this assessment are favourable to peers and the state average.

Audit feedback and other reports are distributed to staff via email, team huddles and team meetings.

Every position description has a section in relation to quality improvement responsibilities for all levels of staff.

The performance review system includes a quality indicator report for all clinicians such as 10 records are audited each six months for each clinician and results are discussed at the performance review.

Quality Management Policy (5) and the Quality Planning, Improvement and Review Procedure (5.1) forms part of the orientation.

All staff are required to sign a statement that they have read and understood the Code of Conduct and was evidenced in all staff files reviewed.

All senior staff have received training in safety and quality including the audit process.

Training is noted in dental staff files regarding CPR, infection prevention and control, patient identification and clinical handover

There are no locums or agency staff used within the service. The preferred method is the use of the casual pool who all receive the same training and orientation as permanent staff

The Supervision Procedure (2.4) identifies the responsibilities for ensuring that regular clinical and administrative supervision in accordance with professional standards, codes of practice and industry benchmarks is provided to employees who are clinical practitioners.

Evidence of clinical supervision was noted with the student dentists, individual file audit tool and feedback, post graduate speciality trainees and all others.

The mandatory training register confirms that all staff have completed the designated training required. The requirement to complete training is documented in the position description

The service is committed to continuing professional development and there are a number of service based courses completed by staff, these include: DHSV Public Oral Health Innovations Conference- 2017 Journey to Value Mental Health First Aid Connecting the Pieces: Train the Trainer- Diversity Jigsaw, Uni of Melbourne Mentor Credentialing, Program, Grad Cert in Dental Therapy (Advanced Clinical Practice), EMROHN CPD Day- Practical Updates in Clinical Dentistry and Grad Cert in Dental Therapy- (Advanced Clinical Practice).

The Risk Management and Compliance Policy (07) provides guidance to the organisation in relation to consideration of risks in organisational decision-making and the application of a systematic process of identification, reduction, management and reporting of risks is vital to the achievement of strategic objectives.

The Risk Register for the Oral Wellbeing program 2018 consists of both strategic, operational and clinical risks. These are all risk rated and have mitigation or control strategies aligned to each item.

All incidents are investigated and reported through to the Board and there is a culture of reporting both incidents and near misses. The RiskMan system was being implemented at the time of assessment.

There is a Radiation Safety Plan consistent with Victorian legislation and all relevant staff have Radiation Use Licences.

There is an organisation-wide definition of the elements of quality for clinical services in relation to effectiveness, safety and consumer experience. The structure of the organisation's quality management system has been reviewed to align the clinical quality objectives to the vision, mission and values for Link Health and Community

There is a coherent, planned and systematic schedule of audits of clinical and organisational systems, and reliable processes to capture findings and implement necessary improvements

This is evidenced by: The Quality Management Policy (5), The Quality Planning, Improvement and Review Procedure (5.1), Business Case Procedure (5.2), and the Evidenced-Based Practice and Research Procedure (5.2), the Quality and Clinical Safety Committee Meeting – Action Tracker 2018, and Workplace Health and Safety minutes and procedures.

There is an extensive audit schedule which is reported through to the highest level of governance and the Dental Health Services Victoria. Results are generally favourable to peers and all actions are addressed via the Quality and Clinical Safety committee

Governance for Safety and Quality in Health Service Organisations
Clinical guidelines are all evidenced based and have been adopted from the Australian Dental Association and the Dental Board of Australia Policies, Codes and Guidelines 2018. The service also has very strong links with the tertiary sector and participates in publication and presentation of peer review journal articles. Clinical guidelines are available at the point of care for all practitioners Dental records are reviewed against each practitioner every six months. This audit contains 26 indicators and results are forwarded to the DHSV. This audit also includes compliance to clinical guidelines. Observational audits are undertaken regularly. There are comprehensive patient dental records that include completed medical/medication history sections The audit of patient dental records to demonstrate that people at increased risk are being appropriately identified There are procedures of protocol for identifying patients who are at an increased risk of harm with particular reference to oncology patients, complex needs patients, those patients on bisphosonates, anticoagulants, dementia, diabetes and many others. All high risk patients are flagged in the clinical record. A review of clinical records during this assessment confirms that a comprehensive medical history is taken identifying at risk patients. There is a well-established program for escalation of emergencies. The clinical escalation protocol is to commences basic life support and call 000 with the exception of anaphylaxis where adrenalin is given by the dentist. All clinical staff are required to complete CPR annually and the compliance is 100%" The service uses the Dental Board of Australia Dental guidelines on dental records. The dental record system is electronic and is available at the point of care. A review of records during this assessment confirmed all records had a medical history, correspondence from other healthcare professionals where appropriate, examination and test results, radiographs, treatment options, treatment plan and the informed consent. The service uses the Dental Board of Australia Dental guidelines on dental records. The dental record system is electronic and is available at the point of care. A review of records during this assessment confirmed all records had a medical history, correspondence from other healthcare professionals where appropriate, examination and test results, radiographs, treatment options, treatment plan and the informed consent." Link has adopted and implemented the Dental Board of Australia Scope of Practice Registration standard, an evidence-based process as the basis for its system of credentialing and defining scope of clinical practice for all clinicians. This includes dentists, dental hygienists, dental prosthetists, dental therapists, and oral health therapists. The audit program includes 10 files per practitioner each six months to ensure that clinicians work within their credentialing and scope of practice. Staff files reviewed demonstrated that scope of practice, performance review, supervision and credentialing occur as required. The service also supports students who work under supervision at all times. The service has a wide variety of practitioners which include dentists, dental hygienists, dental prosthetists, dental therapists, oral health therapists, graduate special needs dentists, overseas trained dentists under supervision, orthodontists and endodontists. Evidence of appropriateness included the DHSV Purchasing Agreement, Triaging Compliance Report and weekly/quarterly/annual scorecards, Wait List, Monash Cancer Clinic and Calvary Bethlehem Reports and current OWB Business Plan. All new services include a Safety & Risk Assessment Tool, project plan, staffing plan, cost analysis and projection and orientation program. Evidenced in the Calvary relocation plan. There is a procedure on clinical supervision which provides guidance to staff to identify the responsibilities for ensuring that regular clinical and administrative supervision in accordance with professional standards, codes of practice and industry benchmarks is provided to employees who are clinical practitioners. (Procedure 2.4) Staff records viewed all had completed performance reviews and evidence of supervision. Performance Development and Management Procedure (2.5) outlines that employees are supported to achieve optimum work performance, improve service quality, develop professionally and assist in achieving Link HC strategic goals. All staff interviewed confirm that they have regular performance reviews as do all staff files viewed.

Governance for Safety and Quality in Health Service Organisations
There is a new quality manager who is in the process of reviewing quality and safety training for staff. Examples provided for this assessment included the Managing Patients Exhibiting Difficult Behaviour Workshop October 2017, Hand Hygiene Auditor Certificates, First Aid training report. Monthly Bites and the DHSV Learning Set. Staff confirm that they are provided with ongoing education regarding safety and quality. Feedback from audit is provided though the Monthly Bites and through individual feedback. The new quality manager is developing a standardised quality training program for all staff. All staff are required to complete the DHSV training suite which includes quality and safety indicators. The service has identified multiple sources of information that provide an insight into the level of workforce engagement with, and understanding of, the organisation's safety and quality system. All staff are involved in quality activities and feedback is sought following all training. The service aggregates and analyses relevant information and use it to develop and improve the effectiveness of the organisation's education and training system, evidenced in the review of the education and training schedule The service has adopted and implemented a comprehensive incident management and investigation system that complies with jurisdictional requirements. The incident hazard report has been recently reviewed and is appropriately designed. Responsibility investigation is clearly designated and the reporting and management framework that will ensures that incident data are utilised to optimal effect. The service is in the process of implementing the Risk Man system and all staff have received training" There is a defined reporting and management framework that ensures that incident data is utilised to optimal effect Incident management is Incorporated into the audit program. Evidence of regular review found in the Board minutes and papers 2018, Safety and clinical Governance committees 2018 and Quality and Safety Committee. Reports are generated and reported to staff and management Risks identified following incident investigation are alerted to Team leaders and managers and if necessary are then placed on the Risk Register. An action plan is then developed to deal with the identified risks. All Incidents are reviewed by senior management and relevant committees. The service has adopted and implemented a complaints management and investigation system. which is appropriately designed, resourced, maintained and monitored. Responsibility for leading and maintaining the system is clearly designated and there is an appropriate reporting and review framework. The Compliments, Complaints and Feedback form is available to patients. The complaints policy is in place and reflective of Victorian Legislation and the requirements of the Victorian Health Policy. All Complaints received are reviewed by the Director of the Oral Well Being service and where necessary the complaint is to an external body. A report is generated monthly to the Board. There are few complaints however, those reviewed demonstrate effective and transparent management consistent with best practice complaints management. Feedback is provided to all staff regarding complaints management. The Open Disclosure Procedure 2017 (7.4) provides guidance to staff to identify the responsibilities for ensuring that open disclosure occurs in the context of both effective risk management and good clinical practice. This is a mandatory competency and all Oral Well Being staff have completed the training The Australian Charter of Health Care Rights is noted at the entrance to the service and in the patient information. There is also a checklist in the patient file. The Australian Charter of Health Care Rights is translated into relevant community languages and interpreters are used as required There were 10 clinical records reviewed. The pre-assessment tool that the patients complete is translated into several common languages with English as well. Pre-treatment assessment observed by assessor confirms that patients are actively involved in the planning of their treatment. All patients are requested to complete a satisfaction feedback survey. All records included confirmation of informed consent and agreement to treatment" There is comprehensive policy, and associated procedures on consent and engagement of patients and their carers in clinical decision making. Consent is managed appropriately with exceptionally clear and concise modality consent forms. The Consent policy ensures that no patient will be treated without an informed consent. All patients have a full assessment on presentation to the service.

Governance for Safety and Quality in Health Service Organisations
The website has a comprehensive library of consumer information regarding all procedures performed at the service.
The clinical record is electronic and is available at the point of care. All access is password protected and access can be audited
The system to support privacy and confidentiality of patient information includes a robust ICT system of controls including IT infrastructure which is password protected and the server based on site. Access is time stamped and monitored closely to ensure no inappropriate access occurs
The medical record is electronic and where paper referrals are used then these are scanned into the E Record.
There is an extensive feedback system where all patients are requested to complete a feedback form. Data is analysed and reviewed extensively.
Improvement action
The organisation meets all of the requirements of Standard 1 and consequently Standard 1 is fully conforming.

Improvement action

Link Health and Community meets the requirements of Standard 1 and because Standard 1 is fully conforming there are no improvement actions.

STANDARD 2

Overview

Partnering with Consumers
There is a Marketing & Publications Reference Group with membership from various community members. Minutes viewed for 2016-2018. The Board is also made up of committed and interested members of the Link Health and Community group.
The Community Engagement and Wellbeing Policy (3.0) provides a framework to promote active community engagement at all levels of the organisation from strategic planning to service delivery. This approach enables Link HC to effectively implement population wide, place based, targeted and life stage community development and health promotion activities. Community Engagement & Co-design Policy & Procedure July 2018 also provides guidance in how to involve the community in the review of policy.
The community demographic is very well understood by Link H.C., with a very low socio-economic and multicultural profile.
Consultation occurs with many groups and has led to significant practice development to improve services such as, the establishment of dental service for chemotherapy clients and the appointment of a patients with special needs dentist. The patient feedback survey results are published in the quarterly Link Health and Community magazine.
Consumers and the community are engaged at all levels of the organisation. This includes both operational and strategic planning. A register of consumer engagement and consultation is kept.
There are policies and or processes in place that describe the role of consumers and/or carers in strategic, operational and service planning and this was confirmed by all staff interviewed.
The papers and minutes of the Marketing & Publications Reference Group demonstrate consumer engagement in strategic and operational planning
Consultation processes held with consumers and/or carers and feedback documented. Input is incorporated into strategic and operational planning processes.
The papers and minutes of the Marketing & Publications Reference Group demonstrate consumer engagement in strategic and operational planning
All new Board members receive governance training and two of the members have completed Australian Institute of Company Directors courses.
Other examples include invitation to communities to engage in participatory action research (evidenced in Together for Equality and Respect Strategy).
There has been extensive feedback from many communities such as the Indian community where four focus groups were held, the focus groups were conducted in English and Hindi. Overall, 40 people participated in the focus groups.
All patients have a full assessment on presentation to the service.
The website has a comprehensive library of consumer information regarding all procedures performed at the service.

Partnering with Consumers
There are policies and or processes in place that describe the role of consumers and/or carers in strategic, operational and service planning and this was confirmed by all staff interviewed. The papers and minutes of the Marketing & Publications Reference Group demonstrate consumer engagement in strategic and operational planning. Consultation processes held with consumers and/or carers and feedback documented. Input is incorporated into strategic and operational planning processes.

Improvement action

Link Health and Community meets the requirements of Standard 2 and because Standard 2 is fully conforming there are no improvement actions.

STANDARD 3

Overview

Preventing and Controlling Healthcare Associated Infections
Link HC demonstrates a strong commitment to regular review, monitoring, audit and assessment at all levels of the infection prevention, surveillance and control within the organisation. Verification confirms a risk management approach to all aspects of the continuum of infection prevention and surveillance system. Governance of systems for infection prevention, control and surveillance is evident The practice has developed a number of protocols which incorporate infection control as an integral part of the process A risk assessment tool is in use throughout the organisation and was demonstrated at each site. Clinical staff at the site were able to demonstrate a risk based approach to service delivery. The infection prevention and control policy is supported by a suite of protocols and guidelines based on the NHMRC Australian Guidelines for the Prevention of Health Care Acquired Infection 2010 The effectiveness of the Infection prevention and Control processes are reviewed through the committee structure. Evidence sighted in the minutes of the Quality and Clinical Safety Committee; Oral Wellbeing staff Meeting Infection Surveillance Oral Wellbeing. Audit Report November 2017 There is a defined reporting and management framework that ensures that incident data is utilised to optimal effect Incident management is Incorporated into the audit program. Evidence of regular review found in the Board Minutes and papers 2018, Safety and clinical Governance committees 2018 and Quality and Safety Committee. Data and reports are tabled at the relevant committees and the staff meetings. The results of surveillance and actions taken for improvement indicate overall very positive outcomes. The Risk Management and Compliance Policy (07) provides guidance to the organisation in relation to consideration of risks in organisational decision-making and the application of a systematic process of identification, reduction, management and reporting of risks is vital to the achievement of strategic objectives. The Risk Register for the Oral Wellbeing program 2018 consists of both strategic, operational and clinical risks. These are all risk rated and have mitigation or control strategies aligned to each item. The quality schedule and plan 2018 incorporate aspects of infection control An extensive consultancy has been completed to drive the safety and quality issues in relation to safety and quality for infection prevention and control. There is an organisation-wide definition of the elements of quality for clinical services in relation to effectiveness, safety and consumer experience. The structure of the organisation's quality management system has been reviewed to align the clinical quality objectives to the vision, mission and values for Link Health and Community. There is a coherent, planned and systematic schedule of audits of clinical and organisational systems, and reliable processes to capture findings and implement necessary improvements. This is evidenced by: The Quality Management Policy (5), The Quality Planning, Improvement and Review Procedure (5.1), Business Case Procedure (5.2), and the Evidenced-Based Practice and Research Procedure (5.2), the Quality and Clinical Safety Committee Meeting – Action Tracker 2018, and Workplace Health and Safety minutes and procedures.

Preventing and Controlling Healthcare Associated Infections
The service addresses infection prevention and control issues using a multi-component, service-wide program. Infection prevention and control risk assessments are completed for all patients attending the service which was noted in all clinical records reviewed Evidenced provided included, the quality improvement plan 2018 which shows implementation, regular review and revision, action, evaluation, feedback of infection prevention and control issues. Infection control is also on the risk register Reports from data systems and/or observational audits of areas where change has been made are noted in the reports to Board and Management. The service has implemented systems and processes to meet the requirements of the National Hand Hygiene Initiative. All permanent staff have completed Hand Hygiene compliance and this is an annual competency. Copies of staff HH training certificates were provided. Hand Hygiene rates are reported as part of the Oral Wellbeing suite of indicators to the executive and the Board. The staff immunisation program for vaccine preventable diseases is consistent with Victorian Health requirements. There are also processes in place for conscientious objectors. A detailed infection control risk assessment is conducted before commencement of works. All category A staff are required to provide evidence of Hepatitis B, diphtheria-tetanus containing vaccination, poliomyelitis vaccine and measles-mumps-rubella and influenza is offered to staff annually (page 11 infection prevention and control policy)" The Risk Management and Compliance Policy (07) provides guidance to the organisation in relation to consideration of risks in organisational decision-making and the application of a systematic process of identification, reduction, management and reporting of risks is vital to the achievement of strategic objectives. The Risk Register for the Oral Wellbeing program 2018 consists of both strategic, operational and clinical risks. These are all risk rated and have mitigation or control strategies aligned to each item. There is a policy in relation to single use items which states that Items are to be used once only then disposed of in the appropriate manner. These items are marked with number 2 in a circle with a diagonal line through it. Re-sterilization of such items shall not be practiced at Link HC under any circumstances. It is the responsibility of the user to ensure the item is only used once on one client then discarded. The service uses a number of invasive devices as per rule 3.1TGA Invasive Medical Devices use to penetrate an orifice such as dental drills, dental mirrors, and many others. All staff have appropriate training in the use of these devices. The use of dental invasive devices is part of the dental training however, observational audits are undertaken regularly in relation to all aspects of practice. Aseptic Technique is defined in the Infection control manual Review of the use of aseptic technique by dental practitioners' is managed by observational audit The service addresses infection prevention and control issues using a multi-component, service-wide program. Infection prevention and control risk assessments are completed for all patients attending the service which was noted in all clinical records reviewed Evidenced provided included, the quality improvement plan 2018 which shows implementation, regular review and revision, action, evaluation, feedback of infection prevention and control issues. Infection control is also on the risk register Reports from data systems and/or observational audits of areas where change has been made are noted in the reports to Board and Management Standard precautions are in place and embedded in the everyday activities of the practice. This in included in the policy. Hand Gel is readily available in all areas of the facility and use is monitored. Audits are completed and reported as part of the regular audit of the infection control. The need for standard precautions is assessed at presentation to the service. Where a patient has a communicable disease, they are requested not to attend or if the procedure is urgent then the patient is booked for the last of the day. Standard precautions are in place and embedded in the everyday activities of the practice. This in included in the policy. Hand Gel is readily available in all areas of the facility and use is monitored. Audits are completed and reported as part of the regular audit The Risk Management and Compliance Policy (07) provides guidance to the organisation in relation to consideration of risks in organisational decision-making and the application of a systematic process of identification, reduction, management and reporting of risks is vital to the achievement of strategic objectives.

Preventing and Controlling Healthcare Associated Infections
The Risk Register for the Oral Wellbeing program 2018 consists of both strategic, operational and clinical risks. These are all risk rated and have mitigation or control strategies aligned to each item. The need for transmission based precautions is assessed at presentation to the service. Where a patient has a communicable disease, they are requested not to attend or if the procedure is urgent then the patient is booked for the last of the day. This is embedded in the policy The use of antimicrobials is limited to prescription only. There are none administered during procedures. The use of clinical guidelines consistent with Therapeutic Guidelines: Antibiotic. Version 15 and Therapeutic Guidelines, Oral and Dental Health. Version, 2012. Where patients identify a previous adverse reaction to a generally prescribed antibiotic, alternatives are found according to the therapeutic prescribing guidelines. Access to the therapeutic guidelines on antibiotic usage either as printed or electronic resources is provided for all clinicians authorised to prescribe was evidenced during the assessment. The use of antimicrobials is limited to prescription only. There are none administered during procedures. Where patients identify a previous adverse reaction to a generally prescribed antibiotic, alternatives are found according to the therapeutic prescribing guidelines. Policies and procedures are in place for environmental cleaning and waste management Cleaning audits undertaken regularly with a checklist developed specific to the needs of the organisation. Cleaning is a contracted service. This is all based on Australian Guidelines for the Prevention and Control of Infections in Health Care Policy 2010 and there are service specific policies in place with an appropriate review date. Material Data Sheets were evident for all chemicals used in the practice. PPE is readily available and part of the audit program. There is a Cleaning Service Agreement for each site which defines the areas to be cleaned. The cleaning audit report stated that "Out of a total of 85 elements across the four clinical areas,81 were satisfactory. This represents an overall compliance rate of 95%, well above the acceptable threshold level of 85% for High Risk Category B rating". There are checklists / inspections which verify that cleaning is being carried out to an acceptable standard as required and according to relevant legislation and infection control standards. The Clinical manager is responsible to initiate and ensure that the corrective / preventive actions are implemented if an item fails to attain an acceptable standard. There are appropriate processes to undertake cleaning, disinfection and sterilisation of reusable equipment. Non Critical items are wipes with CLIN ell towels which is consistent with the requirements of TGO 54. There is a steriliser on site which monitors validation and compliance. The service also audits the sterile stock integrity and supply. The sterile stock cupboard has been redesigned to ensure that no dust accumulates. There is a traceability system to the tray and a copy of the batch is placed in the clinical record. All staff have a minimum of Certificate 3 Dental Assistant which incur[incorporates sterilisation for Dental services There is a specific dental brochure regarding infection risk and this has been translated into the common languages Feedback was sought on the brochure before it was published. The tooth extraction information is in easy read format and addresses the issues of fever and infection.

Improvement action

Link Health and Community meets the requirements of Standard 3 and because Standard 3 is fully conforming there are no improvement actions.

STANDARD 4

Overview

Medication Safety

The service has implemented governance arrangements for medication safety that include roles and responsibilities, reporting lines and mechanisms for identifying risks and measuring improvements in the medication management process.

Medication used are limited to local anaesthetics, injectable anaesthetics, fluoride, saliva substitutes and adrenalin for emergency. All other medications are prescribed.

There is a medication management policy which is consistent with DHVS medication safety requirements. The Medication Safety Procedure (7.9) guides staff to implement and monitor a comprehensive medication safety system to reduce the occurrence of medication incidents and improve the safety and quality of medication management.

These policies, procedures, protocols and guidelines accessible to the workforce which includes, the use of the Therapeutic Guidelines for prescribing and procedures for administering medicines.

Link Health and Community OWB has completed an assessment of the medication management system to assess the safety of medication practices and identify areas for improvement. As a result of this the full pharmacopeia has been reviewed and changed to reduce the number of medications and to minimise waste

All patients have a risk assessment prior to commencement of treatment inclusive of a full medication history.

The Risk Management and Compliance Policy (07) provides guidance to the organisation in relation to consideration of risks in organisational decision-making and the application of a systematic process of identification, reduction, management and reporting of risks is vital to the achievement of strategic objectives.

The Risk Register for the Oral Wellbeing program 2018 consists of both strategic, operational and clinical risks. These are all risk rated and have mitigation or control strategies aligned to each item.

Prescribing is the role of the Dentist and part of scope of practice. The NPS Online training on Medication Safety is mandatory for all Dentists.

Medications are audited as part of the file audit. There are 10 files audited for each practitioner every 6 months.

There is a defined reporting and management framework that ensures that incident data is utilised to optimal effect

Incident management is incorporated into the audit program. Evidence of regular review found in the Board Minutes and papers 2018, Safety and clinical Governance committees 2018 and Quality and Safety Committee.

Incidents are reported to the Clinical Manager and documented in the incident management system. There have been no medication incidents in the last 12 months. Policies are in date with a review date. Evidenced in the Oral Well Being Action Log 2017. Compliance notices are distributed to staff such us use of Neutrafluor. Medication management is part of the clinical audit program.

The service uses the Dental Board of Australia Dental guidelines on dental records.

The dental record system is electronic and is available at the point of care. A review of records during this assessment confirmed all records had a medical history, correspondence from other healthcare professionals where appropriate, examination and test results, radiographs, treatment options, treatment plan and the informed consent.

There is a comprehensive medication history completed for all patients and is inclusive of medications taken both prescribed and non-prescribed. This is all entered onto the medical record

The service uses the Dental Board of Australia Dental guidelines on dental records.

The dental record system is electronic and is available at the point of care. A review of records during this assessment confirmed all records had a medical history, correspondence from other healthcare professionals where appropriate, examination and test results, radiographs, treatment options, treatment plan and the informed consent. Noting of allergies was found in all clinical records reviewed

There have been no reportable adverse reactions in recent years however appropriate processes are in place to monitor this.

The service has a system to report adverse drug reactions within the organisation and to the Therapeutic Goods Administration (TGA) however there have been no reportable incidents in recent years.

The service implemented up-to-date clinical information and decision support tools that guide the workforce with responsibilities in providing safe and effective medication management. The MIMS and appropriate therapeutic guidelines are available electronically to all clinical staff.

Decision support tools are kept up to date and consistent with Australian Therapeutic Guidelines.

Medication Safety
There is an organisation-wide definition of the elements of quality for clinical services in relation to effectiveness, safety and consumer experience.
The structure of the organisation's quality management system has been reviewed to align the clinical quality objectives to the vision, mission and values for Link Health and Community
There is a coherent, planned and systematic schedule of audits of clinical and organisational systems, and reliable processes to capture findings and implement necessary improvements
This is evidenced by: The Quality Management Policy (5), The Quality Planning, Improvement and Review Procedure (5.1), Business Case Procedure (5.2), and the Evidenced-Based Practice and Research Procedure (5.2), the Quality and Clinical Safety Committee Meeting – Action Tracker 2018, and Workplace Health and Safety minutes and procedures.
The structure of the organisation's quality management system has been reviewed to align the clinical quality objectives to the vision, mission and values for Link Health and Community
Incident management is Incorporated into the audit program. Evidence of regular review found in the Board Minutes and papers 2018, Safety and clinical Governance committees 2018 and Quality and Safety Committee.
The Medication Management Policy outlines procedures and work practices for the disposal of unused, unwanted or expired medicines as per the requirements of DHSV.
The pharmacopeia has been recently reviewed to decrease the stock holding to reduce wastage. Expired stock is disposed of appropriately and with scheduled medications these are returned to the supplier or destroyed in the presence of the Clinical Director.
There are very few high risk medications used. An example of such medication is the use of adrenalin for anaphylaxis where a protocol has been developed.
All discharge medication is by the provision of prescriptions to the local chemist. CMI information is given by the pharmacist or by the Dentist The service does not change any pre-existing medication plans. The service does not change any existing medications. Discharge medication is restricted to antibiotics and analgesia both of which are time limited.

Improvement action

Link Health and Community meets the requirements of Standard 4 and because Standard 4 is fully conforming there are no improvement actions.

STANDARD 5

Overview

Patient Identification and Procedure Matching
There are comprehensive patient dental records that include completed medical/medication history sections.
The audit of patient dental records to demonstrate that people at increased risk are being appropriately identified
There are procedures of protocol for identifying patients who are at an increased risk of harm with particular reference to oncology patients, complex needs patients, those patients on bisphosonates, anticoagulants, dementia, diabetes and many others.
All high risk patients are flagged in the clinical record.
There is a defined reporting and management framework that ensures that incident data is utilised to optimal effect
Incident management is Incorporated into the audit program. Evidence of regular review found in the Board Minutes and papers 2018, Safety and clinical Governance committees 2018 and Quality and Safety Committee.
The service has a set of policies, procedures and audits around patient identification. All incidents around patient identification are raised at the clinical safety and quality committee
The service uses at least three unique identifiers including medical record number, date of birth, address and name.
Link Health and Community uses the data from the incident reporting system to recommend and prioritise quality improvement activities. All incidents are reviewed by all clinical committees and aggregated data is reviewed at the Board. Should there be an incident appropriate system are in place to analyse, review and communicate to the members of the service.
The communication process, also used in the context of clinical handover, assists in reinforcing patient identification requirements. These tools are audited for compliance on a regular basis in addition to the clinical handover

Patient Identification and Procedure Matching
observational audit which includes patient identification components. Outcomes of audits indicate that high levels of compliance with patient ID during the clinical handover process. The service has a policy in relation to clinical handover and procedure matching. Team Time Out is an established part of the pre-procedure process. Patient mismatching events are entered into the incident management system and managed appropriately.

Improvement action

Link Health and Community meets the requirements of Standard 5 and because Standard 5 is fully conforming there are no improvement actions.

STANDARD 6

Overview

Clinical Handover
The Oral Health Clinical Handover and Referral Procedure 2015 outlines responsibilities for effective clinical handover. ISBAR is the tool for clinical handover and clinical handover is included in the audit program. The service has identified the key points where clinical handover occurs and these include, Continuing care by same clinician at next visit, Change of treating clinician, Escalation of a complex case to a supervising clinician, Referral to Royal Dental Hospital Melbourne, Referral to another external provider and Referral to an internal provider A review of 10 clinical records demonstrated that all records had "handover to next visit". This enables any staff member to know and understand what the dental management plan is. Clinical handover is embedded into the orientation program for all the clinical workforce. Regular review occurs of the Clinical Handover Policy and handover tools to ensure that best practice is up to date within the service. There are policies to support clinical handover are based on clinical handover-key standard principles. There are local protocols support all clinical areas where clinical handover or transfer of care is required. These are all in date with a review date. Clinical handover has been reviewed systematically across the organisation, with audit of every point of handover. There is an organisation-wide definition of the elements of quality for clinical services in relation to effectiveness, safety and consumer experience. The structure of the organisation's quality management system has been reviewed to align the clinical quality objectives to the vision, mission and values for Link Health and Community There is a coherent, planned and systematic schedule of audits of clinical and organisational systems, and reliable processes to capture findings and implement necessary improvements This is evidenced by: The Quality Management Policy (5), The Quality Planning, Improvement and Review Procedure (5.1), Business Case Procedure (5.2), and the Evidenced-Based Practice and Research Procedure (5.2), the Quality and Clinical Safety Committee Meeting – Action Tracker 2018, and Workplace Health and Safety minutes and procedures " All issues and incidents relating to clinical handover are reviewed by the via the committee and management structure. All Complaints received are reviewed by the Director of the Oral Well Being service and where necessary the complaint is to an external body. A report is generated monthly to the Board. There are few complaints however, those reviewed demonstrate effective and transparent management consistent with best practice complaints management. Feedback is provided to all staff regarding complaints management.

Improvement action

Link Health and Community meets the requirements of Standard 6 and because Standard 6 is fully conforming there are no improvement actions.

CONCLUSION

This assessment has confirmed that Link Health and Community functions to deliver services that promote quality service provision and services are provided in accordance with the criteria for each NSQHSS. The assessment has found that the overall intent of the HSS is being met and also that three actions need to be taken to fully comply with each HSS criteria.

An improvement plan is included in the HDAA assessment system that is provided to the service and can be referenced in the relevant worksheets. There are also worksheets for general observations.

Noting improvements identified in this report, it is the view of the assessors that the intent of the NSQHSS have been met and Link Health and Community should be certified to NSQHSS. Link Health and Community should address the improvements identified for HSS within required time frames in order for certification to HSS to be attained.

2.6 SERVICE SITES SAMPLED

The following provides a list of sampled sites. A detailed description of all sites can be found in the excel worksheet titled "Description" that accompanies this report:

SITE LOCATION	SERVICE STREAM (OUTPUT GROUP)	NUMBER OF STAFF (EFT)	NUMBER OF CLIENTS
Level 1, 9-15 Cooke Street Clayton Victoria 3175	Child Protection and Family Services	3.2	161
8-10 Johnson Street Oakleigh Victoria 3166	Child Protection and Family Services	1.8	104

2.7 AGGREGATE RESULTS OF FILE REVIEWS

The following is a summary of the results of the client file reviews

NUMBER OF FILES REVIEWED	LEVEL OF ATTAINMENT			
	LESS THAN 25%	26 – 50 %	50 – 75 %	75 – 100 %
20 HSS + 10 NSQHSS =30				30

The following is a summary of the results of the staff file reviews

NUMBER OF STAFF FILES REVIEWED	LEVEL OF ATTAINMENT			
	LESS THAN 25%	26 – 50 %	50 – 75 %	75 – 100 %
3 NSQHSS + 6 HSS = 9				9

2.8 AGGREGATE STAKEHOLDER FEEDBACK

The following is an aggregate summary of stakeholder feedback.

Numbers interviewed		Summary of overall feedback:
Clients interviewed	10	• Clients expressed high levels of satisfaction with supports and service provision. Goal-centred plans were discussed and ongoing review of goals was deemed to be much appreciated by those who participated in discussions. There were mixed levels of awareness in relation to the complaints management process, and confirmation that information packs are provided.
Senior Management interviewed	4	• Senior management demonstrated good levels of awareness of requirements for HSS and NSQHSS and were able to provide information on their client groups and associated needs.
Staff interviewed	15	• Staff demonstrated an awareness of their roles and spoke of the need for people's safety and empowerment to be acknowledged within all service and program types. Safety screening checks were verified as needed prior to commencing employment.

2.9 CERTIFICATION OUTCOME

On the basis of sampling, discussions with management, staff, customers, as well as a review of staff and customer documentation, it is the opinion of the assessors that, Link Health and Community has actions with three indicators is required to fully meet the requirements of the Human Service Standards (HSS. All requirements of the National Safety & Quality Health Service Standards (NSQHSS) and met and accreditation to the NSQHSS.

It is the view of the assessors that Link Health and Community should:

- Be awarded certification to the Human Services Standards after the criteria identified as non-conforming are determined to be conforming within the stated timeframes; and
- Be awarded accreditation to the National Safety & Quality Health Service Standards for dental services (Standards 1 to 6).

Role	Name	Signed	Date
Lead assessor	Cheryl de Blaquiere	C deBlaquiere	21 August 2018

This report has been reviewed by the Certification Evaluator and the Certification Evaluator confirms that: (a) the information provided by the assessment was within the scope for certification and meets certification requirements; (b) the effectiveness of correction and corrective actions has been accepted and verified for nonconformities in the following situations: (i) failure to fulfil one or more requirements of the management system standard, or (ii) in a situation that raises significant doubt about the ability of the organisation's management system to achieve its intended outputs; and (c) the organisation's planned correction and corrective action for nonconformities is adequate.

The Certification Evaluator has reviewed this assessment report for Link Health and Community Limited and the recommendation of the assessor, and in accordance with evidence, report, ratings, and attainment principles, confirms that Link Health and Community Limited should:

- be awarded certification to the Human Services Standards after non-conformities are closed out within the required timeframe.
- be awarded certification to the National Safety & Quality Health Service Standards (Standards 1 to 6).

Role	Name	Signed	Date
Certification Evaluator	David Hamer		7 September 2018

2.10 CERTIFICATION CONDITIONS

The following sets out the certification timeframes and conditions of certification for Link Health and Community:

Standard	Initial certification date	HSS progress report due date	Mid-term maintenance assessment due date	Certification expiry date
HSS	19 November 2015	Prior to 18 November 2018[1]	Prior to 16 August 2020	(If certification is granted) 18 November 2021
NSQHSS		Not applicable		
Certification is subject to the following conditions				
The certificate remains the property of HDAA Australia Pty Ltd. Link Health and Community Limited is not to use this certificate or its certification in such a manner as to bring HDAA into disrepute nor should it make any statement regarding this certification which is misleading. Link Health and Community Limited is to inform HDAA Australia Pty Ltd of the following changes to its business or events: (a) a change to is legal status, (b) change of ownership, (c) transferring services to new site or premises (relocation), (d) the closure of any site or cessation of service type, (e) adding in any new sites or service type, and (f) any serious event that requires that a statutory body is notified. Should any of the above events occur, HDAA may, at its discretion conduct a follow-up assessment to confirm adherence to the requirements of certification.				

3. ASSESSMENT PLAN

3.1 ASSESSMENT OBJECTIVES

The objective of this assessment is to determine the organisations functioning in relation to the stated standards by determining the effectiveness of service delivery and the achievement of outcomes as guided by the organisation's funding agreement.

The key steps for the assessment are described in the Assessment Methodology section detailed below.

3.2 ASSESSORS

An assessment team was established to undertake the assessment. The assessors were:

[1] Note: Normally there is a 6 month period but because certification expires on November the improvement actions need to be determined to be conforming prior to that date.

1. Cheryl de Blaquiere – Lead Assessor - Master of Commerce; Diploma of Governance; Diploma of Quality Auditing; Exemplar Global QMS Lead Auditor; Teaching English as a Second Language (TESL) particularly Business English. Cheryl has experience with a broad spectrum of non-profit services and is currently the Governance Manager at a large inner Melbourne community health centre. Governance and Financial Accounting are key arenas that are underpinned by Cheryl's qualifications with her corporate expertise being complemented through extensive experience as a qualified lead assessor. Cheryl provides assessments for community services, disability services, and human services organisations to the HSS, ISO 9001, NSDS, NSQHSS and HSQS quality frameworks and standards requirements. Cheryl values the ethos of Quality Auditing and the opportunity it provides to support organisations in continuous improvement.

2. Chris Coombs – Support Assessor - Adjunct Professor Chris Coombs is a Registered Nurse and Midwife of over 30 years' experience. Her qualifications include Bachelor of Health Science, Masters of Nursing with a major thesis on quality and change management. Chris's career has included time as senior Director of Nursing in large rural hospitals and employment in small community hospitals services managing a wide range of clinical and administrative services and teams including mental health and aged care. Chris's areas of interest are quality, risk management and investigations. Chris is an experienced health service assessor particularly in the National Safety and Quality Standards and National Mental Health Standards and with the Diagnostic Imaging Accreditation Scheme (DIAS).

3.3 ASSESSMENT METHODOLOGY

The service was provided with information prior to the certification assessment. A two day onsite assessment was scheduled. The onsite assessment included:

1. Initial briefing meeting.
2. Interview discussions with staff.
3. Interview discussions with management, financial manager.
4. Individual meeting discussions with people accessing services and or family members.
5. Individual phone calls or surveys with people accessing services and or family members.
6. Review of a relevant sample of documentation and records.
7. Review of a sample of service users' records and service delivery plans.
8. Service overview tour and observations.
9. Debriefing meeting.
10. Provision of a draft report to the organisation and receipt of feedback.
11. Finalising of the report and distribution.

3.4 DESCRIPTION OF SAMPLING APPROACH WITH THE SERVICE

Noting that people accessing the service have the right not to be involved; sampling is based on the service description and deed of agreement requirements. The aim of the sample is to get a reasonable representation of the service. Sampling is an estimation of the characteristics of the service and does not necessarily identify all variance from the standards assessed. The following sampling has been applied:

- The "Central Office".

- The square root of the number of sites. Sampling for community residential care units or out of home care residential units is as follows: (a) 1 unit = 1 unit visited; (b) 2 to 5 units = 2 units visited, (c) 6 to 10 units = 4 units visited, (d) over 10 units = 6 units visited.
- If community residential units and out of home care residential units are managed from the one office, the sampling is applied separately to community residential units and the out of home care residential units.
- If more than one office manages community residential units and or out of home care residential units, the sampling methodology above has been applied separately to the units managed by each office.
- At least two people accessing services per site and per program.
- The sample is determined as 25% of the square root of the number of people accessing services, rounded up.
- The sample is stratified to include files from each service based on their relative size.
- The sample of files is the rounded up square root of the total number of people accessing services with a minimum of 5 files per site reviewed.
- Access to a sample of staff files.

3.5 ASSESSOR TIME ONSITE

The total time taken to coordinate and complete the assessment is equivalent to 49.25 full-time person hours. Time taken to complete each part of the assessment is as follows:

Assessment

DATE OF VISIT	TIME ONSITE	NUMBER OF ASSESSORS	HOURS ONSITE
15 August 2018	9:00 – 5:00 pm	2	16 hours
16 August 2018	9:00 – 4:00 pm	2	14 hours
TOTAL TIME ONSITE		30 hours	

Report write-up

ROLE	HOURS REPORT WRITE UP
Lead Assessor	4 hours
Support Assessor	4 hours
TOTAL HOURS REPORT WRITE-UP	8 hours

Pre and post assessment planning and administration

PLANNING, ADMINISTRATION, REVIEW AND CERTIFICATION	11.25 hours

3.6 CLIENT INVOLVEMENT

The following number of client interviews and file reviews occurred.

NUMBER OF SERVICE USERS INTERVIEWED	NUMBER OF SERVICE USER FILES REVIEWED
10	30

3.7 STAFF AND VOLUNTEER INVOLVEMENT

The following number of interviews and file reviews occurred.

NUMBER OF STAFF INTERVIEWED	NUMBER OF STAFF FILES REVIEWED
15	9

3.8 ASSESSMENT FINDINGS AND REGISTRATION

The assessment team assessed Link Health and Community against the HSS and NSQHSS according to the following scale:

HSS	NSQHSS	Description
Conformity	**Met**	The requirements of a standard, or an element associated with a standard such as a KPI or indicator, are met.
Non-conformity	**Not-met**	The requirements of a standard, or an element associated with a standard such as a KPI or indicator, are not fully met, or the outcome is only partly effective.
Major non-conformity	**Not applicable**	The requirements of a standard, or an element associated with a standard such as a KPI or indicator, are not met, or the outcome is ineffective. A number of related nonconformities may also constitute a major nonconformity.

4. NEXT STEPS

After receiving this report and the accompanying worksheets, the service responded to the improvements by completing the improvement plan and scheduling action in relation to the identified improvements. The service was able to provide additional supporting information where it believed that the identified improvement action was incorrect.

The service was also provided with the opportunity to review the overall report and provide feedback in relation to the report and evidence. This feedback was considered as part of the process of finalising the report.

The level of development required and the service situation (including any imperative for certification) will determine the timeframes for the HSS improvement action but this should be prior to the current certification expiry if certification is to continue.

A progress report providing an update on progress with identified improvements should be sent to HDAA no later than indicated in section 2.10 of this report.

It is recommended that re-assessment occurs no later than 3 months before to the expiry of the certificate or if registration expires within that 3-month period, then re-certification should occur 3 months prior to expiry of registration.

5. CONCLUSION

We aim for the assessment to be a positive helpful and developmental experience for you as a service and for the individuals involved. So please do contact us if you have any questions and we will do all we can to assist; for instance, if you need additional information then we more than likely have in our library, or if you need us to explain any point in the report or relating to the assessment and standards.