Quality and Compliance Policy & Procedure

Statement
St Giles Society Limited (known as the Organisation hereinafter) is committed to continually improving the quality of its services in order to achieve its goals and strategic outcomes, and be inclusive and responsive to participants, staff, volunteers, stakeholders and the wider community through the operation of a quality management system. The Organisation operates in accordance with the requirements of ISO 9001:2015, Australian Community Industry Standard (ACIS) 2016 and the NDIS Practice Standards and as detailed in the Organisation's Quality Manual.

The Organisation operates within the requirements of all relevant Tasmanian and Federal legislation.

Purpose and Scope
The purpose of this policy is to ensure the Organisation's quality and compliance objectives are known, shared and achieved by staff, with a commitment to ensuring that all documents comply with legislative requirements and are controlled for the effective operation of the Quality Management System.

Definitions and Acronyms
Accreditation - is assessment by an external body or agency to determine the level of compliance with agreed standards.

Continuous Quality Improvement (CQI) - ensures continuous cycle of monitoring activities to ensure our aims are met, measure our effectiveness in meeting them, identify and implement improvements.

Improving Performance - is continuous study and adaptation of processes in order to achieve desired outcomes and meet the needs and expectations of members, participants and stakeholders.

Quality - is the extent to which the properties of a service or product produces a desired outcome.

Quality Improvement - is the process of continual review of the Organisation, its structures and functions of governance, management, engagement with participants and other stakeholders and its service delivery.

QMS – refers to the term Quality Management System

Documents - are defined as electronic or hard copy text based objects that contain information on the Organisation's activities and process related requirements, including:

- Policies & Procedures
- Forms /Templates
- Position Descriptions
- Standard Operating Procedures
- Assessments
- Manuals
- Information
- Uncontrolled Documents
- External Documents

Participant – Any person (child or adult) to whom the Organisation provides a service.

Staff – People who perform duties as directed by an organisation. Staff include employees, volunteers and contractors.

Employees – People who are paid wages or salary by the Organisation to perform duties

Amendments
This policy will be reviewed and updated on an as-needed basis, and input is encouraged from Board members, employees and volunteers to advise the Organisation's Quality Manager of any changes required.

Responsibilities
It is the responsibility of Board members, casual, permanent and contract employees and volunteers to adhere to the Quality Policy & Procedure at all times.

Quality Manager
- Coordinates the quality improvement process and system,
- Ensuring that the Quality Management System operates in accordance with the requirements of certification standards and that all processes are controlled, monitored (internal quality audits), measured, reviewed and improved.

Managers and Supervisors
- Supporting staff to coordinate continuous quality improvement systems and practices.
- Participating in, and leading quality improvement activities within the Organisation
- Providing leadership and resource support to quality improvement activities; completing self-assessment audits and documentation.
- Updating staff on processes and procedures.

Employees
- Actively participating in internal and external activities of continuous quality improvement.
- Leading quality improvement activities as relevant.
- Promoting and demonstrating commitment to quality improvement.
- Assisting management to carry out tasks related to quality improvement and accreditation.

Quality and Compliance Objectives
The Organisation's quality and compliance objectives are to ensure that services and resources operate in a consistent and effective manner to:
- Ensure that the Organisation maintains accreditation to ISO 9001:2015 (St Giles specific), ACIS 2016 (ARC specific) and the NDIS Practice Standards.
- Ensure compliance with relevant Legislation and Regulations.
- Ensure compliance with, and meet obligations of the NDIS Terms of Business, Funding and Service Agreements and contractual arrangements.
- Ensure a focus on improving outcomes for participants of the Organisation's services, based on evidence-based practice.
- Identify areas of improvement, and following implementation, measure and monitor these to ensure that service is enhanced and improved.
- Ensure a culture of continuous quality improvement exists, and support staff participation in quality related activities.
- Identify and implement quality activities which are in line with the Strategic Plan and Service Area Plans.

Policy
The Organisation undertakes quality improvement activities based on the process of:
- Monitoring;
- Assessment;
- Action;
- Evaluation; and
- Feedback.

The Organisation's outcomes and objectives as outlined in the strategic plan should be considered in all stages of quality improvement.

The Board, Senior Leaders and Management of the Organisation view risk management as an integral component to the strategic and operational objectives of the Organisation and that risk management is a fundamental element of sound organisational management and continuous quality improvement. A culture of quality improvement will enhance service delivery and as a result participant and stakeholder satisfaction.

Monitoring
The Organisation routinely collects information on its services to identify progress, achievements and areas of improvement. This information is collected through a variety of mechanisms including surveys, participant feedback, interviews, literature reviews, audits, observations and policy/record/system reviews.

Assessment
Analysing information from the monitoring stage can provide an assessment of the current situation and identify the best approach to take for improvement. Individual assessment activities and recommendations that come from assessment activities are shared with relevant staff through staff or team meeting presentations, group discussions or other suitable mechanisms to communicate findings and reach an agreed approach for subsequent improvement activities.

Action
Through the assessment phase, quality improvement actions should be decided upon and/or prioritised. If the activity requires financial resources, an adequate budget should be identified before the activity commences. Similarly if the activity requires significant time/human resources, discussions should take place with management prior to commencing.

Suitable and practical solutions should take into account the needs of the Organisation, participants, staff and stakeholders that may be affected. Actions may range from procedure documentation or policy development to system redesign or creation, e.g. electronic filing.

Evaluation
Once the action has been taken, individuals involved should evaluate the results of that action to ensure the required result was achieved. Key questions to ask in evaluating an activity include:

- Did the action achieve the desired result or outcome?
- Is there any further action to be taken in this area?

Evaluation information should be collected in a similar way to monitoring information.

Feedback
All individuals involved in, or affected by, quality improvement actions/activities are made aware of changes implemented and the results of these activities (to both internal and external stakeholders). Communication at all stages is critical to achieving sustainable results, participant satisfaction and facilitating Organisational change.

Document Control
In order to achieve continuous quality improvement, the Organisation maintains an internal Quality Management System that oversees and controls all documents issued by the Organisation. This is undertaken through a process of development, review, distribution & implementation, access, use, storage and archiving. The Quality Management System is monitored through the use of a Document Control Register and access to controlled documents is available to all staff via the Organisation's intranet.

The Organisation establishes and maintains a record management system to provide evidence of conformity and effectiveness with the QMS. Records are legible, identifiable and protected, with procedures to control their retention, retrieval and disposal.

Records include both paper based and electronic records. Documented procedures are established and maintained to describe what records are to be kept, where to keep them, how long to keep them for, who is responsible for their disposal and whether they are hard copy or electronic media.

Quality records are those records generated through the performance of a function or activity that provides evidence that the service does conform to planned requirements.

Controlled documents have controlled identification and controlled distribution within the Organisation.

Identification

All documents in the QMS include:

- Approved logo of St Giles, ASELCC and/ or ARC logo,
- Document identification,
- Version number,
- Authorised by the QMS Team,
- Date of issue or re-issue, and
- Are formatted in controlled styles and layouts.

Authorised Fonts:

- It is preferential that all documents and handouts are presented in Arial, size 11. There may be circumstances where exceptions to the size used is authorised by the QMS Team.

Document Usage and Layout:

- Where paper documents are issued, only forms are to be copied using a master copy retained for that purpose.
- Where documents are issued electronically, only one electronic file, nominated by the Quality Management Team, is deemed to be a controlled copy. Forms are to be printed from the electronic controlled copy only.
- Controlled documents will have the following layout:
    - Relevant Organisation Logo's (header, far right corner)
    - Document Identification and Version Number: (footer, far left corner)
    - Authorisation: (footer, left of centre)
    - Issued/Re-issued: (footer, right of centre)
    - Page Number: (footer, far right corner)
- Where external documents are used, the original identification from the source is retained and not modified.

Access to Documents

Controlled documents are listed in the Document Control Register, with the following information.

- Type of document
- Document identification
- Version number
- Title of document
- Work area that the document relates to
- Approval by the relevant Manager
- Authorisation by the QMS Team
- Date of issue
- Next review date
- Reason for amending a document or registering a new document

Document Changes and New Documents

Changes and amendments to documents and the development of new documents may be made as a result of:

- Suggestions by staff, participants or other interested parties
- As outcomes from work teams or process improvement teams
- New or improved services being offered
- The internal/external quality audit process
- The policy and procedure review process

Procedure for Document Control
All requested changes to controlled documents must be submitted to the Quality Management Team by emailing qms@stgiles.org.au. Please attach the document to be registered.

The Quality Management Team will review the request, conduct research if required and then prepare the document. In some cases a draft of the changed document (watermarked with draft) may be presented to Senior Leadership or the Organisation's Board for consideration and approval; otherwise the document can be registered at the discretion of the QMS Team.

New documents are developed using the same process.

Before distributing new or amended documents the following process must be completed:

- A copy of the document is saved in the master QMS folder,
- The document is listed on Document Control Register
- The document is added to the Document Listing spreadsheet for the Intranet and then uploaded, and
- The website is updated where applicable.

Distribution
New and amended documents are distributed by the QMS Team to the Manager requesting the document, for final approval. On finalisation the QMS Team will share the new or amended document with appropriate individuals within the Organisation. For example, Organisational policies and procedures are shared with all staff, however, work area specific policies and procedures are only shared with staff and Managers within that area.

Staff are required to confirm via a read receipt or acknowledgement form that they have read and understand the contents of the document being shared.
New and amended policies and forms may be presented at relevant staff meetings, shared with staff via email in the form of Policy of the Month, or as part of a Memo. In certain circumstances documents maybe mailed out to all staff.

Review
All controlled documents are to be reviewed every three years (or sooner if required.) Review dates are noted on the Documents Control Register. The QMS Team will send notification to the relevant Manager to review documents on the date noted. At this time the Manager can make any required updates or request for the document to be archived with reasoning provided. The QMS Team will note in the Document Control Register the date the document was last reviewed.

Document Storage, Retention Periods & File Disposal
Documents are maintained and archived securely, in accordance with the Privacy Policy and Procedure and Archiving Policy and Procedure. The QMS Team is responsible for ensuring the appropriate storage and archiving of quality documents.
Quality files are stored securely, with files that are greater than 7 years old to be considered by Managers for retention or disposal where legally possible, or for electronic conversion.

Archiving Controlled Documents
Obsolete or superseded hard copy documents are removed from circulation and the working environment and destroyed. Only one electronic copy of the last or superseded issue is archived for knowledge and preservation purposes. This copy is saved in the Archive folder within Document Control, and is listed in the Archived Documents section of the Document Control Register. The reasoning for archiving the document is listed, as well as the archive location. The removal of obsolete copies will occur during the distribution of the new or amended copies, as directed by the QMS Team or person who is issuing the document.

Regulatory Standards
Changes to regulatory standards shall be noted at the Board meeting or Senior Leadership Team meeting as they occur, and the impact of the changes discussed and reviewed. Any actions arising from the meeting are minuted and acted upon accordingly.

Relevant Legislation and Standards

- NDIS Quality & Safeguards Framework
- ISO 9001:2015
- ACIS 2016 Standards

Relevant Documentation

- Quality Manual
- Privacy Policy and Procedure
- Archiving Policy and Procedure
- Quality Management System (accessed via intranet)
- Document Control Register
- Risk Register and Management Plan
- Accreditation Reports
- Quality Improvement Report
- Quality Audit Form
- Participant satisfaction surveys
- Performance Management reports

Approved Logo's for Use include

- St Giles Society Inc.:
- ASELCC:
- Studio Space:
- Continence Clinic:

Document Changes Flowchart

Step 1

- Staff share any suggestions and proposed admendments to the identified document with their Manager.

Step 2

- The Manager considers and approves/modifies the recommended improvements and amendements to the identified document.
- The Manager sends the amended document to the Quality Management Team via email; qms@stgiles.org.au for actioning.

Step 3

- The Quality Management Team review the amended document and make any required edits and formatting changes.
- If significant edits are made, the Quality Management Team will return a draft version of the document to the Manager for final review and approval, before document controlling.

Step 4

- The Quality Management Team complete the Document Control process and update the Document Control Register, with appropriate Document Identification, Version number, Issued/Reissued Date, Authorisation details and anticipated Review Date.

Step 5

- The Quality Management Team upload the final approved version of the document to the Quality Management System via the intranet.

Step 6

- The Quality Management Team then send a confirmation email to the Manager, with a weblink to the document. Where apprpriate, the QMS Team will share the new or amended document with appropriate individuals within the Organisation, with a summary of its purpose and intended.
- Managers are responsible for implementing approved documents within relevant work areas and ensuring staff within their team read, understand and apply the document into their work practices.