Attachment C

Revised Plan of Management

Plan of Management – HammondCare Darlinghurst

July 2022

HammondCare
Champion Life

Plan of Management for HammondCare Darlinghurst

The context: HammondCare is an approved provider of Aged Care services and operate 1125 Residential Aged Care beds nationally. Darlinghurst is a Residential Aged Care facility for 42 people that will be approved to receive Residential Aged Care with licences allocated by the Commonwealth Government. The ground floor tenancy is operated by HammondCare and provides a social service. The service will be operated under the Aged Care Act 1997 and will be subject to that regulatory framework.

The complex histories of people who are homeless often involve social dysfunction, with residents potentially being distrusting of both staff and one another. To mitigate this risk, HammondCare will carefully consider the mix of residents on each storey of the home, by using validated assessment tools will be used, including the Care Planning and Assessment Tool, Psychogeriatric Assessment Scale, and Cornell Scale for Depression.

Many who have either slept rough or 'coach-surfed' for several years, sometimes have difficulty 'settling' into permanent residential care. To oversee transitions and to build trust with incoming residents, an Admissions Coordinator will work with other services that the person is accessing. As homeless people usually don't have family support, they will assist residents to obtain an ACAT assessment and access Centrelink support.

Once in care, a case management approach that is focused on knowing the individual and tailoring care for their needs will mitigate the risk of the person wanting to return to living as homeless. Even if the person does have some time away from the home, this will be managed flexibly in the context of knowing the individual resident.

Once in care, multi-skilled care staff will build trust with individual residents to understand and address underlying issues causing social problems.

HammondCare will work with street outreach services, including Rough Edges Café and Way2Home, to identify people who are sleeping rough and who would be possible residents of our new service. These relationships will be both prior to opening of the home and on an ongoing basis. HammondCare will assist those people identified as in need of residential care to obtain an assessment from the local Aged Care Assessment Team (ACAT).

These relationships will be used to refer people to our social club that can provide care for both those using the HammondCare Darlinghurst residential care service and those that may be able to stay outside of care but require referral to a social club.

Model of Care

HammondCare specialises in high-needs residential care, dementia care, psychogeriatric care, and caring for people with behaviours that are challenging to support.

Our Model of Care recognises people's dignity and autonomy, valuing their individuality and tailoring care to their needs. Our focus on is on building relationships with residents. A Clinical Care Manager will oversee care for all residents and maintain relationships with other services, including St. Vincents' Hospital and Catholic Community Services.

Staff will receive training to provide care for homeless people, including trauma-informed care, mental health and building resilience. Managers of the home will receive training from Wintringham, a specialist provider of aged care to homeless people in Melbourne.

A pastoral care worker and volunteer team will be assigned to the home. They will provide support to the residents in maintaining links with their own communities and cultural, spiritual and social practices.

As with our other residential care services, the building will be designed using the principles of a non-institutional, domestic environment. This will provide comfort, safety and security for residents and promote natural engagement with care staff. Store areas and dirty linen will be kept away from everyday care spaces, with hubs for these on the rooftop level and in the basement. As required, back-of-house items will be transported using a designated services lift. Another lift will be exclusively set apart for residents.

There will be multiple common and social spaces, including central kitchens available for use by residents, a ground floor social space and a rooftop garden. Residents will be able to cultivate plants and vegetables in the garden. The social space will allow residents and those accessing an out patient service a place to interact and develop skills.

While the focus is specifically on the aged who are homeless or at risk of homelessness, it is our expectation that many will have cognitive deficits as a result of one or more dementia-related illnesses. These are likely to include Korsakoff's Disease related to substance abuse and frontal-temporal dementia related to acquired brain injury. HammondCare's expertise in dementia care and psychogeriatric medicine means we will be well able to support such residents.

The building will be designed differently to HammondCare's dementia-specific aged care homes, reflecting the nature of the surrounding neighbourhood and the profile of residents. However, it will incorporate the same innovative design principles to promote dignity and independence, and help residents with dementia function at their best.

The building will provide comfort, safety and security for residents by creating a non-institutional, domestic environment. There will be a central kitchen on each floor. The sights, sounds, and smells that are reminiscent of 'home' are closely linked to the kitchen and it services as a familiar reference point for residents.

HammondCare's home will be innovative in its service delivery model, focusing upon trust between residents and staff to ensure individualised care. Developing trust is vital for all aged care services, but even more so for the aged homeless whose life experiences often mean they are wary of trusting others. The service delivery model will include:

- **Individualised care underpinned by case management.** Each resident in the home will be allocated a case manager who will build trust and work closely with the resident to help them achieve their goals. Care will be tailored according to the person's individual needs.

- **Relationship focus.** Staff will focus on building relationships with residents to understand the whole person; spiritually, physically, emotionally, and socially. Staff will encourage residents to be involved in their community and to participate in relationships that are meaningful and significant to them.

- **Comfort focus.** The service will focus on the comfort of the resident not expedient service delivery, facilitating continuity of care and supporting people even into palliative care.

- **Engagement.** Staff will seek to engage residents with things that are important to them. This will include music, art, exercise, and the special interests of residents'. Where possible, staff will facilitate offsite activities that are important to the resident, for example, going to a sports game, going fishing, etc.

- **Empowered staff.** HammondCare will empower staff to pursue the best outcomes for residents. The service will have a multi-skilled staff model in which staff are involved in every aspect of resident care, including medication management, personal care, case management, and everyday tasks like cooking

and cleaning. Staff are involved in residents' lives, building trust and facilitating care in a relational context.

- **Use of environment (physical and social).** The built environment will be optimised for older homeless people. This environment will include an open 'common terrace' running through the central area of each floor, contributing to resident comfort by maximising a feeling of open-air living important to people who have spent time on the streets. Staff will use spaces like the rooftop garden and ground floor café to socially engage with residents.

The aged care home will be staffed with an approximate ratio of one care worker for every four residents. When staff commence, full availability is recorded and working hours are aligned to demand. Flexibility is supported by a part-time workforce (with capacity to work additional hours subject to demand) accommodating short-notice changes (e.g. sick leave).

Care workers will be supported by a multi-skilled staff team including Clinical Care Manager, Registered Nurses, General Practitioners, and specialist health professionals, including nutritionists, psychologists, psychiatrists, psycho-geriatricians, occupational therapists and social workers.

Staff won't just do things for residents, but will involve them in activities of daily living such as cooking in the kitchen or cultivating plants at the rooftop garden. A 'no locks' policy during daytime hours will promote independence and allow residents to choose how they spend their time in the service and the community. Staff will avoid 'blanket rules' and will focus instead on developing trust with individual residents. Re-ablement will be supported through time-limited interventions targeted towards a person's specific goals. This may include educational programs around healthy eating, financial management, and drug and alcohol use, all of which would be facilitated on-site with specialised educators.

Clinical expertise and case management enable early identification and management of changing care needs. On admission and ongoing, assessment data will be used to identify and prioritise care needs and produce care plans in collaboration with residents. Assessment information will be integrated from many sources, including residents, ACATs, GPs, geriatricians, psychogeriatricians, community service providers and allied health professionals. We will observe residents' wellbeing daily and assess safety and function using tools appropriate to the resident. Re-assessments are conducted regularly and in response to observed changes in need.

Transition of Care

When residents require transition into or out of the home, for example to access acute care in hospital, HammondCare will ensure all relevant resident information is communicated accurately. We will remain in contact with health professionals to provide support, discuss ongoing care needs and promote return to our home as soon as practicable. Prior to and on return to the home, the resident's care plan will be reviewed to identify current care needs and support smooth transition.
Transitions will be further supported by:

- An Admissions Coordinator who will provide a central point of communication and will oversee internal resident movements within the home should care needs change
- Regular liaison with ACAT teams, GPs, hospitals and other health professionals for support and assistance in reassessment
- Documentation of medication administration, overseen by a multidisciplinary medication advisory committee
- Involving advocacy services to ensure resident autonomy is promoted

Continuity of care

HammondCare's expertise includes older person's mental health, dementia care, care for people with behaviours that are challenging to support, palliative care, community care and sub-acute hospital care. If the care needs of those in the Darlinghurst home change, or if people seeking care are not appropriate for the home, HammondCare may be able to offer services in its specialised dementia cottages, Special Care Unit for behaviours that are challenging to support, palliative care units or sub-acute older persons mental health units.

Security of tenure

HammondCare has a comprehensive policy supporting security of tenure. If a resident's care needs are unable to be supported within the home, the Manager in collaboration with the resident and relevant health professionals will identify the best outcome for the resident. Referral to ACAT, assistance with accessing and evaluating other services, and advocacy assistance will be provided.

Regards,

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