Community Care Options

Policy Manual

Section Three – Access and Service Delivery

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<u>APPENDICES</u>

Appendix 1 Case Management

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Section 3

ACCESS and SERVICE DELIVERY

3.1 Service Purpose, Philosophy and Outcomes

Our Vision

Creating a better future for our community through leadership and innovation.

Mission Statement

The purpose of Community Care Options is to support and facilitate improved quality of life and independence for people living within our community.

Philosophy

Community Care Options recognise the rights of people within the community to –

- accountable and responsive services;
- easy and equitable access to services;
- make choices in their own lives including decisions about their support needs;
- dignity, respect, privacy and confidentiality; and
- be valued as individuals.

Community Care Options also recognise the –

- obligation to provide a high standard of Case Management and direct services to their client;
- importance of an informal support network, particularly the role of carers; and
- need to observe duty of care and balance this sensitively with a person's right to self-determination.

Community Care Options also recognise the necessity to be aware of and sensitive to the differing needs of people –

- who are from Aboriginal or Torres Strait Islander backgrounds
- who have a disability and/or who are aged
- with cultural, spiritual and language differences
- who live in rural or social isolation
- who are financially disadvantaged
- with mental illness
- with dementia.

Organisational Values

The values of Community Care Options reflect the desire to achieve the following –

- respect and valuing of people as individuals
- to improve the quality of life of clients and carers
- to be guided by an ethical framework
- to operate in a professional way
- to encourage creativity & initiative.

We Value –

Creativity and initiative
Honesty and transparency
Options
Independence and professionalism
Community, connection, cooperation and collaboration
Equality

This means we –

- encourage innovative and dynamic ideas
- promote visionary thinking
- behave in a positive and friendly manner
- provide inspiration and encouragement

- act ethically and with integrity
- are open in our communications and share ideas
- accept responsibility and admit mistakes
- show trust and behave in a trustworthy manner
- share confidential information only where needed and with the permission of the person whose information it is
- protect and keep safe people's private information.

- set achievable goals and work towards them
- continually improve our performance in all areas of operations, striving for excellence
- show leadership
- reflect on our work practices and systematically improve them
- promote a learning culture and are willing to learn
- support and promote professional development
- observe collective and individual boundaries
- account for our actions.

- provide a high quality of services which improve clients' and carers' quality of life
- promote clients' independence
- centre the service on clients' individual choices
- support and empower people in their decision making
- observe our duty of care
- strive for continuity and consistency in service provision.

- treat people with respect and dignity
- respect people's individual way of life, belief systems, culture and views
- welcome diversity and behave in a culturally sensitive way
- treat people fairly
- uphold people's rights and support them to fulfil their responsibilities
- celebrate achievements
- consult people on issues concerning them.

Outcomes

Community Care Options will aim to achieve the following service delivery outcomes, through effective management –

- the clients of the organisation can remain in their own home;
- clients achieve a high degree of independence and quality of life;
- families or other primary caregivers are supported in their role;
- the organisation operates in an effective, efficient and accountable manner;
- people with complex care needs receive case management and flexible support;
- clients are consulted about what service they need and how services are delivered to them;
- clients can have appropriate cross-service referral;
- informal and formal caring networks are integrated;
- effective across service sharing of resources and reduced duplication, such as multiple assessment; and
- sub-regional equity between clients at similar levels of risk.

Schedule for Revision of Policy: SERVICE PURPOSE, PHILOSOPHY AND OUTCOMES				
Date Adopted	Outcome	Author	Next Review	Comments
1996	Adopted	A. Vaughan		
2001	Amended	A. Vaughan		
March 2003	Amended	A. Vaughan		
Nov 2005	Amended	N. Jut	Nov 2008	
	Reviewed & amended	D. Ryan		Dec 2008
16.1.2011	Reviewed & amended	D. Ryan	2013	
22.9.2014	Reviewed & amended	D. Ryan	Sept 2015	Review of mission, vision, values Business Name Change

3.2 Principles of Service Delivery

Position Statement
Community Care Options clearly articulates the principles under which it makes a commitment to operate. These include the principles and applications of the Aged Care Act and the Disability Services Act. We strive for recognition of the client and their rights, to provide options for informed decision making and choice and to encourage and support feedback.

Recognition
Community Care Options recognises the client as the central focus for our service delivery. The agency exists solely to meet their needs. All clients are individuals and therefore have different needs determined by age, gender, cultural background and life circumstances. All client's –

- have the right to make choices in their life;
- have the right to dignity, respect, privacy and confidentiality;
- have the right to access services on a non-discriminatory basis.

Community Care Options recognises that it is accountable to the Community.

Provide Options
Clients will decide which support options they prefer. CCO staff will provide client's/ carers with information, advocacy and assistance in obtaining other services and planning a support package in partnership with them.

This means that, within available resources, we will –

- work with the client to identify formal and informal support options which best meet their needs now and in the future;
- provide support which is tailored to the client's individual, cultural, emotional and physical needs and preferences;
- offer client's a choice of staff, day and time of service and activities;
- follow only a plan that has the agreement of the client (or that of their guardian);
- consult with client's before making any changes in their support plan;
- respect a client's right to refuse a service. This does not make it more difficult for them to get service from us at another time;
- regularly review the support with the client so that the service meets their changing needs;
- keep clear, up-to-date and relevant information about the client and their support;
- only share information with other people or agencies involved in their support if the client agrees to that;
- refer the client to other agencies for support if they wish us to do this;
- give the client a written support plan showing what services we agreed on;
- encourage and support the client to involve an advocate in their interactions with Community Care Options;
- check with the client from time to time to see if the service they are getting are still what they need, and change the support plan if they feel this is necessary or desirable. This will be done by their Support Planner or, in some cases, by

another nominated person.

Encourage Feedback
We will routinely ask the client for feedback on their support. The client's right to express dissatisfaction or make a complaint will be supported. Any compliant will be dealt with fairly, promptly, confidentially and without prejudice.

This means that Community Care Options will –

- regularly contact the client to check how their support is going and whether they want to make any changes or tell us about any problems;
- review their support plan with them at least every three months, or more often if they or their Support Planner thinks this is necessary;
- welcome criticism from the client, and from others. We recognise that criticism gives us information to help us perform and communicate better;
- seek the client's advice on the quality and nature of our support, so that we can use this information to improve our performance both for them and other clients;
- support the client, carer, guardian or advocate in making any complaint about Community Care Options;
- monitor and record all feedback and complaints, and review our policies and procedures accordingly;
- promptly, fairly, sensitively and confidentially respond to any feedback or complaints. If the client is unhappy with our response, we will tell them of other ways they can give feedback, criticism or make a complaint. We guarantee that the client will not be disadvantaged because they make a complaint;
- inform the client of any issues of concern raised about them and give them the opportunity to put their side of the matter, so that the problem can be resolved as soon as possible;
- help resolve any conflict about our service between the client, their family or friends if they ask us to do so;
- ask the client to help evaluate the effectiveness of service provision through regular written client surveys and through feedback to Support Planners during their visits or phone calls to the office.

Schedule for Revision of Policy: Principles of Service Delivery				
Date Adopted by Board	**Outcome**	**Author**	**Next Review**	**Comments**
28 May 2007	**Approved**	**Ruth Thompson**	**2009**	**New Policy**
May 2009	**Reviewed & Updated**	**Deb Ryan**		
August 2010	**Updated**	**Deb Ryan**		
September 2014	**Updated**	**D. Ryan**	**2016**	

3.3 Programs and Services

Position Statement
Community Care Option's core business is to support and facilitate improved quality of life and the independence of people living within our community. We cover three Local Government Areas – Coffs Harbour, Nambucca Heads and Bellingen. Our target group includes frail older people, people with a disability, people with dementia, carers and people being discharged from hospital. Community Care Options does this through the provision of case management support and direct services.

Community Care Options are currently funded to deliver the following programs -

- Home Care Packages – Level 2 and Level 4
- The Community Respite Service (CRS)
- Commonwealth HACC Funding (COP Aged)
- The Community Options Program (COP)
- The Connect Program
- ComPacks
- Transitional Aged Care (TACS)
- Community Support Program Packages (CSP)
- Consumer Directed Care Packages
- Funding provided through individual allocations eg Younger People in Residential Aged Care program (YPIRAC), supported Living Fund (SLF) and Individual Accommodation Support Program (IASP).

Community Care Options also deliver case management support and direct services to people on a fee for service basis. Comprehensive Information about the organisation's programs is found below.

Delivery of the organisations programs and services is underpinned by –

- Case Management principles and guidelines and
- Principal assumptions underlying CCO Case Management practice

and supported by the organisation's -

- Quality Management Plan
- Information Management systems
- Financial Management Systems
- Administration and Rostering systems
- Staff Management systems

Community Care Options seeks funding opportunities for additional places on existing programs or for new programs and services which –

- Add value to the existing range of services provided by the organisation and
- Address barriers and gaps in the community service network
- Are within the current or future expertise and ability of the organisation to

deliver

- Strengthen the organisation's viability
- Are within the scope of the organisation's Business and Strategic Plans.

Schedule for Revision of Policy: Programs and Services				
Date Adopted by Board	**Outcome**	**Author**	**Next Review**	**Comments**
28 May 2007	**Approved**	**Ruth Thompson**	**2009**	**New Policy**
May 2009	**Reviewed & Updated**	**Deb Ryan**		
August 2010	**Updated**	**Deb Ryan**		
11.11.2011	**Updated**	**D. Ryan**		
September 2014	**Updated**	**D. Ryan**	**2016**	

Programs and Services

Community Care Options' core business is the provision of quality Case Management and Direct Services to people eligible for our services.

Programs are available to people living in the Bellingen, Coffs Harbour and Nambucca Local Government Areas.

The organisation currently delivers programs through three Case Management streams; the Complex Care Team, the Aged Care Team and the Compacks Team.

ComPacks

Funding Source: The program was developed in partnership between NSW Health and NSW COP's and is funded by the NSW Department of Health.

Scope: Post hospital discharge support. Compacks is for people who need two or more community services and case management to ensure they can return home safely from hospital with appropriate care in place.

Function: The provision of a package of care which offers clients case management and direct support for up to 6 weeks after discharge from hospital.

Support Planners aim to facilitate access to mainstream services. They work in collaboration with a multidisciplinary hospital team, starting before discharge and continuing for a short time after discharge. At times, they jointly case manage with hospital staff or other service providers.

Compacks provide access to –

- comprehensive assessment, need identification, referrals and linkages including liaison with the person's General Practitioner
- a rapidly assembled, and coordinated package of short term community support, tailored to the individual client's needs
- support options which will continue after the person has exited the program.

The program is funded to provide –

- Domestic Assistance
- Personal Care
- Meals
- Social Support
- Centre-based day care
- Transport
- Respite Care
- Other services as described in the Compacks guidelines
- equipment restricted to low cost safety equipment/items.

Compack clients are able to loan from CCO ‘s extensive equipment pool whilst they are on the program.

Places: The Department of Health and the North Coast Area Health Service determine the number of places to be funded each year. 690 packages in 2014/15.

Eligibility: To be eligible for Compacks, people will –

- be assessed by the participating hospital as requiring two or more community services on discharge, and
- require Compacks support to facilitate discharge

In addition people may be eligible if they are –

- assessed as having clinical needs capable of being jointly met in the community by a Compack and a clinical team such as Community Acute/Post Acute Care
- referred from Emergency Departments if the ASET (Aged Care Services Emergency Team) has assessed them as having in-home care and support needs rather than a need for inpatient care.

The following groups are not eligible for Compacks –

- Current HCP Level 2 recipients (except where additional short term support is required)
- People needing more than 56 hours of service per calendar month
- People waiting placement in an Aged Care Facility
- People waiting for Community Support Program funding.

Referrals: Are accepted from participating hospitals listed in the Compacks guidelines. Referrals are made to NSW Community Options and received by CCO from them. Referrals are made on a one page Compacks Referral Form. Clients are assessed using the ONI assessment tool. CCO receives notification of referral via email and addition to Cometrix System as a referral.

Fees: CCO currently charges a contribution of $10.00 per week for Compacks support as well as a contribution towards travel costs if this is a significant part of the package of support.

Compliance: Compacks operates within the Compacks Program Guidelines and funding contract, the organisation’s policies manual and the organisation’s stated values.

Reporting: Compacks Support Planners maintain ongoing occupancy reports and complete individual outcome reports and invoicing for each client on exit from Compacks.
The Intake Officer updates client outcomes on Cometrix Database and confirms service activity with NSW COPS at the end of the month through a comparison of Cometrix data and CCO records. Cometrix data for each month to be finalised by 4th of following month.

Complex Care Team

Community Options Program (COP)

Funding Source: COP is funded by the NSW State Government, administered through the New South Wales Department of Family and Community Services - Ageing, Disabilities and Home Care (ADHC) under the Home and Community Care (HACC) program.

Scope: COP forms part of the spectrum of support available to people under the HACC services umbrella. Programs funded under HACC aim to provide services that -

- provide a comprehensive, coordinated and integrated range of basic maintenance and support services
- are appropriate, effective, flexible and timely - delivered to respond to people's needs
- are used by special needs groups
- are designed to enhance independence and
- prevent premature progression to higher level services.

Function: The provision of Case Management services to people who require assistance to access and maintain support options that best meet their complex and changing needs.

Case Management can be of a short or long term nature, or be episodic. There is capacity to provide joint Case Management with another service where this is of benefit to the client. Case Management activities include goal setting and review through Lifestyle Support Plans (LSP's) and the coordination of direct services sourced from existing HACC and/or other Government funded services.
There is an allocation of fixed output funds for purchasing or supplying some direct service types as an interim support measure whilst facilitating linkages to other service providers. These service types are –

- Domestic assistance
- Social support
- Personal care
- Meal instances
- Respite
- Home modification
- Home maintenance
- Transport

There is also an allocation of funds for the purchase of goods and the loan or purchase of equipment not available through 'Enable'.

Places: COP is funded to provide a set number of Case Management hours each financial year. The number of clients able to be supported at any one time through COP varies according to the mix and need of those currently on the program.

Eligibility: To be eligible for COP people must require Case Management support because they experience complex and changing support needs. COP clients are –

- people with a moderate to profound disability
- people from HACC identified special needs groups
- carers

HACC Special Needs Groups –

- People from Culturally and Linguistically Diverse backgrounds (CALD)
- Aborigines and Torres Strait Islanders (ATSI)
- People with Dementia
- People who are Financially Disadvantaged
- People living in remote or isolated areas.

Referrals: Anyone is able to refer a person for consideration for assistance through COP providing they have the consent of the person to do so. Referrals are recorded using the Client Information and Referral Record (CIARR). Referrals are prioritised for intake based on the relative need of those on the program's waiting list and according to the organisation's ability to provide for their level of need.

Fees: People on the COP program are asked to make a contribution towards the service. No one is refused service based on an inability to pay. Fees are negotiated with clients with consideration of their financial circumstances and the number of possible HACC services that may be accessing and paying for.

Compliance: COP operations are guided by the funding contract/service agreement schedule, the Community Care Common Standards, the NSW Disability Services Act 1993, the NSW Disability Services Standards, Ageing Disability and Home Care's relevant policies, the Children's Standards, the organisation's policies manual and the organisation's stated values.

Reporting: Support Planners maintain client data set information including case management hours and other services provided either directly or through brokerage, through the client information system TRACCS. The CEO reports client data sets and service outputs to ADHC each three month period through the ADHC MDS process. Financial Acquittals are submitted to ADHC annually along with an Annual Compliance Return.

CONNECT

Funding Source: Funded by the NSW Department of Family and Community Services - Ageing, Disabilities and Home Care (ADHC) under the Disabilities Services Program (DSP).

Scope: Short term intensive support to identify need and create linkages for people who have a disability and complex needs. People with an acquired brain injury have priority of access.

Function: Short term (8-26 weeks) Case Management including comprehensive assessment, goal setting and review through a Lifestyle Support Plan (LSP), high level need identification, options sourcing, referral and service coordination in order to link people into ongoing services which meet their need and enhance independent living.
Direct service provision is sourced from existing HACC and other government funded services. CCO supports goal facilitation and linkages.

Places: We are funded to provide 10 places at any one time.

Eligibility: To be eligible for CONNECT people should be identified as being able to benefit from short term intensive Case Management support and linkage creation. People with a disability who are aged between 18 and 65 years are eligible for support through CONNECT. People who have an acquired brain injury have priority of access to CONNECT places.

Referrals: Anyone is able to refer a person for consideration for assistance through CONNECT providing they have the consent of the person to do so where this is appropriate. Referrals are recorded using the Client Information and Referral Record (CIARR). Referrals are prioritised for intake based on the relative need of those on the program's waiting list and according to the organisation's ability to provide for the level of need.

Fees: People receiving support through the CONNECT program are asked to make a contribution towards the service. No one is refused service based on an inability to pay.

Compliance: CONNECT operations are governed by the funding contract/service agreement schedule, the Disability Services Act 1993, the NSW Disability Services Standards, Ageing Disability and Home Care's relevant policies, the organisation's policies manual and the organisation's stated values.

Reporting: Financial Acquittals are submitted to ADHC annually. Reporting of client data set information and case management outputs is through the CSTDA MDS process quarterly.

AGED CARE TEAM

Consumer Directed Care

In 2010 the Department of Health and Ageing tendered for the delivery of Consumer Directed Care models of aged care support. CCO was successful in receiving an allocation of 8 packages in the first round of a two year pilot program. 8 clients have been supported on this program. CCO participated on the CDC Taskforce and in the evaluation process undertaken by the Department. The pilot program has now ended and these packages have transitioned to mainstream aged care packages, but will however still be offered on a CDC basis. All new packages from 1st July 2013 will be offered on a CDC basis.

Consumer (or self) directed care (CDC) is designed to give older people a greater say and more control over the design and delivery of community care services provided to them and their carers. The program allows older people and their carers to make choices about the types of care services they access and the delivery of those services, including who will deliver the services and when. Expected outcomes of the programs for both care recipients and carers include, a better quality of life due to increased independence and empowerment over the services they are receiving.

Consumer Directed Care places align with the existing subsidy levels of the current Home Care Package programs as below.

CCO has 5 Level 2 and 3 Level 4 CDC packages.

Home Care Packages – Level 2

Funding Source: Funded by the Australian Government Department of Social Services (DSS) under the Community Aged Care Packages Program.

Scope: Delivery of a low level package of case management and direct services which is flexibly tailored to meet individual need, maximise independence and enable people to remain living at home.

Function: The provision of Case Management including comprehensive assessment, support coordination, referrals, regular monitoring and review of agreed support plans to meet changing and complex needs.
There are a range of funded (not fixed output) direct service types from which a low level package of care can be tailored to meet identified need. These include –

- Personal Care
- Social Support
- Domestic Assistance
- Respite
- Home modifications and maintenance
- Meal Preparation
- Transport

There is an allocation of funds for the purchase and loan of equipment.

Places: Community Care Options is funded to provide 141 places. A minimum of 18% of places are dedicated for people who are financially disadvantaged.

Eligibility: People are eligible for support through a Home Care Package Level 2 if they –

- Live in the community and wish to remain living in the community
- Have been assessed by the Aged Care Assessment Team (ACAT) as qualifying for low band community care subsidy
- Require a package of low level direct services and Case Management of their care needs in order to remain living at home
- Are frail aged (70 years or over) or if Aboriginal or Torres Strait Islander (50 years or over)
- Are an aged person with a moderate to profound disability
- Are a younger person but have an age related illness such as Parkinson's Disease or other needs determined by ACAT as fulfilling eligibility criteria.

Referrals: The principles of the CIARR Protocol apply however, to be eligible for a Home Care Package people must be assessed by the ACAT as requiring low level community care services. With the person's consent, CCO will refer to ACAT any referrals received through the CIARR. The ACAT refer to CCO by forwarding a copy of the person's completed assessment form (ACCR). Referrals are prioritised for intake based on the relative need of those on the program's waiting list and according to the organisation's ability to provide for their level of need.

Fees: People receiving support through a Home Care package Level 2 are asked to make a contribution towards the service. No one is refused service based on an inability to pay. The Australian Government sets a maximum fee for people who receive a full pension which is reviewed twice annually. New fee polices commenced on 1.7.2014 include a Centrelink Assessment of additional contributions that may be payable by someone with income assessed as above the basic pension.

Compliance: Home Care Package Level 2 operations are governed by the funding contract, the Aged Care Act (1997) and Principles, the Community Care Common Standards, the organisation's policies manual and the organisation's stated values.

Reporting: Support Planners complete minimum 3 monthly support plan reviews or more often as needed. Support Planners maintain occupancy and client data set reports.

The Client Service Manager reports monthly to the Dept of Human Services to claim subsidies. This includes reporting of some types of recipient data including leave from the program and the amounts of direct service provided to each recipient during the month. Provider Claim forms are submitted and processed by Medicare Australia.

Home Care Packages Level 4

Funding Source: Funded by the Australian Government Department of Social Services (DSS) under the Flexible Care Program.

Scope: Delivery of a high level package of case management and direct services which is flexibly tailored to meet individual need, maximise independence and enable people to remain living at home.

Function: The provision of Case Management including comprehensive assessment, support coordination, referrals, regular monitoring and review of agreed care plans to meet changing and complex needs.
There are a range of funded (not fixed output) direct service types from which a high level package of care can be tailored to meet identified need. These include –

- Personal Care
- Social Support
- Domestic Assistance
- Respite
- Home modifications and maintenance
- Meal Preparation
- Transport.

In addition to these services a Home Care Level 4 package also includes nursing care. CCO employs a Registered Nurse to complete nursing care plans and provide clinical care services to Home Care Package Level 4 clients. All HCP Level 4 clients have an INS system to enable access to out of hours nursing support. Nursing staff and Support Planners work collaboratively to achieve seamless service provision. A regularly reviewed Nursing Care Plan forms part of the HCP Level 4 support plan.

The HCP Level 4 provides for costs associated with the supply of goods (continence and nursing supplies) and the purchase and/or loan of equipment required to maintain safety and provide an adequate level of support.

Costs associated with the provision of oxygen and Enteral feeding are remitted to the HCP provider. These are claimed through the monthly returns.

Places: CCO is funded to provide 15 places

Eligibility: People are eligible for support through a Home Care Package Level 4 if they –

- Live in the community and wish to remain living in the community
- Have been assessed by the Aged Care Assessment Team (ACAT) as qualifying for high band community care subsidy
- Require a package of high level direct services and Case Management of their care needs in order to remain living at home
- Are frail aged (70 years or over) or if Aboriginal or Torres Strait Islander (50 years or over)

- Are an aged person with a moderate to profound disability
- Are a younger person but have an age related illness such as Parkinson's Disease or other needs determined by ACAT as fulfilling eligibility criteria.

Referrals: The principles of the CIARR Protocol apply however, to be eligible for an HCP Level 4 package, people must be assessed by the ACAT as requiring high level community care services. With the person's consent, CCO will refer to ACAT any referrals received through the CIARR. The ACAT refer to CCO by forwarding a copy of the person's completed assessment form (ACCR). Referrals are prioritised for intake based on the relative need of those on the program's waiting list and according to the organisation's ability to provide for their level of need.

Fees: People receiving support through a Home Care Package Level 4 are asked to make a contribution towards the service. No one is refused service based on an inability to pay. The Australian Government sets a maximum fee for people who receive a full pension. This is reviewed twice yearly. New fee polices commenced on 1.7.2014 include a Centrelink Assessment of additional contributions that may be payable by someone with income assessed as above the basic pension.

Compliance: Home Care Package Level 4 operations are governed by the funding contract, the Aged Care Act (1997) and Principles, the Community Care Common Standards, the organisation's policies manual and the organisation's stated values.

Reporting: Support Planners complete 3 monthly care plan reviews or more often as required. A Nursing care plan review is conducted at least 6 Monthly. Support Planners maintain occupancy and client data sets reports.

The Client Service Manager reports monthly to the DSS in order to claim subsidies. This includes reporting of some types of recipient data including leave from the program and the amounts of direct service provided to each recipient during the month. Provider Claim forms are submitted to and processed by Medicare Australia.

Community Respite Service (CRS)

Funding Source: The Australian Government Department of Social Services (DSS) under the National Respite for Carers Program.

Scope: Support for Carers of people who have high support needs and challenging behaviour in order to sustain the caring relationship.

Function: The Community Respite Service is funded to provide respite to carers of people who have dementia or high level support needs. In the Community Respite Service the carer is the client of the organisation. The person being cared for is the care recipient.

Case Management activities include comprehensive assessment, needs identification, support planning and coordination, monitoring and review. The Support Planner may also assist the carer in identifying and sourcing strategies, equipment and aids, other services (CRS clients are eligible for HACC services) and information that assists to manage behaviour and sustain the caring relationship.
Where intensive case management support is required the carer or care recipient may be referred to another case management program such as COP whilst the carer continues to receive respite through the CRS program. Where only a low level of Case Management is required, the Support Planner will provide this as part of the CRS program.

Funded direct service types are limited to the following respite types only –

- In home respite
- Respite - Community access
- Over night in home respite
- Emergency respite

Staff may perform duties such as preparing lunch or performing personal care routines for the care recipient if these assist the facilitation of the respite as the primary function of the service ie. if the respite period includes the care recipient's usual lunchtime and they are unable to make their own lunch.

Where the care recipient requires service types that do not form part of the primary function of respite (domestic assistance, meal preparation for example) the care recipient may be referred to another program (HCP, HACC service) which is funded for these types of direct service delivery. In these instances the carer may continue to receive respite support through the CRS if this is still required. Some equipment may be provided under the program. The organisation can, in consultation with the funding body, allocate funds specifically for the education and training of staff.

Places: CCO is funded to provide approx. 25 places with two designated places for working carers.

Eligibility: People are eligible for the Community Respite Service if –

- they are the resident or non-resident primary carer for a person who has dementia and spend a significant part of their usual day caring for that person
- whilst the care recipient does not need to be determined as having challenging behaviour to be eligible for the program, people who care for someone with challenging behaviour have priority of access.

Referrals: Anyone is able to refer for support through the CRS program. The principles of the CIARR protocol apply. ACAT are able to refer to the program using the CIARR or the ACCR. Referrals are prioritised for intake based on relative need of those of the program's waiting list and the ability of the organisation to provide for the level of their need.

Fees: People receiving support through a CRS package are asked to make a contribution towards the service. No one is refused service based on an inability to pay. The Australian Government sets a maximum fee for people who receive a full pension.

Compliance: The Community Respite Service is governed by the funding contract, the Aged Care Act (1997) and Principles, the Community Care Common Standards, the organisation's policies manual and the organisation's stated values.

Reporting: Support Planners maintain occupancy and client data set reports. The Client Service Manager submits 6 monthly quantitative and qualitative report (Service Activity Reports) to the funding body. Financial Activity Reports (FAR) are submitted 6 monthly along with the SAR.

Community Options Program – Aged (COP Aged)

Funding Source: COP is funded by the Federal Department of Social Services (DSS) under the Home and Community Care (HACC) program.

Scope: COP forms part of the spectrum of support available to people under the HACC services umbrella. Programs funded under HACC aim to provide services that –

- provide a comprehensive, coordinated and integrated range of basic maintenance and support services
- are appropriate, effective, flexible and timely - delivered to respond to people's needs
- are used by special needs groups
- are designed to enhance independence and
- prevent premature progression to higher level services.

Function: The provision of Case Management services to people who require assistance to access and maintain support options that best meet their complex and changing needs.

Case Management can be of a short or long term nature, or be episodic. There is capacity to provide joint Case Management with another service where this is of benefit to the client. Case Management activities include goal setting and review through Lifestyle Support Plans (LSP's) and the coordination of direct services sourced from existing HACC and/or other Government funded services.
There is an allocation of fixed output funds for purchasing or supplying some direct service types as an interim support measure whilst facilitating linkages to other service providers. These service types are –

- Domestic assistance
- Social support
- Personal care
- Meal instances
- Respite
- Home modification
- Home maintenance
- Transport

There is also an allocation of funds for the purchase of goods and the loan or purchase of equipment not available through 'Enable'.

Places: COP is funded to provide a set number of Case Management hours each financial year. The number of clients able to be supported at any one time through COP varies according to the mix and need of those currently on the program.

Eligibility: To be eligible for COP people must require Case Management support because they experience complex and changing support needs. COP clients are –

- people who are aged over 65

- people from HACC identified special needs groups
- carers

HACC Special Needs Groups –

- People from Culturally and Linguistically Diverse backgrounds (CALD)
- Aborigines and Torres Strait Islanders (ATSI)
- People with Dementia
- People who are Financially Disadvantaged
- People living in remote or isolated areas.

Referrals: Anyone is able to refer a person for consideration for assistance through COP providing they have the consent of the person to do so. Referrals are recorded using the Client Information and Referral Record (CIARR). Referrals are prioritised for intake based on the relative need of those on the program's waiting list and according to the organisation's ability to provide for their level of need.

Fees: People on the COP program are asked to make a contribution towards the service. No one is refused service based on an inability to pay. Fees are negotiated with clients with consideration of their financial circumstances and the number of possible HACC services that may be accessing and paying for.

Compliance: COP operations are guided by the funding contract/service agreement schedule, the Community Care Common Standards, DSS relevant policies, the organisation's policies manual and the organisation's stated values.

Reporting: Support Planners maintain client data set information including case management hours and other services provided either directly or through brokerage, through the client information system TRACCS. The CEO reports client data sets and service outputs to ADHC each three month period through the ADHC MDS process. Output Compliance Reports completed on Aged Care Portal. Financial Acquittals are submitted to DSS annually along with an Annual Compliance Return.

Other Clients

The organisation provides Case Management and/or direct services to other people. This can be as part of new and emerging projects or on a fee-for-service basis. Some people are able to pay for private services. Fees for private services are available on request.

The choice to engage CCO on a private fee-for service arrangement does not supplant others on waiting lists nor jeopardise the private client's own prioritised place on the waiting list if they choose to remain on this.

Clients who are already on a CCO program may also choose to supplement the resources of that program by privately paying for additional services.

3.4 Access to Services

Definition
Access refers to the processes utilised to determine eligibility and access of people to available services and resources within the organisation.

Position Statement
Community Care Options will ensure that each person seeking a service has access on the basis of relative need and available resources. We will ensure that access decisions are made on a fair, equitable and non discriminatory basis. All people seeking a service will participate in an assessment process that will assist in identifying their eligibility to receive a service and their relative priority for a service in relation to other people seeking a service. The organisation will ensure that all people seeking a service will be informed of eligibility criteria for each program of support and all assessment and eligibility decisions will be transparent and documented.

Legislation and Standards
Home Care Standard 2 – Appropriate Access and Service Delivery
Expected Outcome 2.1 Service Access –
Each service user's access to services is based on consultation with the service user (and/or their representative), equity, consideration of available resources and program eligibility.
Disability Service Standard – Standard 5 – Service Access

Operational Procedures

Equal Access
We undertake that people will be given equal access to the organisation's services, taking into account people's individual and relative level of need, their resources, their culture and their geographic location.

We will ensure that services are available to all eligible people living within the Bellingen, Coffs Harbour and Nambucca Local Government Areas without discrimination.

People will not be excluded from the service because of their gender, marital status, religious or cultural beliefs, political affiliation, particular disability, ethnic background, age, sexual preference, inability to pay, geographical location or circumstances of their carer.

Promotion of services
Community Care Options will promote their services in a manner which makes sure that people have and equal chance to get service. The service will be responsible for

- developing easy to read promotional material and ensuring it is printed in a clear format;
- developing and maintaining community brochures which give information about the organisation's services and how to access them;
- making information available in other languages if requested. We will offer

and use bilingual staff and professional interpreters where required. Printed material (privacy policy, agreement, pamphlets) will be translated where required.

- distribution of material through all major health and welfare agencies in the region, including government and non-government services and agencies providing services for special needs groups and minority groups, and public places such as shopping centres, libraries and chemists;
- promoting the organisation and its activities through appropriate media releases;
- appointing relevant staff as guest speakers to talk about the organisation's services to interested groups of people;
- providing culturally sensitive and appropriate services for people from culturally and linguistically diverse backgrounds;
- maintaining a list of relevant organisations and for ensuring they have adequate supplies of promotional material.

Planning and Evaluation

We will collect information and statistics about people living in the three local government areas we service. We will compare this demographic information with those people who use the service. This will help us to ensure that the service is available to all groups in the community who qualify for the service and that no particular group of people misses out.

We will monitor our service provision to ensure that people of Aboriginal and Islander descent receive equitable access to our support considering the disability and need characteristics of Aboriginal people.

Records

Records will be kept to monitor all requests for services, the outcome of the request and if service is refused, the reason for refusal.

Eligibility

People are eligible to receive support, through one of our programs if they meet the criteria for access as determined by funding guidelines for that program.

Community Care Options will –

- use clear measures to determine clients' needs over time;
- assess their need in relation to our other clients;
- determine how important it is for clients to be helped with organising their support;
- assess clients' ability to obtain service from other organisations;
- consider particular difficulties people may have because of their disability, lack of community supports, problems with housing, availability of other options, isolation and their cultural and language needs;
- take active steps so that disadvantaged groups have an equal chance to get service; particularly if they are a member of the Aboriginal and Torres Strait Islander community, if English is not their first language, if they have dementia, live in an isolated rural area or if they are financially disadvantaged;

- refer people, who fail to gain access to Community Care Options' support, to other appropriate agencies if they ask us to do so.

People with the highest level of need may not be given highest priority to come on to a particular program. For example, a person's needs may be very high, but they may have enough other resources, for example support from relatives, other community members or services. Alternatively, the organisation's resources may be insufficient to make a significant difference to meeting the person's support needs. This is what we mean by relative need.

Referrals

Different programs may have different referral pathways depending upon the criteria for access as determined by the funding body. For example referrals for our aged care programs must come from the Aged Care Assessment Team to be eligible for support.

Referrals can be accepted from anyone, provided they are made with the express consent of the person being referred or their representative. The organisation prefers to receive written referrals for all except Home Care Packages, on a Common Information and Referral Record (CIARR).

If the prospective client or a carer makes a referral, or it comes from an organisation other than a HACC funded service, eg. health, who may not use the CIARR, we will transcribe the client information on to the CIARR and follow the CIARR protocol.

Staff receiving a referral by telephone or in person will record referral information on a CIARR.

We will refer clients and people enquiring about services who are ineligible or we are unable to assist, to other appropriate organisations, if the person wishes this and agrees to this.

Referral Processing

Administrative Staff -

- transfer telephone enquiries to Intake Officer or leave phone message;
- receive and date stamp written referrals;
- enter details of the referral on to the referral data-base;
- allocate a referral number;
- attach a notes page and a prioritisation tool to the referral;
- place the referral in the intake pigeon hole.

Intake Officer -

- responds to telephone enquiries as a matter of priority;
- investigates written referrals and contacts the referred person and/or the carer and/or others as appropriate and with the referred person's consent to discuss their needs;
- completes progress notes after each contact or action;
- enters data in the client data base;
- determines whether referral meets eligibility criteria for the program being

referred or another CCO program;

- prepares information for review by Intake Panel (Client Services Manager, Intake Officer and Support Planner);
- Intake Panel will review referral at earliest convenience and determine whether eligible. All intake decisions will be clearly documented and outcomes clearly communicated back to the person making the referral. Will also determine priority in comparison to other referrals where there is a waiting list for services, using the prioritisation tool (in line with the 'prioritising requests for support' policy), enter data into the data base and write letters to the referred person and/or the carer and/or others to advise that the referral has been accepted and is on the program's waiting list;
- if a non-standard letter is required (either for a declined or accepted referral) then submit this to the Client Service Manager for approval and enter date letter sent into data base;
- archive declined referrals in the declined referrals folder;
- place accepted referrals in waiting list referral folders per program, per area, per priority;
- review all referrals whenever there is a vacancy;
- review referrals at least quarterly if there is no vacancy;
- follow up with the potential client and/or the referrer to find out if support is still sought and if there are any changes in the person's situation which may affect their priority;
- inform the person referred of their status and of the outcome of their referral;
- note in the client data base any contact made, action and outcomes;
- contact the person to ascertain if they still wish to have our support and to arrange a time for an assessment to be done;
- faxes waiting list for Home Care Packages and NRCP programs to ACAT on a monthly basis;
- faxes Level 4 Home Care Package waiting list and current clients to ACTIP on a monthly basis.

<u>Prioritising Requests for Support</u>
<u>Principles</u>
Our financial resources may not be enough to meet the needs of all those people who need our help. That is why we have to make difficult decisions about whom we can offer a service. We consider –

- a person's needs and compare these with the needs of other people who also ask us for help;
- if our help can make a significant difference to the way the person lives. For example are they able to continue living in their own home rather than having to move into an aged care facility;
- if we can we give people enough help to maintain or improve their quality of life;
- the priority accorded by the referring agency eg ACAT;
- our organisation's resources;
- whether we can provide services safely to the person;
- the issue of geographic equity.

Anti-Discrimination

It is the policy of Community Care Options to comply with all State and Federal anti-discrimination legislation under which it is unlawful, in the provision of goods and services and in employment, to directly or indirectly discriminate on the grounds of sex, race, marital status, pregnancy, disability, homosexuality, transgender status or carers' responsibilities.

Community Care Options will also abide by the provisions of the Commonwealth Disability Discrimination Act 1992 under which it is unlawful to discriminate on any grounds relating to physical, sensory, intellectual and psychiatric impairment, mental illness and the presence of organisms causing disease (covering people who are HIV positive or who have AIDS).

Priority Criteria

We give priority to people who –

- belong to the Aboriginal or Torres Strait Islander communities;
- have a culturally or linguistically diverse background;
- are the carer of a client of the organisation, at the time of the client's death, and meet in their own right, the conditions of eligibility for one of the programs;
- live in a rurally isolated area;
- are financially disadvantaged;
- cannot be adequately supported by other services, their family or the community;
- need an independent advocate to help them access adequate and sufficient support;
- live alone;
- have social contacts, which are limited, non-existent or under strain;
- are unsafe or insecure, possibly because of their home environment or physical, emotional or financial abuse or neglect;
- have been under significant stress or are emotionally distressed.

We also give priority to people whose carers –

- are unable to cope with the burden of care;
- are sole carers with limited support networks or dependent children;
- are frail, ill, stressed, have a disability or are getting little sleep;
- have extensive commitments;
- are socially, culturally or geographically isolated;
- are financially disadvantaged;
- experience strain in their relationship with the person for whom they are caring or with other significant people;
- are likely to have difficulty negotiating and obtaining the range of necessary supports.

Refusal of Service

If a person is denied access Community Care Options will -

- explain, in writing, its reasons for refusing access to the client;
- record the reasons for refusing access so that trends and unmet needs can be reported to the Board of Management, to the community and to government and can be fed into any planning about unmet needs;
- with their consent, refer the person to other appropriate agencies, according to normal referral procedures or provide contact information of relevant agencies.

Schedule for Revision of Policy: Access to Services				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
24/07/2006	New policy	R. Thompson		
29/01/2007	Amended	A. Vaughan	29/1/07	
April 2009	Reviewed & Updated	D. Ryan	2012	
11 November 2011	Reviewed and Updated	D. Ryan		
22.9.2014	Reviewed & updated	D. Ryan	Sept 2016	

3.5 Rights and Responsibilities

Position Statement

CCO believes each person (including children, young people and adults) has rights and should have them respected at all times. Clients are the focus of the organisation's operations and it is important that their rights are acknowledged and promoted at every opportunity. CCO has a commitment to upholding each person's legal and human rights in all aspects of service delivery and will act to promote and protect these rights in accordance with the Universal Declaration of Human Rights, the Charter of Rights for Community Care, and the United Nations Convention on the Rights of Persons with Disabilities. We believe that all people have a right to be looked after properly, treated well and given high quality care and services. We ensure that all clients are made aware of their rights and responsibilities and are provided with a copy of the Charter of Rights. Each person will receive a service that promotes and respects their legal and human rights and enables them to exercise choice like everyone else in the community.

Legislation and Standards

Home Care Standards – Standard 3 - Service User Rights and Responsibilities – each service user and/or their representative is provided with information to assist them to make service choices & has the right & responsibility to be consulted & respected. Service users have access to complaints & advocacy information & processes & their privacy & confidentiality & right to independence is respected.

Disability Service Standards – Standard 1 – Rights – each person receives a service that promotes & respects their legal & human rights & enables them to exercise choice like everyone else in the community.

Universal Declaration of Human Rights 1948

Charter of Rights for Community Care

United Nations Convention on the Rights of Persons with Disabilities

Principles

- All people have the right to respect for their human worth and dignity
- All people have the right to be free from discrimination, abuse or neglect and receive services which respect and promote their legal and human rights
- All people have the right to full participation in society equal to all other people, according to their individual and cultural needs and preferences
- All people have the right to make their own decisions on the way they live their life
- All people should be able to access information on their rights and be supported to exercise these rights
- All people have the right to receive services which maintain the privacy of their personal information in line with relevant legislation
- Equality between men and women
- Active partnerships between services and people, and where appropriate, their families, friends, carers and/or advocates
- CCO's duty of care and legislated responsibilities for client safety may take precedence over confidentiality under certain circumstances (e.g. subpoena, child protection)
- When a client is unable to make a critical decision without assistance, the family, with regard to the best interests of the client, may provide informal support to make the decision

- In the cases of any disagreement about what constitutes the best interest of the client or particularly critical decisions, a legally appointed guardian with the specific decision making function may be required to give or withhold consent
- Sometimes there are disputes between families, legally appointed guardians and service providers in relation to what is in the best interests of clients who lack the capacity to make decisions. If these cannot be resolved through discussion, and a decision is required, it will be made by the legally appointed guardian with the specific function
- Parents have the right to make choices and be involved in decisions about all aspects of services offered to their child
- Children have a right to be consulted directly about decisions that impact on them in age appropriate ways
- CCO is committed to providing each person using a service with information, and support to understand and exercise their legal and human rights both within the service and in the broader community.
- CCO is committed to providing training to staff on the importance of recognising and respecting the legal and human rights of people who use the service
- CCO is committed to providing training and information to staff which ensures they are skilled in identifying and addressing risk factors and in responding effectively and proactively to allegations of abuse or assault.

Operational Procedures

Clients' Rights
The organisation supports the rights of each client to –

- be treated with respect
- be involved in deciding what care will meet their needs
- have a written agreement covering everything they and we have agreed to
- have their care and services reviewed
- privacy and confidentiality of their personal information
- be given information on how to make comments and/or complaints about their care and services
- have their fees determined in a way that is transparent, accessible and fair
- be given a copy of the Charter of Rights and Responsibilities for Home Care
- be respected for their human worth, dignity and privacy;
- have access to services decided only on the basis of need and the capacity of the service to meet that need;
- to refuse a service without this prejudicing their future access to services;
- be free from discrimination when dealing with the organisation;
- be informed about available services, options, their rights and responsibilities and any fees to be charged;
- pursue any complaints about service provision without retribution;
- involve an advocate of their choice;
- have access to all information about themselves held by the organisation;
- have the rights of the guardian or advocate acknowledged and respected to

the extent stipulated in the guardianship or advocacy arrangements;
- be involved in decisions about their assessment and care plan;
- have services provided in a safe manner;
- respect, dignity and independence;
- to receive a service which is responsive to their social, cultural and physical and emotional needs;
- have their privacy respected and their information treated with confidentiality;
- be involved in the organisation's service planning and evaluation.

Dignity
The organisation's staff and staff contracted from other agencies will recognise, respect and protect each client's right to dignity in all areas of their life and personal activities. All staff will treat clients and others with respect and courtesy and in an age appropriate manner.

Sexuality
The organisation will support clients, within agreed support plans, in their choice of age appropriate sexual activities. Information and referral opportunities will be offered as appropriate covering both sexuality and protection from exploitation.

Freedom of Religion
The organisation will support individual clients if requested within a support plan, to pursue their religion or faith of their choice, in their right to refuse religious affiliation and involvement in religious activities.

This means that Community Care Options will –

- have and follow a clear and transparent access policy based on the need of clients and the organisation's ability to meet these needs with available resources;
- adopt a discrimination free assessment process;
- inform clients of available services, options and their rights and responsibilities in relation to Community Care Options support and negotiate client fees with them;
- deal with complaints by clients fairly, promptly and without retribution;
- provide clients with access to their information when requested;
- acknowledge and respect guardians or advocates to the extent stipulated in the guardianship or advocacy arrangements;
- encourage clients to become involved in decisions about their assessment and care plan;
- deliver services in a safe manner which also observe WH&S;
- treat clients with respect, safeguarding their dignity and encouraging their independence;
- provide a service and demonstrate an attitude which is responsive to clients' social, cultural and physical and emotional needs;
- respect clients' rights to privacy and confidentiality;
- involve clients in the planning and evaluation of the service.

Clients' Responsibilities
As service users, clients also have responsibilities to the organisation.

Clients have the responsibility to –

- respect the rights of care workers
- give enough information to us so we can develop and deliver their care plan
- follow the terms and conditions of the written agreement
- allow safe and reasonable access for care staff at the times agreed in their care plan
- pay any fees outlined in their written agreement
- treat the Organisation's staff with respect and courtesy;
- allow the organisation's staff to conduct a work place risk assessment;
- make their home as safe as possible for the organisation's staff to work in;
- not to harass, or vilify our staff or discriminate against them;
- act in a way which respects the rights of the organisation's staff;
- accept the consequences of any decisions they make;
- let the organisation know if they are absent from their home when a staff member is due to visit;
- let the Support Planner know, when they are not happy with their service;
- let the Support Planner know if they want to review their support plan;
- arrange the return of loaned equipment in clean condition, if it is no longer needed.

Whilst the organisation acknowledges the rights of each client, there is sometimes a need to balance potentially conflicting needs and wishes. Staff also have to take into account the limitation and constraints of service provision due to -

Commonwealth and NSW laws, particularly those relating to –

- Work Health and Safety
- Anti-discrimination
- Equal Employment Opportunities
- Industrial Relations - Awards
- Privacy

The organisation's own resources;
The rights of other individuals and its own staff.

This means that the organisation's staff will sometimes need to negotiate solutions which involve compromise, whilst still aiming to optimise outcomes for all affected parties.

Schedule for Revision of Policy: Rights and Responsibilities				
Date Adopted by Board	**Outcome**	**Author**	**Next Review**	**Comments**
28 May 2007	**Approved**	**Ruth Thompson**	**2009**	**New Policy**
May 2009	**Reviewed & Updated**	**Deb Ryan**		
August 2010	**Updated**	**Deb Ryan**		
11.11.2011	**Updated**	**D. Ryan**		
February 2012	**Updated**	**D. Ryan**		
September 2014	**Updated**	**D. Ryan**		

3.6 Information Provision and Consultation

Position Statement
Community Care Options believe that people have a right to make choices in their own lives. The provision of relevant and timely information will help them to do this. We will regularly give clients appropriate, honest, straightforward and knowledgeable information about support, options and what Community Care Options can and will do on their behalf. Community Care Options is committed to ensuring that clients or potential clients have access to information that allows them to make informed decisions about available services, and advises them of their rights and responsibilities in relation to service delivery.

Legislation and Standards
Home Care Standard - Standard 3 – Service User Rights and Responsibilities
Expected Outcome 3.1 – Information Provision – **Each service user, or prospective service user, is provided with information (initially and on an ongoing basis) in a format appropriate to their needs to assist them to make service choices and gain an understanding of the services available to them and their rights and responsibilities.**
Disability Service Standards 1, 2, 3, & 5

Operational Procedures

All clients will be provided with the following information at the time of assessment –

- a Community Care Options brochure;
- information in relation to the programs and services we provide;
- the guidelines and limitations of the program of support that they are being assessed for;
- privacy and confidentiality;
- feedback and complaints;
- client and service provider rights and responsibilities;
- client contribution;
- information about CCO staff;
- information about other service options that are available within the local community.

This will be provided in written format and also discussed with the client and/or their representative.

All client's will be provided with a client information folder which will contain the above information, a copy of their service agreement, and support plan, the name of their Support Planner, and other relevant information. The Support Planner will also discuss the information with clients at subsequent reviews.

In order to ensure that clients know what to expect from the organisation as well as their own obligations, each client will receive a Service Agreement which outlines the following -

- parties to the agreement;
- funding source of the program;

- clients' rights and responsibilities (Charter of Rights)
- a confidentiality undertaking;
- service provision;
- types of services available;
- client financial contribution;
- service termination;
- complaints and disputes;
- accounting Information;
- needs assessment.

The Agreement is signed and dated by the client or carer and the organisation's Support Planner.

One copy of the agreement stays with the client and one with the organisation.

If clients do not speak English, a professional interpreter will be engaged to assist the client to understand the information contained in the handbook, particularly information about rights and advocacy services. If we cannot find someone to interpret, we will use the Telephone Interpreter Service. Other options will include finding a volunteer fluent in the appropriate language and/or general community care information in languages other than English from other agencies. Carers NSW also have kits for people from culturally and linguistically diverse backgrounds.

Part of the Case Management role is supporting client's to access information to assist them to make appropriate decisions and life choices. CCO maintains an extensive service directory data base and keeps informed about new services and programs of support within the local community and available generally.

Support Planners will support client's to source information they need on a range of issues including but not limited to –

- recreation, leisure, hobby pursuits
- health care
- social networks and opportunities
- housing options
- centrelink benefits and entitlements
- guardianship and financial management if needed
- equipment and aides that may assist them
- and other information that they may require.

Schedule for Revision of Policy: Information Provision and Consultation				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
August 2009	**Reviewed**	**D. Ryan**		
11.11.11	**Reviewed & amended**	**D. Ryan**		
September 2014	**Reviewed & updated**	**D. Ryan**	**2015**	

3.7 Privacy, Dignity and Confidentiality - documentation and record keeping

Definition
'Privacy' if freedom from intrusion and public attention.
'Dignity' is treating someone with honour, respect and worthiness that reflects their culture and community and that positively influences their self esteem.
'Confidentiality' is the assurance that written and spoken information is protected from access and use by unauthorised persons. With respect to confidentiality CCO staff members are to refer to the organisations Code of Conduct and Ethics and are to note that disclosure or misuse of confidential information held on official records, including client files, is illegal.

Position Statement
Community Care Options recognises that each person has the right, in all aspects of their lives, to privacy and confidentiality and to be treated with dignity. This recognition will be reflected by CCO services, and by actively encouraging the positive portrayal of people in our service and providing effective quality services in the least intrusive way possible.

The organisation is committed to protecting the privacy of clients' information. Community Care Options will ensure that all documentation and record keeping systems follow principles of best practice and adhere to Australian Privacy Principles. Community Care Options will only collect information that is necessary for the provision of services to each client and will keep records in a standardised, accurate, objective and efficient manner. All client information will be kept in accordance with legal requirements, ensuring that privacy and confidentiality of personal information is maintained at all times. Community Care Options will make information kept about a client available for that individual or their substitute decision makers to access at any time.

Legislation
Human Rights and Equal Opportunity Commission Act 1986
NSW Freedom of Information Act 1989
Disability Service Standards - 1
Commonwealth Privacy Act (1988) and the amended Commonwealth Privacy Amendment (Private Sector) Act 2000.
Australian Privacy Principles 2014
Home Care Standard 3 Service User Rights and Responsibilities
Expected Outcome 3.2 – Privacy and Confidentiality – **Each service user's rights to privacy, dignity and confidentiality is respected including in the collection, use and disclosure of personal information.**

Operational Procedures
Implementation of Australian Privacy Principles

APP 1 – Open and transparent management of personal information

Intake Officers and Support Planners are to ensure that referrers have obtained client consent prior to making a referral to Community Care Options. This may be verbal or in writing.

On first contact, staff of Community Care Options are to check with the client that they have consented to the referral to our service. The client is to be informed about what information will be gathered about them during the assessment process and how that information will be utilised and stored.

Informing the person from whom information is collected
Support Planners will clarify with the client the accuracy of information received through the referral process and will make them aware –

- that information is being collected and for which purposes;
- of the intended recipients of the information;
- whether the supply of the information by the individual is required by law or is voluntary, and any consequences for the individual if the information (or any part of it) is not provided;
- of the client's right of access to, and correction of the information;
- how records are kept – ie client paper file and electronic database;
- that the client has the right to withhold information for privacy reasons. If, however, information about the level of income is not provided fees will be charged at the highest rate.

The only information held by the organisation about a client will be information necessary to assess the need for a service, and to provide the service. Information will be as objective as possible, yet relevant and up-to-date.

APP 2 – Anonymity and pseudonymity
Community Care Options are required to identify clients receiving services to funding bodies. It is therefore unlawful and impractical for us to deal with clients who have not identified themselves.

APP3 – Collection of solicited personal information
Community Care Options collects personal and sensitive information from people only if this information in necessary for the provision of our service, functions and activities and only if consented to by the person.

CCO only collects information in accordance with permitted general and health situations in relation to our service delivery.

CCO will only collect information by lawful and fair means.

Purpose of Collecting Information
The purposes may include –

- prioritising and processing referrals;
- referring clients on to other services (with their permission);
- assessing clients' service needs and offering service, referral and equipment to meet those needs;
- providing relevant agreed services to clients;
- assessing WH&S status of client's homes for the purpose of service provision;
- service provision;
- continuity of care;
- keeping client records;
- sending out and processing client accounts;
- meeting funding, legal and regulatory requirements;
- quality measurement and management.

Information collected and recorded by the organisation includes all information detailed on referral forms and on the organisation's assessment forms.

Type of information collected and held
Includes but is not limited to –

- name and contact and carer details;
- details of birth, language preference and cultural affiliations;
- financial details, government entitlements;
- accommodation, living arrangements;
- health, medication;
- assessment of ability to perform tasks of daily living;
- functional abilities;
- quality of life issues;
- referral requirements;
- carers' needs;
- present and future service requirements.

Documentation kept on the client's individual file includes but is not limited to –

- referral information;
- assessment information – CCO and other;
- WH&S risk assessment and risk management plan if required;
- review information - change in circumstances of the client;
- support plan;
- duties list;
- service agreement;
- consent forms;
- equipment information;
- complaints;
- reports/information from and to other agencies;
- client progress notes.

APP 4 – Dealing with unsolicited personal information
CCO will advise of client's of any information obtained or collected, including unsolicited personal or sensitive information. If the information received is not relevant to the provision of CCO services, function and activities it will either destroy the information or de-identify the information.

APP 5 – Notification of the collection of personal information
All CCO clients will be advised during Intake and Assessment processes about what information CCO collects and for what purpose.

CCO will not collect information form sources that the client has not consented to.

Sources of information
We obtain personal information from the following –

- the individual to whom the information relates;
- the parent or guardian if a person is under the age of 16 years or has an official guardian who is authorised to pass on such information;
- other persons whom the individual has authorised to pass on the information;
- other health or service providers whom the individual has authorised to pass on information to Community Care Options.

APP 6 – Use or disclosure of personal information
The organisation does not disclose any of the above information to others without the client's or the client's authorised representative's consent.

CCO does not disclose or release client information to any persons or entities outside of Australia.

CCO releases or discloses personal information only as permitted by general and health situations and only as required under Australian legislation ie Mandatory reporting, reporting as per government funding contracts.

Disclosure of Client Information
We may also disclose information with the consent of the person responsible where

- the client to whom the information relates is deceased or physically or legally incapable of giving consent to the disclosure, or physically cannot communicate consent to the disclosure; and
- the disclosure is not contrary to any wish (of which the organisation is aware) expressed by the client before that person became unable to give or communicate consent;
- information is needed urgently for medical treatment or when disclosure is essential to protect a person from imminent harm. Even in these circumstances, the client, guardian or "person responsible" would, if possible, be asked permission to release confidential information.

These disclosures and others to third parties may be for –

- referrals and feedback to other service providers, including health

professionals and community services providers;
- client service provision by external contractors, eg. removalists, lawn mowing services;
- financial auditing services;
- auditing by the funding bodies;
- workers compensation issues.

The organisation will provide a list of third parties to whom we may disclose information on request.

The organisation obtains some services from external service providers. Some clients' information may be provided to them on a confidential basis if the client gives his or her consent.

APP 7 – Direct marketing
CCO does not collect personal information for the purposes of marketing.
CCO does not provide direct marketing communications to clients.
CCO does provide newsletters to clients quarterly – these do not contain client personal information and clients can elect not to receive these communications.

APP 8 – Cross border disclosure of personal information
As per APP 6 above.

APP 9 – Adoption, use or disclosure of government related identifiers
CCO users government related identifiers for the purposes of reporting to government only as per funding contracts.

CCO does not adopt, use or disclose government related identifiers.

APP 10 – Quality of personal information
CCO will ensure that all information collected and retained by the organisation in relation to clients is accurate, up to date and complete.

APP 11 – Security of personal information
CCO ensures that it provides security and protection of client personal information from misuse, interference and loss and unauthorised access, modification or disclosure.

We protect the personal information we hold by maintaining physical, electronic and procedural safeguards.

Protecting Clients' personal Information

The organisations physical safeguards include –

- an individual file will be created for each client following initial assessment;
- client's files are stored in the organisations central filing systems;
- client files do not show clients' names externally;
- client names are not visible until files are removed from the filing systems;
- the client filing systems are locked at the end of each working day;

- keys to the client filing systems are kept in a locked cupboard;
- client files are kept locked in the boot of the car when taken out of the office;
- ensuring client information and client related contact is up to date at all times;
- Support Planners will maintain a 'clear desk' policy. This means that all client files and any other client related material will be filed in their appropriate place in the locked filing drawers at the end of each working day;
- ensuring that all client information is filed correctly and in a timely manner;
- staff utilising tools or data management systems as adopted by the organisation.

The organisations electronic safeguards include –

- electronic client information is password protected;
- electronic transmission of information to the funding bodies is encrypted;
- client information is not sent through unprotected emails;
- access to client information is limited to authorised staff.

The organisation's procedural safeguards include –

- all staff are trained in confidentiality and the Privacy Act;
- contractors or people working on site, are required to sign a confidentiality agreement;
- if an outside person enters the office, the staff member closes the computer screen if it shows personal client information;
- meetings with visitors take place in organisation's meeting rooms whenever possible;
- meetings with clients will only be conducted in an area which allows sufficient privacy.

APP 12 – Access to personal information
Access to own information
Under the Australian Privacy Principles clients have the right to access their own information held by the organisation. Clients can make a request to their Support Planner verbally or in writing. On request, a staff member will be made available to explain any terminology to the client. Clients' request for access will be responded to within 10 working days.

The organisation will validate the identity of anyone making a request to access client information. This is to ensure that information is not passed to a person who is not authorised to receive it.

APP 13 – Correction of personal information
If clients find that the personal information we hold on them is not correct, complete or up-to-date, the organisation will correct their records accordingly.

Length of Time Records Are Held
Client records are archived, once the exit procedures have been completed. All information regarding clients will be destroyed seven years after clients cease to receive services or in the case of children when the client reaches age 25 whichever is

the latest.

Direct Support
For clients who receive direct care support a range of specific issues related to privacy, dignity and confidentiality need to by considered –

Personal Hygiene
Staff members are to actively encourage and support clients to be as independent as possible in tasks involving personal hygiene and bathing. Clients are to be provided with the least intrusive support in personal hygiene.

Where the client does require support to complete personal hygiene tasks the staff member is to attend to that task. Interactions with other staff members or clients are not appropriate while such assistance is being given.

For matters related to an individual's personal hygiene the following arrangements are to be made –

- appropriate facilities are used that are private and not shared;
- where doors are closed staff members are to knock to gain permission to enter and respect the person's privacy if permission is refused;
- minimum physical contact including use of sponge/face washer when assisting with bathing;
- maximum possible level of privacy for clients receiving assistance whilst bathing, for example a shower curtain;
- staff are to be sensitive to culturally based differences in attitudes and expectations of individual clients in relation to toileting, bathing, menstrual and genital hygiene;
- observance of appropriate standards and measures to ensure infection control;
- providing clients with information of actions to be undertaken.

Sexuality and Human Relationships
Staff members are to support client lifestyle choices and to ensure that the privacy of these details is respected.

Staff members are to ensure the clients rights to develop and express their sexuality and maintain human relationships is respected.

Social Events and Activities
Arrangements for meeting personal hygiene needs during social events and outings are to be planned and considered in the context of maintaining the privacy and dignity of the client.

Cross Referencing & Further Reading
Consent Policy

Schedule for Revision of Policy: Privacy, Dignity and Confidentiality				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
21/01/ 2002	New policy	A. Vaughan		
29/05/06	Revision	A. Vaughan	29/05/08	
26/7/08	Reviewed & updated	D. Ryan		
8/8/2010	Reviewed & updated	D.Ryan	2012	
11.11.2011	Reviewed & Updated	D. Ryan		
March 2014	Reviewed & updated	D. Ryan	2015	

3.8 Complaints & Feedback Management

Definition
A complaint is any dissatisfaction expressed by an interested party about a specific Community Care Options (CCO) provided service. The complainant (interested party) defines the actual complaint.

Position Statement
CCO is committed to delivering quality client services. The principles of accountability, responsiveness and procedural fairness are central to the provision of quality, client focused services. Issues in service provision can occur so we need to ensure that people can raise their concerns in a constructive and safe way.

Complaints serve an important purpose because they can help us immediately improve or identify opportunities to improve services and quality of care to clients. Effective complaint management seeks to improve our communication and working relationships with our clients, and to develop strategies for continuous service improvement.

Legislation and Standards
Home Care Standard 3 – Service User Rights and Responsibilities
Expected Outcome – 3.3 – Complaints and Service User Feedback –
Complaints and service user feedback are dealt with fairly, promptly, confidentially and without retribution.
Disability Service Standard 4 – Feedback and Complaints
Community Services Complaints and Appeals Monitoring Act (NSW) 1993
Disability Services Act (NSW) 1993 and NSW Disability Services Standards
Human Rights and Equal Opportunity Commission Act (Commonwealth) 1986
Disability Discrimination Act (Commonwealth) 1992
Anti-Discrimination Act (NSW) 1977

Principles of Client Service
CCO's commitment to quality service guarantees our services will -

- be caring, personalised, courteous, timely and accessible;
- involve the least possible interference, restriction or intrusion;
- treat clients fairly, with dignity and respect;
- maintain clients rights to privacy;
- take into account clients cultural backgrounds and religious beliefs;
- be responsive to clients needs.

Goals of effective complaint management
Resolution of customer dissatisfaction and improvement of processes, systems and skills related to service delivery.

Basis of effective complaint management –

- prompt, positive response to complaints;
- two way communication between staff and clients;
- effective problem solving skills;
- consistent, well known management procedures;
- clear recording formats and procedures;
- regular progress reporting to complainant;
- knowledge by clients of their right to complain about a service.

Any person or organisation using CCO services or affected by our decisions, has the right to complaint if dissatisfied. Complaints may also be made by an interested party on behalf of another person. It should be established that an interested party has the authority to make such a complaint and issues relating to confidentiality need to be clarified.

Although the organisation's control over the availability of certain services may be limited due to budgetry constraints, clients are entitled to information about processes and decisions affecting resource allocation.

Staff should ascertain the client's outcome expectation when each complaint is lodged.

Sometimes the concerns of clients can be dealt with promptly within the existing casework relationship through discussion with relevant staff. In such cases, it may not be appropriate or necessary to define the clients concern as a complaint. It should in this case be recorded as feedback.

In cases of this nature, it may be appropriate to dispel any doubts by specifically asking whether the person wishes concerns to be registered as a formal complaint or as feedback.

Stages in Complaint Management

Identification
The complaint/feedback will be defined by the complainant.

Staff are to record all client feedback/complaints on the Complaints Notification Form (CNF).Attached.

Reassure clients and encourage them to continue using the service. Advise clients that their feedback is valued and assists us to improve our service delivery.

Staff receiving the complaint/feedback will need to identify and clarify all the complaint issues, including outcomes expected by the complainant.

After determining the complexity of the complaint/feedback, the staff member will need to determine whether immediate resolution is possible or whether the complaint should be referred to a supervisor for further assessment.

If practicable and expedient, the complainant might be encouraged to put the complaint and related issues in writing if this has not been done and staff should

assist complainants to do so where appropriate.

Staff should summarise the issues and expected outcomes, and check the accuracy with the complainant.

Where the client identifies the issue as feedback rather than a formal complaint the staff member is to refer for appropriate action. The staff member will identify the action taken and record on the CNF before sending to the Complaints Officer.

Investigating the Complaint
All complaints will be referred to the Complaints Officer (Client Services Manager). The CEO will be advised of all formal complaints when they are received.

The Complaints Officer will contact the client and/or other party within 24hrs of complaint being received to acknowledge complaint and gather any other relevant information. This may necessitate a meeting with the client or other party. The complainant will be informed of the complaints process and likely timeframe. The Complaints Officer will provide a letter to the complainant acknowledging receipt of the complaint.

The Complaints Officer is to develop a complaint investigation plan for the perusal/approval of the CEO.

The plan should cover matters such as –

- summary of complainants issues
- identification of persons to be interviewed/consulted
- list of files/documents to be reviewed
- expected target date for completion of report.

The complaint investigation plan will be implemented and investigation completed by the Complaints Officer.

The Complaints Officer would normally be expected to provide a written report summarising the findings and recommending any necessary action to the CEO within 2 weeks of complaint being received.

The report recommendations should focus on options necessary to resolve the complaint and if relevant to preclude recurrence of a similar problem.

All clients will be encouraged to use an advocate of their choice to negotiate on their behalf with the staff and/or management. The advocate may be a family member or friend, or an agency such as the Aged Care Rights Service or Disability Rights Service. The Support Planner will explain to clients how they can access and use an advocate.

CCO will address all complaints promptly, fairly, sensitively and confidentially.

The Complaints Officer will ensure the complainant receives feedback about the progress and outcomes of an investigation.

Resolution
The CEO will provide a response to every formal complaint within 21 working days of the complaint being received. This response may include an outline of any further action to be taken.
Where a complaint is raised in relation to the CEO then the complainant may ask to have the matter reviewed by the Board of Management.

A formal complaint will not be handled by any person who was directly involved in the matter that the complaint was about.

Community Care Options will consider any policy or procedural amendments which are suggested as a result of the resolution of the complaint.

All complainants will be advised of other agencies where there complaint can be taken if not resolved by the organisation.

Clients or those making a complaint can expect that the following will occur in relation to their complaint -

- acknowledgement within 24 hrs of receipt
- investigation as soon as practicable, if necessary by clarifying the details of the complaint with the person complaining or the client, and taking relevant statements from staff and any witnesses
- they will be informed in writing of any outcomes of the investigation and any resultant action on the part of the organisation, eg. a change in policies and procedures
- an apology where the complaint is proven and positive feedback for raising the matter
- that all parties involved in making the complaint receive copies of the organisation's response
- that the complaint is recorded on the organisation's complaints register
- follow up with the client by telephone or in person to ascertain if the complaint has been dealt with to the client's satisfaction and if there are any outstanding issues
- that the complaint will be reported to the Board of Management
- complaints reported in the Annual Report (not including names)
- complaints reported in accordance with any data collection required by Funding Bodies.

Complaints Register
A Complaints Register will be maintained to record complaints by clients.

Feedback from Clients and Others
Where the client provides feedback but does not wish to make a formal complaint the information will be recorded on a feedback register as either positive or negative.

Staff are to indicate on the CNF if the matter is a complaint or feedback.

The matter that is subject of feedback will be investigated as per a complaint

however the matter will be managed in a less formal way with the Support Planner providing feedback to the client as to the outcome of their feedback. The Support Planner or relevant other person managing the feedback will record the actions and outcomes taken on the CNF.
Agencies external to Community Care Options to whom a complaint can be taken include -

The Aged Care Complaints Scheme provides a free service for anyone to raise their concerns about the quality of care or services being delivered to people receiving aged care services subsidised by the Australian Government, including -

- residential care
- Home Care Packages
- Commonwealth funded HACC services.

Aged Care Complaints Scheme – 1800550552 (freecall)
Aged Care Complaints Scheme
Australian Department of Social Services*
GPO Box 9820
(Your capital city and state/territory)

Online – agedcarecomplaints.govspace.gov.au

Disability Services
NSW Ombudsmen
Phone: 02 9286 1000
Toll free (outside Sydney metro): 1800 451 524
Web: www.ombo.nsw.gov.au
Email: nswombo@ombo.nsw.gov.au
Fax: 02 9283 2911

Where else to get help
Anti-Discrimination Board NSW
(02) 9268 5555
www.lawlink.nsw.gov.au/ADB

Australian Human Rights Commission
(02) 9284 9600
Complaints: 1300 656 419
complaints@humanrights.gov.au
www.humanrights.gov.au

ADHC (in the Department of Family and Community Services)
(02) 8270 2000
www.adhc.nsw.gov.au/contact_us/make_a_comment,_enquiry,_complaint_or_compliment

Disability Discrimination Legal Centre
1800 800 708 (NSW only)
www.ddlcnsw.org.au

Health Care Complaints Commission
(02) 9219 7444 Free call:1800 043 159
hccc@hccc.nsw.gov.au
www.hccc.nsw.gov.au

Intellectual Disability Rights Service
(02) 9318 0144
Free call 1800 666 611
info@idrs.org.au
www.idrs.org.au

NSW Health
(02) 9391 9000
nswhealth@doh.health.nsw.gov.au
www.health.nsw.gov.au

Schedule for Revision of Policy: COMPLAINTS & FEEDBACK MANAGEMENT POLICY				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
27.1.2009	**Adopted**	**D.Ryan**	**2012**	
11.11.2011	**Reviewed & Updated**	**D. Ryan**		
22.9.2014	**Reviewed & updated**	**D. Ryan**	**Sept 2015**	

FEEDBACK/COMPLAINT REGISTRATION **NO.:**

Date Received : _____ Person Receiving Feedback/Complaint: _____
Position - _____

By: ☐ Telephone ☐ In Person ☐ Correspondence

Complainant: **Client No.:**

Name	
Address	
Telephone	

☐ Client ☐ Family Member ☐ Other Service Provider
☐ Funding Body ☐ Other - _____

Program Area:

☐ Level 2 HCP ☐ TACS ☐ COP
☐ Level 4 HCP ☐ Private ☐ Connect
☐ CRS ☐ ☐ CSP
☐ COP Aged ☐ Compacks ☐ PSP

Nature of Feedback/Complaint:

☐ Attitude/conduct of staff member ☐ Failure to follow policy/procedure
☐ Failure to provide service ☐ Insufficient resources
☐ Standard/Quality of service ☐ Other

Issue:

_____
_____
_____
_____
_____

Action Required:

_____
_____
_____
_____

Action Taken:

_____
_____
_____
_____

Signature: _____ Reported To: _____

Received By: _____ Date: _____

Action Taken:

_____
_____
_____
_____
_____

Outcomes:

_____
_____
_____
_____

☐ Resolved ☐ Further Action Required

Signature: _____ Position: _____

Reported to CEO – Date:

_____

Recorded on Feedback/Complaint Register: _____

Complaint Reviewed by Management Team – Date: _____

Recommendations for review of policy, procedure or practice – yes/no

_____
_____
_____
_____
_____

Training Need Identified – yes/no

_____

Breach of Policy or Procedure Identified – yes/no

_____

Performance Management Identified – yes/no

_____

Above actioned through addition to service improvement plan – yes/no

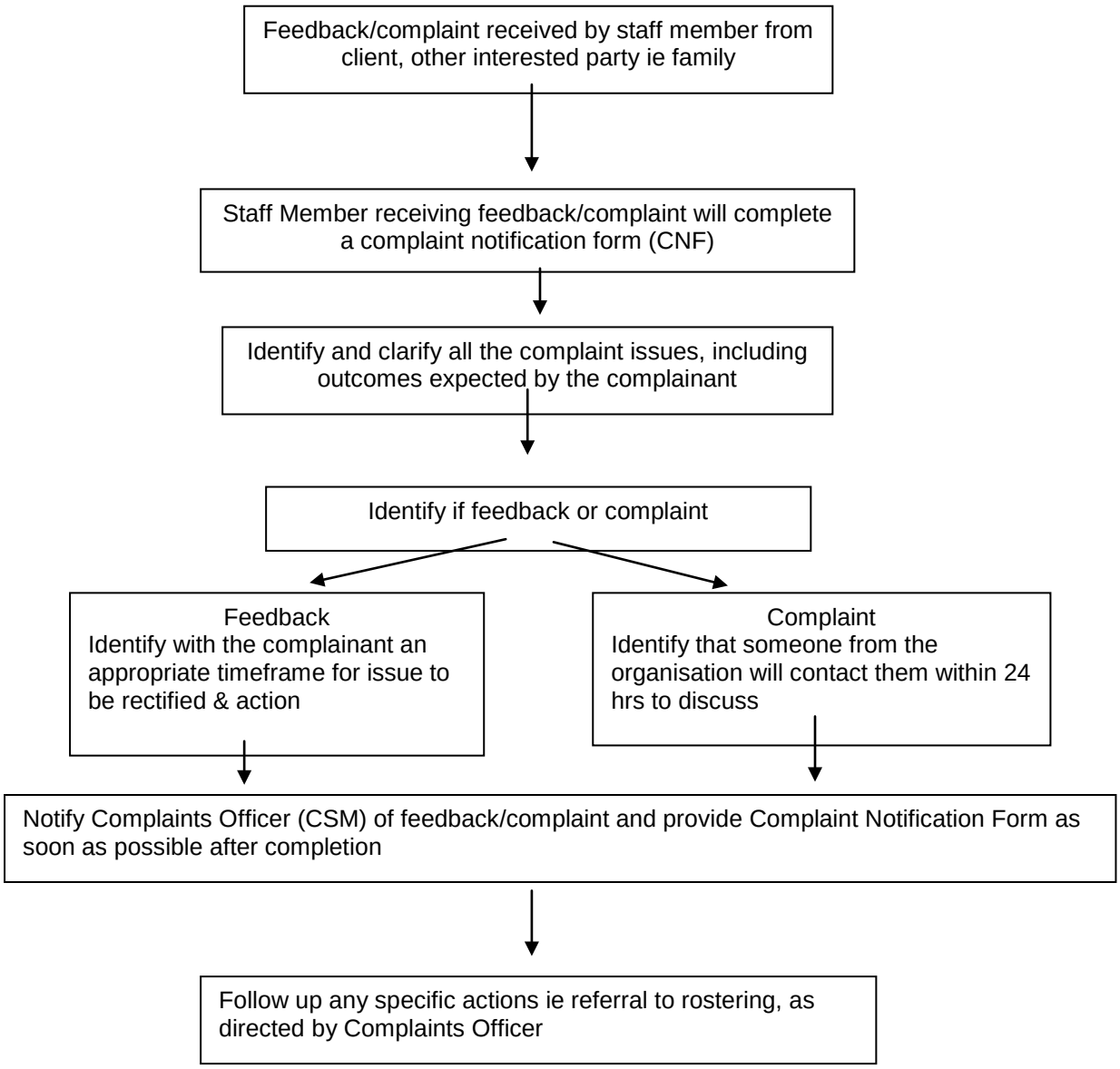
_____

Complaint Finalised – yes/no

_____

Signature: _____ Position: _____
Date: _____

COMPLAINTS REPORTING PROCESS



Defining a complaint – it is any dissatisfaction expressed by an interested party about a specific CCO provided service. An interested party can be the client, an advocate, a friend, family member, staff member.

Sometimes the concerns of consumers can be dealt with promptly within the existing casework relationship through discussion with relevant staff. In such cases, it my not be appropriate or necessary to define the consumers concerns as a complaint.
In cases of this nature, it may be appropriate to dispel any doubts by specifically asking whether the person wishes their concerns to be registered as a formal complaint.

COMPLAINTS RESOLUTION PROCESS

Complaints Officer to register complaint on Complaint or Feedback Register

Contact made by Complaints Officer with Complainant to advise of receipt of complaint and to get further information (within 24hrs)

Notify CEO of complaint (same day)

Complaints Officer to investigate complaint, identify further actions needed and resolve where possible

Documentation re complaint actions/resolution or recommendations for further action to CEO

Outcomes reviewed by Management Team at next meeting

Actions as identified above implemented may include policy, practice review,

Complaints Officer to update register re outcomes

CEO advises complainant of outcome of complaint

Complaint finalised and filed

3.9 Advocacy

Definition
An advocate is a person who, with the authority of the client, represents the client's interests.

Position Statement
Clients may use an advocate of their choice to negotiate on their behalf. This may be a family member friend or advocacy service. Advocates will be accepted by Community Care Options as representing the interests of the client. Advocates may be used during assessments, reviews, complaints or for any other communication between the client and the organisation.

Legislation and Standards
Home Care Standard 3 – Service User Rights and Responsibilities
Expected Outcome 3.4 –
Each service user's (and/or their representative's) choice of advocate is respected by the service provider and the service provider will, if required, assist the service user (and/or their representative) to access an advocate.
Disability Service Standards 1,2,3,5

Operational Procedures

Community Care Options will inform each client of the advocacy services which are available in the local area. If no advocacy service or advocate is available, Community Care Options will, if requested, assist clients in their attempts to find an advocate who –

- will listen to and follow the client's instructions;
- will fairly and impartially articulate the client's wishes;
- is independent;
- will assist the client to be better informed, to achieve desired change and to meet the client's needs;
- will increase the client's confidence, independence, power and achievement of desired outcomes.

Where it has not been possible to recruit an independent advocate, the organisation will offer to act as an advocate for the client in interactions with other services.

Advocacy is seen as being a component of the case management process.

Staff will make sure clients are aware of their right to use an advocate, and will regularly remind clients of this option. This information is available in the Client's Agreement and will be explained at formal assessments and reviews and through informal discussion and from time to time, in the clients' newsletter.

The organisation's staff will receive training in the use of advocates*.*

Procedure for Appointing an Advocate
Clients wishing to use an advocate should inform the organisation, if possible in

writing, of the name of the person they wish to negotiate on their behalf. The client has the right to change their advocate at any time and should inform the organisation of any change.

Advocacy Services

Advocacy services are free, confidential and independent.

What can an advocate do?

An advocate can -

- give you information about your rights and responsibilities
- listen to your concerns
- help you resolve problems or complaints with your aged care service provider
- speak with your service provider if you wish
- refer you to other agencies when needed.

Who do I contact about advocacy?

The National Aged Care Advocacy Line is - 1800 700 600.

New South Wales
The Aged-Care Rights Service Inc.
Level 4
418a Elizabeth Street
SURRY HILLS NSW 2010
Phone: (02) 9281 3600 or 1800 424 079 (freecall)
Email: tars@tars.com.au
Website: www.tars.com.au

Disability Advocacy NSW
Head Office
Suite 1, Level 2
408 King Street
Newcastle West 2302
Phone: (02) 4927 0111
1300 365 085
Fax: (02) 4927 0114
Email: da@da.org.au

Coffs Harbour

Office address
79 West High St
Coffs Harbour NSW 2450

Postal address
PO Box 418
Coffs Harbour NSW 2450
Telephone: 1300 365 085 or (02) 6651 1159
Fax: (02) 4927 0114
Email: coffsharbour@da.org.au

Schedule for Revision of Policy: Advocacy				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
29/01/2007	New policy	A. Vaughan	29/1/07	
April 2009	Reviewed & Updated	D. Ryan	2012	
11 November 2011	Reviewed and Updated	D. Ryan		
September 2014	Reviewed and updated	D. Ryan	2016	

3.10 Decision Making, Choice and Consent

Position Statement
Community Care Options (CCO) recognises and respects the right of people to make their own decisions to a level which is appropriate to their individual capacity; empowers and supports self determination and dignity of risk; helps clients and carers to build on their own strengths to maximise their independence; and ensures that clients who have reduced decision making ability have processes in place to ensure their wellbeing.

Legislation and Standards
Home Care Standards – Standards 2 &3 – Appropriate access and service delivery; Service user rights and responsibilities
Disability Service standards – Standard 3 Individual Outcomes

Informed Decision Making
The organisation is committed to empowering clients to make their own decisions as far as possible throughout the decision making process. Staff will therefore –

- help clients explore their individual needs, goals and options and support them in making their choices;
- help clients consider possible consequences and benefits arising from their decisions;
- assist people to access the information, advice and support they need to make an informed decision;
- maximise people's understanding by ensuring such information is tailored to individual need including where needed, the use of interpreters, visual or aural aids, age appropriate language and the like;
- support clients to take calculated risks (see Dignity of Risk/Duty of Care policy);
- employ a sensitive and non-judgemental approach;
- facilitate evaluation of decision outcomes;
- help strengthen resilience, skills and independence by helping clients identify successes and opportunities for learning or change;
- assist clients to plan for and make known wishes for their future care whilst they have ability to do so and to access legal processes to formalise these i.e. Wills, Power of attorney, Enduring power of attorney, Advanced Health Care directives, funeral plans.

Operational Procedures
Each person accessing services is supported to exercise choice and control over the design and delivery of their supports and services. Every person has the right to make their own decisions and to have choices which enable them to fully participate in their community.

Support Planners will maximise person centred decision making by –

- respecting the rights of each person to be at the centre of decision making and to have responsibility, as much as possible, for each decision which

affects them

- supporting each person to determine the involvement of their family, carers and advocates in panning and decision making processes
- respecting the views of family and carers in planning and decision making processes. The client has the final say in the process
- ensuring staff respond in innovative and flexible ways to each person's need for decision making support which reflect their individual and cultural needs
- making every effort to enable a person to make a decision or assist families, carers and advocates to come to an agreement before a substitute decision maker is engaged
- working together with the person to develop and implement a plan that identifies and builds on the person's strengths, aspirations and goals. Plans should draw on broader family, cultural and religious networks and community organisations
- supporting each person, and (when necessary with consent) their family, carer or advocate to develop, review, assess and adjust their plan as their circumstances or goals change.
- recognising the importance of risk taking and enabling each person to assess the benefits and risks of each option available to them and trialling approaches even if they are not in agreement
- working with other organisations and community groups to expand the range of service options available in their community
- regularly reviewing their person centred approaches to ensure the organisation has the capacity and capability to deliver flexible and responsive supports and services that meet individual needs and expectations.

Duty of Care

CCO is committed to ensuring that, in the first instance, a client is the person who makes decisions in regards to themselves and the service they receive. CCO recognises however, that some clients have reduced decision making ability and may therefore require support to make decisions which are in their own and others best interest. CCO fulfil their Duty of Care to such clients, to CCO staff and others in the community by –

- identifying clients who may have reduced decision making capacity;
- referring such clients to professionals who are qualified to determine decision making capacity;
- facilitating the appointment of a 'substitute decision maker' for clients who are deemed not capable of making their own decisions in one or more areas of their life (ie. a person may require a financial manager but be deemed capable of making own lifestyle decisions);
- respecting and supporting the nominated substitute decision maker's role;
- reporting any decisions which involve the possibility of unlawful acts or which have the potential to endanger or harm the client or others to relevant authorities in consultation with the Client Services Manager.

Substitute Decision Makers

At no time shall staff employed by CCO be appointed or act as a substitute decision maker for any client of CCO.

CCO will ensure that clients who have reduced decision making ability have one of the following –

A Person Responsible

- A Guardian (including an enduring guardian who has the function of consenting to medical, dental and health care treatments);
- If there is no guardian: The most recent spouse or De facto spouse with whom the person has a close, continuing relationship. De facto spouse includes same sex partners;
- If there is no spouse or De facto spouse: An unpaid carer who is now providing support to the person;
- If there is no carer: A close relative or friend may act as the person responsible as long as they are not receiving remuneration for any services from the person.

Guardianship Tribunal

If there is no 'person responsible' it may be appropriate to make an application to the Guardianship Tribunal for the appointment of a formal substitute decision maker. The Guardianship Tribunal's purpose is to keep paramount the person's interests and welfare through facilitating decisions on their behalf.

The Guardianship Tribunal has specific and limited powers. It can –

- Make guardianship orders to appoint a private guardian (family member or friend) and/or the Public Guardian;
- Make financial management orders to appoint a private financial manager and/or the Public Trustee;
- Provide consent for treatment by a doctor or dentist;
- Review enduring powers of attorney;
- Review an enduring guardianship appointment;
- Approve the person's participation in a clinical trial.

In order to maintain workable relationships with clients and families it is CCO's preference that a professional other than the CCO Support Planner take the lead role in making application to the Guardianship Tribunal. Should there be no other person who is able or willing to make application to the Guardianship Tribunal on behalf of the client the CCO Support Planner may do this in consultation with the Client Service Manager.

CCO Support Planners –

- provide support to the client throughout the application process including maximising understanding of and participation in the process;
- may attend Tribunal hearings with the client if this is required to support and advocate for the client;
- may provide a letter to support the application to the Tribunal if this is required. Such a letter will be in accordance with relevant CCO policies and must be approved by the Client Services Manager;
- must legally abide by decisions handed down by the Guardianship Tribunal;

- liaise with appointed decision makers as required to ensure effective service provision;
- provide Case Management support within program scope.

Should the Support Planner have concerns about the conduct of any appointed substitute decision maker than these should be conveyed to relevant authorities in consultation with the Client Services Manager.

Advocates
CCO recognises and facilitates the right of clients to have access to an advocate if this is desired by the client. The role of an advocate is to assist a client to express their needs or to speak on behalf of a client. Advocates are however, not regarded as substitute decision makers.

Children and young people
Children and young people who are clients of Community Care Options should be involved in making decisions and choices about things that affect them to a level which is appropriate for their capacity to understand and their decision making skills. Families, including parents and carers of children should be involved and considered in decision making processes. Legal age limits vary for specific decisions requiring young people giving consent. If need arises CCO staff will seek advice to clarify legality of choice and decision making ability for young people.

Consent
In no instance are staff employed by CCO able to sign any form or documentation on behalf of a client. If a client is competent to give consent but is physically unable to sign consent on a CCO document, and clearly indicates a desire to do so, the Support Planner should write on the form that the client was unable to sign but has used an alternative method (ie. verbal, signing) to consent or not consent.

If the client has been assessed by a qualified professional as unable to give consent then the client's substitute decision maker should sign on their behalf within their authority to do so.

Schedule for Revision of Policy: Decision Making and Consent				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
30/07/07	**approved**	**R. Thompson**	**30/07/10**	**New Policy**
11.11.11	**Reviewed & Updated**	**D. Ryan**		
September 2014	**Reviewed & updated**	**D. Ryan**	**2016**	

3.11 Client Contribution

Definition
A client contribution is the amount of money that a client is requested to contribute towards the costs of care.

Position Statement
Community Care Options (CCO) is dependent upon government funding to provide services to its clients. This funding is a nominated subsidy depending upon the program. The government expects and encourages services to also request a contribution from clients to supplement the costs of service provision. The government determines appropriate fee schedules. Clients that have the capacity to pay are requested to pay a contribution, however clients will not be refused a service due to an inability to pay.

Any revenue from contributions will be used to enhance and expand the provision of services.

Legislation and Standards
Aged Care Principles
Home Care Standards – Standard 1 – Effective Management
Disability Service Standards – Standard 6 – Service Management

How contributions are calculated

Contribution rates are determined by funding bodies for some programs.

The government determines what is a reasonable amount to request from a client. Fees for Home Care Packages changed on 1st July 2014. Clients can now be requested to pay a basic fee of up to 17.5% of the single basic age pension and an income tested care fee if your income is over a certain amount.

The basic fee for a Home Care Package, including Consumer Directed Care, that the government has determined service providers can charge is up to $135.80 per person per fortnight ($9.70 per day or **$271.60 per month**) (from 20th September 2014 until 19th March 2015).

Depending on your income, you may be asked to contribute more to the cost of your care. This extra amount is known as an income tested care fee. The Department of Human Services works out the income tested care fee based on an assessment of client financial information.

As identified above the Dept Social Services sets what it considers to be a reasonable contribution rate for clients on Home Care Packages.

The assessment does not include the value of your home or any other assets.

Clients can only be asked to pay an income tested care fee if they have a yearly

income above the following thresholds –

Individual person - $25,118.60
Member of a couple but now separated due to illness (individual income) - $24,650.60
Member of a couple living together (combined income) - $38,984.40

Clients who can afford to pay the full contribution are encouraged to do so.

Operational Procedures
Community Care Options reviews its contribution levels twice a year, in line with recommendations made by the Department of Social Services (previously Department of Health and Ageing). This fee contributes to the cost of delivering services. Every year, in March and September, the Department of Social Services publishes its rate increases in line with changes to the Aged Pension.

CCO recognises that this rate is not always affordable for clients and has determined the following minimum contribution levels for clients -

Minimum contribution for clients in receipt of 3.5 - 5 hours a week of service on a **Home Care Level 2 package (CACP)** including CDC will be $30 per week or **$120 per month.**

Minimum contribution for clients in receipt of 10 – 16 hours a week of service on a **Home Care Level 4 package (EACH)** including CDC will be $50 per week or **$200 per month.**

Minimum contribution for clients in receipt of 3 – 6 hours a week of service through the **Community Respite Service (CRS)** will be $30 per week or **$120 per month.**

Minimum contribution for clients on the **Compacks** program is **$10 per week.**

Minimum contribution for clients in receipt of direct services on the **COP or COP Aged Care** program is **$10 per week** for the first **4 weeks** then **$10 per hour** after this.

Capacity to pay

- Before commencing service the client and or representative negotiate with the Support Planner a monthly contribution. The contribution takes into account the person's individual capacity to pay, equity with other clients, the total effect of the range of charges being paid by each client and other family, housing and disability commitments.

- Clients are asked to advise their Support Planner within 30 days of any significant changes in circumstances which may alter their status in relation to the payment/ non-payment of a contribution (e.g. receipt of compensation payments, compensation payments cease etc).

- Clients are required to complete a Centrelink Income Assessment Form and this will be used by the Department of Human Services to calculate any requirements for a client to pay both the basic care fee and the income tested care fee. CCO's subsidies from government are reduced as determined by the client's assessed capacity to pay the income tested care fee.

Confidentiality
All contribution negotiations and clients' information regarding their income will be treated with the strictest confidentiality.

How contributions are varied
The agreed contribution will apply until it is renegotiated. The same monthly contribution is payable even if the service is reduced, increased or suspended. Clients will be asked to advise Community Care Options if their financial situation changes markedly and this affects their ability to pay any agreed contribution.

Financial Hardship
If a client is unable to pay the agreed contribution temporarily the Support Planner may submit a request to reduce or waiver the contribution for a period of three months. The waiver request form will be reviewed and considered by the Management Team.

Payment for additional services
Clients can choose to pay for additional support over and above the level offered by Community Care Options or government subsidies. These will be billed at the full cost of service, not the usual contribution for service.

Appeal
Clients, potential clients and their advocates may lodge an appeal with the Support Planner if they are unhappy with the level or extent of contributions charged. This can be done in writing or by telephone and only requires that the client asks the Support Planner to review their contribution. All clients will be advised of the appeal process which is described in more detail below.

Appeals Mechanism
The process for appeals is –

- the client contacts the Support Planner in writing or by phone about their concerns with the contribution;
- the Support Planner responds within 7 working days and subsequently meets with the client to discuss the situation;
- in some instances, based on the principles outlined under "Financial Hardship" (above), the Support Planner may submit a request for the contribution to be waived;
- if the client is not satisfied with the result of the Support Planner response, they may follow the "Complaints Procedure".

No client will be disadvantaged or penalised as a result of lodging an appeal about the contribution charged. A client's right to appeal is included in the Client's

Agreement and is fully explained at the time of assessment and reviews.

How clients pay their contribution
We send out a contribution advice around the first week of each month. This contribution advice will be for services received during the previous month. For example, the advice for services provided in March will be received by clients in the first part of April. Clients can send us a cheque, postal order or bring the money to the office. Clients are able to use direct debiting or Centapay systems. Contributions may be waived if collection costs exceed potential income.

Client's who refuse to pay their agreed and assessed contributions may have services suspended as a result. Support Planners are responsible for following up client contribution payments, reviewing these annually and discussing payment options with clients to ensure continued service provision. No client service will be suspended without having exhausted all options and negotiations with the client and/or their representative.

Schedule for Revision of Policy: CLIENT CONTRIBUTION POLICY				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
24/07/2006	New policy	R. Thompson		
29/01/2007	Amended	A. Vaughan	29/1/07	
21.9.2009	Reviewed & Updated	D. Ryan	2012	
6.1.2011	Reviewed and Updated	D. Ryan		
11.11.11	Reviewed and Updated	D. Ryan		
25.2.14	Reviewed and Updated	D. Ryan		
August 2014	Reviewed & updated	D. Ryan		

3.12 Assessment of Client's Individual Needs

Definition
Assessment is a component of support planning that involves a comprehensive discussion with the client and or their advocate to determine what the client needs in relation to their request for service.

Position Statement
Community Care Options operates with a person centred, strengths based approach to support planning and service delivery. We meet with each new prospective client to discuss what they require from service delivery, their goals and aspirations, their strengths, what is currently working well for them and what areas they need support with. Each potential client's support needs are identified through the assessment process.

Legislation and Standards
Home Care Standard 2
Expected Outcome 2.2 – **Each service user participates in an assessment appropriate to the complexity of their needs and with consideration of their cultural and linguistic diversity.**
Disability Service Standards 2 & 3

Operational Procedures

Community Care Options utilises a Case Management model of service delivery for most of its programs. Case Management involves a number of stages/phases –

- engagement
- assessment
- planning
- monitoring
- evaluation and outcomes.

The following principles are used to guide our practice –

- case management facilitates the personal development of clients
- case management advocates for client rights
- case management is purposeful
- case management promotes sustainable solutions
- effective communication underpins Case Management.

Case Identification and Assessment
Clients who meet eligibility criteria are identified and an assessment is completed. An element of screening occurs at Intake to determine the initial needs of the client. These needs are matched against the eligibility criteria for CCO programs and an assessment is then completed. The client and Support Planner are linked through processes of referral. Case identification involves the collection of information about perceived client needs or risks. Case identification results in a decision to either accept or decline services for a person based on appropriateness within the aims, and objectives of programs.

Assessment is a process that underpins all subsequent case management actions. It is an ongoing process of gathering and appraising data from various sources to identify areas where the Support Planner and client will focus their efforts. The identification of needs commences during the assessment phase and may be facilitated through actions such as risk assessments and interviews.

Potential clients are assessed upon receipt of referral for service.

Assessment Guidelines
The Support Planner is expected to –

- Ensure that clients understand their rights and responsibilities, supported by evidence of clients consenting to be involved in the program.

- Gather information about clients while respecting their confidentiality and privacy with the aim of not duplicating assessments.

- Identify and prioritise the client's initial needs to inform more comprehensive assessment once initial screening is completed. A comprehensive assessment, reflecting the client's situation and program guidelines, is completed within a reasonable timeframe. The Support Planner and client focus on areas within a defined social model of health that may influence the client's health and well-being. Explain the assessment process to client's and ensure the client understands the complaints/appeal processes that apply to programs.

- Understand the client's specific cultural needs so that appropriate services and support for client development occurs.

- Identify and analyse risk factors that the client experiences/may experience.

- Communicate those needs which fall within the aims and objectives of the program (including any third party restrictions).

- Consider the client's current situation, probable future situation and ensuing care needs.

Assessments will –

- be conducted by one of the organisation's Support Planners or by another suitably trained person selected by the organisation ie Intake Officer;
- in the case of Level 4 Home Care Packages the assessment will be done jointly with a registered nurse (RN). The RN will make a nursing assessment and the Support Planner the overall service provision assessment;
- validate the client meets entry and targeting requirements;
- be purposeful, and be conducted with efficiency and sensitivity. The Support Planner will respond to the needs of each client, considering her/his cultural or religious beliefs, language, location, disability or age;
- be based on a process which ensures clients in similar circumstances are

treated fairly and equitably;
- result in a support plan and service delivery which encourage maximum client independence and meet the individual's need;
- protect the client's privacy and right to self determination.

In consultation with the potential client, the Support Planner will consider each person's -

- existing support and skills;
- level of functional ability/disability;
- social, cultural and psychological needs;
- circumstances which could put the person at risk;
- quality of life.

The Support Planner will also consider –

- WH&S issues relating to service provision;
- the carer's requirements in relation to the type and level of assistance required to maintain their capacity to continue caring;
- the carer's quality of life;
- the cost effectiveness of the service.

Attending the assessment interview will be –

- the person seeking the organisation's support;
- their legal guardian if required;
- an advocate if the person chooses to have one;
- anyone the person wishes to attend;
- the organisation's Support Planner ;
- an interpreter if required;
- other service providers if appropriate and the client wishes this.

In order to avoid duplication, assessment information will, with the client's permission and where possible –

- be obtained from assessments done by other agencies, eg the CIARR, Comprehensive Assessment or Form 2624 used by ACAT;
- be recorded on the organisation's assessment form or the ONI which incorporates all information required by the CIARR.

<u>Principles to be observed in Assessments</u>
In conducting the assessment/review, the following principles will be observed –

- The client will be made aware that they have been referred to one of the organisation's programs and are being assessed/reviewed to determine their need for services. They will be informed of the criteria used and the outcome of the assessment/review;
- Client will be informed that their need for services will be reviewed by the Support Planner at a minimum, every three months, and that the services

provided may change as a result of the review. If services are provided on a temporary basis clients should be made aware of the duration of service;
- The client will be provided with a copy of the Client's Information folder at the time of assessment with the content being verbally explained at the assessment and any subsequent review.

Individual needs and preferences
The individual needs of the client are taken into account including their physical, cultural, social, economic, nutritional needs and the needs of their primary caregiver.

Complaints
The complaints policy and procedures will be explained at the initial assessment.

Advocacy
Clients should be made aware that they may ask a relative, friend or other person to advocate on their behalf.

Assessment Procedure
Appointment
- Ascertain, whether an interpreter/advocate is required;
- Introduce yourself and tell client the reason for the visit;
- Tell client the process of the assessment;
- Ask the client if they wish to invite a friend or relative to attend the assessment;
- Ask for full address and directions including distances from landmarks (in rural areas);
- Ask about any potential risks in the client home that the assessor needs to be aware of to ensure their work health and safety.

Preparation
- Write client's name, address, telephone number and directions into diary;
- Allow enough time for travel and at least 1.5 hours for the initial interview;
- Take with you - diary and mobile phone, map of the area and directions, information folder including our Assessment/Application Form, assessment form completed with the information available prior to the assessment;
- For Level 4 Home Care Packages only, arrange a joint visit with a Registered Nurse who will complete the nursing assessment.

Assessment
- Introduce yourself and why you are there;
- Allow time for rapport building, before discussing specific services available;
- Direct the talk from general conversation to specific difficulties in daily living;
- For Level 4 Home Care Packages only, a Registered Nurse will complete the nursing assessment;
- If client will not identify areas of difficulty guide client through daily routines;
- Try to get a composite picture of emotional physical and social difficulties encountered by the client;
- Confirm that you understand correctly and clarify where necessary;
- Complete a home environment risk assessment.

Ask Client to suggest solutions.
Ask Client about "ideal situations" eg. what would be their optimum outcome. Together with the client generate options to achieve adequate and optimum outcomes.

Ask Client to make choices.

- If appropriate, discuss cost of different services and client contribution;
- Assess relevant safety problems in the home using the work place risk assessment form;
- If solution to problems include equipment ask to be shown the actual position, e.g. where rails need to be situated;
- Consider purchase of equipment as an alternative to service provision, especially where this increases the client's safety and independence;
- At the initial visit, suggest the minimum number of changes which ensure client safety and which solve the major problem, "fine-tune" later.

Once the Client and you have worked out a plan of action –

- summarise what has been agreed on and make sure the client understands the situation and action and welcomes it;
- Spell out what you are going to do, when you are going to do what, and what further communication the Client can expect from you or from other services;
- If there is a delay in action inform the client about this;
- Complete our Application form and allow client/carer to read it or read it to them if they are unable to do this for themselves;
- Explain the consent part of the application form and obtain a signature. If the client is unable or unwilling to sign, please notate accordingly.

If the person cannot be accepted as a Client –

- Explain why;
- Work out with the Client ways of addressing their major problems;
- Offer to refer to other services as required;
- Confirm the refusal in writing;
- Advise the client on when and how to reapply for service in the future.

If Client is accepted –

- Hand over Information Folder and go through content;
- Explain the agreement and/or leave it with the client to read at their leisure;
- If appropriate, discuss complaints procedure. Otherwise leave until next visit;
- Explain you will draft a support plan for their approval and return;
- Explain that at your next visit you'll bring an agreement which spells out the conditions of the program as well as their rights and responsibilities, as the client, and our rights and responsibilities, the service provider;
- Thank the client, remind him or her when you will next be in touch and go.

Decisions
Following the initial assessment, the Support Planner will inform the person

requesting the service within two working days of the organisation/s decision regarding the request for assistance. The decision can be –

- refusal of service;
- referral to another agency;
- provision of service;
- placement of the request on a waiting list.

Refusal of Service after Assessment

The person requesting service will be advised giving reasons why the service will not be provided.

Information will be provided on other available services and if appropriate a referral will be made.

Information will be provided on when, and under what circumstances the person could reapply for the organisations support.

The person will be made aware of the organisation's complaints policy and procedure should they not be happy with the assessment decision.

Waiting List

If a person is placed on a waiting list he or she will be advised of this.

Information will be provided on alternative services and a referral made if the client wishes this.

The person will be informed that their application will be reviewed every three months and that they can ask for a reassessment at any time if their circumstances change.

The person will be made aware of the organisations complaints policy and procedure.

Clients with Special Needs

People from non-English speaking backgrounds

In cases where the person does not speak English an interpreter service will be used to ensure that the client understands the assessment and review process, the services being offered and the general information provided in the client's information folder.

The need for an interpreter service should be clearly identified at the front of the client's file.

Aboriginal and Torres Strait Islander Clients

The organisation will endeavour to provide Aboriginal clients with culturally appropriate services. This means that, whenever possible and if the client wishes this, the assessment will be done jointly with staff from an Aboriginal or Torres Strait Islander service provider. Also, whenever the client wishes and it is possible, services will be delivered by Aboriginal staff. Staff will ensure that the information

regarding the assessment, review, support plan and services are available in culturally appropriate formats and are clearly explained and understood by the client.

Clients Who Cannot Read or Write

In cases where a client cannot read or write, the information in the client's information folder, and information regarding the assessment, review, support plan and services are provided in aural form where appropriate and clearly explained to the client.

Clients with Dementia and Other Special Needs Groups

Staff are trained in how to deal with people with dementia or specific disabilities and every effort made to ensure that services are delivered in an appropriate and sensitive way. For people with severe dementia or severe intellectual, psychiatric or brain injury disabilities, the focus will be more on ensuring that the carers or advocates are fully aware of the contents of the client's information folder and that they are aware of the information regarding assessment, review, support plans and services. However, to whatever extent possible the client will be given the same information and their questions answered.

Coordination with other services

Referrals to another service require prior approval by the client. The organisation will not pass information about clients to other agencies or receive information about the client without the client's consent.

When a referral is made to an organisation, which has adopted the CIARR, the CIARR protocol will be followed. One copy of the referral will be kept on the client's file and a copy forwarded to the referral agency. Referrals will be followed up, and the outcome noted on the assessment form or support plan. Confidentiality will be maintained at all times.

In particular, the organisation will maintain regular contact with the local Aged Care Assessment Team (ACAT) and will use their services for specialist support, assessment as well as determination of eligibility to some programs.

Other options

When the organisation is unable to provide a service, or if the client refuses the service the Support Planner will provide information on alternative services and fee for service options. The client has the right to refuse a service. Refusal will not prejudice their future access to services.

Schedule for Revision of Policy: Assessment of Client Individual Needs				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
24/07/2006	New policy	R. Thompson		
29/01/2007	Amended	A. Vaughan	29/1/07	
April 2009	Reviewed & Updated	D. Ryan	2012	
11 November 2011	Reviewed and Updated	D. Ryan		
22.9.2014	Reviewed & updated	D. Ryan	Sept 2016	

3.13 Across Agency Coordination – service user referral

Definition
This policy defines the way that Community Care Options will work collaboratively with other agencies to meet the needs of its clients.

Position Statement
Coordination with other government and non-government services at a local level is important to ensure that services are provided in the most effective and efficient manner and to avoid duplication or gaps in services.

Legislation and Standards
Home Care Standard – Standard 2 – Appropriate Access and Service Delivery - Expected Outcome 2.5 Service User Referral – **the service provider refers service users (and/or their representative) to other providers as appropriate.**
Disability Service Standard – Standard 3 – Individual Outcomes.

Operational Procedures
In order to optimise the benefits of coordination the organisation will –

- keep an up-to-date data-base of relevant services (including interpreter and advocacy services);
- attend relevant forums such as Extended Care Meetings, Disability Interagency meetings, HACC forums, other planning and consultation meetings as well as individual clients' case conferences;
- ensure that other services and individuals are well informed about Community Care Options, so that they may promote the organisation to their own clients;
- ensure the organisation's staff work towards an interagency coordinated approach to service provision;
- share relevant information about the service and programs and individual clients with consent;
- discuss common issues and needs including training;
- ensure that gaps in services are identified and met across the region;
- avoiding duplication of services;
- inform people enquiring about services about services available from other agencies;
- make relevant referrals to other agencies.

<u>Support Planning Procedure</u>
The Support Planner will identify -

- the services to be provided by the organisation;
- other agencies already providing services to a client or who may need to provide services;
- referrals that need to be made to other services.

With the written permission of the client or the client's representative, the Support Planner will –

- contact the agencies identified above to discuss a support plan;
- make relevant referrals according to the referrals procedures below.

Referrals to other services will be determined through client assessment, review and ongoing discussion with clients/carers/guardians.

Where a need for additional services or support is identified for a client the Support Planner will make a referral to the appropriate organisation on their referral form. CCO utilises the Client Information and Referral Record (CIARR) referral form where this is utilised by other HACC services. CCO also utilises HSNet E – Referral where this is available with other service providers.

Support Planners will support and advocate for the client's access to the services required. The Support Planner will also be responsible for coordination of services that the client requires to ensure that they are effectively working together to meet the clients identified needs.

The other agencies, the client and the CCO Support Planner will decide who will be the principal service provider and develop a draft support plan.

The principal service provider will -

- take responsibility for discussing the care plan with the client and their carer, negotiating any changes required and gaining the acceptance of the plan by the client;
- provide a final copy to, and inform the other agencies involved that the support plan has been accepted and should now be implemented.

Working with other service providers
With the client's consent, the Support Planner may discuss the client's needs with appropriate other service providers directly, within the framework of a case conference or a client review meeting.

Working with support from Case Managers from other agencies
Some of the organisation's clients need specific case management due to their disability or other needs, such as mental health needs. Where a staff member from another organisation provides specialist case management, the Community Care Options (CCO) Support Planner will, with the client's consent, work closely with the other Case Manager to ensure optimum outcomes for the client. The CCO Support Planner will ensure that the roles and responsibilities of both providers and Case Managers is clear to all parties, including the client and his or her representative.

Relinquishing the role of Support Planner
The organisation will not give up the principal service provider responsibility for a client without first discussing this with the client and other agencies providing services, and ensuring that another agency takes on the principal service provider role. Any change in the principal service provider will be clearly identified in the support plan.

Monitoring

Each client's situation will be monitored in a way that ensures changes in the client's needs are identified and addressed in consultation with others involved in the support plan. The Support Planner will –

- exercise judgment in determining effective monitoring arrangements, who will be involved, how often and by what method. For Level 4 Home Care Packages, the role of monitoring clients' nursing needs will be agreed between nursing staff and Support Planners;
- physically visit each client at least once every three months. More frequent visits will be necessary depending on the support plan, the changing needs of the client, the client's well-being and degree of satisfaction with the support plan;
- document a client's changed circumstances and modified support arrangements.

For Level 4 Home Care Packages the following applies –

- a joint assessment with the Registered Nurse ;
- ongoing liaison between the RN and the Support Planner;

Coordination with General Practitioners (GPs)

If a client gives consent, the following will apply –

- Support Planners will inform GPs of clients' relevant health issues and seek their assistance where appropriate;
- Support Planners consult and cooperate with GPs to achieve optimum health outcomes for clients;
- where appropriate a copy of the support plan, not including the client fee, is sent the client's GP with a covering letter.

Schedule for Revision of Policy: Across Agency Coordination				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
24/07/2006	New policy	R. Thompson		
29/01/2007	Amended	A. Vaughan	29/1/07	
April 2009	Reviewed & Updated	D. Ryan	2012	
11 November 2011	Reviewed and Updated	D. Ryan		
September 2014	Reviewed and updated	D. Ryan	2016	

3.14 Person Centred and Lifestyle Support Planning

Definition
A lifestyle support plan is a written plan of action. It specifies client strengths, agreed upon priorities, goals, objectives and strategies designed to meet the needs and ambitions of the person receiving a service. A client's lifestyle support plan may also be known as a support plan, a care plan or an individual plan.

Position Statement
Community Care Options (CCO) recognises that the aim of the Support Planning process is to support each person to move towards an identified future which is positively different from his/her current lifestyle, with enhanced social integration, participation in the community and valued social status. The process emphasises the client's participation in the formulation of a plan of action that is based on specific positive outcomes for the client and which will enhance the client's opportunity to make decisions and direct the services they receive. The plan will reflect both the client's needs and the service's ability to directly meet or coordinate other services to meet the clients need.

Legislation and Standards
Human Rights and Equal Opportunity Commission Act 1986
Disability Service Standards 2 & 3
Home Care Standard 2 – Appropriate Access and Service Delivery
Expected Outcome – 2.3 – Care Plan Development and Delivery
Each service user and/or their representative, participates in the development of a care/service plan that is based on assessed needs and is provided with the care and/or services described in their plan.

Operational Procedures
CCO utilises person centred approaches to planning to enable each person to achieve their individual outcomes.

Support Planners work together with the person to develop and implement a plan that identifies and builds on the person's strengths, aspirations and goals. Plans should draw on broader family, cultural and religious networks ad community organisations.

Support Planners support each person, and (when necessary with consent) their family, carer or advocate to develop, review, assess and adjust their plan as their circumstances or goals change.

CCO recognises the importance of risk taking and enables each person to assess the benefits and risks of each option available to them and is prepared to trial approaches even if we are not in agreement.

CCO works with other organisations and community groups to expand the range of service options available in our community.

CCO regularly reviews our person centred approaches to ensure that the

organisation has the capacity and capability to deliver flexible and responsive supports and services that meet individual needs and expectations.

The Support Plan
CCO staff are to advise clients at the time of intake to the service that service delivery centres on the support planning process, and what this involves.

If a client, after being informed as to the process involved in support planning, consents to receive a CCO service it is implied that they consent to support planning.

Support Planners will undertake a comprehensive assessment of client needs as a basis for the support planning process. CCO utilises the Ongoing Needs Identification tool (ONI) and its own comprehensive assessment tool including a WH&S risk assessment tool. See 3.3 Assessment of Client Individual Needs Policy.

Following the assessment, the Support Planner together with the client and/or the client's representative, will develop a plan of support – the Lifestyle Support Plan/Care Plan/Support Plan. This plan will -

- demonstrate Community Care Options' commitment to a creative and flexible approach tailored to the needs, preferences and rights of each individual;
- reflect the client's needs and wishes;
- identify Community Care Options' ability to meet these needs;
- respect the client's dignity, independence and other rights;
- not proceed until the client and/or carer have given their agreement;
- be reviewed and modified in consultation with the client.

The support plan is developed through a planning process, involving assessments of the client's strengths, requests, needs, their social, physical, emotional and cognitive functioning, matched with what the service is able to directly or indirectly provide. The planning process frequently involves a planning meeting to assist with the bringing together of the assessment information and the client, family/carer/ advocate and service provider/s to develop a plan of support.

The plan is to be developed within three months of the client entering the service, and is to be reviewed within the timeframe specified on the plan, in line with the time frames attached to specified tasks or strategies of the plan.

The plan is to define agreed upon objectives to be achieved through the development of skills, the securing of resources, access to and coordination of services, the meeting of social, physical, medical, vocational, recreational and emotional needs.

The plan is to include a lifestyle and environment plan, particularly where direct services are to be provided by CCO staff. This component of the client's plan is a written description or outline detailing the minimum daily requirements of the client. It specifies any client requirements (eg need for assistance in a particular situation or setting, access to preferences and likes, identification of particular dislikes or conditions the client finds disturbing, interaction and community requirements,

means by which the client can indicate choice and assert effective and respected control in their daily lives). This plan sets out the client's basic needs, their requirements for support and the supports available to the client.

The plan is to provide the basis for case management. Case management is the ongoing organisation and coordination of services to the client and their support network.

Each plan is to describe the role of each support service, if more than one agency is involved, and identify the case manager and a contact person from each service.

CCO staff are to ensure the involvement of the client in all aspects of the development of the plan. This includes actively encouraging, supporting and educating the client to enable their participation in the meeting and decision making.

Goals identified for inclusion in the plan are to be consistent with the stated aims of the planning process.

All goals on the plan are to be prioritised according to achievable resources.

The Planning Meeting

A plan is usually developed at a planning meeting. The Support Planner is to ensure that the client is available and able to participate in the meeting.

The planning meeting is to be the forum used to determine the clients' specific life goals and needs and to design the strategies and associated tasks to meet those goals.

The meeting is to identify each person responsible for implementing the strategies and carrying out the tasks to achieve each goal identified in the plan.

The Support Planner is to be responsible for gathering relevant data, information and assessment results for the meeting.

The Support Planner is to be responsible for assisting the client to make decisions on the key people to attend the meeting. Participants might include - the client, family/carers/advocate/friend/guardian, the Support Planner, GP, specialists, representatives from other agencies including school and work.

To facilitate meaningful participation in the planning meeting, participants including the client, are to be fully informed of the following in a format that meets their communication needs and understanding -

- purpose of the meeting;
- people attending and their role;
- information required/to be discussed;
- ethical issues regarding confidentiality, individual rights, conduct and protocols;
- possible follow up activities;

- date time and venue.

The chairperson, frequently the Support Planner, is to be responsible for facilitating discussion, keeping the meeting on task and ensuring that confidentiality is maintained.

All decisions made at the planning meeting are to be recorded, preferably on the client's plan and/or file. All participants of the meeting are to agree to the goals and sign the planning forms. A review date is to be identified.

Implementation of the Support Plan
The Support Planner is to be responsible for writing up the plan, ensuring the recording of the review date on CCO's client system and that copies of the plan are forwarded to the participants with the client's consent.

The person or service directly providing a service identified in the plan is to be responsible for ensuring that programs are developed and that continuing assessment and monitoring of programs and activities occurs.

The Support Planner is responsible for following up with other services that tasks have been implemented.

Goals are to be timetabled for implementation.

Implementation of the plan and goals is to be monitored by the Client Services Manager through client review and Support Planner support and supervision processes.

The support plan will include –

- the agreed long-term objectives of the client and carer;
- the services to be provided;
- the frequency of service provision and name of the Support Planner and support staff;
- a nursing plan (Level 4 HCP only);
- any other agencies providing service;
- the name and telephone number of the GP;
- emergency contact;
- a list of duties and any special requirements;
- a work place risk assessment;
- client contribution (only on the client's and the organisation's copies);
- a signed client agreement with consent;
- emergency response procedures – if the client lives alone and is not responding to a scheduled visit;
- If services are to be provided on a temporary basis then this should be clearly stated.

In developing the support plan, Support Planners will ensure that –

- clients are involved in decision making about the plan design, review and implementation;
- that individual needs and preferences are taken into account, including – physical, emotional, cultural and religious, socio-economic;
- the client is aware of and able to choose from the range of relevant services or service providers available in the community;
- If services are required every day, arrangements for public holidays and weekends should be written into the support plan;
- The client signifies his or her agreement to the support plan by signing it.

Review of the Support Plan
The purpose of the review is to monitor progress towards goals and to adjust goals to reflect changes in the client's circumstances and preferences.

Reviews of the plan are to be conducted regularly, in line with the specified time frames to achieve the tasks outlined in the plan, when significant unplanned changes occur or as requested by the client.

As part of the regular reviews of the complete plan, the client's lifestyle and environment requirements are to be specifically examined in order to –

- review the content of support pans for adequacy and suitability;
- review the implementation of each of the plan's elements;
- review achievements and difficulties associated with the plan and its implementation.

Client's are to be consulted on amendments made to the plan.

Clients are to be involved in an informal review of the plan and consulted on the progress of the plan at least quarterly. Support Planners will record quarterly reviews on the Client Case Review form and submit to the Client Services Manager.

Reviews are to be fully documented in the client's file and the client system updated as part of case management. Unmet goals should be identified and discussed and reasons for non achievement documented. Goals may be adjusted in consultation with the client.

Annual Reviews
All plans are to be formally reviewed at least annually.

The annual review is the formal review of the plan and its implementation and should be conducted with the members of the planning team.
It determines and sets goals for the next twelve months to meet the client's goals.

Monitoring and Evaluation
The effectiveness of the planning process will be monitored through regular client reviews and clinical support and supervision as part of an overall quality assurance mechanism.

The monitoring and evaluation process is intended to enable the service to gauge and evaluate its performance with regard to planning.

The plan will be evaluated in terms of the degree to which client goals have been achieved and the client's life enhanced. The client will provide feedback as to their satisfaction with the planning process.

Schedule for Revision of Policy: Person Centred Planning				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
24/07/2006	New policy	R. Thompson		
29/01/2007	Amended	A. Vaughan	29/1/09	
19.3.2009	Reviewed	D. Ryan	2012	
11.11.2011	Reviewed and Updated	D. Ryan		
September 2014	Reviewed & updated	D. Ryan	2016	

3.15 Community Participation, Integration and Inclusion

Definition
Participation – the action of taking part in something
Integration means that the person is part of a community and is involved with other community members. It refers to the social processes that offer a person the same chances and choices as other people to participate in activities and be a member of communities.
Community integration happens when people are seen in ordinary places, join everyday activities, share experiences, interact and become interdependent.

Social inclusion, community inclusion, social connectedness, normalisation, social integration, social citizenship - all these are terms that relate to the importance of the links between the individual members of our society and the role of each person as a member of this group.

Position Statement
Community Care Options is committed to actively supporting and encouraging clients to participate fully and be involved in the life of the local and wider community. Services and activities will promote and enable the meaningful participation and integration in community life in ways that meet clients' individual preferences. Community Care Options will maximise people's ability to utilise community resources and contribute to removing the barriers to full participation and inclusion.

The values that underpin participation, integration and inclusion -

Everyone Is Ready – none of us has to pass a test or meet a set of criteria before we can be included.

Everyone Can Learn – as human beings we all grow and change and make mistakes: and we are all capable of learning.

Everyone Needs Support - sometimes some of us need more support than others.

Everyone Can Communicate – not using words doesn't mean we don't have anything to say.

Everyone Can Contribute – we need to recognise, encourage and value each person's contributions - including our own.

Together We Are Better – we are not dreaming of a world where everyone is like us - difference is our most important renewable resource.

Legislation and Standards
Disability Services Standard 2 - Participation and Inclusion
Home Care Standard 3 – Expected Outcome 3.5 Independence

Operational Procedures
To achieve community participation and integration -

Each client will have an individual plan of support, created in consultation with them, the Support Planner and others including, where appropriate the clients' family members, friends or other service providers. Through the planning process Support Planners will seek to identify areas of interest for the client in terms of community activities; develop information resources that inform the client about community based facilities, organisations and calendars of events. Such plans will seek to maximise the opportunities for community access and integration in accordance with individual clients' preferences.

Support Planners will help clients consider a range of options and opportunities and make choices.

Staff will encourage and support clients to participate and maintain involvement in activities and programs in the community.

Support Planners will help clients identify their strengths and areas where additional skills are required to optimise community integration. Service plans will include strategies for clients to develop and maintain these skills.

Staff will encourage and support clients to develop social networks.

Staff will provide positive support and encouragement to promote the abilities and valued status of clients in order to facilitate the client's participation and integration in the community.

Staff will ensure that an appropriate risk assessment is completed for all community based activities and that the client is supported to ensure their safety and wellbeing whilst accessing or participating in community based activities.

Cross Reference & Further Reading
Duty of Care and Dignity of Risk policy

Schedule for Revision of Policy: COMMUNITY PARTICIPATION AND INTEGRATION				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
24/07/2006	New policy	R. Thompson		
29/01/2007	Amended	A. Vaughan	29/1/2009	
April 2009	Reviewed & Updated	D. Ryan		
August 2010	Reviewed & updated	D. Ryan	2012	
11.11.11	Reviewed & updated	D. Ryan		
22.9.2014	Reviewed 7 updated	D. Ryan	Sept 2015	

3.16 Dignity Of Risk

Position Statement
Community Care Options recognises the right of clients to make informed choices and to take calculated risks. Every person has the right to experience and learn from life, to take advantage of opportunities, develop competencies and independence even when these situations may pose a threat to their well being. Everyone has the right to the assumption of competence.

Ability to make informed Decisions
Clients will be supported to make informed choices and decisions about their care at all times. This may require the support of others with the client's consent (family/ friends/advocates other professionals). Informed decision making involves a general awareness of the consequences of the decision which needs to be made voluntarily and without coercion.

If staff have serious concerns about the client's ability to make a particular informed decision, staff may seek an assessment by a qualified health professional with prior permission from the client or the client's representative. Where clients need ongoing formal support in making major life choices, a Guardianship Order may be required.

Balancing Duty Of Care With Dignity Of Risk
Where a Dignity of Risk issue is in conflict with a Work Health and Safety (WH&S) issue, the WH&S legislation overrides dignity of risk.

In situations where duty of care obligations outweigh dignity of risk the client should be informed of the decision and why the decision was made.

When balancing duty of care with dignity of risk staff will work with the client to –

- Explain the issues of duty of care and dignity of risk which impact on a particular situation;
- Identify the consequences of a particular action including the risk/s and likelihood of harm to the client or others;
- Assess the type and seriousness of the possible harm;
- Identify what precautions could be taken to minimise the risk/s or harm or the seriousness of the risk/s or harm;
- Assess the client's ability to make informed decisions;
- Weigh up the benefits and importance of the activity to the client against the possible negative consequences;
- Generate solutions to achieve the benefits to the clients whilst minimising the potential harm.

Schedule for Revision of Policy: DIGNITY OF RISK				
Date Adopted	**Outcome**	**Author**	**Next Review Date**	**Comments**
24/07/2006	New policy	R. Thompson	**24/07/2008**	
August 2008	Reviewed	R. Thompson	**2011**	
11.11.11	Reviewed & Updated	D. Ryan		
September 2014	Reviewed & Updated	D. Ryan	**2016**	

3.17 Duty of Care

Position Statement
Community Care Options has a *Duty of Care* to provide services and support in a manner that supports the safety, welfare and wellbeing of clients and their families. Duty of Care must be balanced with Dignity of Risk. This policy should be read in conjunction with the organisation's policy on Dignity of Risk.

What is Duty of Care?
Everyone owes a duty of care to another person, if it can be foreseen that the person is likely to be injured or harmed (physically, economically, emotionally) by the first person's actions or failure to act. The law requires staff to take reasonable care in carrying out their work by ensuring that reasonable standards of care are met.

Fulfilling Duty of Care
The standard of care required to fulfil Duty of Care is assessed on what action a reasonable person would take in a particular situation. Duty of care is breached by failing to do what is reasonable or by doing something unreasonable that results, or could potentially result in harm, loss or injury to another.

To ensure Duty of Care obligations are met staff must –

- Recognise when people are at risk or injury from themselves or others;
- Determine when harm or injury is foreseeable;
- Not intentionally harm or injure another person;
- Safeguard others and support people to take risks as safely as is possible;
- Ensure clients are consulted, involved and informed in decision making;
- Ensure client's rights are not compromised;
- Recognise that some risks are reasonable;
- Act within the organisation's values;
- Seek advice and support when confronted with issues that challenge duty of care and dignity of risk;
- Avoid discrimination and overly restrictive options;
- Report concerns or incidents about the client's safety;
- Seek medical advice about the clients decision making ability and Guardianship orders where necessary;
- Maintain appropriate documentation.

Schedule for Revision of Policy: DUTY OF CARE				
Date Adopted	**Outcome**	**Author**	**Next Review Date**	**Comments**
24/07/2006	New policy	R. Thompson	**24/07/2008**	
August 2008	Reviewed	R. Thompson	**2011**	
11.11.2011	Reviewed & Updated	D. Ryan		
September 2014	Reviewed & Updated	D. Ryan	**2016**	

3.18 Independence

Definition
The state or quality of being independent, freedom from dependence, exemption from reliance on, or control by, others, self-subsistence or maintenance, direction of one's own affairs without interference.

Position Statement
Community Care Options - Vision –creating a better future for our community through leadership and innovation. Our mission statement describes the purpose and intent of our service provision – to support and facilitate improved quality of life and independence for people living within our community. Community Care Options demonstrates and reflects this focus in all of our dealings with clients and their families.

Legislation & Related Standards
Home Care Standard 3 – Service User Rights and Responsibilities
Expected Outcome – 3.5 – Independence
Disability Service Standards 2 & 3

Older people and people with a disability value being independent as much as the rest of the community: Independence is held as a core principal of personal identity, social participation and citizenship. Because our society is diverse, an individual's idea of what independence means will vary and their needs for support and strategies to maintain independence throughout life will differ.

Many people encounter physical decline as a barrier to maintaining independence in their activities of daily life. However older people identify that maintaining autonomy over decisions, exercising preferences and choices, and maintaining relationships and social connections are equally important as physical capacity, and are critical for sustaining individuals to be who they are as a person.

Service models that define people in terms of their illnesses can foster dependency and institutionalisation. Alternatively, service models, such as that offered by Community Care Options, that are person-centred and focus on enabling an individual to achieve what is important to them, promote independence and support positive ageing.

Social support and social activities are critical to maintaining the well-being of people. People have a right to expect that services respond to their individual needs and support their independence in ways that are relevant and appropriate to their lives.

Independence means being able to continue throughout life to be engaged in the activities and relationships that are important to us. The meanings of independence to older people and people with a disability are therefore as diverse as they are themselves. Older people share a concept of independence that is linked to a sense of self and personal identity. While they often discuss their needs in terms of their personal circumstances and the physical barriers encountered as they age, they do not draw a distinction between autonomy – the capacity to exercise control over

decisions and make choices in daily life activities – and independence, which is commonly used to describe the ability to perform functions related to daily living.

Independence includes –

- Maintaining identity “me”;
- Autonomy - making decisions;
- Relationships and social networks;
- Participation, social inclusion and citizenship;
- Physical capacity – activities of daily life, with or without assistance;
- Information and knowledge.

The following reflect ways we as an organisation can support the maintenance of independence for our clients.

Maintaining identity “me”
Independence is integral to ones sense of self, and to maintaining the boundaries of personal identity. Independence is valued as part of who we are as a person, and as such, is a state of being that is important to each individual’s dignity and personhood. Independence can be expressed in a range of direct and indirect ways, for example -

• Self-reliance - Being able to do things for myself that I choose to do.
• Separate priorities - my children have their own lives and are very busy.
• Maintaining roles, commitments and responsibilities – I am caring for my wife and that is something I will always want to do.
• Being socially active and participating - maintaining my social life and making time for the things I like to do; being able to keep up with my interests.
• Being able to maintain standards (perhaps with help)
• Being strong enough to know when assistance is needed to maintain lifestyle
• Feeling self-confident and secure - feeling safe living by myself.

Autonomy - making decisions
Control over our own decisions is a core expression of independence. Exercising autonomy includes making decisions on big things and little things that are important in life to the individual. Autonomy also encompasses doing things for yourself, and having things done ‘your way’. For example –

• Being able to do as much for myself as I can without assistance
• Doing things without worrying other people - Not having to rely on other people
• Making their own decisions – as long as I have mental capacity
• Keeping control of bank accounts and other personal business.
• Living in our own home - Maintaining my home – despite my health issues
• Keeping drivers’ licence as long as you can.

Relationships and social networks
Older people say that independence is expressed through their relationships and social networks, and that sustaining the connections and boundaries between self and others is important to prevent dependency. Relationships with others are valued as central to a life worth living, and include –

- Keeping in touch with family and friends
- Active involvement with grandchildren and great grandchildren
- Knowing where to get assistance if needed - accepting that help is there
- Fostering and maintaining relationships
- Neighbours – important to have community but people are too busy working
- Social connection requires willingness to talk to people – communication is 'two way'.

Participation, social inclusion and citizenship
Being engaged in the full range of life opportunities at whatever age is the key to achieving a fulfilling and empowered life. Independence enables older people and people with a disability to participate in valued activities such as –

- Neighbourhood, community and civic duty
- Festivals and community events
- Sport and physical recreation (bowls, athletics, hobbies,
- Cultural interests – staying involved and active
- Volunteering
- Entertaining and having a social life.

Physical capacity – with or without assistance
Older people and people with a disability say that physical incapacity and illness are big challenges to maintaining independence throughout life. They understand the need to adapt to physical challenges, and value appropriate support services to maintain independence. These include –

- Access to services when they are needed.
- Help with cleaning, cooking and shopping at times that suit.
- Maintaining driving skills eg. night driving, and having good transport options for those who do not drive.
- Health - maintaining well being / dealing with disability and setbacks, now and in the future
- Being physically active and involved.

Information and knowledge
Older people, people with a disability and carers say that they require accurate, relevant and timely information to maintain their independence. They appreciate the need to maintain skills and knowledge, and to learn new things in order to remain independent throughout life. Interpreter services are essential for people who speak languages other than English. Information and knowledge underpin independence in many ways such as –

- Keeping my mind active
- Maintaining or updating skills
- Putting together your information- finding strategies to meet life's changes
- Being able to access doctors, hospitals, services when needed
- Knowing where to get assistance if needed
- Being well informed so as to feel comfortable in my own decisions.

Operational Procedures
CCO Support Planners will from the time of engagement with clients seek to empower and support the client to be as independent as possible in determining the services and support they require and how this support will be delivered to them.

We will seek at every opportunity to involve the client actively in the planning and review of their services and support their decision making about their lifestyle and choices, valuing their privacy, dignity and confidentiality and them as people.

We will seek to support and sustain existing informal networks and relationships and enhance the person's life by respecting their decisions and choices.

We will not provide services to a person where they are able to complete tasks for themselves.

Community Care Options will implement rehabilitative, restorative and enabling approaches to support clients to achieve maximum independence.

Our approaches will have three main focal points –

- Enhancing and maintaining quality of life;
- Restoring physical, psychological and social functioning by recognising the health potential of the individual; and
- preventing disease and illness.

The following are practical ways staff can support our focus across a range of domains -

Physical –

- enhance sensory and motor functioning;
- focus on actual and potential strengths and abilities of the person;
- understand symptoms and what they mean from the perspective of the person;
- help to adapt to changes in function;
- incorporate the perspectives of carers and family in the adaptation to changes.

Emotional –

- understand and respect the coping strategies used by the person;
- suggest ways of reducing stress, tension and anxiety, including complementary therapies if appropriate and acceptable;
- provide advocacy, or access to advocacy, in all aspects of decision making as and when required;
- facilitate a range of support systems for the person, and all other carers and family;
- be sensitive to, and respect, different cultural perspectives and needs.

Mental –

- identify and take account of previous life history and usual routines;
- undertake appropriate mental health assessments to provide an understanding of the person's ability to adapt and adjust;
- if required, provide a range of activities to decrease mental confusion and optimise mental functioning;
- offer choice and enhance autonomy relevant to cognitive state.

Spiritual –

- ensure the person is able to maintain contact with their social world;
- be aware of, and facilitate, the continuity of all religious and spiritual activities.

Schedule for Revision of Policy: Independence				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
23.6.2011	New policy	D. Ryan		
22.9.2014	Reviewed & updated	D. Ryan		

3.19 Valued Status

Definition
Refers to the social role and value that is placed upon it by society.

Delivering a service in a way that enables people, particularly a person with disability, to live and work in ways that are valued by the community.

Position Statement
Community Care Options (CCO) is committed to promoting the valued status owed to all people in particular those with a disability. As such CCO provides or facilitates opportunities that contribute to the acknowledgement of the valued status of each person with a disability.

CCO is committed to promoting through its service provision and business activities a positive image of people with a disability and taking a pro-active role to advance their right to dignity and respect; recognising this can positively influence the self-esteem, citizenship and valued community status of people with a disability.

Community Care Options will ensure that each client has the opportunity to develop and maintain skills to participate in activities that enable them to achieve valued roles in the community.

Purpose
To provide an overarching framework for CCO services and business activities that –

- ensures design, content and activities reflect a positive image of people with a disability including printed and electronic media and all other interactions.
- enhances the valued status of people with a disability by recognising and promoting their right to –

- an identity as an adult and citizen
- self determination
- information about any matters that impact on their life
- ownership and responsibility for their lifestyle choices
- respect and value for individual differences and choices
- not be referred to in written or verbal communication in such a way that detracts from their valued status.

- improves quality of life for every person supported as a direct consequence of their opportunity to fulfil valued roles in the community; through –

- promoting and encouraging the personal belief of every person CCO supports to fulfil a valued role in the community.
- promoting opportunities for those who use the service to fulfil valued roles in the community.
- providing support in line with the stated or funded purpose of the service to develop and maintain the skills that will assist each person to fulfil valued roles and contribute to their valued status in the community.

- to meet the Disability Services Standards and comply with all relevant legislation.

Legislation and Standards
Disability Service Standard 2 – Participation and Inclusion
Home Care Standard 3 – 3.5 Independence

Operational Procedures
Community Care Options will support people in ways that observe and promote a positive image. This means that –

- all members of the organisation will promote the strengths of people;
- the services will be in accordance with a strengths based model and empower clients to strive towards achieving their potential;
- the focus of service provision will be on producing good client outcomes;
- Support Planners will help identify and generate opportunities for clients to develop and maintain the skills required to participate in a range of activities that enable them to achieve valued roles in the community;
- when talking to clients or writing to or about them, staff will use language that is respectful and age appropriate
- clients are respected and supported as valued customers.

Staff, at times in conjunction with other service providers, will –

- offer services and encourage activities to people that are age appropriate;
- assist clients to understand and practice good grooming, and appropriate dress and behaviour, and opportunities to learn and practice life skills that promote independence;
- assist clients to develop good social skills;
- encourage and support clients to develop and maintain social relationships;
- respect clients privacy, dignity and confidentiality;
- provide opportunities and support to allow clients to express their needs and to exercise maximum control and choice;
- encourage, support and respect clients when they make complaints.

Schedule for Revision of Policy: VALUED STATUS				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
29/01/07	**New Policy**	**A. Vaughan**	**29/1/10**	
25.8.2011	**Reviewed**	**D. Ryan**	**2013**	
22.9.2014	**Reviewed & updated**	**D. Ryan**	**Sept 2015**	

3.20 Behaviour Intervention and Support

Definition
Challenging Behaviour **-** any behaviour of a person which is of such intensity, frequency or duration that the safety (physical/emotional) of the person or those nearby is put at risk.

Position Statement
Community Care Options is committed to providing services and support to people who have challenging behaviour. People with challenging behaviour are entitled to the same rights and safeguards as others in the community. This policy is based on 'The Positive Approach to Challenging Behaviour', Department of Ageing, Disability and Home Care's,1997. The policy is designed to prevent abuse, and support clients in a respectful and dignified manner.

Practices and Principles
The following work practices and principles apply to CCO staff working with people with challenging behaviours –

- Potentially challenging behaviours are identified on assessment and as part of the risk management plan;
- Staff receive appropriate training, including strategies on how to manage particular challenging behaviours;
- Where appropriate, clients may be referred for specialist behaviour assessment and management plans;
- Staff will work towards preventing challenging behaviour from occurring and from re-occurring in the future.

Behaviour management strategies consider –

- the whole person;
- the person's environment and lifestyle;
- what kind of supports the person needs in order to reach their potential and life goals.

Staff Responsibilities
- Support Planners will address any situations involving challenging behaviours, consult with other appropriate professionals, resource direct care staff and make appropriate referrals;
- Direct care staff will report any incidents of challenging behaviours on the appropriate incident form;
- All staff demonstrate respect for individuals' needs and goals, balance duty of care, dignity of risk and occupational, health and safety issues.

Behaviour Intervention
Any proposed intervention to alter the behaviour of a person will be explained to the service user, their guardian/advocate/primary carer before the program begins. All such programs will be based on a 'positive approach' to challenging behaviour. All procedures and plans will be approved and overseen by the Support Planner with

written consent of the legal guardian.

This means –

- If Behaviour Intervention Planning is deemed necessary the Support Planner will call a planning meeting involving the service user, advocate, guardian, and/or primary carer and, where appropriate other professionals and/or service providers;
- Prior to implementing a behaviour management plan, written consent must be obtained from the service user's legal guardian;
- Behaviour intervention will use the least intrusive options;
- All Behaviour Plans will be sighted and signed off by the Client Services Manager.

The Behaviour Intervention Plan will aim to eliminate the causes of challenging behaviour long term. It will take into account –

- Detailed assessment of the reasons for a particular behaviour that is deemed challenging. The assessment will consider environmental, physical, medical, emotional and lifestyle components as well as data collected at the time of occurrence of the behaviour e.g. Antecedent, Behaviour, Consequence (ABC) forms. Professional advice will be sought to ensure a comprehensive understanding of the person eg. medical check up, psychological report, etc;
- A review of the Lifestyle Support Plan together with examination of the person's total lifestyle and environment;
- Planned strategies for changing the various conditions that may be maintaining the behaviour;
- Consideration of other activities and skill development that the person finds more rewarding and/or educates them to develop alternate, more appropriate behaviour;
- An Incident Response Plan/Crisis Intervention Plan.

The Behaviour Intervention Plan will be incorporated into the Lifestyle Support Plan. Strategies for intervention are implemented alongside the daily routines of the person.

Assessment of the person's lifestyle needs and goals will include assessment of –

- the existing environment;
- environmental adjustments required to facilitate the person's integration eg. visual schedules, additional one-to-one support at specific times;
- possible communicative or other functions of the specific behaviour(s);
- educational needs;
- need for skill development;
- medical, neurological and/or psychiatric conditions;
- the person's cultural and linguistic background;
- other possible factors that may arise in particular situations.

The Behaviour Intervention Plan will –

- respect the needs of the person with a disability and with challenging behaviour;
- acknowledge the communicative function of challenging behaviour;
- teach appropriate skills, particularly more appropriate communication methods;
- provide opportunities to participate in positive and productive activities such as employment and leisure;
- encourage a variety of valued relationships, including within the person's own cultural group;
- enhance the quality of life of the person with a disability and challenging behaviour;
- aim to lessen the need to communicate in inappropriate ways.

Prohibited Practices
A number of practices which were used in the past are against the law, or are unethical. They cannot be used in any circumstances. These include –

- Corporal punishment or physical abuse;
- Verbal abuse or ridicule;
- Depriving people of meals, sleep, clothes, outings or personal hygiene.

Any staff member using any prohibited practice will be liable to legal charges and termination of employment unless it should occur in the protection of the person or others from serious physical harm.

Restrictive Practice
Community Care Options has a commitment to ensure the safety of service users and staff within the organisation. Restrictive Practices will only be used if other, non-restrictive practices have been unsuccessful. In addition, restrictive practices will not be used in isolation, but form an element of a behaviour intervention plan for the individual. All restrictive practices that are implemented will be time limited and reviewed consistently as outlined in the procedures below.

Restrictive practices refer to those methods employed that involve some intrusion on the person's freedom in order to curtail a particular behaviour. These practices are restrictive in the sense that they restrict a person's rights. They are also classified restricted in the sense that there are significant restrictions placed on staff regarding their use. The following practices are restricted –

- Physical restraint – the use of any device or strategy that restricts the individual's movement;
- Restraining the individual by the use of chemical substance or mechanical or physical means whereby movement of any part of the person's body is prevented, restricted or subdued;
- Restricted Access – Restricting an individual's independent access to activities or experiences through physical barriers or staff intervention;
- Seclusion or exclusionary time-out (containment).

In crisis situations, such as in self defence, there may be the need for restrictive practices. However, minimum intervention possible for the situation should always be used.

Principles for the use of restricted practices are –

- They should only be used if other, non-restrictive practices have been unsuccessful;
- They should not be used alone, but must have a time limit and form part of a Behaviour Intervention Plan, accompanied by positive approaches and educational strategies;
- Other than in a crisis situation, restricted practice will not be used without legal consent and proper approval;
- Approval for the use of restricted practices must be given by the CEO. They should only be part of a documented plan developed in a collaborative, consultative process with professionals, family, carers, guardians and advocates;
- Written documentation must be kept on the procedures to be used and the Support Planner is responsible for informing staff of conditions and authorisation.

Procedure

If the need for restrictive practice is identified, the Support Planner undertakes an initial assessment of the behaviour. Support Planners are to ensure they are familiar with ADHC "Positive approach to Challenging Behaviour" policy and guidelines. This initial assessment will involve a review of incident reports, feedback from the individual, family and staff.

If the behaviour is considered to place individuals in immediate physical danger the Support Planner may need to take action promptly. This action will be taken in consultation with the Client Services Manager of Community Care Options. If the behaviour does not require an immediate response, the Support Planner will examine possible responses to the behaviour to determine alternative non restrictive practices wherever possible.

The Support Planner will arrange for a review of the individual's lifestyle and environment to attempt to determine the possible causes of the challenging behaviour. There may be other factors that have caused the behaviour which can be satisfactorily addressed without the need to implement a restrictive practice.

If it is determined that a restrictive practice is necessary the Support Planner will develop a management plan for the individual involved in consultation with all stakeholders, including where appropriate, with other professionals. This plan must be submitted for review by the CEO. The restrictive practice document will form part of this management plan. The management plan will be based on each individual's specific needs and issues, but may include the following information –

- Guiding Principles which direct the support for the individual;
- Lifestyle environment review or Individual Design Plan;
- Medical/Medication Plan;

- Incident Prevention and Response Plan;
- Restrictive Practice documentation and sign off;
- Data recording sheet documentation;
- Outline of review mechanism.

The proposed restrictive practice needs to be the least restrictive option for the individual and needs to maintain the dignity of the individual as much as possible.

The restrictive practice needs to be authorised and signed off by the following parties

- Person Responsible (Family Member);
- Community Care Options' Client Services Manager;
- A Clinical Psychologist;
- Support Planner (or person who develops the management plan);
- CCO's CEO.

After implementation of the restrictive practice, staff working with the person will record frequency of the behaviour, environmental factors and staff responses. The data collected will be used for formally review the plan and indicate whether there is a need for the restrictive practice to continue, be maintained or changed.

The Support Planner, or person delegated will review each restrictive practice at least quarterly, if appropriate with assistance of a clinical psychologist. Any recommendations will be based on this review, including a decision on the ongoing need for the restrictive practice, any training identified, modifications, update of strategies or program changes that are required.

Schedule for Revision of Policy: BEHAVIOUR INTERVENTION & SUPPORT				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
24/07/2006	New policy	R. Thompson		
29/01/2007	Amended	A. Vaughan	29/1/07	
April 2009	Reviewed & Updated	D. Ryan	2012	
11.11.11	Reviewed and Update	D. Ryan		
September 2014	Reviewed & Updated	D. Ryan	2016	

3.21 Client not responding to scheduled visit – Emergency Plan

Definition
This policy is to advise staff on the procedure to be followed in they attend a client home for a scheduled service and the client is not at home or not responding.

Position Statement
There is public concern that frail older people have died alone in the community and have not been found for weeks or months after they have passed away. It is acknowledged that deaths will occur in the community care setting, even when service providers are providing required levels of care. Community care providers cannot prevent deaths from occurring or change the environment in which they take place. Community Care Options as a provider of community care services plays an important role in helping to keep frail older people who live alone in the community safe from harm. We are in regular contact with clients who could potentially be at risk. Community Care Options will take appropriate and timely action when a client does not respond to a scheduled visit and thereby may reduce the risk of an adverse event, or result in earlier discovery of a mishap.

Legislation and Standards
Home Care Standards
Aged Care Act 1997

Operational Procedures
Each client who lives alone is required to have a planned response for when they do not respond to a scheduled visit. Support Planners during assessment will ensure that such a response is discussed and individualised for each client, and documented in the client support plan or service agreement with a copy made available to the client.

In the event that a client does not want any response, this should also be documented in the client support plan or service agreement.

Information about the client's response plan will be included in TRACCS roster alerts for easy access of On Call staff and others to advise Support Workers in the event of attendance and the client not responding.

It should be noted that even where a client has requested that they do not want a planned response, if a Support Worker has concerns or there is an indication that there may be something wrong, they should raise their concerns with the organisation and have their concerns documented.

There are many reasons why a scheduled visit is missed. These include –

- The client may have inadvertently forgotten to inform the Support Planner that he/she would not be at home;

- The client may have fallen, been injured or taken ill and still be in the home.

When a client does not respond to a scheduled visit/rostered service, the Support Worker is to contact Community Care Options **immediately** to advise that the client is not responding. This will be to the Support Planner during office hours (8.30am – 4.30pm) and to On Call if outside of office hours. If the Support Planner is unavailable the SW should advise the Client Services Manager or CEO if CSM not available.

The Support Planner will advise if they have received communication from the client that they would not be at home and will instruct the Support Worker on the individualised response for that client if no such communication has been received. Similarly this will be done by On Call if outside of office hours.

The Support Planner or On Call person will in the first instance ring the client to check that they are not at home. If no response they will check the client's individual response plan in roster alerts and follow the planned response as indicated.

Levels of Responsibility

To ensure the timely and appropriate response to a situation where a client might be at risk it is important to establish the level of responsibility of the organisation, the Support Worker and the client.

The Support Planner as representative of the organisation, the Support Worker and the client should have a clear understanding of who will be responsible for the various steps outlined in the individually agreed process.

Regularly updated carer and/or emergency contact details need to be included in a service delivery response agreed with the client. Support Planners will check that emergency contact details are accurate at each quarterly client review and client to advise if these change.

Some clients, such as those who are assessed as at risk, or with a pattern of not responding to scheduled visits, should have appropriate documentation on how the Support Worker is to respond.

The client/carer agrees to notify Community Care Options if the client is not going to be home for the pre-arranged visit.

The client/carer is to ensure that the emergency contacts know they have been nominated as a contact and that emergency contact details are current.

Schedule for Revision of Policy: Client not responding to scheduled visit				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
24/03/2011	New policy	D. Ryan	2013	
22.9.2014	Reviewed & updated	D. Ryan	Sept 2015	

3.22 Death and Dying

Community Care Options provide support to people who are dying or who may die whilst they are clients of the organisation.

Position Statement
Community Care Options recognises the importance of sensitive and appropriate service provision for clients, their family and carers during the dying process and acknowledge issues of loss and grief which may arise for its staff.

Supporting clients and their families/carers
Community Care Options provide support to clients and their families during the dying process and at death, which is appropriate and sensitive to clients' or their substitute decision makers –

- expressed and lawful wishes;
- cultural beliefs and customs associated with dying and death;
- spiritual or religious beliefs and rituals associated with dying and death.

Support Planners work with people who are dying to –

- Comprehensively assess the person's end of life needs;
- Facilitate informed decision making by –
    - ensuring that clients are competent to make informed choices and if deemed not competent, facilitating appointment of a substitute decision maker;
    - providing clear and helpful information to clients, their families and carers;
    - assisting the client to access lawful processes to document their wishes and decisions for death (such as an Advanced Care Directive or a No Resuscitation Order);
- Identify, implement and coordinate needed services from the range available (Palliative Care Team, G.P, Community Nursing staff, Grief and Loss counsellors and the like) including facilitating options for needed equipment and aids;
- Facilitate admission to hospital or a residential care facility if this is required;
- Facilitate access to spiritual or religious leaders, community elders or others as required;
- Keep in regular contact with the client and their family to monitor and review changing needs, ensure services in place are adequate and suitable and check for any possible changes in the client's wishes.

Community Care Options Support Planners and staff must work only within the range of duties they are employed to perform ie. Only medical staff are qualified to advise clients on medical issues. A Support Planner would identify a need for, and facilitate access to a Medical professional.

When a client dies

- The client's family/carer ring the ambulance or contact the client's G.P who will determine death and assist the family with further arrangements;
- If there is any doubt surrounding the nature or cause of the death the police may also need to be called;
- The family is asked to advise Community Care Options that the client has died as soon as they are reasonably able to do this;
- The Support Planner expresses condolences on behalf of the organisation and may also explore further support for the family/carer where this is appropriate and within resources;
- Within a sensitive timeframe the Support Planner explores with the family what burial arrangements are in place and their wishes in terms of staff attendance;
- Organisational Exit procedures are commenced;
- Within a sensitive and reasonable timeframe the Support Planner works with the family/carer to return any property belonging to CCO and to pay any monies which are owing.

Dying at home

Community Care Options is able to support clients who make an *informed choice* to spend part of the dying process, or to die, at home –

- within the reasonable range and scope of available resources;
- within the availability of required multidisciplinary support;
- with due consideration to the organisation's duty of care to clients and staff.

Should Community Care Options consider it not viable to provide this support –

- the final decision will be made in consultation with the Client Services Manager;
- the reasons for the decision will be conveyed to the client and carer/family;
- Community Care Options will continue to assist the client to explore and access other viable options for support including admission to hospital or a residential aged care facility.

Supporting staff

Community Care Options is committed to –

- supporting and resourcing staff to work effectively and sensitively with people who are dying;
- recognising the possible emotional impacts of work related grief and loss;
- responding appropriately to staff grief reactions when a client they have 'cared' for, dies.

Community Care Options support their staff by –

- Providing staff with access to information and resources about death and grief and loss;
- Providing opportunities for professional development;

- Assisting staff to develop realistic expectations of its client group;
- Ensuring that the client's current, or recent staff, are provided with sensitive and timely advice (where this is possible) about impending, or actual death of the client;
- Enabling staff to say goodbye to a dying client where this is consented to and appropriate;
- Enabling staff time (unpaid) to attend burials or other death rites if desired by the staff member and consented to by the client's family;
- Providing opportunities for peer support;
- Offering professional debriefing and supervision;
- Offering access to counselling and other services through the Employee Assistance Program where this is required.

When a client does not answer their door or phone at a time that a service is scheduled and death is suspected –

- Direct care staff advise the Support Planner, or delegated substitute (On Call if out of hours);
- The Support Planner will follow the procedure agreed to by the client in relation to emergency response;
- The Support Planner advises the client's family/carer or client's substitute decision maker and requests them to attend and investigate. The Support Planner may also attend for support should the family/carer wish this;
- If the family/carer or substitute decision maker are unable to attend, consent is requested for CCO staff to access the client's home;
- If there is no family/carer/substitute decision maker, the Support Planner and another suitable staff member attend the home and investigate;
- Where there is no lockbox or other lawful means of access to the home, emergency services should be called;
- If the client is found and death is suspected, an ambulance and/or the client's G.P. is called;
- The ambulance service or Doctor will determine whether the client has died and will take responsibility for the person's body;
- The death of the client and actions of staff should be reported to the Client Services Manager and documented in the client's case notes;
- The Client Services Manager, ensures that staff are able to continue working and what other support is required.

Support Resources

- National Association for Loss and Grief (NALAG – NSW Inc. (02) 9988 3376
- Coffs Harbour NALAG Charter: - 02 66 513 675

Schedule for Revision of Policy: Death and Dying				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
28 May 2007	**Approved**	**Ruth Thompson**	**28/05/09**	**New Policy**
August 2009	**Reviewed**	**D.Ryan**	**2012**	
11.11.2011	**Reviewed & Updated**	**D. Ryan**		
September 2014	**Reviewed & updated**	**D. Ryan**	**2016**	

3.23 Ensuring Good Nutrition

Position Statement
Community Care Options recognises the importance of promoting good nutritional health as part of clients' overall well being and support planning. Community Care Options acknowledges clients' right to access food which is enjoyable, nutritious and culturally appropriate.

Community Care Options strives to achieve and maintain clients' nutritional health by

- Ensuring clients have access to good nutritional health by ensuring that –

- Food preparation conforms to applicable regulations and legislation;
- Food preparation preserves nutritional value;
- Food is nutritionally adequate, varied, appealing and tasty;
- Consideration is given to physical or visual difficulties with eating, drinking, swallowing, special seating, positioning, special utensils and supervision whilst eating or drinking.

- Recognising that clients may have a range of food related support requirements including –

- medical needs (allergies, diabetic diets, peg feeding, swallowing difficulties);
- dietary needs, other therapeutic needs (weight loss or weight gain programs, level of activity).

- Involving, as far as possible, clients, their families, carers or substitute decision makers in assessment and decision making processes about the client's nutritional health by ensuring that –

- Clients, and/or their families or substitute decision makers are actively encouraged to be involved with menu planning and food selection.

- Individual need and preference is catered to within the range of resources available –

- Clients are encouraged to actively participate, where able, in all aspects of meal preparation, food selection and purchase;
- Clients receive appropriate information about the relationship between their health and their food choices;
- Individual freedom of choice is balanced with our Duty of Care.

- Recognising and respecting client's religious, cultural needs and other personal preferences in food preparation and meal selection –

- Food provision is assessed on an individual basis taking into account the person's gender, age, culture, religion, likes and dislikes;
- Client diversity is valued and is reflected and demonstrated through the choice and preparation of food and the presentation of meals.
- Ensuring that a preventative and risk management approach to individual

nutritional health is employed by –

- Identifying and managing individual risks related to food intake, nutritional health and needs, food storage and appropriate food preparation;
- Ensuring access to and seeking assistance from health professionals as required (Dieticians, Nutritionists, Doctors and Specialists, Speech Pathologists);
- Providing education and information to staff involved in meal preparation;
- Developing and regularly reviewing individualised support plans and risk management plans;
- Regularly monitoring that the support provided is adequately meeting the client's nutritional and health needs.

Source
This policy has been informed by and complies with the objectives outlined in the Department of Ageing, Disability and Home Care's policy document 'Ensuring Good Nutrition'.

Other Resources
Nutrition in Practice and Food Services Manual, *Department of Ageing, Disability & Home Care*
Nutrition Information Kit and Fact Sheets *(links are available on the Department of Ageing, Disability & Home Care website)*
Disability Standards in Action *Department of Ageing, Disability & Home Care*
The Australian Guide to Healthy Eating *Commonwealth Department of Health and Family Services.*

Schedule for Revision of Policy: Ensuring Good Nutrition				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
28 May 2007	**Approved**	**Ruth Thompson**	**2010**	**New Policy**
11.11.2011	**Reviewed & Updated**	**D. Ryan**		
September 2014	**Reviewed**	**D. Ryan**	**2016**	

3.24 Family Centered Service Provision

Position Statement
Community Care Options recognises the value of people's informal support networks and strives to assist the client to maintain these wherever possible.

Operational Procedures
Assessments and reviews take a holistic approach and take into account the person's informal networks, including family, friends, advocates and guardians.

With the client's consent and where this is appropriate, family and other significant people are involved in key decision making and support planning.

Case management and goal setting activities include social capital building and strengthening caring relationships through the provision of education, training and support to maintain and promote family independence.

Support offered, is of the least restrictive nature, and does not replace or duplicate existing care arrangements which are sustainable by family or friends, nor that which creates increased dependence.

All clients are encouraged and helped to maintain free and open access to their family members, friends, advocates and guardians in ways that are culturally and linguistically appropriate. This includes communications with others as well as practical help, including help with transport.

Where the client is a child under 18 years of age or where there is a guardianship order, all key decisions require consultation with and agreement by the person's parent or guardian.

Furthermore, Community Care Options Staff will –

- Respect a person's right to choose not to maintain contact with their family, friends or advocates.

If asked by a client, offer assistance in mediation between clients and their family, friends or advocate.

Where there is conflict between clients and their family, the rights and well-being of the client are given priority.

Schedule for Revision of Policy: FAMILY CENTRED SERVICE PROVISION				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
24/07/2006	New policy	R. Thompson		
29/01/2007	Amended	A. Vaughan	29/1/09	
March 2009	Reviewed	D. Ryan	2012	
11.11.2011	Reviewed and Updated	D. Ryan		
September 2014	Reviewed & updated	D. Ryan	2016	

3.25 Freedom from Abuse

Definition
Abuse is defined as the systematic pattern of behaviors in a relationship that are used to gain and/or maintain power and control over another.

Purpose
The purpose of this policy is to guide commitment of all staff of Community Care Options in preventing and responding appropriately to the abuse of older people and people with a disability. In addition, CCO will act in the best interests of a person who has been abused by upholding their rights and in ensuring that the dignity and respect of people accessing our services is upheld at all times.

This policy will assist CCO –

- to achieve a consistent understanding of the forms of abuse in the community
- to ensure that staff are protected and supported by the CCO policy governing the management of suspected or actual cases of abuse, particularly staff who may be unwilling to report abuse for fear about their own safety, should the perpetrator of the abuse become aware
- to drive change that prevents abuse from re occurring such as interagency and multidisciplinary responses, (eg. joint case planning, regional partnerships and service systems) that support people experiencing abuse and address systemic issues that are identified locally.

Position Statement
Abuse of older people and people with a disability is a human rights issue. Community Care Options takes seriously its responsibilities and is committed to ensuring the legal and human rights of people, especially those who are vulnerable, are upheld in relation to the prevention of neglect, sexual, physical and emotional abuse.

Key Principles
CCO recognises that abuse does exist in the community and supports the NSW Government in promoting the general principle that all people have the right to –

- be treated with dignity and respect.
- make their own decisions and choices.
- live in a safe environment.
- access the protections available to other adults in the community.

CCO also recognises that in the course of its work, staff may encounter potential, suspected and alleged abuse situations involving older people, people with a disability and sometimes carers.

Legislation & Standards
Disability Service Standards
Home Care Standards
Preventing and responding to abuse of older people NSW interagency policy 2014

Responses by the organisation to identified abuse of clients and carers should seek to achieve in order of importance –

- freedom;
- safety;
- least disruption of lifestyle;
- least restrictive care alternatives.

This policy is in respect of older persons, and people with a disability who are a client or carer of the organisation and relates to abuse which takes place within a relationship of trust. This covers relationships between family members, friends, volunteers and staff of the organisation. It does not include self neglect, commercial abuse or criminal or other acts by strangers. It can include -

- financial or material abuse – illegal or improper uses of finances or property;
- psychological abuse – infliction of mental anguish eg humiliation, threats;
- physical abuse – infliction of physical pain or injury or physical coercion;
- sexual abuse – sexually abusive or exploitative behaviour;
- neglect – the failure of a carer to provide the necessities of life whether intentionally or unintentionally.

Operational Procedures

Key issues in defining abuse of older persons and the abuse of people with a disability include –

- the worker's judgements;
- the person's capacity to make their own decisions;
- the frequency, duration and severity of the abuse;
- the effect on the person;
- documentation.

'Key risk' factors include –

- carer stress - financial difficulties, lack of respite, multiple responsibilities, inadequate support;
- dependency - where a dependant relationship exists, a client or carer may not feel that they can change or leave the situation due to emotional, physical or cognitive dependency;
- family conflict - abuse can be a continuation of domestic violence, family violence or unresolved sexual abuse, which re-emerges as abuse in the caring relationship. In some families violence may also be seen as a normal reaction to stress;
- isolation - physical, social, and emotional isolation of the client and/or carer increase the risk of abuse;
- psychological issues - this may include a history of mental illness, mental health conditions, difficulty controlling anger, low self esteem. A person may also abuse a carer where there is dementia or mental illness present;
- substance abuse - alcohol or drug dependency by the client or carer can increase the risk of abuse.

The following principles guide Community Care Options in responding to the abuse of people living in community settings –

- The views of the person are taken into account even when they cannot make their own decisions.
- Information is provided about all relevant options available to them, including services trained to support and empower them and equipped to help them end abuse when it occurs.
- Respect is demonstrated by encouraging and assisting decision making by offering choices, including respecting the decision not to act and refuse services if they are competent to make that decision.
- Responses will be in the interests of the person at risk or who has been abused and focussed on ensuring safety and ongoing protection from violence and abuse.
- Many forms of abuse of people are crimes. Legal remedies and protections are available for people who have experienced - violence, sexual assault, physical assault, domestic violence, abuse, threats, fraud, neglect, stalking, intimidation and harassment.
- Responses to the abuse of people will be consistent with the NSW Charter of Victims Rights which is accompanied by the NSW Code of Practice for the Charter of Victims Rights.
- Responses to the abuse of people will as far as possible take account of the needs of the person in relation to Aboriginality, culture, disability, language, religion, gender and sexuality.
- The needs of the person at risk of abuse or who has been abused and the abuser must be kept separate at all times. This is particularly important in situations where the abuser has been the victim's carer or has complex needs of their own.
- When the safety of others is involved, confidentiality cannot be offered unconditionally. In situations where a report to NSW Police is required, such as criminal activity, the consent of the person involved is not necessary.
- Any person should be able to report abuse of people without fear of retaliation or retribution and in a supportive environment.

Community Care Options is committed to dealing effectively with the abuse of older people and people with a disability and is committed to -

- Creating a climate of trust, where staff are encouraged, comfortable and confident about identifying and responding to abuse
- Protecting staff from any adverse action when making a report.
- Developing a process to deal with reports thoroughly and taking appropriate action to address the reported abuse and prevent it from re occurring.
- Providing resources and training for staff about how to identify and respond to abuse
- Properly managing any workplace issues that the allegations identify or that result from a report or any other identified problem (e.g. staff safety).
- Working collaboratively within the agency and across agencies to achieve the best outcome for the person and prevent abuse from reoccurring (e.g. share and review effective intervention and prevention strategies).

- Reassessing / reviewing the policy periodically to ensure it is relevant and effective.

Identification
All staff play an important role in identifying suspected abuse and protecting people by responding to suspected cases of abuse. CCO recognises five (5) forms of abuse of people within NSW - financial abuse, psychological abuse (including social isolation), neglect, physical abuse and sexual abuse. This policy embodies the view that social isolation is a key risk factor and that people experiencing abuse often lack social connection. The policy also recognises that –

- More than one abuse type can coexist.
- The presence of one or more indicators does not mean that abuse has occurred, but does require staff to be observant and hold knowledge about abuse types, signs and indicators.
- Indicators of abuse are not always obvious and can vary, but the relationship between frontline staff and the person means they are best placed to recognise behavioural changes that may be a sign that a client is being abused.
- Staff have a duty of care to report incidents, suspected incidents and/or changes in well-being to their manager. Staff observing or suspecting abuse or neglect of a client should immediately notify the Support Planner or Client Services Manager and document their concerns on the organisation's hazard/incident report form.

Support Planners and direct care staff will refer to this policy to help them recognise abuse of adults and seek further clarification and guidance. If staff identify reasonable grounds for belief that abuse is occurring, they should establish the wishes and, in general, the capacity of the person and discuss with the Client Services Manager or CEO. A referral to appropriate agencies or professional groups can then be made for assessment.

Abuse types and indicators

Financial abuse
Financial abuse is the illegal or improper use of a person's property or finances. This includes misuse of a power of attorney, forcing or coercing a person to change their will, sign documents, taking control of a person's finances against their wishes and denying them access to their own money, stealing goods and money.

Indicators of financial abuse may include -

- Unexplained or sudden inability to pay bills, significant bank withdrawals, and significant changes to wills, unexplained disappearance of possessions, for sale sign on the street, lack of funds for food or clothing, disparity between living conditions and money, recent addition of a signature on a bank account, stockpiling of unpaid bills, carer making excuses for not providing receipts from an ATM.

Neglect
Neglect is a term used to describe the failure of a carer or responsible person to provide the necessities of life to another person. Necessities of life are usually considered to be adequate food, shelter, clothing, medical or dental care. Neglect may also involve the refusal to permit others to provide appropriate care for the person.

Indicators of neglect may include –

- Dehydration, poor skin integrity, malnutrition, inappropriate clothing, poor hygiene, unkempt appearance, under/over medication, unattended medical or dental needs, exposure to danger or lack of supervision, absence of required aids, exposure to unsafe, unhealthy, unsanitary conditions, an overly attentive carer in the company of others.

Psychological abuse (including social isolation)
Psychological abuse is the infliction of mental stress involving actions and threats such as verbal abuse, threats, bullying, intimidation and harassment, social isolation, fear of violence, deprivation and feelings of shame and powerlessness. Examples include treating an older person or a person with a disability as if they are a child, engaging in emotional blackmail and preventing contact with family and friends and/or access to services and community activities, religious (spiritual) and cultural events.

Indicators of psychological abuse may include –

- Depression, demoralisation, feelings of helplessness, disrupted appetite or sleeping patterns, tearfulness, excessive fear, confusion, agitation, resignation, unexplained paranoia, cancelling of services by a live in carer.

Physical abuse
Physical abuse involves the infliction of physical pain or injury, or physical coercion. Physical abuse can also include physical acts such as hitting, beating, biting, scratching, shaking, arm twisting, scalding, slapping, pushing, punching, kicking, burning, restraining such as tying a person to a chair or bed, locking a person in a room and overuse or misuse of medications.

Indicators of physical abuse may include -

- Internal and external injuries such as bruises on different areas of the body, lacerations particularly to mouth, lips, gums, eyes or ears; abrasions; scratches; choke marks and welts; burns inflicted by cigarettes, matches, iron, rope; immersion in hot water; sprains, dislocations and fractures; evidence of healing bones, hair loss (perhaps from pulling); missing teeth; eye injuries, scalding through immersion, pressure sores through the use of physical restraint.

Sexual abuse
Sexual abuse is a broad term used to describe a range of sexual acts where the victim’s consent has not been obtained or where consent has been obtained through

coercion. Examples can include non-consensual sexual contact such as rape, digital rape, indecent assault including inappropriate sexual handling or touching, exposure to pornography against their will, forced nudity, cleaning or treating the person's genital area roughly or inappropriately.

Indicators of sexual abuse may include –

- Trauma around genitals, rectum or mouth; injury to face, neck, chest, breasts, abdomen, thighs or buttocks; presence of sexually transmitted infections; human bite marks and bruising, anxiety around the perpetrator and other psychological symptoms, torn or bloody underclothing or bedding, difficulty walking or sitting, or discomfort when bathed or toileted.

Risk factors
Some people may be at heightened risk of abuse. Vulnerability/risk factors can be present for both the person at risk of abuse and the alleged abuser. Understanding the local demographic will help identify any interagency responses in terms of preventative action.

Generally people are at risk where the following factors are present –

- Socially isolated from neighbours, family and/or community.
- Confused about their property, belongings and/or surroundings.
- Vulnerable to other persons taking advantage of them because of deteriorating health, cognitive decline, dementia and capacity issues
- Physically or verbally violent/aggressive because of progressively worsening conditions such as dementia or challenging behaviours
- A history of family dysfunction and abuse.
- Insecure accommodation.
- Substance abuse and gambling.
- Financial difficulties.
- Personality and/or behaviour changes due to illness and some other progressively worsening condition.
- Relative powerlessness because of diminished ability to advocate effectively for themselves or to modify their environment.
- A history of domestic violence where often women are the victims and have failed to report, for many years.
- Cultural issues and dependency.

Carers and family members play a crucial role in caring for older people and people with a disability but may become abusive in certain situations such as the stress of the carer role. Stress factors can include, but not be limited to concerns from –

- Financial, emotional and physical situations.
- Sleep deprivation.
- Challenging behaviours from the person being cared for.
- Lack of support from family, community and the service system.
- Substance abuse and gambling.
- Cognitive decline of the carer.

- Cultural issues.
- Lack of skill in the caring role.

Assessment
In line with the wishes and capacities of the person who is victim of the abuse and their carers, recommend appropriate intervention. Requests for assessments can be directed to an appropriate agency, which may include –

- Aged Care Assessment Team (ACAT);
- Police;
- Mental Health Services;
- Hospital Emergency Services;
- General Practitioners;
- Centrelink;
- Domestic Violence Services.

Key considerations in responding to the abuse of older people
Duty of Care
When the abuse of a person is recognised, disclosed or suspected, staff have a duty of care to take reasonable action to ensure others are not harmed in the course of their work and to prevent abuse from reoccurring. In responding to abuse the priority is to provide an appropriate, adequate and timely response, with a focus on the immediate safety of the person, the carer (if applicable) and the staff member. Staff should only provide advice which is within their competence and position responsibilities.

Practices and partnerships
This section intends to provide guidance to general considerations. Suggestions include –

- Developing local procedures and protocols that align to the Preventing and responding to abuse of older people NSW interagency policy 2014.
- Responding promptly in situations of abuse of people.
- Identifying the wishes and needs of the person as crucial in the response to abuse situations and the development of care/case plans that are meaningful and sustainable.
- Identifying a first point of contact where the abuse or risk of abuse of a person has been identified within our agency and the community.
- Considering all possible referral options, even if they fall outside of the responsibility of CCO. Service delivery will be negotiated between agencies seeking advice from the NSW Elder Abuse Helpline and Resource Unit where necessary.
- Seeking opportunities to work collaboratively and identify opportunities and constraints of service providers in the local area.
- Giving consideration to a case management approach through case meetings to allocate overall responsibility for implementing and monitoring a care/case plan where this is considered necessary and with the consent and involvement of the person.
- Reporting and consulting a manager within the limits of job roles

- Documenting, recording and monitoring as appropriate.
- Developing resources and training for staff in consultation with the NSW Elder Abuse Helpline and Resource Unit.
- Regular in services for staff on abuse as part of employment with CCO.

Information sharing
Privacy and confidentiality refers to protecting the information provided to a staff member by a client in the context of a professional relationship.
Under federal and NSW state privacy legislation privacy principles relate to collection, usage, disclosure and storage of personal information. In the case of managing suspected or actual abuse of people, staff have an obligation to gain the persons consent in sharing information. The person has the right to decide what personal information is to be revealed to someone else outside the agency.
There are some exceptions where the requirement of confidentiality can be lawfully overridden and complete confidentiality cannot always be guaranteed to any person who raises a concern about the abuse of an older person or a person with a disability. These situations include where the agency believes, on reasonable grounds that the use and disclosure is necessary to prevent or lessen a serious and imminent threat to the life or health of the individual concerned or another person. This includes the person themselves, a relative, a fellow worker or a member of the public.

Situations include –

- There is an obligation to report a crime which may require a criminal investigation by the NSW Police.
- Disclosure may be required when in the person's interest:
- The person is believed to lack capacity or insight to make an informed choice.
- Where the person is suicidal and/or there is a concern for the safety and well being of the person and others, such as staff.
- There may be a duty to warn a third party who is in danger and/or a wider public interest.

Emergency response
Many forms of abuse are crimes. Given the exemptions listed under privacy legislation, there are situations where a report to NSW Police or other emergency service should be actioned without delay.

Many forms of the abuse of people constitute domestic and family violence. Domestic violence involves violent, abusive or intimidating behaviour carried out by a partner, carer or family member to control, dominate or instil fear. It includes physical, emotional, psychological, financial, sexual or other types of abuse.

The current definition of domestic violence, under Section 5 of the *Crimes (Domestic and Personal Violence) Act 2007*, includes relationships involving those dependent on the ongoing paid or unpaid care of the other person, as well as family members, partners, those living in the same household, and those in an intimate relationship.

The *Preventing and Responding to Abuse of Older People: NSW interagency policy 2014* lists the following circumstances that require intervention by the NSW Police.

Regardless of the victim's views, agencies must ensure workers report to NSW Police any instances where -

- The abusive situation results in serious injury inflicted on the victim.
- The perpetrator has access to a gun and is threatening to cause physical injury to any person
- The perpetrator is using or carrying a weapon (including guns, knives or any other weapon capable of injuring a person) in a manner likely to cause physical injury to any person or likely to cause a reasonable person to fear for their safety.
- An immediate serious risk to individual/s or public safety exists.
- Workers are threatened.

Additional points to consider are –

- Protecting evidence for a NSW Police Investigation.
- Agencies can seek guidance from NSW Police, other emergency services or EAHRU where there is genuine and realistic concern about harm to a person's safety and the agency is unsure if the situation poses an immediate or serious risk to the person or public safety. Where this action is taken, it is not considered a breach of confidentiality as workers are deemed to be acting with lawful excuse.
- Training and providing support to frontline workers who witness abuse or where abuse is disclosed and suspected (whether legal, physical and psychological).

Mental Capacity and Consent

In NSW there is a legal presumption that all adults have the mental (cognitive) capacity and ability to make their own decisions until proven otherwise. Mental capacity is the ability to understand an act or a decision and its consequences. Impaired mental capacity can make an older person or a person with a disability susceptible to abuse. Part of the response to abuse of a person is an assessment of the person's needs and will require consultation with the person, other relatives/ carers or external agencies (such as service providers) who deliver services to the person in their home.

Staff within CCO are to be aware that capacity to make informed decisions is critical and will consider issues of mental capacity, undue influence and consent when determining the most appropriate response to reports of actual, potential and suspected abuse.

A person lacking capacity to act or make decisions may need a guardian or financial manager if they have not appointed an enduring power of attorney or enduring guardian while they are capable.

Support Planning

As part of their support planning role, the Community Care Options Support Planner will ensure coordinated provision of appropriate services for clients and carers who are victims of abuse. The Support Planner will monitor family needs and act as an advocate, referrer and broker. It may be appropriate to jointly case manage with staff

from other agencies, particularly where there is suspected abuse of people from a culturally diverse or Aboriginal background.

Intervention
Community Care Options' response to abuse of adult clients, including older people and people with a disability is as follows –

- the organisation will comply with NSW law which requires all criminal acts to be reported to the Police;
- the organisation will also follow the "*Abuse of Older People: Inter-Agency Protocol*" issued by NSW Advisory Committee on Abuse of older People (1995);
- appropriate services should be offered including residential care, health or community services.

Any actions taken by a staff member or the organisation should be taken with due caution and in ensuring the person is not placed in a position of greater risk or abuse. The intent of this policy and procedure is to ensure that the client's situation is enhanced not made more difficult.

Legal intervention
At times, legal intervention may be required. The least restrictive legal intervention should be used. Legal intervention may include the following –

- report to the police where a criminal act has been committed;
- seeking to give or revoke a Power of Attorney;
- application for Guardianship or to the Public Trustee in relation to the management of a person's finances and/or decision making;
- apprehended violence orders where there is a fear of violence or intimidation.

Special Needs Groups
<u>People with Dementia and their Carers</u>
People with dementia and their carers are at particular risk of abuse or neglect. Research suggests that people with dementia may be at particular risk of financial abuse and neglect, while carers looking after someone with dementia are often subject to physical and verbal abuse. In cases of abuse involving a person with dementia, a full multi-disciplinary assessment by ACAT is essential. Intervention may include respite care, carer support services and support from dementia care counsellors.

Apprehended Violence Orders are inappropriate when the abuser has dementia. However an application to the Guardianship Board may be appropriate.

<u>Aboriginal and Torres Strait Islander People</u>
Aboriginal and Torres Strait Islander people will be provided with culturally appropriate services and support by acknowledging the impact of change, dispossession of land, culture and the breakdown of traditional ways of life in Aboriginal communities that contributes to the vulnerability of older Aboriginal people and people with a disability.

CCO will support staff to -

- Seek advice from the person's local Aboriginal community, acknowledging that cultural difference may require special sensitivity in relation to the abuse of people in their communities.
- Provide service delivery that is flexible, offers choice and is culturally responsive to build family and community resilience.
- Recognise that service support should be provided from Aboriginal-specific worker or organisation, depending on the person's choice and circumstances such as an Aboriginal Health Worker or Aboriginal Police Liaison Officer where possible.
- Recognise that the term 'Elder' has different meanings for different Aboriginal communities. In some, an 'Elder' can be any respected member of the community regardless of age. It is important to recognise that elder abuse is something that can happen to any older Aboriginal person, not just Elders.
- Understand that the average life expectancy of Aboriginal people is 17 years shorter than non- Aboriginal people and account for this difference in accessing aged care support as well as the expected increase in the Aboriginal population.
- Accommodate the role of kinship in Aboriginal communities where members of the community, including older members take on responsibility for multiple roles, such as caring for children who have been removed from parents.

People from Culturally and Linguistically Diverse Backgrounds

CCO recognises the diversity of our community and respects the cultural norms that influence how families function and the place of the person within the family context. Culture, language, ethnicity or religion can impact on a person's freedom to make decisions. Cultural factors also influence how all forms of abuse are viewed, and specific strategies and responses to abuse of people should address such differences. Advice should be sought from people experienced with the particular cultural group. The local Migrant Resource Centre can be approached to identify the appropriate ethnic agency for assistance on issues of abuse. Decision making may be enhanced through a family collective, community collective or a well respected member if the community or an elder. Consideration should be given to the impact of religion on medical treatments. It must be noted that cultural acceptance of abuse is no defence to criminal charges.

All staff will treat people from a CALD background with culturally appropriate services and support by acknowledging that factors including isolation, dependency, concepts of individual rights of people and stress in the care relationship are of particular concern for people in CALD communities. CCO will support staff to –

- Provide appropriate support to people from CALD background such as interpreter services recognising that lack of English language skills and cultural influences can mean that a person is more vulnerable to abuse where it occurs, and that they are less likely to identify abuse or seek support.
- Understand the different cultural world views that can affect the way that the abuse of people is perceived.
- Seek advice from people experienced with the particular cultural background of the family concerned, acknowledging that cultural difference may require

sensitivity in relation to the abuse of people in CALD communities (eg. Police Domestic Violence Liaison Officer, bi-lingual staff).
- Respond sensitively where actions reflect the important role of family and that separating people from their family may be an inappropriate response.

People with a Disability

People with a disability, particularly an intellectual disability can be particularly susceptible to abuse and neglect. Advice and information can be sought from the Intellectual Disability Rights Service if abuse or neglect are suspected.

Staff roles and responsibilities

Managers

Managers play a lead role in identifying and responding to the abuse of people in accordance with policies and protocols and consistent with the Preventing and Responding to Abuse of Older People: NSW interagency policy 2014.
Consideration of safety, protection, consent, confidentiality and duty of care issues –

- Assess and responding to immediate and serious risk of harm of a person and exercise duty of care to make reports to the Police
- Support staff that respond to an emergency situation and protect evidence.
- Identify response options including collection of information about what the person wants and for referral options.
- Discuss options with the person
- Support the person with empathy, asking what the person wants, exploring needs.
- Refer, if appropriate, to a specialist response agency for further assessment, investigation or to negotiate a support plan such as the Aged Care Assessment Team (ACAT)
- Complete agency specific documentation.
- Support the identifier of abuse, including providing access to debriefing and training such as an Employee Assistance Program.
- Capacity decisions - referral to a specialist service or professional with the expertise to assess capacity such as legal practitioners, medical practitioners or specialist medical officers, Aged Care Assessment Teams.

Staff

Staff play a key role in responding to abuse situations by identifying abuse (potential, suspected or actual abuse) reporting to the manager, documenting and following agency procedures.

- In an emergency situation, contacting the NSW Police and/or other emergency services and protect evidence.
- Initial detection of abuse.
- Support the person with empathy, asking what the person wants, exploring needs.
- If safe to do so, inform the alleged victim of the responsibility to tell a senior staff member about concerns for the person’s health, safety or wellbeing.

- Inform managers about what happened and what was noticed, said and done in the situation.
- Referral, if appropriate, to a specialist response agency for further assessment, investigation or to negotiate a support plan.
- Documentation and reporting.
- Participation in debriefing where appropriate
- If there is an issue about the person's mental capacity to act or make decisions, seek advice from the Manager.

Schedule for Revision of Policy: FREEDOM FROM ABUSE				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
28/08/2003	New policy	R. Thompson		
27/11/2006	Amended	A. Vaughan	29/1/09	
20/12/2008	Reviewed	D. Ryan	2012	
8/8/2010	Reviewed			
11.11.2011	Reviewed and Updated	D. Ryan		
September 2014	Reviewed & updated	D. Ryan	2016	

3.26 Mandatory Reporting

Definition
Mandatory reporting is a term used to describe the legislative requirement imposed on selected classes of people to report suspected cases of child abuse and neglect to government authorities.

Position Statement
Community Care Options are committed to ensuring the safety of children to whom they provide services. As a provider of services to children with a disability, Community Care Options staff working with children and managers, supervising such work, are mandatory reporters of suspected risk of harm to children. Under the Children and Young Persons (Care and Protection) Act 2000, mandated persons are legally required to report children (aged 0-16 years) suspected to be at risk of harm.

Child abuse is a complex and serious problem which often occurs in environments that are isolated and stressful and affects those who are most vulnerable. In its most serious forms, abuse can lead to death or long-term harm to the physical and emotional wellbeing of a child and or young person. (New South Wales Interagency Guidelines for Child Protection Intervention, 2000).

Children and young people with a disability may be more vulnerable due to mobility constraints, dependence on others or limits on their ability to communicate. Intervening early to support families experiencing stress and difficulty is a key child abuse prevention strategy. (New South Wales Interagency Guidelines for Child Protection Intervention, 2000).

Effective care and protection incorporates community action to –

- Prevent and reduce the abuse and neglect of children and young people in the community;
- Provide timely support to families experiencing difficulty;
- Respond to reports of suspected risk of harm in a timely manner so that the safety of children and young people is effectively addressed and appropriate support is provided; and
- Ensure offenders are appropriately sanctioned.

Due to the vulnerability of people with a disability, staff of ADHC-funded services are required to also report to the Department of Family and Community Services (DoCS) any young person (aged 16-17 years) suspected to be at risk of harm or any unborn child suspected to be at risk of future harm. Young people should be involved in the decision to report and the process of reporting, unless there are exceptional reasons for excluding them, for example, where a person's disability prevents them from an adequate understanding of the matter. If the young person is against the report being made, this information should be conveyed to DoCS staff. DoCS are required to consider the young person's wishes in any subsequent assessment and investigation.

Reporting children, young people and unborn children suspected risk of harm to DoCS –

All Community Care Options staff members will discuss their concerns with the Client Services Manager or the CEO, prior to making a report. If staff or management are unsure about whether a report should be made, they can call the Department's Hotline on 13 36 27 for advice.

Staff must make a report to DoCS when they have current concerns about the safety, welfare and wellbeing of a child for any of the following reasons –

- the basic physical or psychological needs of the child or young person are not being met (neglect);
- the parents or caregivers have not arranged necessary medical care (unwilling or unable to do so);
- risk of physical or sexual abuse or ill-treatment (physical or sexual abuse);
- parent or caregiver's behaviour towards the child causes or risks; psychological harm (emotional abuse);
- incidents of domestic violence where as a consequence a child is at risk of serious physical or psychological harm (domestic or family violence).

Failure to comply with legal mandatory reporting obligations can incur a financial penalty.

Making a report
The threshold for making a report of suspected risk of harm is "reasonable grounds to suspect". It is not necessary to prove that abuse or neglect has actually occurred or who is responsible. Staff who are unsure about whether to make a report may discuss the matter with a DoCS Helpline caseworker, without having to identify the child concerned. Other sources of advice may include a supervisor, NSW Health Sexual Assault Services or a paediatrician. Staff will familiarise themselves with this policy prior to making a report and check the Reporting check list.

To make a report, staff will call the DoCS Helpline 13 3627 and provide the following information –

- your name and position in Community Care Options;
- full name, date of birth (or approximate age), address and phone number of the child/ren;
- full name (including any known aliases), approximate age, address and phone number of the parents or carers;
- a description of the child and their current whereabouts;
- why you suspect the child is at risk of harm (what you have seen, heard or been told);
- whether a language or sign interpreter may be required, whether support is required for a person with a disability or an Aboriginal agency is involved;
- your contact details.

Safeguards for reporters
Section 29, Children and Young Persons (Care and Protection) Act 2000, provides protection for people who make reports of suspected risk of harm to DoCS. Making a report to DoCS does not constitute a breach of professional etiquette or ethics or a departure from accepted standards of professional conduct.

The identity of a person who makes a report cannot be disclosed without either the consent of the person or the leave of a court. If a person is threatened or fears personal violence as a result of making a report to DoCS, this should be reported to the police, who may apply for an apprehended violence order on their behalf.

DoCS' response to reports of suspected risk of harm
When responding to reports of suspected risk of harm DoCS will –

- Provide feedback to all reporters and indicate what action, if any, is being taken;
- Assess reports of suspected risk of harm;
- Secure the safety, welfare and wellbeing of a child or young person who is in need of care and protection; and
- Request information relating to the safety, welfare and wellbeing of a child or young person.

DoCS staff will work collaboratively with other agencies in order to address care and protection issues.

Reporting a matter to the police
If it is believed a criminal offence has been committed, the matter should be reported to the police as well as reporting to other agencies, for example DoCS.

Confidentiality
It is important to maintain confidentiality. When making a report to ICAC or the Ombudsman, staff should not advise the alleged perpetrator. Failure to handle reports confidentially may prejudice any subsequent investigation and may cause unnecessary hurt or embarrassment to individuals.

Responding to allegations of child abuse and neglect against employees
Investigation
If a staff member is suspected of causing harm to a child or young person while working, the CEO will appoint a delegate to conduct an initial risk assessment and an investigation. The initial risk assessment will ascertain whether the child or young person is at immediate risk of harm and to determine any immediate action in relation to the employee. This assessment must be conducted whether or not a report is made to DoCS or the police.

Any action taken will be commensurate with the likely seriousness of the matter and may include –

- Immediate suspension of the employee from all employment;
- Immediate suspension of the employee from any work where they have

contact with children or young people but not from employment generally;
- No action concerning the employee while the matter is under investigation.

The investigation aims to ascertain whether the allegation is true. The CEO must conduct the investigation or appoint a delegate and oversee the investigation. The CEO may also request that the Ombudsman completes the investigation.

The rights of the staff member under investigation
The principles of natural justice apply during the investigation and appropriate advice, support and assistance is to be given to the staff member who is the subject of the allegation. The Principles of the policy on disciplinary action apply.

Some examples of support that staff members have access to are –

- To consult their employee association for assistance;
- To request a support person be present at interviews; and
- To request counselling in accordance with the Employee Assistance Program.

NSW Commission for Children and Young People
ADHC-funded services have an obligation to report any employee who has been the subject of completed relevant employment proceedings to CCYP. Completed relevant employment proceedings means disciplinary procedures against an employee by the employer or by a professional or other body that supervises the professional conduct of the employee, being proceedings involving –

- Reportable conduct by the employee, or
- An act of violence committed by the employee in the course of employment and in the presence of a child.

Reportable conduct means –

- Any sexual offence, or sexual misconduct, committed against, with or in the presence of a child (including a child pornography offence), or
- Any assault, ill treatment or neglect of a child, or
- Any behaviour that causes psychological harm to a child
- Whether or not, in any case, with the consent of the child.

Reportable conduct does not extend to –

- Conduct that is reasonable for the purposes of the discipline, management or care of children, having regard to the age, maturity, health or other characteristics of the children and to any relevant codes of conduct or professional standards; or
- The use of physical force that, in all the circumstances, is trivial or negligible, but only if the employer is an agency the which Part 3A, Ombudsman Act 1974 applies and the matter is to be investigated and the result of the investigation recorded under workplace employment procedures; or
- Conduct of class or kind that is exempted from being reportable conduct by the guidelines under section 35, Child Protection (Prohibited Employment) Act

1998.

It is not necessary to notify CCYP where completed employment proceedings have proven the allegations to be false, vexatious or misconceived. However, where the allegation was unsustained, unconfirmed or sustained, it must be notified. For more information, refer to the Disclosure of Relevant Disciplinary proceedings to the Commission for Children and Young People (Premier's Circular 2000-73). Employment screening of staff working with children and young people see policy on pre-employment screening.

Schedule for Revision of Policy: MANDATORY REPORTING				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
29/01/07	**New Policy**	**A. Vaughan**	**29/01/09**	
July 2009	**Reviewed & updated**	**D. Ryan**	**2012**	
11.11.2011	**Reviewed & Updated**	**D. Ryan**		
September 2014	**Reviewed & updated**	**D. Ryan**	**2015**	

3.27 Medication Policy

Definition
Medicine – any substance used in the treatment or prevention of disease or illness. Includes prescription and non prescription medicines.

Position Statement
While medicines make a significant contribution to the treatment and prevention of disease, increasing life expectancy and improving the quality of life, they also have the potential to cause harm. It has been shown that inappropriate or incorrect use of medicines can have an adverse effect on health. The quality use of medicines can have a positive impact on health and can improve quality of life.

Community Care Options recognises that many of its clients may have acute or chronic health conditions that require treatment with medications. It also recognises that due to frailty, disability or other factors the client may require assistance with the safe administration of medications. CCO seek to promote quality use of medicines and better medication management for its clients.

CCO is committed to ensuring that where clients are requiring assistance with medications this is provided in the safest manner possible with due regard to the health and safety of both clients and staff.

Medications are given to cure or prevent illness or disease. Medication has the power to help or harm the client. Because of this the administration of medication is one of the most significant responsibilities facing our staff. Clients who use CCO services and programs are owed a duty of care by staff and management. In assisting clients with their medication it is important that staff understand their duty of care to the clients. Different clients need different types of assistance with their medication.

Legislation and Standards
NSW Health Policy Directive (PD2005_105) Medication Handling in Community Based Health Services/Residential Facilities in NSW – Guidelines.
Aged Care Act and Regulations
NSW Poisons and Therapeutics Goods Act 1966
Poisons and Therapeutic Goods Regulation 1994
National strategy for quality use of medicines (QUM)
APAC Guiding principles for medication management in the community June 2006

Operational Procedures

CCO has a quality framework surrounding medication management that includes –

- A monitored quality framework for medication supervision and administration in the community that ensures clients medication requirements are met appropriately and safely;
- Training and assessment of staff in the area of medication administration and supervision;

- Regular review of client's ability to self medicate and determination of level of assistance required. May include liaison with pharmacist and Dr in relation to over the counter and prescription medications and administration aides and labelling;
- A system for documenting and reporting medication requirements including medication incidents;
- Staff that follow the CCO quality framework for medication assistance;
- Use of Webster pre packed systems for solid form oral medication.

CCO adheres to the guiding principles for medication management in the community (Australian Pharmaceutical Advisory Council) as follows –

Guiding Principle 1 – Information resources
All support staff have access to current, accurate and balanced information about medicines. This will assist them to provide clients with appropriate information, including Consumer Medicine Information (CMI), and advice about medicine use, in a timely manner.

Support Planners should establish at assessment the client's level of understanding of their medication including how to take it and what would happen if they don't. This should take into account the consumer's literacy and language skills, their cultural background and their medication regime. Where a client requires support with managing their medications and the Support Planner requires further information about the client's medicine(s) they may with the client's consent, consult the client's pharmacist and/or doctor. Support Planners will ensure that direct care staff are resourced with information and procedures for the provision of medication assistance to the client. All such procedures will be documented, monitored, reviewed and evaluated regularly.

Consumer Medicine Information (CMI)
CMI is designed to inform consumers about prescription and pharmacist-only medicines. CMI leaflets are brand specific and are produced by the pharmaceutical company that makes the particular medicine. They might be included in the medicine package, but can always be requested from the pharmacist or doctor.
A CMI guide is available, which provides information about how CMI can be used by consumers and health care professionals to build better relationships to achieve the quality use of medicines.

Refer to:
www.nps.org.au or telephone 1300 888 763
www.betterhealth.vic.gov.au (select 'library' then 'medicines guide')
www.appco.com.au/appguide
www.health.gov.au/internet/wcms/publishing.nsf/Content/nmp-consumers-cmi.html
www.medicinesaustralia.com.au

Medicines Line
Medicines Line gives consumers access to independent, accurate, up-to-date and specific information about medicines, provided by experienced medicines information specialists and clinical pharmacists.
Telephone 1300 888 763.

Adverse Medicine Events Line
The Adverse Medicine Events Line allows clients to report or receive advice on adverse medicine events.
Telephone 1300 134 237

Guiding Principle 2 – Self-administration
CCO clients should be encouraged to maintain their independence for as long as possible, including managing their medicines in a safe and effective way. Clients should be encouraged to self-administer their medicines (including prescription and non-prescription medicines and complementary health care products). Clients might want to administer only some of their medicines (for example, take oral medicines, but might require an authorised health care professional to administer injections). CCO will support clients in their choice of self-administering their medicines.

CCO staff will encourage clients to talk to their prescribers (GP or Specialist) and pharmacists about all of their current medicines. Prescribers should talk to client's about the safe and effective use of all their medicines, including prescription and non-prescription medicines, and complementary health care products, and the potential interactions between these.

If there is doubt that a client is able to safely administer and store their medicines then the Support Planner should organise for this to be formally assessed by their GP or through a Home Medicine Review (HMR). Should a Support Worker find that a client is having difficulty in administering their medicines, the Support Worker should alert the Support Planner to the need for a formal assessment by a health care professional.

All support strategies should be trialled with clients, carers and/or Support Workers before a health care professional is engaged to manage medicines. Strategies might include the provision of Dose Administration Aids (DAAs) or engaging a nurse or care worker to help with aspects of administering medicines.

Any strategies in use should be documented in the client's record. Provision of Consumer Medicine Information (CMI) and organising a Home Medication Review might help a client to administer medicines safely and in a way that suits their needs.

Documentation on self-administration should show whether a client is administering their own medicines, any potential problems, and any strategies in place to make sure they are administering and storing medicines safely and in compliance with the instructions. Information regarding possible adverse health outcomes that could be caused by a potential medicines interaction, or possible adverse effects, should be made available and/or discussed with the client and documented.

Guiding Principle 3 – Dose Administration Aids
Dispensed medicines should be retained in the original manufacturers' or other dispensed packaging unless a Dose Administration Aid (DAA) could help to overcome specific problems that a client or Support Worker might face.

A DAA is a device or packaging system for organising doses of medicines according to the time of administration. Different types of DAAs include blister or bubble packs, compartmentalised boxes, and compliance packs such as those provided by automated medication dispensing systems. A DAA is a tool to be used in a coordinated approach to medication management.

Role of Support Workers
A Support Worker should only physically assist a client in using their DAA if the client is responsible for their own medication management, and where agreement has been reached between the client and Support Planner in accordance with relevant legislation and CCO policy and procedures.

The Support Worker might remove medicines from a DAA or prompt a client to remove and take the medicine. Support Workers are provided competency-based training in relation to this. Support Workers should monitor medication management by clients and be guided by CCO's medication management policies and procedures if there are any suspected adverse medicine events.

Safety and quality
The DAA should contain features that will show if the container has been tampered with before the medicine has been administered, depending on the individual requirements of the client receiving the medicines. If a Support Worker is to help a client use their DAA and it is evident that the DAA has been tampered with, it should be returned to the pharmacist for repacking.

In the event of a dosage or medicine change where the client is self administering medicine from a DAA, the DAA should be returned immediately to the pharmacy for re-packing and re-delivery. The Support Worker or Support Planner should liaise with the client about returning the DAA to the pharmacy and arrange alternate supply where necessary.

Consumer Medicine Information (CMI)
Even when medicine is supplied in a DAA, CMI should be provided, in accordance with professional guidelines. Support Planners should ensure where we are supporting clients with medicine administration that copies of CMI are provided with the medication chart in the client's folder to resource Support Workers and the client.

<u>Guiding Principle 4 – Administration of medicines in the community</u>
CCO plays an important role in making sure that clients who live at home receive suitable information and/or assistance so that they take their medicines correctly. Communication and coordination between health care professionals, Support Workers and CCO are essential elements for safe and effective medicines administration. This becomes particularly important when a client is unable to take responsibility for their own medicines and/or their carer needs help in managing and/or administering the clients medicines.

Support Planners will ensure that an up-to-date record of the clients medicine is kept on the clients file. There should be clear instructions on a clients support plan about what steps the Support Worker will take to support a client and/or their carer in the administration of medicine. Support Planners should be aware of the

Support Workers levels of skill and knowledge, and provide the necessary training to ensure duty of care is met. They should not expect or require Support Workers to perform tasks beyond their knowledge, skills, experience and training.

Role of care workers in supporting the administration of medicine
A trained and competent Support Worker can help when a client or their carer requires physical assistance to administer the consumer's medicines.
Support Workers are generally able to help clients who are responsible for managing their own medicines, by unscrewing bottle lids, removing tablets from dose administration aids. It is important that all Support Workers are educated and competent to assist the client with medication management.

Support Workers should only provide services that are consistent with their level of training and competence. The delivery of care will depend on the client and their health care needs. Support Workers are not authorised to make any decisions about whether the medicine should be administered and should seek assistance from the client's Support Planner if they have any concerns about medication management.

Where a client runs out of their current supply of medicine, Support Workers should seek the advice and/or assistance of the client's doctor, pharmacist, registered nurse, or the usual source of supply.

Balancing the clients' rights with our duty of care is also important. For example clients have a right to refuse medications. It is the staff duty of care to report this to the Support Planner as well as any discrepancies that might be discovered.
Support staff are responsible for ensuring the 3R's of medication administration –

the right amount of medication is given to the right client at the right time and on the right day.

They are also responsible for -

- Only giving medication from approved administration aides.
- Witnessing that the client has swallowed the medication
- Observing the client for possible adverse drug reactions
- Documenting the assistance given with medication
- Reporting any discrepancies, incidents with medication
- Reporting any difficulties the client is having with medication.

Support staff may be required to assist clients to self administer medications.

Clients can only be assisted with medication, if this is dispensed via a blister pack (Webster Pack) which clearly shows day and time the medication is due and lists the relevant medications on the back. Staff will check that the medications contained for the dosage being taken by the client match the description ie number indicated on the back. (right amount).

Staff will not administer any medications (tablets) that are not contained in a webster pack, nor any other forms of medications ie creams, lotions, oral medications that are not in their original labelled containers.

Support Workers are not to assist with medication unless this is specified in the client's support plan or duties list.

All clients who are assisted with medication administration, will have a medication sheet in their client folder for staff to record that they have observed/assisted the client with their medication. Staff assisting with medication will document assistance provided according to the medication sheet.

Staff should ensure that any tablets refused are disposed of, documented and recorded according to the medication procedure.

All staff must report to the Support Planner whenever a client refuses or is unable to take their medication, if assisting with medication is part of the support plan.

Staff may not pick up S8 drugs (eg. Morphine) from the chemist on behalf of clients.

Staff must collect prescriptions from the chemist at least 3 days before medications run out, if this is part of the support plan, unless specific alternative instructions are given.

Staff will contact the Support Planner if a client is having a reaction to prescribed medication. In extreme cases they must call an ambulance.

If support staff have any problems or concerns regarding medication, they must inform the Support Planner immediately. eg. Client has too much medication at home if using more than the Webster pack.

Staff will not assist with the following procedures unless they have been specifically trained to do so, assessed as competent, and this is identified as a specific duty requiring support for that client (where this is the case staff will be specifically trained in that client's procedure) -

- Injections
- Feeding tubes/pegs
- Suppositories & enemas
- Medicated lotions & creams – Field staff may only apply non-medicated lotions (eg. moisturiser) but not medicated lotions (eg. Hydrocortisone cream). If unsure, contact the Support Planner before applying.
- Herbal supplements are considered to be medications and must not be dispensed.

Client requests for assistance with medications should be referred to the Support Planner where these are not specifically identified in duties lists or support plans.

Staff that have been trained can administer nose, ear and eye drops where these are specifically requested by the Support Planner. The Support Planner will ensure that there are specific directions for their administration. Staff will ensure that they check all instructions before dispensing ie right medication, right client, right route of administration, medication is within use by date.

It is the policy of CCO that staff will –

- Practice universal precautions (eg. wear gloves, wash hands before and after) even whilst applying non-medicated lotions.
- Be aware of appropriate storage and used-by-dates on all medications. (Particularly eye drops which commonly expire 28 days after being opened and must be kept refrigerated).

Guiding Principle 5 – Medication lists

Client's should be supported in maintaining a current list of all their medicines. This list should be available and easily accessible to the client and all those involved in the clients care.

All clients are encouraged to keep a list of all of their current medicines, including prescription and non-prescription medicines, and complementary health care products.

Health care professionals, Support Planners, Support Workers and carers should actively encourage this practice regardless of whether medicines are being self-administered or administered with assistance.

At a minimum, the medication list should include –

• The consumer's complete name, address and date of birth.
• The name and contact details of the consumer's doctor/prescriber and pharmacy.
• Details of all medicines the consumer is currently taking, including brand name and active ingredient, strength and form, dose, frequency, route, duration and indication.
• Any allergies and previous adverse drug reactions that the consumer has experienced.
• Details of any vaccinations the consumer has received.

The health care professional, Support Planner or carer should confirm with the client that they understand any changes to their medication regimen (including brand substitution) and the need to update the medication list accordingly.

The medication list should indicate whether the client is receiving assistance with the administration of any of their medicines.

The medication list should be kept with the client's medicines and be accessible at all times to the person responsible for administration of these medicines. It should be available to all involved in the client's care so that it can be easily produced for reference by other health care professionals or health services, for example, in an emergency.

Informed consent to share information on the client's medication list with others involved in the clients care, for example health care professionals and providers, should be obtained from the client.

Guiding Principle 6 – Medication review

Clients are encouraged to have their medicines reviewed by members of their health care team. As part of good quality care, it is essential that all medicines be reviewed regularly. Reviews should involve collaboration between the client and/or carer and appropriate members of the health care team, eg doctor, pharmacist, nurse, other health care professionals, and Support Planners.

Home Medicines Review (HMR), is a service to clients living at home and is a formalised medication review carried out within an agreed process. The goal of HMR is to maximise an individual client's benefit from their medication regimen, and prevent medicine-related problems. HMR is based on a team approach that involves the client's GP and preferred community pharmacy, and other relevant members of the health care team such as nurses, or Support Planners.

During the HMR, an accredited pharmacist will comprehensively review the client's medication regimen (including prescription and non-prescription medicines and complementary health care products). The pharmacist will discuss with the client how they take their medicines and any difficulties or uncertainties about them. The pharmacist will then talk to the GP about the results of the home visit, and the GP and the client and/or carer will then agree to a Medication Management Plan. The client and/or carer, and the GP, are central to the development and implementation of this plan. It is recommended that CCO have access to the Medication Management Plan and identify any need for further support. As these plans are the property of the client, the Support Planner should request access to the document so that they are aware of the results of the review.

Guiding Principle 7 – Alteration of oral formulations

Some clients might need to have oral formulations altered, for example, tablets broken or crushed, to aid administration. However, some medicines cannot be altered and the client might need alternative formulations or different medicines instead. These clients should be given the help they need to guarantee their medicines are managed safely and effectively.

Wherever possible, alteration of formulations should be avoided. However, where alteration may be required, advice from a pharmacist should be sought before any formulation alteration is considered.

Support Workers should not alter a medicine without instruction from a prescriber or other relevant health care professional. They should check the dose administration aid or medicine container for any instructions about altering the oral formulation (e.g. 'do not crush or chew') before helping the client. Support Workers who are asked to alter oral formulations against the advice of pharmacists should refer the matter to the client's Support Planner.

Guiding Principle 8 – Storage of medicines

Clients using medicines in the community should be encouraged to store their medicines in a manner that maintains the quality of the medicine and safeguards the client, their family and visitors in their home.

Generally, medicines should be stored in their original container in a cool, dry and

secure place. The stability/effectiveness of some medicines depends on storing them at the correct temperature, for example, those medicines requiring refrigeration.

Clients who need help in managing their medicines might also need help in storing them safely, for example, away from children and people who might be unable to read or understand labels.

Where there is a major risk of medicine misuse, such as accidental overdose by clients who are diagnosed with confusion or dementia, CCO (in conjunction with other family members if appropriate/available) might need to take a lead role in making sure that the medicines are appropriately secured. In such cases, medicines should be stored out of the clients reach and sight, while still being accessible to those assisting in medication management. For example, medicines could be stored in a locked box in the top of the pantry or kitchen cupboard. In such cases clear instructions as to the location and access to medicines should be documented in the client's support plan.

Guiding Principle 9 – Disposal of medicines

Clients and/or their carers should be encouraged to return any unwanted, ceased or expired medicines to their local community pharmacy for safe disposal.
To avoid accidental poisoning, medicine misuse and toxic releases into the environment, the safe disposal of unwanted and expired medicines is a priority of the Australian Government.

Guiding Principle 12 – Risk management in the administration and use of medicines in the community

CCO will work together with health care professionals, and clients and/or carers to manage risks and incidents associated with medicine use in the community.
Clients have the right to be protected against products, production processes and services that are hazardous to health or life.

CCO seeks to reduce or eliminate the risk of medication errors and incidents.

Medication errors and other medication incidents can occur at numerous points, from the prescription or selection of a medicine to its ingestion. There are formal and informal safety and quality checks at many points along this path, for example, the prescriber using electronic prescribing information, the pharmacist dispensing the prescription, the client reading the Consumer Medicine Information, and the Support Worker administering the medicine.

When a medication incident occurs or where a medication incident has been averted (referred to as a 'near miss'), all staff are required to document this on a CCO Hazard/Incident Report Form and submit as soon as possible. Staff are also advised to contact the office immediately to report medication incidents. The Incident/Hazard will be managed through CCO's WH&S risk management system to minimise the likelihood of medication errors and prevent their reoccurrence.

All staff are responsible for their own actions and should report any medication incidents or near misses immediately on a Hazard/Incident Report Form.

Medication incidents will be monitored and reviewed by the organisation as part of risk management and continuous quality improvement systems and processes.

Risk assessments will take place as part of regular reviews, when a change in process is implemented, and when an adverse incident or near miss occurs.

Schedule for Revision of Policy: MEDICATION POLICY				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
18/10/2005			**18/10/07**	
April 2009	**Draft policy developed**			**For consultation**
11.11.2011	**Reviewed & Updated**	**D. Ryan**		
September 2014	**Reviewed & updated**	**D. Ryan**	**2015**	

3.28 On Call Policy

Position Statement
Community Care Options (CCO) recognises it has contractual obligations and a duty of care to ensure that staff and clients have reasonable access to appropriate and responsive assistance as and when required. Community Care Options complies with these obligations by -

Supporting clients with information and resources that enable them to access appropriate assistance as independently as possible.

In line with the core values of CCO Case Management practice (promoting independence, empowerment, strength based and least restrictive practice) Support Planners work with clients, in the first instance, to –

- set reasonable and realistic expectations of the organisation's role and capabilities within program guidelines, standards and funding
- facilitate and build independent access to appropriate assistance.

Providing access to CCO emergency assistance through 'on-call' arrangements.

CCO's 'On call' service provides assistance to clients and staff between the hours of

- 6 am and 8:30 am and from 4:30 pm to 10 pm on weekdays and
- 6am and 9 pm on Saturdays, Sundays and Public Holidays.

Legislation and Standards
"On Call" arrangements are a contractual obligation for Home Care Packages. Level 4 clients must have access to 24 hour nursing assistance. CCO complies with this obligation through the provision of an INS alarm system (24 hour nursing assistance) installed and paid for by CCO for the duration of all Level 4 client's stay on the program.

For operational, human resource management, quality assurance and safety reasons, CCO extends on call access to all clients and staff of the organisation.

Operational Procedures
The purpose of 'On call' is to deal with urgent matters relating to client service delivery which must be addressed before 9am of the next working day. On call solutions should address the identified short term need in the most cost efficient, client focused and effective manner ensuring the safety of staff and clients.

On call will not cover matters which can be arranged or dealt with on the following working day. Enquiries and requests that do not require a response during 'on call' will be politely re-directed for follow up within usual office working hours.

On Call Responsibilities
The 'On Call' staff member is responsible for –

Providing the **minimum acceptable and effective response** required to ensure the short term solving of the immediate problem and the safety of clients and staff.

Sourcing and implementing the **most cost efficient solution**. The On Call staff member has delegation to approve necessary expenditure up to $500. When resolving emergency situations however, the On Call person must evaluate the relative cost of different solutions and opt for the cheapest effective solution. ie. a CCO support worker is usually cheaper to provide than a brokered staff member. It is even more cost efficient for a family member to attend to the client's needs or for the client to be assisted to generate a solution from within their own resources.

Discharging the Organisation's **duty of care** by redirecting matters outside our area of authority and qualifications to other appropriate services ie –

- **medical needs** must be addressed by medical staff via the client's GP, local hospital emergency department or ambulance service. The client's consent to access medical assistance should be obtained. If this is not forthcoming however, you should explain to the client that you have a duty of care to seek medical assistance on their behalf. The client retains the right to refuse medical treatment but will have access to medical advice on which to make an informed decision.
- **criminal matters** and community safety matters should be addressed by the police.
- **mental health matters** should be addressed by after hours mental health services or by counselling services such as Lifeline.
- **emergency respite** services, where appropriate can be directed towards the Commonwealth Respite and Carelink Centre (CRCC). CRCC is able to approve, provide and pay for emergency respite for eligible carers. The On Call person needs to gain approval from the CRCC after hours staff prior to arranging the respite. CRCC can be asked to broker CCO support staff to provide the emergency respite if this is considered of benefit to the carer or care recipient. If agreed to, the On Call person then arranges for CCO support staff to provide the service.

Ensuring the solution is **client focused** and considers the client's needs.

Ensuring that client and staff **privacy and confidentiality** is maintained at all times.

The **provision of essential client services** until at least 9 am of the next working day. If a Support Worker advises they are unable to work, the On Call person needs to find a suitable replacement worker who is available and competent to perform the duties required. It is preferable to use a worker who already works with that client. Client duties list and risk assessments are located in the client's home and replacement staff should be referred to these. The On Call person will alert the replacement staff member about risks they need to be aware of prior to attending the client's home and furnish them with relevant information contained in roster alerts. The On Call person will advise the client that the rostered support worker is

unavailable, gain their consent to send an alternate worker, advise the client of the first name of the replacement worker and any other changes to the service. Due consideration must be given to ensuring compliance with relevant employment and WH&S legislation and award conditions when rostering staff.

Ensuring their **availability** whilst on call. The On Call mobile phone must be adequately charged, switched on, and with the On Call staff member at all times during On Call periods. In cases where there is no signal, the On Call mobile phone must be redirected to a suitable landline. On Call messages must be checked and responded to at least ½ hourly.

Being available for **Call outs** if necessary**.** The "On Call" person must be available to respond to emergencies, including if necessary, travel to clients, when On Call.

A Support Planner would only attend, in person, to an On Call matter if –

- there were no other suitable staff available at a more cost effective rate of pay and,
- the circumstances required a higher level of skill and competency than that able to be provided by Support Workers under their employment category, and
- it was considered essential and safe to address the matter in person, and
- no other solution to the matter is available.

Should the On Call person consider a call out to be necessary, they should phone the Client Services Manager or, if unavailable, the CEO for approval. If both are unavailable, the On Call staff member should contact same on return to work to advise of and justify the call out.

Informing relevant people of On Call matters and completing required follow up actions in a timely manner –

- by contacting relevant people whilst On Call if necessary (the client's family, carer or guardian if required or support staff if a service is cancelled or altered for example)
- if appropriate, contacting and informing the client's Support Planner as early as possible on the next working day so they are able to follow the matter through. Significant occurrences should also be reported to the Client Services Manager.

The On Call staff member is also responsible for ensuring that rostering staff –

- are informed of staff/roster changes that were made On Call
- are requested via an email to re-roster services for staff who have advised that they are unable to work in a timely manner which facilitates remedial rostering action to be taken.

Documenting the On Call incident and actions taken in the client's case notes where applicable and also recording the call on the On Call Register.

Ensuring they are resourced with tools and information required to perform the responsibilities of On Call including identifying and seeking additional training and guidance if required.

The On Call staff member has responsibility for collecting the **On Call bag** on the day they commence On Call. The On Call staff member should ensure that the following equipment is present and in working order in the On Call bag –

- On Call lap top, charger and mouse
- On Call mobile phone, charger and instructions
- paper copies of - the On Call policy and procedure; list of current staff and contact numbers; list of service providers and contact numbers; a copy of the current recipient list from TRACCS; a current 'day manager' roster from TRACCS.

The **On Call lap top** contains electronic versions of –

- the On Call policy and procedure
- the organisation's phone list which includes all current staff, staff details and contact phone number and phone numbers of other services
- all relevant client data and information (client listings/support plans/LSPs/ duties lists/risk assessments, case notes)
- support staff rosters

The **On Call mobile phone** contains -

- all staff contact numbers
- other service contact numbers

CCO will delegate a staff member (currently the Admin Team Leader) to be responsible for ensuring that the **On Call lap top** and **On Call mobile** phone are maintained and updated regularly so that on call staff are resourced adequately with up to date information and tools.

On Call staff

All Support Planners will participate on the On Call roster as per their employment condition. If a staff member is unable to perform all, or part of, their On Call turn, the rostered staff member must negotiate a suitable replacement staff member and inform the Client Services Manager of the change.

Rates of pay

CCO pays an On Call rate that is higher than that determined by current awards. $50.00 per night. Call outs are paid as per the staff members' award classification or at Category 4 Year 1, whichever is the highest.

Schedule for Revision of Policy: ON CALL POLICY				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
23/10/2006	**New policy**	**R Thompson**	**18/10/07**	
August 2009	**Reviewed**	**D. Ryan**		
7.4.2011 & 11.11.11	**Reviewed & Amended**	**D. Ryan**		
September 2014	**Reviewed & updated**	**D. Ryan**	**2015**	

3.29 Service Reviews – service user reassessment

Position Statement
Community Care Options is committed to ensuring that services remain suitable to client needs. To this end we will ensure that services are monitored and reviewed frequently and adjusted as required to meet client need. Reassessment of client needs will occur as an ongoing part of this review process.

Legislation and Standards
Home Care Standard 2 – Appropriate Access and Service Delivery
Expected Outcome 2.4 – Service User Reassessment –
Each service user's needs are monitored and regularly reassessed taking into account any relevant program guidelines and in accordance with the complexity of the service user's needs. Each service user's care/service plans are reviewed in consultation with them.
Disability Service Standards – Standard 3 - Individual Outcomes

Operational Procedure
To ensure that service is effective, fulfils the organisation's duty of care and is satisfactory to clients, the Support Planner will review the support plan. Reviews will be conducted regularly with clients. Reviews may be conducted by phone.

The Support Planner will ensure that they check with clients within 4 weeks of joining one of our programs that the services are in accordance with their expressed needs.

Support Planners will undertake a client home visit at a minimum of every three months to check with the client that the service continues to meet their needs and to review all aspects of their support plan. Plans will be updated following this review where a change is indicated and/or needed. A client case review form will be completed at these visits. They provide an opportunity for clients to discuss how things are going, things that are working well and things that need adjustment.

CCO utilises the Ongoing Needs Identification Tool (ONI) to assess clients. This tool enables the Support Planner to continually update information in line with client changing needs. Support Planners will update this tool as changes are noted.

Nursing reviews for Level 4 client's will be conducted as agreed to between the nursing staff and the Support Planner or as identified by the Support Planner, and client changing health needs.

Client's and/or their representatives may request a change to their support plan at any time to suit their changed needs and preferences; will be involved in any review of the care plan; work together with the Support Planner to achieve optimum service outcomes; will have a new support plan explained to them by the Support Planner.

The timing of a review will take into consideration the needs of the client, carer, guardian or advocate; the urgency of the situation; the personal arrangements of the client; efficient travel and workload arrangements of the staff.

Reviews should focus on any change in the client's circumstances and on service

delivery enhancements. Reassessment and review may require or result in referral to other providers as appropriate. See Referral Processes.

Client cases will also be reviewed quarterly by the Client Services Manager through discussion with the Support Planner, with a focus on evaluation of the effectiveness of current supports, whether they are within funding and program guidelines and discussion of any emerging issues.

Annually Support Planners will discuss and develop a new plan of support with the client if there have been few changes during quarterly reviews. Clients will be requested to sign a new agreement, a new client home risk assessment will be conducted, new contribution negotiated and the ONI updated to reflect any changes. Services will be adjusted to reflect any changes identified and negotiated.

Complaints
Clients will be made aware that they can lodge a complaint should they have any concerns regarding their assessment, support plan or review. This will be emphasized to them at the time of review when the information in the client's Information folder is rediscussed with them.

If a client is not happy with their support staff or Support Planner, the organisation will, where possible, allocate a different staff member to the client.

Coordination with other services
If other agencies provide significant services, they will be involved in the review of client services whenever appropriate. The client's permission needs to be obtained prior to organising joint review sessions.

Case Conferences
Clients or Support Planners with the client's permission, may call a case conference. Case conferences will be used to resolve major complex issues which impact on the support and safety of the client. Case conferences will also be called when the organisation's resources are insufficient to provide the client with support, which ensures the basic safety of the client and the organisation's staff. The person calling the conference is responsible for identifying and inviting proposed participants, organising the venue and compiling and distributing the agenda.

Case conferences should be attended by all people and agencies that have major involvement in the care and support of the client. Generally these include –

- the Client
- a carer, family member, advocate or friend of the clients
- the Support Planner of the organisation
- the General Practitioner
- relevant Allied Health Specialists, eg. Physiotherapists, Occupational Therapists
- the ACAT staff member who has the greatest involvement with the client (Case Manager), if applicable
- other relevant Community Service Providers.

Case conferences should have a constructive and positive outcome for clients. The person convening the conference is responsible for –

- Facilitation and proper conduct of the conference in a safe and supportive environment
- ensuring that all present are heard in an equitable and fair manner
- summarising and checking with the participants agreed outcomes and follow-up action required
- documenting the process and outcomes of the meeting
- producing and distributing the minutes to all participants.

Schedule for Revision of Policy: Service Reviews				
Date Adopted by Board	**Outcome**	**Author**	**Next Review**	**Comments**
28 May 2007	**Approved**	**Ruth Thompson**	**2009**	**New Policy**
May 2009	**Reviewed & Updated**	**Deb Ryan**		
August 2010	**Updated**	**Deb Ryan**		
11.11.2011	**Updated**	**D. Ryan**		
February 2012	**Updated**	**D. Ryan**		
September 2014	**Updated**	**D. Ryan**		

3.30 Exit from the organisation

Reasons for leaving
Clients will leave Community Care Options on –

- death;
- entry to long term residential care;
- placement in hospital until residential care becomes available;
- relocation to an area outside Community Care Options' geographical catchment.

Or because –

- they no longer want the organisation's support;
- they no longer need Community Care Options' support. This may occur where the person's circumstances have changed so that the client is adequately supported by general community services and no longer needs the organisation's support;
- they or their carer are unwilling or unable to fulfil their responsibilities or meet reasonable conditions required in the support plan including payment of agreed contributions.

Or because Community Care Options can no longer support the client due to –

- the organisation's inability to comply with their duty of care in respect of the client;
- meeting the client's support is severely endangering the health, safety and well-being of others, including Community Care Options' staff or the staff of contracted agencies;
- the organisation's resources are insufficient to meet the client's needs.

Withdrawal Process
Community Care Options will ensure that the withdrawal of support from any client is conducted in a planned and monitored way. With the consent of the client or their representative the Support Planner will –

- assist the client to seek out and access other agencies which may be required;
- make follow-up contacts, appropriate to each client's needs and disability levels;
- refer to the Aged Care Assessment Team, if residential care is required;
- send the client an "exit letter" informing the client, and if appropriate, the client's representative of how the client may be re-admitted to Community Care Options' support;
- decide whether to discharge a client, balancing such a client's needs and circumstances against those of other applicants.
- a client will not be discharged from Community Care Options because a person of higher level need has been referred to the program.

Appeals
Clients or their representatives can appeal against the organisation's decision to discharge the client from one of the organisation's programs by following the "Complaints Procedure".

Schedule for Revision of Policy: Exit from the Organisation				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
28 May 2007	**Approved**	**Ruth Thompson**	**2010**	**New Policy**
11.11.2011	**Reviewed & Updated**	**D. Ryan**		
Septemb3r 2014	**Reviewed & updated**	**D. Ryan**	**2016**	

Appendix 1 CASE MANAGEMENT

The practice of Case Management underpins delivery of the organisation's programs to clients who have complex needs.

History of Case Management

The beginnings of the case management model can be traced back to the 1970's but it rose to prominence, particularly in Australia, during the late 1980s and early 1990s with the growth of provision of care to frail older people and young people in the home and community. This coincided with moves by governments to deinstitutionalise care and maintain people within their families and community for the longest possible time.

Case Management plays a role in the service system discrete from other service types in that it assists individual clients to access multiple services/programs and alternative resources including informal supports.

What is Case Management?

The peak national body for Australian Case Managers –'The Case Management Society of Australia' defines Case Management as

'a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individuals health needs through communication and available resources to promote quality cost-effective outcomes'. National Standards of Practice for Case Management 2004.

The term 'health' is used in the broadest sense of the word including the physical, mental, spiritual and social well being of the person.

Case Managers provide a single point of contact for clients who require a complex range of services and/or require intensive levels of support on either an ongoing, short term or episodic basis. They work with and for the individual, enhancing independence and control.

Case Management involves working across many boundaries, with healthcare and various systems that interlink in many ways throughout a person's life. Case Managers understand how each system interacts with the other and the importance of getting that interaction right.

Case Management ensures a match between the available resources and client's needs, making the best use of what is available. This benefits the individual client as it provides appropriate services and supports, as well as the system as a whole by reducing client dependence on funded supports where this is possible.

Case Managers unravel dilemmas relating to an area of life that clients find they need assistance in, and address issues which other people take for granted as being able to solve with little consideration. When case management is expertly performed the complexity of the process often goes unnoticed by others. It is the complexity of the individual's need and the response provided that defines and distinguishes case management from other models which essentially focus on single need care coordination.

Case Management takes a holistic approach to the individual, cuts across traditional funding and program boundaries and harnesses generic community resources and informal supports to provide best quality outcomes for clients.

Case Management functions:

Comprehensive needs assessment

Ongoing collaboration with clients and their families to identify personal needs and function levels, drawing on specialist expertise such as Occupational Therapists, General Practitioners or Geriatricians where required.

Care/Support and Service Planning

A plan is developed in consultation with the client, nominating short and long-term goals, incorporating family/carer needs, defining the actions and/or service responses required, timeframes and who is responsible for actioning.

Resourcing the plan

The plan is resourced through safe, efficient and effective –

- use of brokerage funds to purchase services and support
- provision of services from relevant programs
- use of informal supports including those provided by carers, family, friends and other social capital including community capital

Navigation

Case Managers know, and are skilled in discovering, the various services and supports available for people. In consultation with the client, they determine what is needed and how to utilise and maximise what is available for an individual.

Implementation

- referrals to and coordination of other services across networks
- fostering community supports
- and linking with and commencing services where required in a timely fashion

Monitoring

Reviewing and ensuring the client is receiving the level and quality of service provision that best meets their changing need

Advocacy

Supporting the client in appropriating services that meet individual needs and goals. Supporting and educating the individual to develop self-reliance in self-advocacy. Whilst Case Managers advocate on behalf of clients they also encourage and empower clients to advocate on their own behalf.

Evaluation

Ensuring services provided are –

- meeting the needs of the client and are still required
- are cost effective to the service system
- within program guidelines and funding parameters

Where this is no longer the case alternative case arrangements are facilitated

Transitioning and Closure

When case management is no longer required, or may not be required at some future point, transitioning the client from the support by –

- setting clear expectations at program commencement of how things will look when people no longer require case management support
- ongoing review of progress towards goals and futures planning
- provision of information and contacts for self management
- transition planning, withdrawal and closure

Sources

Case Management and Community Care jointly written by the Case Management Society of Australia and the Aged and Community Services association. May 2006

National Standards of Practice for Case Management, Case Management Society of Australia 2004

Schedule for Revision of Policy: Case Management - Appendix				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
28 May 2007	**Approved**	**Ruth Thompson**	**2008**	**New Appendix**

Appendix 2
Principal Assumptions Underlying Case Management Practice

Community Care Options practice Case Management in accordance with the principles articulated by the Case Management Society of Australia. CCO Case Management practice is also underpinned by the following assumptions -

- We practice *lawfully* by –

    - Operating within program *Guidelines* and funding allocations
    - Adhering to *Service Standards* (hyperlink to same)
    - Abiding by relevant legislation (hyperlink to OH&S, EEO, Anti Discrimination)
    - Reporting accurately

- We practice *professionally*. We demonstrate this by engaging in –

    - Ongoing *Professional Development*
    - Continual *Quality Improvement* (hyperlink to policy?)
    - Critical monitoring, reflection and redesign of our practice through active participation in Supervision, Appraisals and Client Reviews forums
    - Sharing knowledge with and supporting our peers
    - Operating within the Values and Culture of the Organisation

- Our practice acknowledges that all people have *strengths and abilities*. We demonstrate this by –

    - Applying a *Strength Based* approach to enable people to build on their own resources and abilities
    - Applying a *Solution Focused* approach to empower people to be active participants in the discovery of their own needs, goals and solutions and the design of their services and supports
    - Enhancing *independence* by –

        - Offering *Least Restrictive Options* on a sliding scale of intervention.
        - Supporting learning through providing opportunities to practice and learn new skills and knowledge
        - Supporting people to make informed decisions and to take risks to manage their own lives whilst balancing this with our Duty of Care (hyperlink to dignity of risk/duty of are policy and policy on decision making)
        - Empowering people with information, resources and options
        - Supporting and promoting people's own social capital including family, friends, neighbours and other community networks (hyperlink to family centred practice)

- Our practice upholds the *dignity* of all people. We demonstrate this –

- By being respectful in all our actions and in the way we speak about people
- Through developing trustful, helpful and professional relationships and rapport with clients
- Treating people with *positive regard* and as equals
- Enabling people to be as *self determining* as possible

- Our practice acknowledges the uniqueness of each person. We demonstrate this by

  - Using a *Client Focused* and *Person Centred* approach through –

    - Comprehensive and holistic assessment of each person
    - Tailoring services and approaches to meet individual need
    - Valuing individual culture, beliefs and value systems and designing services which are relevant and appropriate to these
    - Responding flexibly to emerging or changing needs

- Our practice recognises that people exist as part of an ecological system and acknowledges structural and power inequities that impact upon people. We demonstrate this by –

  - Ensuring *Access* to our programs for people from identified priority groups
  - Encouraging and effectively responding to feedback and complaints
  - Working within a *Community Development* framework
  - Developing strategies to support people which take into account the context in which they operate
  - Working in collaboration with others involved in the person's care
  - Applying *Empowerment Principles* to each interaction
  - Providing *Advocacy* for people where this is appropriate
  - Protecting those who are at risk

- Our practice reflects equitable distribution of resources. We demonstrate this by –

  - Distributing resources based on *Relative Need*
  - Distributing resources equitably across Local Government areas
  - Working in ways which are accountable, transparent, justifiable, cost effective and efficient
  - Negotiating service fees which balance client and organisational need (hyperlink to policy)

Schedule for Revision of Policy: Principal assumptions Underlying Case Management				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
28 May 2007	**Approved**	**Ruth Thompson**	**2009**	**New Appendix**