Community Care Options

Policy Manual

Section Three – Access and Service Delivery

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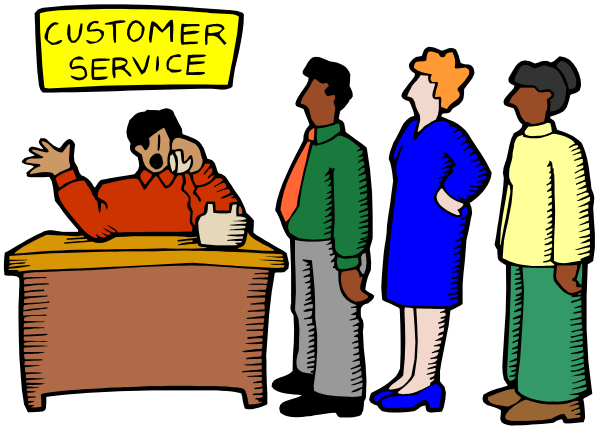
ACCESS and SERVICE DELIVERY



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.

Aged Care Quality Standards
- ✓ *Standard 1 - Consumer Dignity & Choice*

National Disability Standards
- ✓ *Standard 6 - Service Management*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

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;
- 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;
- need to observe duty of care and balance this sensitively with a person's right to self-determination;
- inherent human rights of all people;
- principles of Consumer Directed Care and the National Disability Insurance Scheme.

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; and
- 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; and

- 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;
- supported and satisfied clients;
- a clear person-centred focus;
- 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;
- 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**
January 1996	**Adopted**	**A. Vaughan**		
January 2001	**Amended**	**A. Vaughan**		
March 2003	**Amended**	**A. Vaughan**		
November 2005	**Amended**	**N. Jut**	**2008**	
December 2008	**Reviewed & Amended**	**D. Ryan**		
January 2011	**Reviewed & Amended**	**D. Ryan**	**2013**	
September 2014	**Reviewed & Amended**	**D. Ryan**	**2015**	**Review of mission, vision, values Business Name Change**
December 2016	**Reviewed & Amended**	**D. Ryan**	**2018**	
August 2018	**Reviewed**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed**	**D. Ryan**	**2025**	

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 National Disability Insurance Scheme guidelines and rules (the rules 2018) 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.

Aged Care Quality Standards
- ✓ *Standard 1 - Consumer Dignity & Choice*
- ✓ *Standard 3 - Personal Care & Clinical Care*
- ✓ *Standard 4 - Services and Supports for Daily Living*
- ✓ *Standard 6 - Feedback and Complaints*
- ✓ *Standard 8 – Organisational Governance*

National Disability Standards
- ✓ *Standard 1 - Rights*
- ✓ *Standard 2 - Participation and Inclusion*
- ✓ *Standard 3 - Individual Outcomes*
- ✓ *Standard 4 - Feedback and Complaints*
- ✓ *Standard 5 - Service Access*
- ✓ *Standard 6 - Service Management*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

Recognition
CCO 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. Community Care Options recognises the principles of the NSW Disability Inclusion Act 2014.

Human Rights
CCO recognises and supports the Human Rights principles of –

- respect for the inherent dignity, independence of persons and individual autonomy, including the freedom to make one's own choices;

- non-discrimination;
- full and effective participation and inclusion in society;
- respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- equality of opportunity;
- accessibility;
- equality between men and women;
- respect for the evolving capacities of children with disability and respect for the right of children with disability to preserve their identities;
- active partnerships between services and people with disability, and where appropriate, their families, friends, carers and/or advocates.

Quality Services
CCO recognises and supports the Quality Management principles of –

- a focus on outcomes for people who use services and supports;
- providing leadership;
- involving individuals and staff;
- using a process approach;
- taking a systems approach;
- encouraging continuous improvement;
- making evidence-informed decisions;
- engage in collaborative partnerships.

Provide Options
Clients will decide which support options they prefer. CCO staff will provide clients/ 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;
- 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 regularly to see if the services they are receiving are still what they need, and change the support plan if necessary or desirable. This will be done by the Support Coordinator or, 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. All complaints are 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 Coordinator thinks this is necessary;
- welcome feedback from the client, and from others. We recognise that all feedback 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 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 respond to 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, feedback to Support Coordinators during their visits and/or client visits and phone calls to the office.

Conflict of Interest
Community Care Options (CCO) is approved as both a registered Plan Management provider and as a registered provider of a wide range of other support services under the National Disability Insurance Scheme (NDIS). CCO is aware of the potential for real or perceived conflict of interest in performing both these roles for an individual. The NDIS requires that "If a registered plan management provider is also a provider of other supports received by the participant, then the registered plan management provider will need to have mechanisms in place for dealing with any conflicts of interest that might arise. These mechanisms would normally involve both policies and administrative procedures."

All CCO Directors, staff and volunteers acknowledge and are committed to the following policy statements -

The overriding philosophy of choice underpinning the NDIS
The NDIS is designed to support people to pursue their own goals and to build their capacity to lead a meaningful life. CCO acknowledges that participant choice and self determination are the overriding philosophies underpinning the NDIS.

CCO acknowledges that its dual roles as an NDIS Plan Manager, Coordinator of Supports and NDIS Service Provider require that it complies with the NDIA policy of separation. CCO will take all reasonable measures to ensure that the CCO NDIS Conflict of Interest Policy and associated procedures and guidelines comply with any recommendations and guidance provided by the NDIA in relation to the policy of separation.

Standards
Standards including the NDIS Practice Standards, National Disability Standards and the Aged Care Quality Standards emphasise the requirements of service providers to meet the needs and expectations of government, clients, and community. Each standard is made up of the same basic elements of - human rights, outcomes, a statement of minimum requirements and indicators of practice. Community Care Options makes a clear commitment to meeting and exceeding standards and expectations. We focus on promoting human rights, achieving outcomes and demonstrating best practice.

Rights
This standard emphasises the importance of –

- dignity and respect;
- freedom of expression;
- self-determination;
- choice and control;
- confidentiality and privacy;
- freedom from discrimination, exploitation, abuse, harm, neglect and violence;
- the role of families, friends, carers and advocates in the safeguarding of rights;
- comprehensive systems to prevent or promptly respond to any breaches of rights.

Participation and Inclusion
The standard emphasises the importance of –

- promoting a valued role for people with disability in public and private life;
- connection to family, friends and chosen communities;
- economic and community participation and associated benefits to the individual and the broader community;

- participation based on an individual's interests, identity, heritage, preferences, goals and aspirations (which may change over time);
- the role of family, friends, carers, advocates and other organisations in promoting participation and inclusion.

Individual Outcomes
The standard emphasises the importance of –

- people with disability leading and directing their supports with support from family, friends, carers and advocates (with consent);
- service planning, implementation and review being based on individual strengths, needs and life goals;
- collaboration and dialogue;
- responsiveness to diversity;
- options.

Feedback and Complaints
The standard emphasises the importance of –

- clear and regular communication about how to provide feedback including how to make a complaint;
- the use of feedback and complaints to continuously drive service improvements;
- regular, proactive and inclusive feedback systems;
- effective complaints management and resolution;
- transparent dispute management;
- access to independent information, support, advice and representation to ensure people are able to provide feedback or make a complaint.

Service Access
The standard emphasises the importance of –

- accessible information to respond to diversity of need;
- transparent and consistently applied service commencement and leaving a service processes;
- information provision and active referral when a service is not available;
- the value of partnerships with other agencies and relevant community members to enable referral;
- regular reviews to identify and respond to any potential barriers to accessing services.

Service Management
The standard emphasises the importance of –

- sound governance and management in all aspects of service planning development and provision;

- clear communication to staff, people with disability and other stakeholders;
- continuous improvement and evidence based practice;
- a range of methods for active participation of people with disability and their family, friends, carers and advocates in planning, delivery and review at the individual, service and organisational levels ;
- compliance with workplace related legislation and regulation including Work Health Safety, human resource management and financial management.

Schedule for Revision of Policy: PRINCIPLES OF SERVICE DELIVERY				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
May 2007	**Approved**	**R. Thompson**	**2009**	**New Policy**
May 2009	**Reviewed & Updated**	**D. Ryan**		
August 2010	**Updated**	**D. Ryan**		
September 2014	**Updated**	**D. Ryan**	**2016**	
December 2016	**Updated**	**D. Ryan**	**2018**	
September 2018	**Reviewed**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed**	**D. Ryan**	**2025**	

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.

Aged Care Quality Standards
- ✓ *Standard 2 – Ongoing Assessment and Planning with Consumers*
- ✓ *Standard 3 – Personal Care and Clinical Care*
- ✓ *Standard 8 – Organisational Governance*

National Disability Standards
- ✓ *Standard 3 – Individual Outcomes*
- ✓ *Standard 5 – Service Access*
- ✓ *Standard 6 – Service Management*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

Community Care Options is currently approved, registered and/or funded to deliver the following programs -

- Commonwealth Home Support Program (CHSP);
- Consumer Directed Home Care Packages – Levels 1 - 4 (HCP);
- Transitional Aged Care (TACS);
- Disability Support for Older Australians (DSOA);
- Out of Hospital Care (OHC).

CCO is registered as an NDIS Service Provider and delivers the following supports to participants of the National Disability Insurance Scheme (NDIS) -

- Plan Management
- NDIS Direct Care – High Care for all ages
- Coordination of Support (COS)

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 outlined below.

Delivery of the organisations programs and services is underpinned and supported

by –

- Case Management principles and guidelines;
- Principal assumptions underlying CCO Case Management practice;
- Quality Management Plan;
- Strategic 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;
- 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 Mission, Objectives, Business and Strategic Plans.

Programs and Services

Out of Hospital Care

Funding Source

The program is funded by NSW Health and delivered in partnership with Care Connect.

Scope

Post hospital discharge support. Out of Hospital Care 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. Includes End of Life care and Safe and Supported at Home (SASH).

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.

Case Management for this program is provided by Care Connect staff who 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.

Out of Hospital Care provides access to –

- comprehensive assessment, needs 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 can 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 OHC guidelines;
- Equipment restricted to low-cost safety equipment/items.

Places
The Department of Health and the North Coast Area Health Service determine the number of places to be funded each year.

Eligibility
To be eligible for Out of Hospital Care, people will –

- be assessed by the participating hospital as requiring two or more community services on discharge;
- require OHC 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 OHC 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.

To confirm eligibility refer to the OHC Guidelines –

Referrals
Are accepted from participating hospitals listed in the OHC guidelines. Referrals are made to Care Connect and CCO receives notification of referral for direct services via email.

Fees
Care Connect may request a weekly contribution for OHC support as well as a

contribution towards travel costs if this is a significant part of the package of support.

Compliance
OHC operates within the OHC Program Guidelines and funding contract, the organisation's policies manual and the organisation's stated values.

Reporting
CCO invoices Care Connect monthly for services delivered under the OHC program.

Disability Care Services

CCO is a registered provider with the National Disability Insurance Agency (NDIA) to deliver services and supports under the National Disability Insurance Scheme (NDIS).

Participants in the NDIS may purchase services through a registered provider of their choice and/or the NDIA may approve funding directly to individuals and families where they may choose to purchase alternative mainstream and community services. The NDIS is an Insurance Scheme similar to Medicare and is paid for by all Australians.

The NDIS supports people to:

- access mainstream services and supports;
- access community services and supports;
- maintain informal support arrangements;
- receive reasonable and necessary funded supports.

Reasonable and necessary supports are funded by the NDIS to help a participant to reach their goals in a range of areas, which may include:

- education;
- employment;
- social participation;
- independence;
- living arrangements;
- health and wellbeing;
- transport;

These supports will help participants to:

- pursue the goals outlined in their plan;
- increase their independence;
- increase social and economic participation and develop their capacity to actively take part in the community

CCO is a registered NDIS Provider for the following services:

- Plan Management
- Direct Care – High Care – all ages
- Coordination of Support (COS)

Eligibility
Eligibility to participate in the National Disability Insurance Scheme (NDIS) is determined by the National Disability Insurance Agency (NDIA).

Fees
CCO claims for services provided as per the NDIS Price Guide. No additional fees are applicable.

Aged Care Services

Community Care Options is funded by Australian Government Departments to deliver of a range of programs for older Australians.

Home Care Packages (HCP)

CCO has been delivering Consumer Directed Care models in line with government requirements since 2010. Consumer Directed Care offers greater choice and control about the types of aged care and services that clients can access and the delivery of those services, including who will deliver the services and when. The introduction of an individualised budget through CDC provides greater transparency to client's about what funding is available under their package, and how those funds are spent. Home Care Packages are portable meaning that packages are now allocated to clients not providers, and can transition with the client if they wish to change providers.

The Australian Government funds 4 levels of home care packages –

Home Care Package Levels
Level 1 – basic care needs
Level 2 – low level care needs
Level 3 – intermediate care needs
Level 4 – high care needs

A Home Care Package provides a co-ordinated package of services tailored to meet client specific care needs to help them to stay in their own home as they get older and give them choice and flexibility in the way their care and services are provided to them at home.

The services that are provided under a Home Care Package are specific to individual client needs. CCO works with clients to determine what these needs are, and how their supports will be delivered.

Services may include -

- Personal services – such as help with showering or bathing, dressing and mobility;

- Support services – such as help with washing, ironing, house cleaning, gardening, basic home maintenance, home modifications, and transport and support for shopping, to visit the doctor or attend social activities;
- Clinical care – such as nursing and other health support including physiotherapy (exercise, mobility, strength and balance), services of a dietician (nutrition assessment, food and nutrition advice, dietary changes) and hearing and vision services.

CCO employs a Registered Nurse to complete nursing care plans and provide clinical care services to Home Care Package Level 3 & 4 clients. All HCP Level 4 clients have an INS system to enable access to out of hours nursing support. Nursing staff and Support Coordinators work collaboratively to achieve seamless service provision. A regularly reviewed Nursing Care Plan forms part of the HCP Level 3 & 4 support plan.

Eligibility

People are eligible for support through a Home Care Package 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 a community care subsidy;
- Require a package of support (HCP level 1 – level 4) to receive 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

To be eligible for a Home Care Package people must be assessed by the ACAT as requiring low level community care services. Once a client has been assessed and approved for a Home Care Package they are able to choose an approved provider for their service delivery.

Fees

People receiving support through a Home Care package may be asked to make a contribution towards the service. The Australian Government sets a maximum fee for people who receive a full pension which is reviewed twice annually. Some client's may also be assessed as needing to pay an Income Tested Fee.

Reporting

Support Coordinators/Care Managers complete minimum 3 monthly support plan reviews or more often as needed. Support Coordinators/Care Managers maintain occupancy and client data set reports. Where required a Nursing care plan review is conducted at least 6 Monthly.

Disability Support for Older Australians (DSOA)
This program is a closed program and eligible clients were those who at December 2017 were aged 65 years and in receipt of state funded disability services. These clients were deemed ineligible for the NDIS but transitioned with individualised funding to the DSOA program.

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Transitional Aged Care (TACS)
Community Care Options is contracted by the Local Health District (LHD) to provide direct support services for aged clients leaving hospital who require support for up to 12 weeks post discharge.

Commonwealth Home Support Program (CHSP)

The Commonwealth Home Support Program is the entry level point for the aged care system.

CCO is funded for service delivery under two sub programs:

- **Community and Home Support**
- **Care Relationships and Carer Support**

Our services are person centred, with our focus on empowerment, building on strengths and supporting the client with decision making and planning processes

Referrals
Referrals are made through My Aged Care and may be made following assessment by the Regional Assessment Service (RAS). 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 CHSP 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 other services that may be accessing and paying for.

Reporting
Support Coordinators maintain client data set information including case management hours and other services provided either directly or through brokerage, through the client information system The CEO reports client data sets and service outputs to DEX monthly. Output Compliance Reports completed on Aged Care Portal - DEX. Financial Acquittals are submitted to DOH annually along with an Annual Compliance Return.

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Flexible Respite (CHSP) - Care Relationships and Carer Support

Scope

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

Function

The Flexible Respite Service is funded to provide respite to carers of people who have dementia or high-level support needs.

Case Management activities are not specifically funded through this program however onboarding for this program includes comprehensive assessment, needs identification, support planning and coordination, monitoring and review. The Support Coordinator may also assist the carer in identifying and sourcing strategies, equipment and aids, other services and information that assists to manage behaviour and sustain the caring relationship.

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) which is funded for these types of direct service delivery.

Eligibility

People are eligible for the Flexible 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;

Commonwealth Home Support Program (CHSP) - Community and Home Support

Scope

CHSP forms part of the spectrum of support available to people under this umbrella.

Programs funded under CHSP aim to provide services that:

- provide a basic range of entry level 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

Minimal Case Management is provided under this program. Service Coordination is provided to people who require assistance to access and maintain support options that best meet their complex and changing needs.

There is an allocation of fixed output funds for purchasing or supplying some direct service types. These service types are;

- Domestic assistance;
- Social support;
- Personal care;
- Food Services – meal preparation;
- Home modification;
- Home maintenance;
- Transport;

There is also a small allocation of funds for the purchase of goods and equipment.

Places

CHSP is grant funded to provide services to as many clients as possible within resources. The number of clients able to be supported at any one time through CHSP varies according to the mix and needs of those currently on the program.

Eligibility

To be eligible for CHSP people must require entry level services only and no case management. CHSP clients are –

- people who are aged over 65;
- people from identified special needs groups;
- entry level needs;

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;

- LGBQTI;

Additional Client Services

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.

Community Care Options provides a range of services to private clients where needed. 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.

At times, the organisation is brokered by other agencies to provide services to their clients or to provide additional support to existing CCO clients.

We have existing service agreements with a range of agencies.

Schedule for Revision of Policy: PROGRAMS AND SERVICES				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
May 2007	**Approved**	**R. Thompson**	**2009**	**New Policy**
August 2010	**Updated**	**Deb Ryan**		
November 2011	**Updated**	**D. Ryan**		
September 2014	**Updated**	**D. Ryan**	**2016**	
December 2016	**Updated**	**D. Ryan**	**2018**	
December 2018	**Reviewed**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	**Changes to some programs**

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.

Anti-Discrimination Act
Aged Care Quality Standards
- ✓ *Standard 1 – Consumer Dignity and Choice*
- ✓ *Standard 3 – Personal Care and Clinical Care*
- ✓ *Standard 4 – Services and Supports for Daily Living*

National Disability Standards
- ✓ *Standard 3 – Individual outcomes*
- ✓ *Standard 5 – Service Access*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

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.
In the case of people with individualised funding seeking a service, Community Care Options will assess available resources and capacity to provide the service. If CCO are unable to provide a service, we will ensure that the individual or their representative is informed of alternative services that may be able to meet their need.

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 My Aged Care 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.

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 relevant Program Manager 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;

Program Manager –

- 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, Manager People and Culture and Service Coordinator);
- 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. The panel 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;

Prioritising Requests for Support

Principles

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

Community Care Options complies with 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.
CCO abides 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 and/or 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 and/or live alone;
- need an independent advocate to help them access adequate and sufficient support;
- 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, have extensive commitments
- are sole carers with limited support networks or dependent children
- are frail, ill, stressed, have a disability or are getting little sleep
- 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**
July 2006	**New policy**	**R. Thompson**		
January 2007	**Amended**	**A Vaughan**	**2007**	
April 2009	**Reviewed & Updated**	**D. Ryan**	**2012**	
November 2011	**Reviewed & Updated**	**D. Ryan**		
September 2014	**Reviewed & updated**	**D. Ryan**	**2016**	
December 2016	**Updated**	**D. Ryan**	**2018**	
September 2018	**Reviewed**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

3.5 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, and complaints or for any other communication between the client and the organisation.

Aged Care Quality Standards
- ✓ *Standard 2 – Ongoing Assessment and Planning with Consumers*
- ✓ *Standard 6 – Feedback and Complaints*
- ✓ *Standard 8 – Organisational Governance*

National Disability Service Standards
- ✓ *Standard 1 – Rights*
- ✓ *Standard 2 – Participation and Inclusion*
- ✓ *Standard 3 – Individual Outcomes*
- ✓ *Standard 4 – Feedback and Complaints*
- ✓ *Standard 5 – Service Access*
- ✓ *Standard 6 – Service Management*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

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 (TARS) 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
Email: da@da.org.au

Coffs Harbour
13/15 Park Ave,
Coffs Harbour NSW 2450
PO Box 418
Coffs Harbour NSW 2450
Phone – 1300 365 085 or
(02) 6580 2111
Email – coffsharbour@da.org.au

Schedule for Revision of Policy: ADVOCACY				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
January 2007	**New policy**	**A. Vaughan**	**2007**	
April 2009	**Reviewed & Updated**	**D. Ryan**	**2012**	
November 2011	**Reviewed & Updated**	**D. Ryan**		
September 2014	**Reviewed & Updated**	**D. Ryan**	**2016**	
December 2016	**Updated**	**D. Ryan**	**2018**	
September 2018	**Reviewed/Updated**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

3.6 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.

Aged Care Quality Standards
- ✓ *Standard 1 – Consumer Dignity and Choice*
- ✓ *Standard 2 – Ongoing Assessment and Planning with Consumers*
- ✓ *Standard 3 – Personal Care and Clinical Care*
- ✓ *Standard 4 – Services and Supports for Daily Living*
- ✓ *Standard 6 – Feedback and Complaints*
- ✓ *Standard 7 – Human resources*
- ✓ *Standard 8 – Organisational Governance*

National Disability Standards
- ✓ *Standard 1 – Rights*
- ✓ *Standard 2 – Participation and Inclusion*
- ✓ *Standard 3 – Individual Outcomes*
- ✓ *Standard 4 – Feedback and Complaints*
- ✓ *Standard 6 – Service Management*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

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 Coordinator 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 Coordinator 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 Coordinator/Care Manager 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 Coordinator 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 Coordinators or by another suitably trained person selected by the organisation ie Program Manager;
- in the case of Level 3 & 4 Home Care Packages the assessment will be done by a registered nurse (RN). The RN will make a nursing assessment and the Support Coordinator the overall service provision assessment;
- validate the client meets entry and targeting requirements;
- be purposeful, and be conducted with efficiency and sensitivity. The Support Coordinator 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 Coordinator/Care Manager 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 Coordinator/Care Manager 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 Coordinator;
- 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 ACAT/ RAS;
- be recorded on the organisation's assessment form.

Principles to be observed in Assessments

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 Coordinator/Care Manager 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 (WHS).

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, eg. 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 Service Agreement 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, as 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 Coordinator 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, 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 Coordinator 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: ASSESSMENTOF CLIENT INDIVIDUAL NEEDS				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
July 2006	**New policy**	**R. Thompson**		
January 2007	**Amended**	**A. Vaughan**	**2007**	
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November 2011	**Reviewed & Updated**	**D. Ryan**		
September 2014	**Reviewed & Updated**	**D. Ryan**	**2016**	
December 2016	**Updated**	**D. Ryan**	**2018**	
October 2018	**Reviewed**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

Comprehensive Assessment Form

Community Care Options

Client Details
Title:
Family Name:
First Name:
Preferred Name:
Contact Issues:
Email:
Carer/NOK/Appointed Guardian:
Name:
Relationship to client:
Telephone No:
Address:
GP Name:
GP Address:
GP Telephone No:
Pharmacy:
Pharmacy Telephone No.
Webster Pack: Yes □ No □ Delivered: Y □ N □

Usual Address
Unit or House No:
Street:
Suburb:
Post Code: LGA:
Telephone:
Email:
Current Address (if different to above):
Unit or House No:
Street:
Suburb:
Post Code: LGA:
Telephone:
Email:

Action Required:
□ **Urgent** □ **Full Assessment** □ **Short Term**
Referral made by:
Organisation:
Contact Details:
Reason for referral:
Client Aware of referral: Yes □ No □
Carer/NOK aware of referral: Yes □ No □
Name of person providing details:
Others present at assessment:
Location of assessment:

Demographics:
Date of Birth: Age:
Country of Birth:
Ethnicity:
Language spoken at home:
Interpreter required: Yes □ No □
Identifies as:
Aboriginal □ Torres Strait Islander□
Gender: Female □ Male □ Transgender □
Rural Isolation: Yes □ No □
Social Isolation: Yes □ No □
Case Manager:
Negotiated Start Date:

Financial Contribution:	
Agreed amount per month $	
Method of payment:	
Centrepay □ Direct Debit □ Cash □ Cheque □	
Owned own home in last 2 years: Yes □ No □	
Financially Disadvantaged: Yes □ No □	
Program referred to:	
Home Care Level: 1 □ 2 □ 3 □ 4 □	
OHC □	CHSP □
NDIS □	
Private □	
Other □	
ACAT approval Date:	

Income:
Aged Pension: Full □ Part □
Disability Pension: Yes □ No □
Self Funded Retiree: Yes □ No □
Medicare Number:
DVA Card Type: Gold □ Orange □ White □
DVA Card Number:
Compensation Pending: Yes □ No □
Private Health Insurance: Yes □ No □
Ambulance Subscriber: Yes □ No □
Pension Number:

CARER	
Do you have a Carer? Yes □ No □	Do you have any NOK? Yes □ No □
Relationship to Client	
Resident Carer: Yes □ No □	
Name:	Phone No:
Address:	
Identifies as: Aboriginal □ Torres Strait Islander □	
Date of Birth:	Age:
Country of Birth	Ethnicity:
Working Carer: Yes □ No □	
Caring commenced:	Carer vulnerability/stress: Yes □ No □
Carer support services or respite services utilised?	

Accommodation – Usual Living Arrangements		
□ With Spouse/Partner only	□ Home Owner	□ House
□ Live alone	□ Private Tenant	□ Caravan
□ Other relatives/persons	□ Public Tenant	□ Unit
	□ Other	□ Granny flat
Specify	Specify	□ Garage

		□ Other

Current formal resources						
Eg: lawn mowing contractor; CRCC; Alzheimer's Australia						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Current Informal resources						
Eg: any assistance provided by family/friends/neighbours/Church Group.						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Can all of these supports/resources continued to be used?						
Can your informal supports assist on public holidays? □ Weekends? □						

PETS
Type and Name/s
Emergency Contact/Boarding Kennel or Cattery:
Comment – (secured/known to bite/aggressive)
Veterinary Surgery & phone number:

Financial Management		
Manages finances independently:	Yes □	No □
Manages day to day purchases but:	Needs help with banking □	Unable to handle money □
Who assists?		
Power of Attorney	Yes □	No □
Name:	Telephone:	
Enduring Guardian	Yes □	No □
Name:	Telephone:	
Public Trustee	Yes □	No □
Name:	Telephone:	
Solicitor/Will	Yes □	No □
Name:	Telephone:	

Respite – identify respite options used:			
Residential respite	Low □		High □
Day Therapy Centre: □	Location:		
In Home Respite □			
Awareness of Commonwealth Respite & Carelink Centre?		Yes □	No□
Assistance from relatives or friends?		Yes □	No □
Comments			

Social Resources	
What social issues impact on the person?	
Social Isolation and community Access □	Bereavement/Loss □
Insecure accommodation □	Lack of informal support □
Recent change of address □	Depression □
Mental health issues □	Physical/rural isolation □
Change to routine □	
Comments	

Health			
Medical conditions/Diagnosis/Allergies:			
Medications:			
Diagnosis of Dementia	Yes □	No □	Diagnosed by:
Type of Dementia:			
Individual's perspective of medical conditions and health difficulties?			
Possible effect on service delivery?			
Dietary needs - swallowing difficulties:			
Dental Health:			

Mobility & Equipment		
Assistive equipment needed?	Yes □	No □
Type of equipment:		
OT or Physio assessment required?	Yes □	No □
Able to access 4 wheel drive?	Yes □	No □
Feet - conditions requiring visits to podiatrist?	Yes □	No □

Vision/Sight			
Satisfactory	Yes □	No □	Wears Glasses □
Can read large print □			
Unable to read due to poor vision □			

Uses talking books	
Has modified phone or other assistive technology □	Type □
Linked to Vision Australia or Guide Dogs Australia □	

Hearing			
Satisfactory	Yes □	No □	
Hears with difficulty □			Profoundly deaf □
Uses hearing aids: Left □			Right □
Phone has been modified □			
Assessed by Hearing Clinic?	Yes □		No □

Communication			
Satisfactory	Yes □	No □	
First language:			
Able to understand?			
Able to be understood?			
Unable to speak/condition?			
Able to use the phone?	Yes □	No □	

Behaviour		
Does the person require assistance because of behavioural problems?	Yes □	No □
Problems identified:		
Wandering □	Disruptive behaviour □	
Physical aggression □	Sleep disturbance □	
Verbal aggression □	Sexually inappropriate □	
Other □		
Describe behaviour:		
When does the behaviour occur? (triggers):		
Suggested actions/strategies that work for carer:		

Lifestyle Choices		
Does the person smoke?	Yes □	No □
Is the person alcohol dependent?	Yes □	No □
Does the person identify a gambling problem?	Yes □	No □
Is there a dependence on other substances?	Yes □	No □

Future Planning:
Client Goal/s:
Options/plans/preferences for the future:
How will client know when…
Location of Important documents – (emergency only):

Additional Services Required:		
□ Carers Allowance	□ ACCR Approval (ACAT)	□ Taxi Transport Subsidy Scheme
□ Carer Payment	□ IPTAAS	□ Mobility Parking Scheme
□ Rent Assistance	□ Life Support Registration - Origin	□ Seniors Card
□ DVA	□ CAPS – Continence Aids	□ ENABLE
□ Mobility Allowance	□ Health Care Card	□ Other

Life History/Personal Story – possible topics to consider:		
Former occupation	Education/schooling	Spouse details
Places has lived	Children/grandchildren	Music/reading preferences
War service	TV watched/ times	Past /Present hobbies
Regular visitors	Volunteer work	

Services Required:			
Identified required services	**Hours per week**	**Who will provide/fund?**	**Essential**
□ Case Management			Yes □

			No □
□ Domestic Assistance			Yes □ No □
□ Personal Care			Yes □ No □
□ Meal Preparation			Yes □ No □
□ Social Support			Yes □ No □
□ Shopping			Yes □ No □
□ Assistance with bills/errands			Yes □ No □
□ Assistance to medical appointments			Yes □ No □
□ Transport			Yes □ No □
□ Medication monitoring			Yes □ No □
□ Lawn mowing			Yes □ No □
□ Garden maintenance			Yes □ No □
□ Other			Yes □ No □
□ Other			Yes □ No □
Total hours per week			
Comments:			

Referrals Required:		
□ Allied Health – Community Nurse	□ Mental Health	□ ACAT
□ Allied Health – Continence Clinic	□ CAPS	□ Home Care
□ Allied Health - Podiatry	□ GP	□ Neighbour Aid
□ Allied Health – Diabetes Clinic	□ Community Transport	□ Kincare
□ Respite Services – Day/in Home/facility	□ Home Modifications	□ Home Nursing Group
□ Meals on Wheels	□ Enable	□ OT/Physiotherapy

Service Considerations:							
Days client is unavailable for services:	□ Mon	□ Tues	□ Wed	□ Thurs	□ Fri	□ Sat	□ Sun
What arrangements does client have for Public Holidays							
Support Worker Requirements:	□ Male		□ Female		□ no preference		
Specific training requirements:							
Vehicle requirements:	□ Car		□ 4 WD		□ Bus		□ Wheelchair Taxi
Does client have microwave for MOW?							

3.7 Assistance with daily personal activities to NDIS participants who live alone

Position Statement
Community Care Options are committed to ensuring the highest quality of service delivery is afforded to our clients. To this end, we are committed to ensuring effective checks and balances are in place to assess and review the quality of personal support services delivered to NDIS participants who live alone, and choose to access these supports from a sole worker.

NDIS participants who are provided with personal support in their own home may experience a level of risk if those supports are provided by the same individual NDIS worker for any extended period of time. The risk is likely to be greater where the NDIS participant lives alone. The NDIS has imposed an additional condition on CCO's NDIS Registration which seeks to strike a balance between addressing this risk and allowing an NDIS participant choice in relation to their personal support arrangements. The condition will ensure that personal supports are provided with appropriate protections being put in place by CCO. The additional condition will help to ensure that CCO has -

- worked with the NDIS participant to assess any risks to them, and
- established appropriate arrangements for monitoring the quality of those supports and to monitor the participants satisfaction with them.

Legislation
Section 73G NDIS Act 2013

Operational Procedures
Community Care Options **must not** allow personal support to be provided by a sole support worker to a NDIS participant unless we have undertaken the following –

- Assessed whether any of the risk factors exist in relation to the participant; and
- Have entered into a written service agreement with the participant; or has prepared a proposed written service agreement to enter into with the participant.

Risk Factors
The risk factors identified by the NDIS are as follows –

- The participant is not receiving, from any other NDIS provider, supports or services that involve regular, face to face contact with the participant.

- Any one or more of the following applies -

    - The participant or the participants plan indicates that the participant has limited or no regular, face to face contact with relatives, friends or other people with whom the participant is well acquainted.

- Without the assistance of another person the participant has limited or no physical mobility.
- The participant uses equipment to enable them to be physically mobile or to facilitate their physical mobility.
- Without the assistance of another person the participant has limited or no ability to communicate with others.
- The participant uses equipment to enable or facilitate communication with others, including to enable or facilitate the use of phone or other device.

Those staff undertaking assessment of the participant for CCO services (COS, SAO, SSO) must –

- ➢ Document their assessment of the participant's risk factors;
- ➢ As soon as reasonably practicable after completing the assessment, provide a copy of the assessment to the participant;
- ➢ Place a copy of the assessment in the client's file; and
- ➢ As soon as practicable after CCO becomes aware of any change in circumstances that may have significant impact on the provision of personal support to the participant –

  - Update the assessment to take account of the change;
  - Provide a copy of the updated assessment to the participant; and
  - Place a copy of the updated assessment in the client's file.

The Service Agreement or the proposed Service Agreement between CCO and the participant must take into account the participant's risk factors and must specify –

- ✓ The rights and obligations of the participant and CCO, respectively, under the agreement;
- ✓ The means by which the participant's support worker will be selected, including the participant's role in the selection;
- ✓ A procedure that will be used to review the implementation of the agreement, which must include someone other than the support worker checking directly with the participant, and with appropriate frequency, the participant's level of satisfaction with the type, quality and frequency of personal support being provided;
- ✓ The means by which CCO will supervise and monitor the performance of the support worker to ensure the performance is consistent with the agreement and the participants safety and well-being, which must include (as far as practicable) visits by a supervisor to the participant's home, at a specified and appropriate frequency, to undertake in person supervision of the support worker;
- ✓ The means by which CCO will communicate with the participant, which must include (as far as practicable) face to face communication with the participant in the participants home at an appropriate frequency;
- ✓ The means by which CCO will engage with other providers who may be involved in providing supports or services to the participant in the participant's home or in supporting the participant to access community-based activities.

If any risk factor has been identified as existing in relation to the participant CCO must ensure that –

- There is a documented plan for supervision of the participant's support worker that is appropriate having regard to the participant s risk factors and the plan is implemented;
- All of CCO's key personnel receive regular reports in relation to the care and skill with which personal support is being provided to the participant by the support worker, with the regularity of the reports being appropriate having regard to the participants risk factors; and
- Appropriate action is taken by CCO, without any unreasonable delay, to address any concerns identified in those reports.

The CEO and Disability Program Manager must keep an up to date record of all participants to whom CCO allows personal support to be provided by a sole support worker.

Policy	Date	Review Date	Comments
New Policy	16.3.2021	March 2022	Distributed to all disability staff responsible for client assessment
	January 2023	Reviewed & Updated	

3.8 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'. The policy is designed to prevent abuse, and support clients in a respectful and dignified manner.

Aged Care Quality Standards
- ✓ *Standard 3 – Personal Care and Clinical Care*
- ✓ *Standard 8 – Organisational Governance*

National Disability Standards
- ✓ *Standard 1 – Rights*
- ✓ *Standard 2 – Participation and Inclusion*
- ✓ *Standard 3 – Individual Outcomes*
- ✓ *Standard 8 – Service Management*

NDIS Practice Standards
- ✓ *Core Module 1-4*
- ✓ *Implementing Behaviour Support Plans*

NDIS (Restrictive Practices and Behaviour Support) Rules 2018
NDIS (Incident Management and Reportable Incident) Rules 2018

<u>Behaviour support</u>
Behaviour support is about individualised strategies for people with disability that are responsive to the person's needs, in a way that reduces the occurrence and impact of behaviours of concern, and minimises the use of restrictive practices.

Behaviour support under the NDIS Commission Rules has a focus on person-centred interventions to address the underlying causes of behaviours of concern, or challenging behaviours, while safeguarding the dignity and quality of life of people with disability who require specialist behaviour support.

Person centred interventions include undertaking a functional behavioural assessment, then developing an NDIS behaviour support plan containing evidence-based, proactive strategies that meet the needs of the participant.

What is a behaviour support plan?
A NDIS behaviour support plan is a document developed for a person with disability by a NDIS behaviour support practitioner.

It specifies a range of evidence-based and person-centred, proactive strategies that

focus on the individual needs of the participant. This includes positive behaviour support to build on the person's strengths, and increase their opportunities to participate in community activities and develop new skills. It also includes any restrictive practices that may be required, subject to conditions.

Behaviour support plans are developed in consultation with the participant, their family, carers, guardian, and other relevant people, as well as the service providers who will be implementing the plan.

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.

Behaviour Intervention
Where a behaviour of concern is identified it is the responsibility of all staff to complete a Hazard or Incident report form, so that the matter is raised with the Executive Team.

It is a requirement of the NDIS Rules that all behaviour interventions are developed by a trained Behaviour Practitioner. CCO staff are not to develop or implement procedures or strategies without these being overseen by a Behaviour Practitioner and developed as part of a comprehensive Behaviour Support Plan.

This means –

- If Behaviour Intervention Planning is deemed necessary the Program Manager Disability will request the Coordinator of Supports if there is one to make a referral for Behaviour Support.
- If no Coordinator of Support the Program Manager is to contact the NDIS to advise that Behaviour Support Planning is required. If there are sufficient NDIS funds in current plan then referral is to be made for Behaviour Support Plan development. If insufficient funds, then a request for review of this aspect

of the person's plan is to be made.
- All parties are to be involved in any planning meetings eg client, advocate, guardian, and/or primary carer, Behaviour Practitioner and 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/restrictive options;
- All Behaviour Plans will be sighted and signed off by the Disability Program Manager and recorded on CCO's Behaviour Support Register.

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 eg. 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
What is a restrictive practice?
Restrictive practices include seclusion, and chemical, mechanical, physical, and environmental restraints. In the past, restrictive practices were often used as a first response to behaviours that caused significant harm to the person or others. It has long been recognised that restrictive practices can represent serious human rights infringements.

Registered providers delivering behaviour support are required to abide by the NDIS Quality and Safeguarding Framework, which is underpinned by the same high-level guiding principles, including human rights and a person-centred approach.

States and territories continue to be responsible for the legislative and/or policy arrangements for authorisation and consent to the use of a regulated restrictive practice.

Where a NDIS participant's behaviours of concern place themselves or others at risk of harm, and a regulated restrictive practice is required, a registered provider will need to develop a behaviour support plan. The NDIS Commission Rules outline the requirements for registration and monitoring of restrictive practices used in behaviour support plans for NDIS participants.

Restrictive practices involve the use of interventions and practices that have the effect of restricting the rights or freedom of movement of a person with disability.

These can include restraint (chemical, mechanical, environmental or physical) and seclusion (keeping someone in isolation).

Restrictive Practices Authorisation is authorisation for a particular practice to be implemented by staff with a certain individual, in a particular service setting, under clearly defined circumstances. The decision to authorise use of restrictive practices will be based on supporting information including behaviour support documentation, such as a Behaviour Support Plan (BSP) informed by a functional assessment of behaviour, by a suitable qualified and approved Practitioner.

The NDIS Quality and Safeguards Commission will regulate behaviour support for NDIS registered service providers, including restrictive practices.

Authorisation of restrictive practices is required in accordance with NSW policy while a nationally consistent model is developed.
Service providers must comply with the new NSW Restrictive Practices Authorisation Policy and Procedural Guide.

- Restrictive Practices Authorisation (RPA) Panels will continue to be the primary mechanism in NSW for reviewing RPA submissions and either granting or declining authorisation.
- Requests to the RPA Panel for authorisation must be submitted via the NSW RPA ICT System, and must include a Behaviour Support Plan (BSP).
- Restrictive practices should be minimised or eliminated.
- Restrictive practices should only be used in the context of a Behaviour Support Plan, based on an assessment of behaviour.
- Authorisation under NSW Government policy is required for the use of restrictive practices.
- Consent is required for the use of restrictive practices.
- Reporting is required on the use of restrictive practices.
- Service providers convene RPA Panels, or access existing RPA Panels, to obtain authorisation.
- Unauthorised use of restrictive practices is a reportable incident.
- Restrictive practices are defined by the NDIS Quality and Safeguards Commission Rules and these definitions have been adopted for NSW.
- The routine use of medication or chemical substance is defined as a restrictive practice. Chemical restraint is the use of medication or chemical substance for the primary purpose of influencing a person’s behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition.
- National oversight of behaviour support is conducted by the NDIS Quality and Safeguards Commission.
- FACS provides independent specialist members of RPA Panels.
- NDIS registered providers administer and manage requests for *authorisation* through one online system provided by FACS.
- NDIS registered providers report on the use of restrictive practices to the NDIS Quality and Safeguards Commission.

Under the NDIS (Restrictive Practices and Behaviour Support) Rules, there are five (5) categories of regulated restrictive practice. The Commonwealth definitions will now be applied nationally. See below:

NSW Definitions	Commonwealth Definition
Seclusion	Seclusion
Exclusionary Time Out	
Physical Intervention / Restraint	Physical Restraint
	Mechanical Restraint
PRN Psychotropic Medication for behaviour	Chemical Restraint
Routine dose medication for behaviour *	
Restricted Access	Environmental Restraint
Response Cost	

*Not previously a Restrictive Practice in NSW

In exceptional circumstances, interim authorisation for the use of restrictive practices is required pending the development of a behaviour support plan and authorisation by an RPA Panel. This should be sought as soon as practicable, not exceeding **3 months.**

A senior manager of the provider can provide this interim Authorization having regard to the interim plan for behavior supports, including restrictive practices, and the context of the provider's Authorization. In providing interim Authorization the senior manager of the provider specifies the length of time for which the interim authorisation applies, not exceeding **6 months.**

Full authorisation can be provided for up to 12 months. The RPA panel must not specify a period longer than 12 months as the period for which a restrictive practice is authorised.

An RPA Panel is the mechanism for authorising the use of restrictive practices.

The RPA Panel –

- includes at least two people –
    1. a manager familiar with the operational considerations around the use of a restrictive practice in the intended service setting; and
    2. an independent specialist with expertise in Behaviour Support

- may include additional members such as a senior clinician or an advocate
- receives submissions requesting authorisation via the NSW RPA ICT system

- records its decision in a formal Outcomes Summary
- *panel members cannot make a submission to that panel*

The service provider will convene an RPA Panel, or access an existing RPA Panel. FACS can provide independent specialists to ensure that local RPA Panels have access to independent behaviour support expertise.

Procedure – Using restrictive practices as part of a behaviour support plan
If the plan contains a restrictive practice, the use of that practice must meet NDIS Commission conditions, and might require authorisation or consent under the relevant jurisdiction's legislative and policy frameworks.

The registered specialist behaviour support provider must ensure that –

- a behaviour support practitioner will work with the participant, informal supports, and implementing provider to develop a behaviour support plan that is based on a functional behaviour assessment
- a statement of intent to use a restrictive practice is given to the participant and their supports in an accessible format
- the behaviour support plan contains strategies that are outcomes focused, person centred, and proactive, and that address the participant's needs and the functions of the behaviour
- the behaviour support plan contains strategies to reduce or eliminate the use of restrictive practices with the participant over time
- the behaviour support plan is registered with the NDIS Commission to enable monitoring of regulated restrictive practices.

All providers using restrictive practices when delivering NDIS supports need to meet conditions of registration. These include the following –

- A restrictive practice **can only be used** when it is part of a behaviour support plan developed by a specialist behaviour support practitioner.
- If a restrictive practice is used, it must be the least restrictive response possible in the circumstances, reduce the risk of harm to the person or others, and be used for the shortest possible time to ensure the safety of the person or others.
- If the state or territory requires authorisation for the use of a restrictive practice, the implementing provider must obtain it.
- The provider must register the behaviour support plan and the regulated restrictive practice with the NDIS Commission, and comply with monthly reporting requirements.

Providers must meet certain obligations in delivering behaviour support that includes restrictive practices. These obligations include the following –

- Providers who deliver specialist behaviour support—including undertaking functional behavioural assessments and developing behaviour support plans—and who use restrictive practices must be registered.

- These providers must engage a specialist behaviour support practitioner, qualified to do behaviour support assessments and develop behaviour support plans.
- NDIS participants who may be subject to restrictive practices must have a behaviour support plan developed and lodged with the NDIS Commission.
- The use of restrictive practices will be subject to conditions, including that the person must have a behaviour support plan in place, specifying that person-centred strategies must be applied first, with restrictive practices used as a last resort, in response to a risk of harm to the person or others, and in line with any state or territory authorisation and consent requirements.
- Providers who use restrictive practices must provide monthly reports to the NDIS Commission.
- Providers must understand how NDIS policies and procedures support participants with behaviour support needs.
- Providers must help staff, participants, families, and decision-makers understand the NDIS Commission's behaviour support function.
- Providers implementing behaviour support plans must work closely with the NDIS behaviour support practitioner, the participant, and their family and carers on the development of the NDIS behaviour support plan.
- Providers must ensure that any staff involved in implementing positive behaviour strategies or restrictive practices have received appropriate training.
- Providers must report the unplanned or unapproved use of a restrictive practice to the NDIS Commission as a reportable incident.

Who will oversee behaviour support?

The Senior Practitioner will lead the NDIS Commission's behaviour support function, and will –

- oversee behaviour support practitioners and providers who use behaviour support strategies and restrictive practices
- provide best-practice advice to practitioners, providers, participants, families, and carers
- receive and review provider reports on the use of restrictive practices
- follow up on reportable incidents that suggest there are unmet behaviour support needs.

The Senior Practitioner's team is available for advice and guidance during the development and implementation of the NDIS behaviour support plan. This support is available to anyone—behaviour support practitioners, providers using the plan, participants, family members, carers, and advocates.

How to lodge a behaviour support plan with the NDIS Commission

Forms for lodging a new behaviour support plan (developed after 1 July 2018) with the NDIS Commission are provided in the Behaviour Support Manual as well as by the direct links below (control/click)

- Behaviour Support Practitioner – Interim behaviour support plan
- Behaviour Support Practitioner – Comprehensive behaviour support plan

Once the form is completed and CCO has agreed as the implementing provider to follow the plan, it is emailed to the NDIS Commission at behavioursupport@ndiscommission.gov.au.

Once received, the NDIS Commission will –

- Advise the implementing provider that the plan has been lodged
- Request the implementing provider to provide details of consent and authorisation once obtained
- Provide the implementing provider with the restrictive practices reporting form.

The restrictive practices reporting form is also provided in the Behaviour Support Manual as well as by the direct links below (control/click).
Restrictive practices reporting form

Staff need to be aware of inherent risks associated with the transmission of information via email and otherwise over the Internet.

If there are concerns in this regard, the NDIS Commission has other ways of obtaining and providing information including email, telephone and the NDIS Commission's secure file transfer system, FilePoint.

For advice about how to use FilePoint, please contact the NDIS Commission on 1800 035 544. If it is necessary to lodge a behaviour support plan or notification form through FilePoint outside of business hours, please email – behavioursupport@ndiscommission.gov.au

Staff Responsibilities

- Reporting behaviours of concern via Hazard/Incident Report, other mechanism.
- Reports trigger need for Behaviour Support referral.
- CCO has a Behaviour Support Register – where clients have been referred for Behaviour Support Plan development this is to be flagged with the Program Manager Disability, and CEO.
- The CEO will maintain a register of all clients who have a current Behaviour Support Plan.
- This will include a Register of clients who have approved Restrictive Practice Approvals and the review and reporting requirements.

Schedule for Revision of Policy: BEHAVIOUR INTERVENTION & SUPPORT				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
July 2006	**New policy**	**R. Thompson**		
January 2007	**Amended**	**D. Vaughan**	**2007**	
April 2009	**Reviewed & Updated**	**D. Ryan**	**2012**	
November 2011	**Reviewed & Update**	**D. Ryan**		
September 2014	**Reviewed & Updated**	**D. Ryan**	**2016**	
December 2016	**Updated**	**D. Ryan**	**2018**	
April 2019	**updated**	**D. Ryan**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

Community Care Options

WORKING WITH CHALLENGING BEHAVIOURS

Staff Resource

Before getting started some simple exercises!

See what you know and think about challenging behaviours. Circle "True" or "False" for each of the statements below.

True or False 1. There is very little you can do to prevent most clients' challenging behaviours
True or False 2. It takes discipline and hard work to respond and not react to a client's challenging behaviour.
True or False 3. It is your responsibility to control how a client acts.
True or False 4. It is rare that something triggered a client's challenging behaviour.
True or False 5. What you do can sometimes make a challenging behaviour worse, not better.
True or false 6. The more you know a client, the better you will be at working with any challenging behaviours.
True or False 7. Look for any health reason for a client's challenging behaviour first.
True or False 8. Never walk away from a client during a challenging situation.
True or False 9. Asking other care team members for help with a challenging situation means YOU have not done your job.
True or False 10. If your first attempt at handling a challenging behaviour doesn't work, try something different.

Individual exercise:

You have chosen to work for an organisation that provides services for people with a potential for or a known history of challenging behaviour.

Employee attitudes influence client behaviour. Describe your reasons for making the choice to work with Community Care Options, instead of choosing a job with less risk of being exposed to challenging situations.

- What attracted me to this job?

- What keeps me here?

- What is my attitude towards the industry?

- Why am I suited to this position?

WHAT IS CHALLENGING BEHAVIOUR?

BEHVIOUR IS:	**BEHAVIOUR IS NOT:**
✓ Any action that can be seen or heard ✓ Is observable ✓ Is measurable	▪ Your reaction to the situation ▪ Your interpretation of the situation ▪ Your expansion of the situation

- A behaviour is the action or reaction to something under specified circumstances. When it comes to a behaviour that is challenging the key focus is to identify what triggers the reaction.
- Challenging behaviour is a behaviour, which is of such intensity, frequency, or duration that the physical safety of the person or those nearby is put at risk.
- The behaviour may also limit the person's ability to participate in daily life and enjoy wider experiences.
- Until you know the **triggers** of why the behaviour occurs, you won't know how to stop it. If you can pin point what causes the problem, changing that, may be easier then changing the reaction that the person has.

IDENTIFYING BEHAVIOURS

Types of Challenging Behaviour

The more common types of challenging behaviour include –

- Self-injurious behaviour – biting, hitting, head butting, ingestion or inhalation of foreign bodies
- Aggression – screaming, spiting, punching, hitting others, kicking
- Property destruction – throwing objects, stealing
- Sexualised behaviour – public masturbation, groping
- Stereotyped behaviours – repetitive rocking

Causes of Challenging Behaviour

- Biological – pain, medications, the need for sensory stimulation
- Social – boredom, seeking social interaction, the need for an element of control, lack of knowledge of societal norms, insensitivity of others
- Environmental – physical aspects such as noise and lighting or gaining access to preferred objects or activities
- Psychological – feeling excluded, lonely, devalued, labelled, disempowered, living up to people's negative expectations

NOTES

When Behaviour becomes challenging

Many clients are under a great deal of stress and it would be unreasonable to think that they can handle that much stress gracefully all of the time.

All behaviour is meaningful and challenging behaviours are messages about unmet needs and the quality of a person's life. For example –

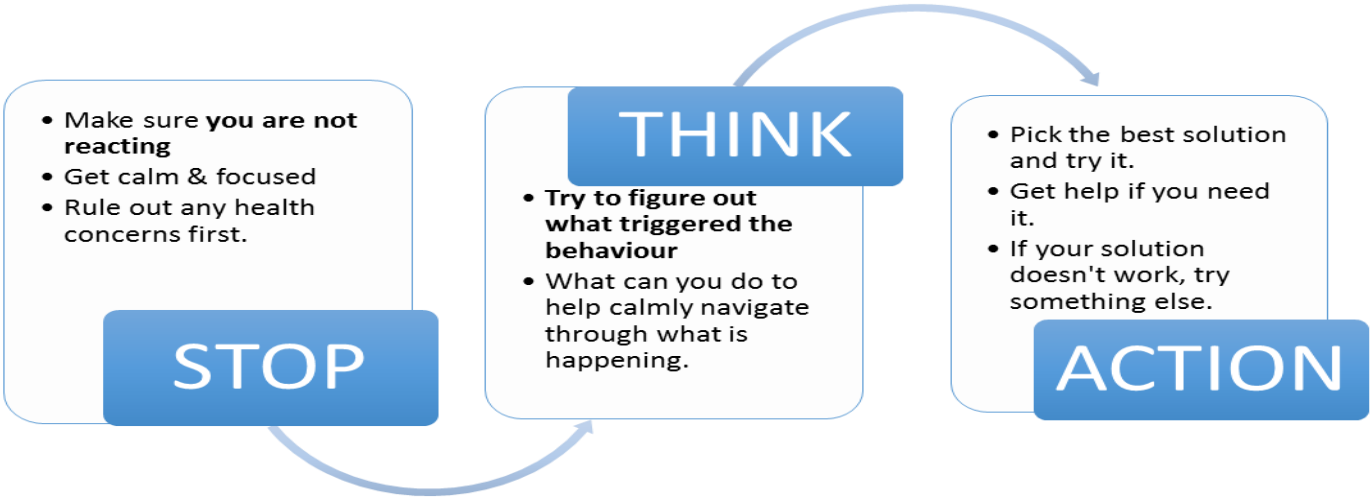
- I don't feel safe
- I have no power
- I'm lonely
- I'm bored
- You don't value me
- I don't know how to tell you what I need

As a Support Worker, your role is to use a conscious, logical approach to help calm and resolve the situation respectfully and safely. You want to –

- Get to know what triggers a client's challenging behaviour.
- Learn what i) helps prevent it from happening in the first place and ii) what things help stop or minimize the behaviour when it happens.
- Remain calm and respond, NOT REACT, to the situation.
- Make sure your behaviour does not create or intensify the situation.
- Know when YOU need help and should get others involved.
- Keep other care members updated through documenting and reporting.
- Get medical or other emergency help when it is needed.

Steps to Navigating Challenging Behaviours

There are three main steps that will help you to navigate through a challenging behaviour. If you are new to the support working role, the more experiences you have, the more you will find yourself automatically following the steps.



Even with experience, dealing with challenging behaviour can be unsettling. You may experience feelings of guilt, anger, frustration or be overwhelmed. After the situation is over, you may even second guess every step and wonder if you handled things correctly. These are normal feelings and part of the reason these situations are considered a "challenge". Be patient with yourself and remember that self-reflection and debriefing with your team are essential.

Individual exercise:

Briefly describe the most challenging behaviour you have experienced with a client. If you are new to the role of support worker and haven't yet experienced a challenging situation with a client, describe a challenging situation from your own life or another job.

What were some of the emotions you felt when first faced with the situation?

What did you do to get calm so you could focus on handling the situation?

STEP 1 – Stop, pause, get calm & focus

Most challenging behaviour has a **cause or trigger**. There is a reason for the behaviour. A client's challenging behaviour is likely a **reaction** to something that set the behaviour in motion. Reacting means that the client is unconsciously, emotionally, and possibly impulsively behaving without any thought.

"REACTIONS ARE EMOTIONAL ACTIONS WITHOUT THOUGHT"

A person who is reacting is often –

Unlikely to:
- Be aware of anything besides what he or she is experiencing
- Listen or be open to another person's perspective
- Slow down and think through the consequences of his or her actions
- Be patient or calm

Likely to:
- Be consumed with emotion – making it difficult to control the emotion or think
- Feel justified in the way he or she is acting
- Be easily provoked into becoming even more emotional

Just being around someone who is highly reactive/emotional is **contagious.** It can be hard not to get pulled into his or her energy. If **YOU** begin to react to the situation, you are -

Less likely to:
- Listen and get the information you need to understand what is actually happening
- Stay calm
- Get the situation resolved quickly

More likely to rush in and:
- Become emotionally 'hooked in' yourself
- Provoke the client even further
- Make the situation worse – not better

"REACTING OFTEN MAKES THE SITUATION WORSE NOT BETTER"

You can't control the client's behaviour. You can control your response to it. You need to work hard to **RESPOND** to what is happening not **REACT** to it.

Responding to a situation helps you:

- Not add more fuel to the client's challenging behaviour
- Look at things more objectively
- Conserve your own emotional energy
- Not become defensive, angry or upset
- Logically choose the best approach

- You are ready to respond when –

- Your breathing is close to normal – not shallow or elevated
- You are consciously aware that you are thinking – not emotionally reacting
- You are observing the situation from the outside – not caught in it
- Have an idea of what to do

"RESPONDING IS ACTION WITH THOUGHT"

<u>Individual exercise</u>

We all have patterns in how we look, feel and act when we react. Think of a situation where you know that you have reacted to a situation instead of responding. For example, a client throwing their lunch at you or another driver cutting you off.

Describe what happens when you react –

1. In your body (e.g. rapid breathing, clenched fists, tense shoulders)

2. With your emotions (e.g. anger, fear, freeze/numb)

3. In your head (e.g. "get me out of here", "I can't stand this", "what an idiot")

All of us have things, events, people, environments or types of situations that push our buttons and trigger a reaction. It is even harder work to respond, stay calm and not react when your personal buttons are pushed.

Make a list of things, events, people, environments or types of situations most likely to push your buttons!

Describe ways that you calm yourself and regain focus (e.g. slow breathing, remove yourself from the environment, recognize that it is not about you).

STEP 2 – Think, figure out what is happening, any triggers?

Your excellent detective, active listening and observation skills are needed to figure out what is happening. What caused or triggered the challenging behaviour? Remember, most challenging behaviour has a reason.

In working with any client, it is always important to -

Get to know the client, learning his/her:

- Routines, preferences and daily rhythms
- Life history and significant events

Be emotionally available:

- Show genuine interest and concern
- Realize that your own personal feelings of stress, worries and time pressures can add to any emotional tension that the client is experiencing
- Actively listen to the client

There are many reasons why a client may not be able to communicate with words what he or she needs or wants. Clients may not be able to –

- Speak
- Process things quickly enough to explain what is happening or needed in the moment
- Understand themselves due to their disease or condition
- Have the strength to get the words out. For example, they may be in too much physical or emotional pain.

Sometimes, what you may see as a challenging behaviour may be **the only way that the client can tell you that he or she needs or wants something.**

Triggers – there are three main categories of triggers that might cause or worsen a client's challenging behavior -

1. **Biological/ physical triggers -** symptoms of his or her disease or condition, infection, pain, medication, dehydration or reaction to care given.

2. **Environmental triggers -** too much noise or people, intrusion into his or her space, temperature (too hot or cold), something unfamiliar being added to the environment, or something familiar being move or removed from the environment or lack of privacy.

3. **Psychological/ emotional triggers -** overwhelming feelings of past or current events or relationships such as the loss of a loved one, loneliness, a fight or disappointment with a relative/friend/another worker, anxiety or fear.

The client's perspective is what's important when looking for possible triggers. What has triggered the client's challenging behaviour can be very different than what would trigger yours.

"WALK IN THE CLIENT'S SHOES INSTEAD OF YOUR OWN"

GROUP EXERCISE: Read the following scenario.

You have been working with Jenny for six weeks. She is 35 years old, has been diagnosed with schizophrenia and can experience delusions and paranoid behaviour. You have been helping her with medication prompts, meal planning, personal care prompts and social outings.

This morning she told you that she was so excited that her sister was coming for a visit this afternoon, that she had a hard time sleeping last night.
Her sister was two hours late. They took a short drive and stopped to get ice cream. The weather turned cold and they got caught in some heavy rain when they walked back to the car. Jenny was wet and cold and didn't have a jumper. Jenny's sister dropped her home without going in the home. Jenny had not eaten lunch or taken her midday and afternoon medications.

You arrive for the dinner service and hear Jenny's neighbour trying to calm Jenny down. She had forgotten her house keys, was highly agitated, pacing back and forth and accusing the neighbour of stealing her keys and other items from her home.

List at least 4 things that may have triggered Jenny's challenging behavior.
1.

2.

3.

4.

STEP 3 – Take action to handle the situation respectfully and safely.

There is no "one size fits all" formula to handle challenging behaviour. What works in one situation may not work ten minutes later. What works with one client may have the opposite result with another. **The best way to deal with challenging behaviour is to adapt as you go to each unique client and situation.** This means you must be –

- Constantly aware of what signals the client is giving off on that day
- Ready to adapt, walk away, soothe, distract or respectfully steer the client away from what triggered the behaviour

- Willing to do something different if what you tried doesn't seem to be working

"ADAPT AS YOU GO TO EACH UNIQUE CLIENT AND SITUATION"

Best practices in handling challenging behaviour
The following are some general best practices to help guide you in possible actions to take when faced with a challenging behaviour.

- **Get help**

  One of your first decisions is whether or not you get other members of the team involved. There should be policies and procedures about how to address certain situations. Generally, this will include who, when and how to get the client medical attention (both physical and mental health), or get other team members, client's family, friends or guardian involved.

  If you need help get it! This is especially important when medical or other emergency help is needed.

  The safety and well-being of all involved is your top priority. This includes you.

  Never put yourself in danger.

  Finally, **speak up immediately** if you ever feel you are at you own breaking point/limits in dealing with a client's challenging behaviour. Talk with your Case Manager or supervisor.

"NEVER LET YOUR FRUSTRATION LEAD TO THE POSSIBILITY OF LOSING CONTROL OR HARMING A CLIENT"

- **Minimise or eliminate the trigger**

  Do you have an idea of what is causing the behaviour? Is there something YOU can do, help make happen or give the client that will stop or minimize the trigger? Then do it!

  Widen your perspective about what is acceptable in the moment. Adapt and be creative. If meeting a client's need or request has a good chance of minimizing or eliminating the behaviour, ask yourself the following questions -

- Does it hurt anyone to do it?
- Are YOU the road block because it
  - Makes you change or adjust YOUR schedule?
  - Might look odd or unusual to others?
  - Requires you to "think outside the box"?

- Would be easier to do it the “regular” way or at a less busy or unusual time?

➢ **Adapt**
Look for ways to adapt to the client and his/her routine. This can include –

- Changing when or how he/she receives care
- Breaking tasks down into smaller steps
- Taking frequent breaks to allow the client more time to do each step
- Doing some more prompting or cuing
- Using assistive devices to their fullest extent

Observe the subtle details
Getting to know things like what a client likes to eat and when or how he or she wants certain personal care tasks done is **one** level of what you need to know about a client. There are other, more subtle, details to learn about a client.
Being aware and observant of these subtle details can be even more important when dealing with challenging behaviour. The answer for successfully navigating through challenging behaviour is often in the subtle details of **who the client is as a person.**

- How do you know when the client likes or doesn’t like something?
- What types of things, situations, or people seem to make the client frustrated, anxious or nervous, angry?
- What pace of activity is comfortable for that client? How do you know when it is too fast or too slow?
- How does the client communicate (both verbally and with body language) what he or she wants?
- Is there anything you can learn about the client’s general personality that gives you an overall sense of the best way to work with him or her?
- Is there anything unique to that client’s culture that could be contributing to the challenging behaviour?

When you get to know some of these more subtle things about a client, you can watch for early warning signs of possible problems. Take action immediately to help the client feel more calm and reassured (reduce or minimise the trigger, give space, calm, distract, reassure)

You have to have (or learn to have) the patience, desire and emotional and physical energy to stop and take the time to adapt and work through the client’s challenging behaviour.

➢ **Give space**

Ask yourself whether giving the client some space would be the best option. If it is safe, come back in 5 or 10 minutes. This may give the client time to calm down. Some quiet time for the client may be all it takes to resolve the situation.

Giving space can also mean staying with the client and respecting his or her need for personal space. How much space does the client appear to need around his or her physical body? Is the client hypersensitive to touch? Movement? Claustrophobic? Is there a particular way you can approach the client that seems less unsettling to him or her? Knowing the answers to these questions can help guide you in how best to approach the client any time, but is especially critical when he or she is highly reactive.

Tips when approaching a client

Pay special attention to how you approach a client. A client's sense that you are invading his or her personal space is a common trigger of challenging behaviour.

Always –

- Knock. Ask permission to enter a client's personal space
- Approach a client from the front so he or she knows you are there
- Smile genuinely
- Try to get a client's attention before you talk
- Move slowly. Avoid sudden movements
- Identify yourself and why you are there
- Address the client by the name he or she prefers
- Spend a few minutes talking with the client before providing care. This gives you time to see how the client is doing and gauge if it is safe to proceed with care
- Explain what you are going to do

➢ **Sooth and comfort**

- Slow down you own movements and energy
- Try not to show any anxiety or other intense emotions. They will likely increase the client's reactions
- Speak slowly, softly with a low pitch and in a reassuring tone. Make sure the client can hear you if he or she has trouble hearing
- Offer things you know comfort that client (warm blanket, favourite music, television show, object)
- Reduce distractions or background loud noises as much as possible. For example, turn down the television or lights, ask others to leave the room. Always ask the client's permission before doing any of these things

As a general rule, remember that your body language is your best communication tool. This means it is critical that –

- Your posture, facial expressions and stance are relaxed and open
- Your tone is respectful and calm
- You move slowly
- You stop what you are doing and focus on the client
- Your body language matches the words you say to the client

- **Reassure**
  - Listen! Let the client talk about his or her feelings. Don't ask a lot of questions at first. Let the client get some of the excess emotions out. Listening helps make sure the client knows he or she has been "heard" by you.
  - Be understanding and sympathetic (within reasonable limits – you don't want to reward the challenging behaviour). For example, say "It looks to me like you're upset, Sue. How can I help?" This lets the client know he or she is not alone and you are there to help.
  - It isn't acceptable if you are treated with disrespect or threatened. Set clear boundaries with the client. For example, "Sue, I can see you are upset but this does not mean you can yell at me and call me names. What will help you right now?"
  - Be careful with your delivery, manner and tone when communicating things like this. What's important is how the client hears it. The client is much more likely to respond favourably if you sound sympathetic rather than insincere, annoyed, frustrated or angry.
  - This is not the time to have a long talk with the client about his or her behaviour. Wait until later when the situation is calmer to work through any boundary issues or concerns.

- **Distract or redirect**
  - Distract the client by offering choices such as a calming or favourite activity. Examples include a walk, offering a snack or beverage or turning on the television.
  - Change the conversation to something positive that may absorb him or her.
  - Encourage the client to take several deep breaths.
  - Reinforce any glimmer of positive behaviour.

- **Encourage**
  - Listen, listen, listen!
  - Reinforce all positive behaviour – no matter how small
  - Encourage the client to keep happy reminders, such as family pictures or treasures keepsakes in plain view
  - Encourage the client to choose healthy behaviours in diet, exercise and socializing with others. These things are known to support a client's overall well-being (and health).

Self care after a challenging situation

As a Support Worker, you need to replenish your emotional reserves after handling a stressful situation. This requires good self care, taking the time to deal with your emotions and feelings.

There are many different ways you can get overloaded or overwhelmed as a support worker. It may physically, mentally, emotionally or even spiritually. When overloaded in one area, use one of the other areas to get back to a better place of balance and well-being. For example, if you are emotionally overloaded after a challenging situation, talk a walk (physical), read a magazine (mental) or meditate for a few minutes (spiritual).

After a challenging event, many support workers find it helpful to talk through what happened with other team members. This can –

- Help you process what happened and understand and let go of the emotions attached to it
- Let other care team members share their thoughts and help brainstorm how to work with the client in the future
- Help reinforce that challenging situations happen to others. It isn't just you

"Remember to guard a client's right to privacy and confidentiality"

Prevent or minimize challenging behaviors

Once the heat of the moment has passed, you will have more time to reflect on what triggered the challenging behavior. This information helps you take steps to avoid these situations from happening again. With more time to reflect, you may see additional patterns or concerns.

Document and report

You will have important information to share with other client team members. Other support workers need to understand and learn from what you observed, what actions you took, and what did and did not work.

There will be policies and procedures for documenting and reporting challenging situations that you must follow. Objectively writing down what happened and what actions you took gives everyone a record. This record will also help make sure you don't forget even small details that, when reviewed again, might reveal important information.

Looking At Specific Behaviors

The information covered in the beginning of this training relates to any challenging situation. The following are some additional suggestions to consider when dealing with a specific behaviour.

- **Handling a Client's Anger**

• Don't take the anger personally. Most of the time, the client's anger is not about you.
• Listen carefully. Allow the client to express the anger before responding.
• Pay attention to the feelings behind the client's actions and words.
• Acknowledge the anger. Let the client know that you realise he or she is angry. For example, "Sara, it looks to me like you are really upset that someone took your favorite pen." Find something to agree about. "Yes, the mail carrier hasn't been coming as early as he used to." "You're right, these sheets are all wrinkled up."
• Give the client a chance to make decisions and be in control.
• Help the client regain a sense of control. Ask if there is anything that would help him or her feel better. Remember, sometimes that means giving the client some space and coming back later.
• Offer alternative ways to express anger. Examples might include talking through it,

drawing pictures or another form of artistic expression, or writing a complaint list.

If the client is unable to control the anger and/or you fear that he or she could be a threat to you or others, get help immediately.

- **When anger turns to possible violence**

We all have an internal alarm system that lets us know when something is off or possibly dangerous. If you feel afraid or have a “funny” feeling, pay attention. Deal with your uneasiness first. Once you do, you will be better able to respond to the situation and ensure everyone’s safety.

- Do not isolate yourself with anyone you think may be dangerous. Keep a safe distance, do not turn your back and stay seated (at eye level with the other person) if possible.
- Leave the door open or open a closed door, and sit near the door. Be sure that someone else is near to help if needed.
- Don’t let anyone get between you and the door/exit.
- Soothe and calm if possible
- NEVER touch the client or try to remove him or her from the area. Even a gently push or holding the person’s arm may be misinterpreted and the client may respond with violence.
- If the situation worsens, find a way to excuse yourself, leave the room/area and get help. For example, “you’ve raised some good questions. I’ll talk with my supervisor to see what we can do”. “I think I hear someone at the door. Excuse me for a minute while I go see who it is”. “I have to go to the bathroom. I’ll be right back”. Then, get help.

3.9 Client Focus Meetings

Protocol for Client Focus Meetings

OBJECTIVES

The objectives of a client focus meeting are -

- To provide Care Managers, Support Coordinators, Service Coordinators and Support Workers with a consistent framework to ensure efficient and effective use of resources - time and skills - as a means to obtain optimal outcomes for clients and minimise work place risks to staff.
- To ensure the effective planning and service delivery for high level/complex clients
- To assist in the identification and resolution of any issues identified in supporting the client
- To ensure consistent information, client management strategies and understanding of client support needs
- To enable Care Managers, Support Coordinators to educate, instruct or train direct care staff in client needs and support procedures
- To enable Support Workers to discuss any issues of concern, debrief, have input into development of consistent client care strategies
- To encourage and support team work between Support Workers, Service Coordinators, Support Coordinators and Care Managers.
- To encourage effective communication for all stakeholders involved.

It is recommended that high needs clients in receipt of Home Care Level 4, NDIS, and others with complex needs and numerous workers have a regular client focus meeting at least once every 6 months. More frequently if needed.

All meetings will be documented and minutes retained on client files. All participants will be given a copy of agreed strategies/ procedures following the meeting.

All meetings will be professional and sensitive and respectful of the client and their needs in all discussions.

It may be appropriate to invite the Operations Manager and the Client Services Manager if there are complex issues requiring Management input and to support SW's to effectively develop successful relationships and practice.

Suggested Agenda for meetings

- Identification of what is working well - strengths
- Identification of what is not working – issues
- Opportunity for all staff to provide feedback about how they manage the issues – sharing of techniques/tips/debriefing
- Agreement on and documentation of consistent strategies to be utilised and practised by all

- Actions for follow up by Care Manager, Support Coordinator including WH&S issues.

Care Managers/Support Coordinators should endeavour to facilitate client focus meetings in a timely manner if requested by SW's.

Preparations prior to calling a focus meeting -

- Complete Request for Client Focus Meeting. Submit to Client Services Manager for approval to proceed.
- Determine suitable venue and book prior to the day of the meeting.
    - If based in Urunga office - ensure the meeting area within the office is available and can accommodate the size of group in attendance.
    - If based in Coffs Harbour office - ensure you use the 'room booking sheet' to book at suitable room at the office. See Intranet for room bookings.
- Email CSR to Service Coordinators to arrange a Client Focus Meeting with all relevant staff. Ensure you extend the invite to a relevant Service Coordinator as they will be able to provide valuable insight into the rostering practice and staff availability. The Care Manager/Support Coordinator must identify a preferred date and time however due to staff rosters it may be necessary to vary this time to ensure all staff can attend.
- Service Coordinators are to confirm with the Care Manager/Support Coordinator who will be in attendance and whether the date and time has had to change. They must also confirm who, from the Service Coordination team, will be in attendance.
- At least 2 weeks before the Client Focus Meeting, the Care Manager/Support Coordinator, must send out a Staff Memo to all staff currently rostered to the client asking for feedback about what is working and not working for the client and staff. This memo will formulate the agenda and allow all staff to have an active role in the meeting. See memo below.
- Support workers must return the memo to the Care Manager/Support Coordinator prior to the meeting. If this is not practical then the Support Worker must bring the completed memo to the Client Focus meeting for discussion on the day.
- Care Managers/Support Coordinators are responsible for ensuring room set up and resources needed are available for meeting.
- Minutes of Client Focus Meeting and any agreed upon strategies, actions to be sent to all participants and the Client Services Manager.

Where possible Client Focus Meetings should be scheduled during CCO keep free time on Tuesday afternoons.

SW Support & Supervision Meetings will be held bi-monthly going forward, which creates a lot of additional rostering as you know. If we can prioritise Client Focus Meetings for the non S&S months this would be great. If urgent to hold one please let your Manager know & this can be accommodated.

Client Focus Meeting – memo template:

Staff Memo – Client Focus Meeting			
To:		**From:**	
Date of memo:		**Client:**	
Venue:		**Date & Time:**	

Hello _____ ,

Next week a Service Coordinator will contact you to invite you to attend a client focus group meeting with the staff rostered to provide services to _____. Prior to the meeting could you complete the form below by outlining areas of service provision that are of concern and areas of success, along with strategies, that can be shared with the rest of the group?

The purpose is to ensure we are all working with the same information to be able to provide a safe, supportive service for _____.

Areas of concern

1. ----------
2. ----------
3. ----------
4. ----------
5. ----------

Areas of success

1. ----------
2. ----------
3. ----------
4. ----------
5. ----------

Any questions please let me know otherwise please return this completed form to me.
Thank you,
Care Manager/Support Coordinator _____
Telephone _____

3.10 Code of Conduct

Definition – although no one set of rules can answer all ethical questions, the Code of Conduct provides the organisation with an ethical framework for the decisions, actions and behaviour of its staff. It explains the values that guide the organisation, the principles covering appropriate conduct in a variety of contexts, and it outlines the minimum standard of behaviour expected of employees.

Position Statement
Community Care Options has an obligation as a non-profit community services organisation to respect the law and system of government, as do all persons associated with it. CCO will provide a responsive service to the community, that delivers responsible duty of care to improve quality of life. All of the organisation's members will operate with integrity and diligence, economy and efficiency, demonstrating professionalism, respect and value for people as individuals. Every person associated with the organisation must accept these obligations and abide by this policy.

Legislation
All persons engaged by Community Care Options are bound by legislation relevant to the provision of services to the aged, children, and people with disabilities. This includes, but is not limited to, the following -

- ✓ The Aged Care Act 1997
- ✓ Aged Care Principles 1997
- ✓ Children and Young Persons (Care and Protection) Act, 1998
- ✓ The Disability Services Act 1993
- ✓ Disability Service Standards
- ✓ Health Records and Information Privacy Act 2002
- ✓ Privacy Act 1988
- ✓ Anti-Discrimination Act 1977;
- ✓ Privacy and Personal Information Protection Act 1998
- ✓ Protected Disclosures Act 1994;
- ✓ Public Finance and Audit Act 1983.
- ✓ Child Protection (Prohibited Employment) Act 1998;
- ✓ Community Care Common Standards.

Aged Care Quality Standards

- ✓ *Standard 8 – Organisational Management*
- ✓ *Aged Care Code of Conduct*

National Disability Standards

- ✓ *Standard 6 – Service Management*

NDIS

- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*
- ✓ *NDIS Code of Conduct*

Community Care Options is committed to upholding the principles, provisions and requirements of all relevant legislation concerning the provision of care and services for people in its care.

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 all people, including clients, carers and staff equally
This means we –

- 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

We value a high quality of life for clients and carers
This means we –

- 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

We value acting ethically
This means we –

- Act honestly 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

We value professionalism
This means we –

- 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

We value creativity & initiative
This means we –

- Encourage innovative and dynamic ideas
- Promote visionary thinking
- Behave in a positive and friendly manner
- Provide inspiration and encouragement
- Motivate and mentor people

General Principles
In carrying out duties and responsibilities staff will -

- uphold the vision, mission and values of the organisation;
- act in a lawful manner and in accordance with this Code;
- act in an ethical manner;
- not act corruptly or support anyone else acting corruptly;
- act in a manner that will not bring the organisation into disrepute;
- take all necessary steps to ensure the health and safety of themselves and others (including clients) whilst at work;
- ensure that work is performed efficiently, effectively, impartially and with integrity;
- provide honest, accurate and responsible advice and information;
- ensure that decisions are made fairly and based on the best possible information available;
- ensure that at all times they remain accountable for, and strive to improve, professional competencies and quality of work;
- work in a cooperative and positive manner with colleagues;
- ensure that Community Care Options resources are not used improperly;
- always act respectfully towards, and in the best interests of, those people who are users of our services.

Operational Procedures

All of Community Care Options staff will receive training in both the NDIS and Aged Care Code of Conduct at Induction.

All of Community Care Options staff are expected to comply with these Codes of Conduct in all interactions with client's and other.

Everyone has the right to receive safe and quality community care services. The Codes aim to improve safety and wellbeing for people receiving disability or aged care and to boost trust in services.

The Codes help staff to better understand what is expected of them in the delivery of care, supports and services.

The Codes describes the behaviour expected of NDIS and aged care providers, their governing persons (eg. board members and Chief Executive Officers) and direct care staff.

The Codes apply to approved aged care providers of residential, home care and flexible care services and NDIS Providers:

- their governing persons (e.g. board members and CEOs)
- aged care and disability workers who are:
    - employed or otherwise engaged (including on a voluntary basis) by the provider
    - employed or otherwise engaged (including on a voluntary basis) by a contractor or subcontractor of the provider to provide care or other services to consumers.

THE NDIS CODE OF CONDUCT

The NDIS Code of Conduct requires workers and providers delivering NDIS supports and services to do the following in providing those supports and services:

1. Act with respect for individual rights to freedom of expression, self-determination and decision-making in accordance with applicable laws and conventions.
2. Respect the privacy of people with disability.
3. Provide supports and services in a safe and competent manner, with care and skill.
4. Act with integrity, honesty and transparency.
5. Promptly take steps to raise and act on concerns about matters that may impact the quality and safety of supports and services provided to people with disability.
6. Take all reasonable steps to prevent and respond to all forms of violence against, and exploitation, neglect and abuse of, people with disability.
7. Take all reasonable steps to prevent and respond to sexual misconduct.

The Code of Conduct for Aged Care

When providing care, supports and services to people, I must –

a) act with respect for people's rights to freedom of expression, self determination and decision-making in accordance with applicable laws and conventions

b) act in a way that treats people with dignity and respect, and values their diversity

c) act with respect for the privacy of people

d) provide care, supports and services in a safe and competent manner, with care and skill

e) act with integrity, honesty and transparency

f) promptly take steps to raise and act on concerns about matters that may impact the quality and safety of care, supports and services

g) provide care, supports and services free from –
   (i) all forms of violence, discrimination, exploitation, neglect and abuse
   (ii) sexual misconduct

h) take all reasonable steps to prevent and respond to –
   (i) all forms of violence, discrimination, exploitation, neglect and abuse
   (ii) sexual misconduct.

3.11 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.

National Disability Standards
- ✓ *Standard 2 – Participation and Inclusion*

Aged Care Quality Standards
- ✓ *Standard 4 – Services and Supports for Daily Living*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

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.

The International Day of People with Disability, 3 December 2014, marked the commencement of the visionary *Disability Inclusion Act 2014* (NSW) (the Act or the DIA).

The *Disability Inclusion Regulation 2014* (the Regulation) supports the Act and provides the necessary detail for the Act to work properly.

The Act and the Regulation can be viewed on the NSW legislation website.

The Act –

- makes it clear that people with disability have the same human rights as other people
- promotes the inclusion of people with disability by requiring government departments and local councils to engage in disability inclusion action planning
- supports people with disability to exercise choice and control through individualised funding wherever possible
- provides safeguards for people accessing NSW funded disability supports and services, including new employment screening requirements and the need for disability providers to report abuse or neglect of people with disability to the NDIS Quality and Safeguards Commission.

CCO is committed to working together with other agencies to dismantle existing barriers so that people with disability can participate fully in their communities, to the advantage of everyone.

Operational Procedures
To achieve community participation and integration –

Each client will have an individual plan of support, created in consultation with them, the Support Coordinator and others including, where appropriate the clients' family members, friends or other service providers. Through the planning process Support Coordinators 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 Coordinators 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 Coordinators 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.

Schedule for Revision of Policy: COMMUNITY PARTICIPATION AND INTEGRATION				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
July 2006	**New policy**	**R. Thompson**		
January 2007	**Amended**	**D. Vaughan**	**2009**	
April 2009	**Updated**	**D. Ryan**		
August 2010	**Updated**	**D. Ryan**	**2012**	
November 2011	**Updated**	**D. Ryan**		
September 2014	**Updated**	**D. Ryan**	**2015**	
December 2016	**Updated**	**D. Ryan**	**2018**	
December 2018	**Reviewed**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

3.12 Complaints & Feedback Management

Definition
A complaint is any dissatisfaction expressed by an interested party about a specific Community Care Options (CCO) 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.

Aged Care Quality Standards
- ✓ *Standard 6 – Feedback and Complaints*
- ✓ *Standard 8 – Organisational Governance*
- ✓ Serious Incident Response System

National Disability Standards
- ✓ *Standard 4 – Feedback and Complaints*
- ✓ *Standard 6 – Service Management*

NDIS Act 2013

NDIS (Complaints Management and Resolution) Rules 2018

NDIS (Incident Management and Reportable Incidents) Rules 2018

NDIS Practice Standards
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*

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 client's needs.

Goals of effective complaint management
Resolution of customer dissatisfaction and improvement of processes, systems and skills related to service delivery.
Feedback and Complaints Management forms part of CCO's Serious Incident Response System.
Basis of effective complaint management –

- prompt, positive response to complaints;
- two-way communication between staff and clients – nothing about me without me;
- effective problem-solving skills;
- consistent, well known and well documented management procedures;
- clear recording formats and procedures;
- regular progress reporting to complainant;
- knowledge by clients of their right to complain about a service; and
- support to make a complaint.

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 negative 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 negative feedback.

Feedback and complaints are a valuable tool for CCO in understanding how we can improve the quality of our services. Encouraging feedback about our service is an important way to empower people to speak up. Paying attention to what our clients are saying, and how we have learnt from their feedback, without becoming upset or defensive that a complaint was received, sends a strong message that speaking up is worthwhile.

How we respond to the complaint is just as important as whether or not the complaint is resolved. Even if you cannot fully resolve the complaint, it is critical that

the person who made the complaint feels that they have been listened to; that their opinion was valued; and that you did everything you could to address their concerns. The process really is as important as the outcome, and is critical to building and strengthening relationships between clients and service providers, especially in a client choice market.

Stages in Complaint Management

Acknowledgement
The complaint/feedback will be defined by the complainant.
Staff are to record all client feedback/complaints on the CCO Feedback/Complaints Form. Attached to this policy.

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 Manager 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 negative 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 Feedback/Complaint form before sending to the Complaints Officer – CEO. Action taken in relation to negative feedback should also be case noted and advise provided to person making complaint as to actions taken.

Answers – investigating the Complaint
All complaints will be referred to the Complaints Officer (CEO). 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.

Actions
The Complaints Officer is to develop a complaint action plan for the perusal/approval of the CEO. CEO may delegate this to an appropriate Manager.

The plan should cover matters such as –

- summary of complainant's 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 or delegate.

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 Complaints Officer 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.

Apology
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 Directors. Complaints for review by CCO's Board of Directors, in relation to the CEO can be submitted via admin@cco.net.au

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 satisfactorily resolved by the organisation.

Client Expectations

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 Directors
- complaints reported in the Annual Report (not including names)
- complaints reported in accordance with any data collection required by Funding Bodies including the NDIS Quality and Safeguards Commission and the Aged Care Quality and Safety Commission.

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 Feedback/Complaint form 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 Coordinator, Service Coordinator or Care Manager providing feedback to the client as to the outcome of their feedback. The person actioning the feedback will record the actions and outcomes taken on the Feedback/ Complaint form and in client case notes.

Staff Training relating to Feedback/Complaints Management

Complaints and feedback may be raised at any level of the organisation and complaints should be dealt with directly and quickly at the point of service, unless the complaint requires further investigation or escalation. It is critical that all workers understand CCO's complaints processes, how to respectfully acknowledge the person's concerns and if necessary, refer the matter to an appropriate person to manage.

All staff receive training in Complaints Management at Induction as part of professional documentation. CCO has a commitment to a positive complaints culture, from the highest levels of management to frontline staff. This provides the foundation on which all other components of our complaints management system are built.

Effective complaints management is built on rights-based principles. CCO staff receive training in Human Rights.

Regular discussion with all staff and clients at events such as - Friends of CCO Meetings, All Staff Meetings and workgroup meetings where appropriate, of the importance of Feedback/Complaints to organisational performance.

CCO's Executive Team will review Complaints and Feedback information on weekly basis. Issues for consideration and reflection regarding the complaints process and outcomes include –

• What was the complaint about? What service, policy or procedure did it call into question?
• What was the experience for the person who made the complaint, or for any affected participant?
Were the issues resolved for them?
• What information did the complaint provide that will allow us to identify and improve those services,
policies and procedures and our organisation as a whole?
• How effectively did you communicate with the person who made the complaint, any affected
participants, affected staff and other stakeholders?
• Do people using our services, their families, carers and friends require more or improved information
about their rights and the complaints process? Does the person who made the complaint feel more comfortable about speaking up in the future?
• Does anything need to change in our complaints handling system or approach to dealing with complaints?
• Do staff require further training?
• Did the handling of the complaint reflect our stated values and expectations for complaint handling?
Or, was the complaint perceived as something negative that needed to be dealt with as quickly as possible?

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 aged care services.

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

Online – agedcarecomplaints.govspace.gov.au

Aged Care Quality and Safety Commission – 1800951822

Disability Services
In NSW, a complaint can be made to the NDIS Quality and Safeguarding Commission by –

- Phoning: 1800 035 544 (free call from landlines) or TTY 133 677. Interpreters can be arranged.
- National Relay Service and ask for 1800 035 544.
- Completing a complaint contact form. www.ndiscommission.gov.au

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

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				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
January 2009	**Adopted**	**D. Ryan**	**2012**	
November 2011	**Reviewed & Updated**	**D. Ryan**		
September 2014	**Reviewed & Updated**	**D. Ryan**	**2015**	
December 2016	**Updated**	**D. Ryan**	**2018**	
October 2018	**Reviewed/Updated**	**D. Shipman**	**2020**	
November 2020	**Reviewed & Updated**	**D Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

Office Use Only –

Date Received -

No.

FEEDBACK and/or COMPLAINT FORM

Complaints & feedback may be raised at any level of CCO & complaints should be dealt with directly & quickly at the point of service, unless the complaint requires further investigation or escalation.
It is critical that all workers understand CCO's complaints processes, how to respectfully acknowledge the person's concerns & if necessary, refer the matter to an appropriate person to manage – CCO's Complaints Officer – CEO.

Feedback & complaints are a valuable tool for CCO in understanding how we can improve the quality of our services. Encouraging feedback about our service is an important way to empower people to speak up. Paying attention to what our clients are saying, & how we have learnt from their feedback, without becoming upset or defensive that a complaint was received, sends a strong message that speaking up is worthwhile. **Refer to Staff Resource**

Please specify if you are providing -

Negative Feedback □ Formal Complaint □ Positive Feedback □

Date Received	
Person receiving Feedback or Complaint	
Position	

Feedback Received by -

☐ Telephone ☐ In Person ☐ Correspondence

Feedback or Complaint from -

Name	
Address	
Telephone	

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

Program

Aged Care
☐ CHSP
☐ CHSP Respite
☐
☐ Level 1 HCP
☐ Level 2 HCP
☐ Level 3 HCP
☐ Level 4 HCP

Disability
☐ Coordination of Support
☐ Plan Management
☐ Direct Service Only
☐ VIP
☐ TACS

Other
☐ Private
☐ OHC
☐ Other

Nature of Feedback or Complaint

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

Issue

Action Required – What outcome are you seeking?

Action Taken – by whom, when

Outcomes

☐ Resolved ☐ Further Action Required

Name	
Signature	
Date	

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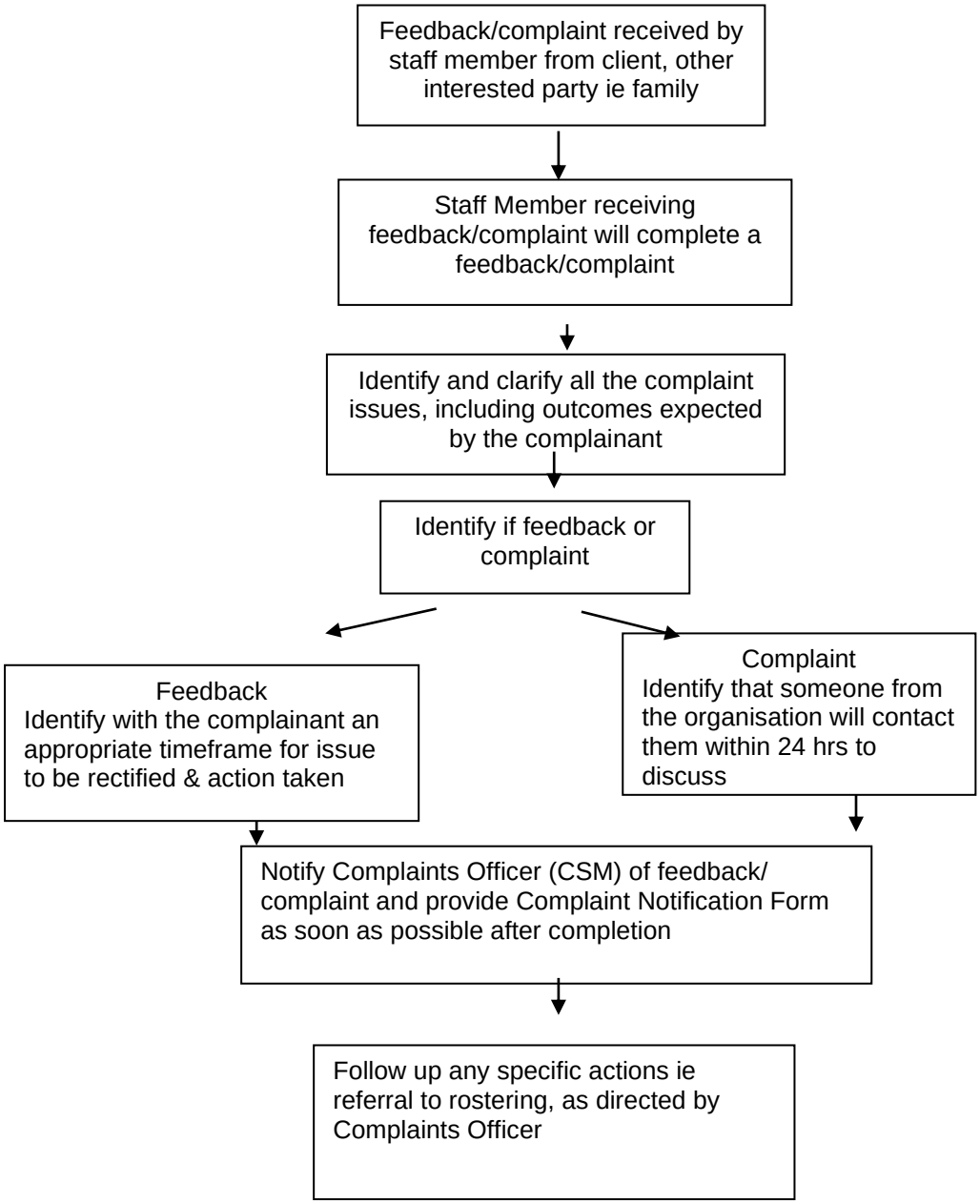
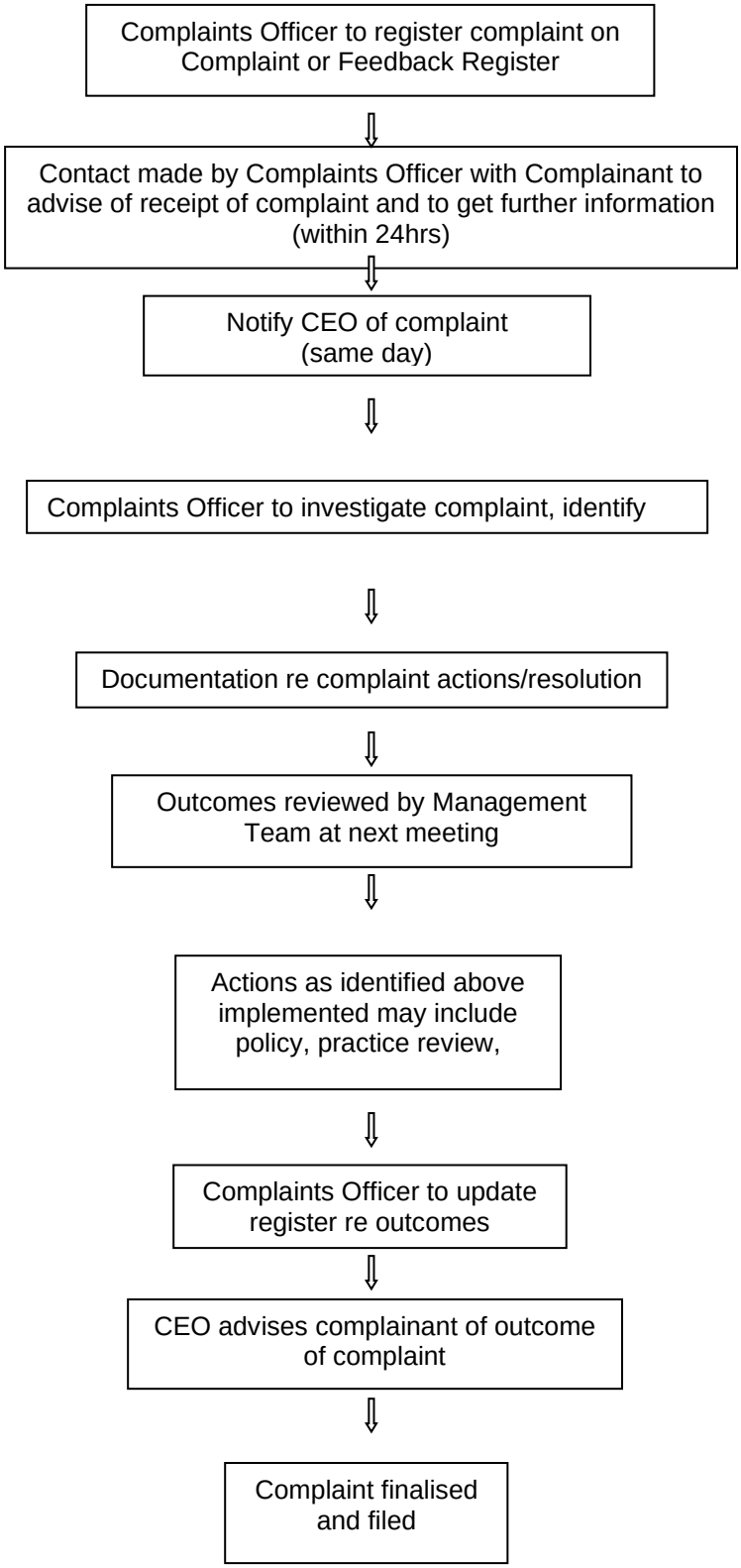
Action	**Yes/No**	**Date**
Recorded on Feedback/Complaint Register		
Reported to CEO – formal complaints		
Feedback/Complaint to CEO		
Action - Resolved		
Feedback/Complaint Reviewed by Management Team		
Recommendations for review of policy, procedure or practice		
Training Need Identified		
Breach of Policy & Procedure Identified		
Performance Management Identified		
Addition to service improvement plan		
Complaint Finalised		

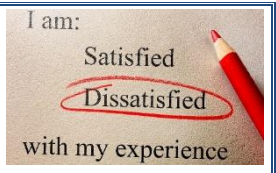
COMPLAINTS REPORTING PROCESS



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 may 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





Staff Resource - **How to respond to a complaint**

Complaints & feedback may be raised at any level of CCO & complaints should be dealt with directly & quickly at the point of service, unless the complaint requires further investigation or escalation.

It is critical that all workers understand CCO's complaints processes, how to respectfully acknowledge the person's concerns & if necessary, refer the matter to an appropriate person to manage – CCO's Complaints Officer.

Feedback & complaints are a valuable tool for CCO in understanding how we can improve the quality of our services. Encouraging feedback about our service is an important way to empower people to speak up. Paying attention to what our clients are saying, & how we have learnt from their feedback, without becoming upset or defensive that a complaint was received, sends a strong message that speaking up is worthwhile.

How we respond to the complaint is just as important as whether or not the complaint is resolved.
Even if you cannot fully resolve the complaint, it is critical that you - the CCO employee, make the complainant feel that they have been listened to; that their opinion was valued; & that you did everything you could to address their concerns.

The process really is as important as the outcome, & is critical to building & strengthening relationships between clients & service providers, especially in a client choice market.

Most people are seeking one or more of the following outcomes from a Complaint or Feedback.

Acknowledgement
This is the most important step as it sets the tone for the rest of the process. Making a complaint can be difficult for people. It is important that people feel that their concerns have been understood & that the impact on them is recognised.

Acknowledgment can include -
- genuinely listening to the person without interrupting
- empathising
- making sure the person feels comfortable talking to you, & being aware of whether you are feeling defensive & how this may be perceived
- acknowledging how the situation has affected the person
- rectifying by asking the person what a good outcome would look like for them, &
- notifying the person what steps you will take to report their complaint, ensuring commitments aren't made that can't be fulfilled.

Answers
People want to know why something has or has not happened, or why a decision was made. People need to understand what has happened in order to better understand how they can move on to resolving their concern. Answers should include a clear explanation that is relevant to the concern raised but ONLY if you know the facts.

Actions

People want you to fix or take steps to address their concerns. This may be in relation to their specific complaint, or more broadly around systems to ensure that similar issues won't occur for other people.

Apology

An apology may be part of, or the sole outcome a person is seeking. It is important to consider who should provide the apology & the form of the apology.

Actions

Sometimes you won't be able to fix the issue raised, but you can initiate actions to prevent it from happening again. Taking action to prevent recurrence may validate the concern for the person making the complaint. A good way to approach actions is to use an action plan, which includes –

- what will be done - fill in Feedback/Complaint form
- who will do it - staff member for or with client as required
- when it will be done by - let's do it now
- how the progress of the complaint & outcomes will be communicated to the person making the Complaint – Complaints Officer, &
- how the progress of the complaint actions & implementation will be oversighted – Complaints Officer.

Apology

Genuine apology can be a meaningful step, however a poorly provided apology can make the situation worse. An apology should often come from the person complained about, as well as a more senior member of the organisation, in order for the person complaining to be satisfied that their concerns were taken seriously.

When providing an apology, it is helpful to consider –

- timeliness
- sincerity
- being specific & to the point
- accepting responsibility for what occurred & the impacts caused
- explaining the circumstances & causes (without making excuses), &
- summarising key actions agreed to as a result of the complaint.

A genuine & timely apology is a powerful healing force & a way to separate the past from the future, to put things to rest & get on with any agreed new arrangements.

All CCO staff members, without exception will record Feedback/Complaints received by clients & other interested parties, even if they have been resolved, so that these can be recorded on CCO's Feedback/Complaints Registers, & so that important service delivery issues are addressed & resolved in an effective, consistent and planned way.

3.13 Critical Support Service

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 Coordinators 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.

Aged Care Standards
- ✓ *Standard 3 – Personal care and Clinical Care*
- ✓ *Standard 4 – Services and Supports for Daily Living*
- ✓ *Standard 8 – Organisational Governance*

National Disability Standards
- ✓ *Standard 1 – Rights*
- ✓ *Standard 3 – Individual Outcomes*
- ✓ *Standard 6 – Service Management*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

Providing access to CCO emergency assistance through 'critical support' arrangements.

CCO's Critical Support Service provides assistance to clients and staff:

- Monday – Friday 5pm – 9pm
- Weekends and Public Holidays from 6am – 10am and 5pm – 9pm
- Staff on call will receive an "on call" allowance for this service.

Critical Support arrangements are a contractual obligation for Home Care Packages. Level 3 & 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 the client's package for the duration of all Level 3 & 4 client's stay on the program.

For operational, human resource management, quality assurance and safety reasons, CCO extends Critical Support access to all staff of the organisation and client's identified as high risk.

Operational Procedures
The purpose of Critical Support is to deal with urgent matters relating to client service delivery which must be addressed before 6am of the next working day. Critical Support 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.

Critical Support 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 from Critical Support will be politely re-directed for follow up within usual office working hours.

Critical Support Responsibilities
The Critical Support 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 Critical Support staff member has delegation to approve necessary expenditure up to $500. When resolving emergency situations however, the Critical Support 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 Carer Gateway. Carers NSW is able to approve, provide and pay for emergency respite for eligible carers. The Critical Support person needs to

gain approval from the Carer Gateway after hours staff prior to arranging the respite. Carer's NSW 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 Critical Support 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 6am of the next working day. If a Support Worker advises they are unable to work, the Critical Support 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 Critical Support 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 Critical Support 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 Critical Support mobile phone must be adequately charged, switched on, and with the Critical Support staff member at all times during Critical Support periods. In cases where there is no signal, the Critical Call mobile phone must be redirected to a suitable landline. Critical Support messages must be checked and responded to at least ½ hourly.

Being available for **Call outs** if necessary**.** The Critical Support person must be available to respond to emergencies, including if necessary, travel to clients, when providing Critical Support.

A Support Coordinator would only attend, in person, to a Critical Support 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 Critical Support person consider a call out to be necessary, they should phone the CEO for approval. If the CEO is unavailable, the Critical Support staff member should contact same on return to work to advise of and justify the call out.
Informing relevant people of Critical Support matters and completing required

follow up actions in a timely manner –

- by contacting relevant people whilst providing Critical Support 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 Coordinator 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 Critical Support staff member is also responsible for ensuring that rostering staff –

- are informed of staff/roster changes that were made during Critical Support
- 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 Critical Support incident and actions taken in the client's case notes where applicable and also recording the call on the Critical Support Register.

Ensuring they are resourced with tools and information required to perform the responsibilities of Critical Support including identifying and seeking additional training and guidance if required.

The Critical Support staff member has responsibility for collecting the Critical Support **bag** on the day they commence Critical Support. The Critical Support staff member should ensure that the following equipment is present and in working order in the Critical Support bag –

- Lap top, charger and mouse
- Mobile phone, charger and instructions
- paper copies of - the Critical Support 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 Critical Support **lap top** contains electronic versions of –

- the Critical Support 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 Critical Support **mobile phone** contains -

- all staff contact numbers

- other service contact numbers

CCO will delegate a staff member (currently the Support & Development Offcier) to be responsible for ensuring that the Critical Support **lap top** and **mobile** phone are maintained and updated regularly so that Critical Support staff are resourced adequately with up to date information and tools.

Critical Support staff

All Support Coordinators and Service Coordinators will participate on the Crittical Support roster as per their employment condition. If a staff member is unable to perform all, or part of, their Critical Support turn, the rostered staff member must negotiate a suitable replacement staff member and inform the Client Services Manager of the change.

Schedule for Revision of Policy: ON CALL POLICY				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
October 2006	**New policy**	**R Thompson**	**2007**	
August 2009	**Reviewed**	**D. Ryan**		
April & November 2011	**Amended**	**D. Ryan**		
September 2014	**Updated**	**D. Ryan**	**2015**	
December 2016	**Updated**	**D. Ryan**	**2018**	
December 2018	**Reviewed**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	**Changes to process**

Critical Supp

Changes to the manner in which Oncall is remunerated under the SCHADS Awards has meant we've needed to radically change the manner in which we offer support to staff outside of business hours.

Commencing 4th July 2022, the Oncall service will cease and a new service will introduced – the Critical Support Service. The new service will have some key changes as follows:

- A new number which will be issued to CCO staff end eligible clients only (those assessed as genuinely vulnerable and deemed eligible by Management)
- New hours Monday – Friday 5.00 – 9pm and Saturday and Sunday 6am – 10am & 5pm – 9pm
- A standardised response to all communication received
- Strict rules round what is and isn't appropriate to raise with the Critical Support Service
- Clear guidelines to enable the Critical Support Officer to identify when escalation of an issue is required.
- New reporting/timekeeping requirements for the relevant Critical Support Officer
- The introduction of penalties for any users found to be using the service or sharing the number inappropriately

From 4th July 2022, **Support Workers will be able to contact the office from 6am**. The office will not physically open until 8am but will be **available for issues relating to Critical Support**. This enables us to reduce the impact of being 'oncall' to office based staff and gives Support Workers and clients a dedicated and skilled line of communication for early morning support.

Issues appropriate to raise	**Issues not appropriate to raise**
Client not responding/home for scheduled service Critical Support Service to work with Support Worker to enact the client's Emergency Response Plan and establish client' whereabouts	**Support Worker requiring a roster** First affected service only to be given
Client hospital admission If services are scheduled to continue prior to the next business day and client will not be home. Otherwise, Support Worker to report admission during business hours via phone or email.	**Medication Issues** Critical Support Officer cannot offer medical advice. The Support Worker should note the issue in the Communication Book and phone/email during business hours to report. If concerned about risk to client, Support Worker to contact client's pharmacy.
Staff member unwell or unavailable for	**Unsure if medical attention is**

work Contact between the hours of 5:00 - 9pm Monday –Friday and 6am – 10am & 5pm – 9pm Saturday and Sunday only.	**required** If in doubt, call an ambulance.
Staff member injured or involved in an accident at work Contact between the hours of 5.00 - 9pm Monday –Friday and 6am- 10am & 5pm – 9pm Saturday and Sunday only.	**Concern re. wound** If genuinely concerned about wound progression or client showing other signs of being unwell, call an ambulance. Otherwise, phone/email during business hours to report.
Lifter/Equipment broken down Contact between the hours of 5.00 - 9pm Monday –Friday and 6am – 10am & 5pm – 9pm Saturday and Sunday only.	**Client Complaints** Should be referred to office during business hours
Running late for clients Support Worker to contact if running more than 15mins late or if a second Support Worker may be waiting for them at a service	
Second Support Worker hasn't arrived for service	
Requiring Lock Bock code Contact between the hours of 5.00 - 9pm Monday –Friday and 6am – 10am & 5pm – 9pm Saturday and Sunday only. Critical Support Officer to note impacted client so investigations can be completed on why required code was not issued – except in an Emergency Response scenario.	

In an effort to streamline issues managed by the Critical Support Service (formerly Oncall) the following has been developed:

Responding to Calls
All calls are to remain unanswered. Callers will be met with a voicemail that encourages them to leave a message in order for their issue to be triaged. Callers will be advised that if the message does not meet the terms required for Critical Support, no return call will be made. Where the Critical Support Officer deems a response is required, they will act accordingly. Where the issue is triaged and a response is deemed unnecessary, the information will be logged for dissemination to relevant parties during business hours and no response will be given to the caller.

Support Worker requesting a roster
It is a Support Worker's responsibility to pick up their roster or ensure it has been received by email (if that's their preferred delivery method) by close of business each

Friday. If a Support Worker advises over the weekend that they have not received their roster, the Critical Support Officer is to give them the details of their first service only and advise they must contact the office during business hours on Monday to arrange a roster. Not having a roster is not an emergency for the Critical Support Service to manage. If the Support Worker is required to work over the weekend and does not have their roster, the Critical Support Officer is to give them client details verbally and remind them of their responsibility to collect their roster each Friday.

Support Planner/Coordinator input required
No other staff are to be contacted by the Critical Support Officer or have their number given out to a vested stakeholder. If input is required or a decision is needed, please contact Deb Ryan in the first instance. If Deb does not return your call within 30 minutes or the issue requires immediate support, then contact Liz Anscombe.

Support Worker unavailable for work
It is the Critical Support Officer's responsibility to re-allocate all services over the course of a weekend. The Critical Support Officer is not expected to factor in overtime, days worked etc but simply meet the client need. All NDIS clients require a familiar and appropriately trained Support Worker. These teams are limited and generally accommodating so when sourcing a staff member, start with those already providing same on a regular basis. If you are unable to reallocate services easily or have spent more than 15mins working on an issue, the issue is to be escalated to Deb Ryan for support and or approval.

Client unhappy with Support Worker
All complaints need to be managed by the responsible Support Planner during business hours. Please do not offer to re-roster services over the weekend or after business hours due to an alleged complaint. We provide essential services only so if the client is unhappy with the rostered Support Worker and refuses their services, they can choose to cancel.

Remote Access/Server down
Phone 1300 GET TCA (1300 438 822). This will go straight to a voice message where you can select the afterhours number or leave a message. TCA's office number (6650 5500) also works but can take up to 70 seconds to transfer to a mobile. If TCA do not respond, contact Deb Ryan or Liz Anscombe whom can contact the owner directly.

Support Worker accident/injury
Please report all accidents/injuries to Deb Ryan or Liz Anscombe when they occur.

3.14 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.

CCO also recognises that the unexpected death of a client can have a profound impact on others eg staff and carers.

Depending upon the circumstances, a client death, may also be a Reportable or Serious Incident as defined by the NDIS or the Aged Care Act. The CEO will review the circumstances of a client death to identify if it requires reporting the appropriate authorities.

Aged Care Quality Standards
- ✓ *Standard 3 – Personal Care and Clinical care*
- ✓ *Standard 4 – Services and Supports for Daily Living*
- ✓ *Serious Incident Response System*

National Disability Standards
- ✓ *Standard 3 – Individual Outcomes*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS (Incident Management and Reportable Incident Rules) 2018*

Operational Procedures
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.

CCO Care Managers and Support Coordinators 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 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 Care Manager or Support Coordinator 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 Care Manager or Support Coordinator 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 Care Manager or Support Coordinator 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 Care Manager or Support Coordinator works with the family/carer to return any property belonging to CCO and to pay any monies which are owing.
- CCO's CEO will determine if the death requires reporting to the NDIS Quality and Safety Commission or the Aged Care Quality and Safeguarding Commission.

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 and CEO;
- 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.

Unexpected Death of a Client
Community Care Options staff may be the ones who discover that a client has passed away or be involved in an incident which results in a client death.

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 are to advise the Care Manager, Support Coordinator, or delegated substitute (On Call if out of hours);
- the Care Manager or Support Coordinator will follow the procedure agreed to by the client in relation to emergency response;
- the Care Manager or Support Coordinator advises the client's family/carer or client's substitute decision maker and requests them to attend and investigate. The Care Manager or Support Coordinator 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 Care Manager or Support Coordinator and another suitable staff member will 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 GP is called;
- the ambulance service or Doctor will determine whether the client has died and will take responsibility for the person's body;
- the GP or ambulance service may be the ones who advise the next of kin of the death of the client. In rare circumstances this may be required of CCO staff, and should be referred to the Client Services Manager or CEO;
- **if the death is of a person with a disability then this becomes a reportable incident and the CEO is to be advised immediately, following the steps above. Refer to Reportable Incident Policy. In some circumstances this may also require reporting to the Aged Care Quality and Safeguarding Commission as a Serious Incident, f an aged care client.**
- 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/Manager People and Culture to ensure that staff

are able to continue working and what other support is required eg debriefing, counselling.
- the death will be reported by the CEO to the appropriate authority if necessary ie: NDIS Quality and Safety Commission or the Aged Care Quality and Safeguarding Commission.

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 – this is to be done as soon as possible following the death, via a personal phone call from the Care Manager or Support Coordinator or in their absence the Client Services Manager.
- 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.

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**
May 2007	**Approved**	**R. Thompson**	**2009**	**New Policy**
August 2009	**Reviewed**	**D. Ryan**	**2012**	
November 2011	**Reviewed & Updated**	**D. Ryan**		
September 2014	**Reviewed & updated**	**D. Ryan**	**2016**	
December 2016	**Updated**	**D. Ryan**	**2018**	
October 2018	**Reviewed/Updated**	**D. Ryan**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

3.15 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.

Aged Care Quality Standards
- ✓ *Standard 1 – Consumer Dignity and Choice*
- ✓ *Standard 2 – Ongoing Assessment and Planning with Consumers*
- ✓ *Standard 3 – Personal Care and Clinical care*

National Disability Standards
- ✓ *Standard 1 – Rights*
- ✓ *Standard 3 – Individual Outcomes*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

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 Coordinators 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/CEO.

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 Coordinator 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 Coordinator may do this in consultation with the Client Service Manager.

CCO Support Coordinators –

- 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 Coordinator 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/CEO.

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 Coordinator 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, CHOICE AND CONSENT				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
July 2007	**Approved**	**R. Thompson**	**2010**	**New Policy**
November 2011	**Reviewed & Updated**	**D. Ryan**		
September 2014	**Reviewed & Updated**	**D. Ryan**	**2016**	
December 2016	**Updated**	**D. Ryan**	**2018**	
October 2018	**Reviewed**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

3.16 Delegation of Clinical Care

Position Statement
CCO is committed to ensuring each consumer receives safe and effective personal care, clinical care, or both personal and clinical care, that is best practice; that is tailored to the their needs, goals and preferences; and which optimises their health and well-being.

Legislation and Standards
DVA Nursing Guidelines
Nursing Standards
Aged Care Standard 3 – Personal Care and Clinical Care
NDIS Standards – Nursing Care

Operational Procedures
Guide for nursing practice decisions
Decision-making within a sound risk management, professional, regulatory and legislative framework is a considered, rational process that enables nurses to work to their full and potential scope of practice.

The Statements of principle set out below provide guidance to CCO's nurses and others about processes that will help to ensure, that safety is not compromised, when making decisions about nursing practice and about whether to delegate activities to others.

Statements of Principles
1. The primary motivation for any decision about a care activity is to meet clients' health needs or to enhance health outcomes.

Explanatory Statements
Decisions about activities are made in a planned & careful fashion & –

- whenever possible, in partnership with the client, their families & support network & in collaboration with other members of the multidisciplinary health care team
- based on a comprehensive assessment of the client & the client's needs
- only where there is a justifiable, evidence-based reason to perform the activity
- after identifying the potential risks/hazards associated with the care activity, & strategies to avoid them.

2. Nurses are accountable for making professional judgements about when an activity is beyond their own capacity or scope of practice & for initiating consultation with, or referral to, other members of the health care team.

Explanatory Statements
Judgements are made in a collaborative way, through consultation & negotiation with other members of the health care team, & are based on considerations of –

- lawfulness (legislation & common law)

• compliance with evidence, professional standards, & regulatory standards, policies & guidelines
• which is the most appropriate discipline to provide the education & competence assessment for the activity
• context of practice & the service provider/employer's policies & protocols
• whether there is organisational support, including sufficient staffing levels & appropriate skill mix, for the practice.

Nurses wishing to integrate into their own practice activities not currently part of the accepted, contemporary scope of nursing practice must ensure that –

• they have the necessary educational preparation & experience to do so safely
• their competence has been assessed by a qualified, competent health professional or provider (who may be a more experienced/qualified registered nurse)
• they are confident of their ability to perform the activity safely
• they have any necessary authorisations or certifications & organisational support.

3. Registered nurses are accountable for making decisions about who is the most appropriate person to perform an activity that is in the nursing plan of care.

Explanatory Statements
• the registered nurse has completed a comprehensive health assessment of the client's needs.
• there is an organisational requirement for an authority/ certification/credential to perform the activity.
• the level of education, knowledge, experience, skill & assessed competence of the person who will perform an activity that has been delegated to them by a registered nurse from a nursing plan of care has been ascertained by a registered nurse.
• the person is competent, confident of their ability to perform the activity safely, or is ready to accept the delegation, & understands their level of accountability for performing the activity.
• the appropriate level of clinically-focussed supervision can be provided by a registered nurse for a person performing an activity delegated to them by a registered nurse.
• the organisation in which the nurse works has an appropriate policy, quality & risk management framework, sufficient staffing levels, appropriate skill mix & adequate access to other health professionals to support the person performing the activity, & to support the decision-maker in providing support & clinically-focussed supervision.

4. Nursing practice decisions are best made in a collaborative context of planning, risk management, & evaluation.

Organisational employers/managers, other health workers & nurses share a joint responsibility to create & maintain –

• environments (including resources, education, policy, evaluation & competence assessment) that support safe decisions & competent, evidence-based practice to

the full extent of the scope of nursing practice.
- processes for providing continuing education, skill development & appropriate clinically focused supervision.
- infrastructure that supports & promotes autonomous & interdependent practice, transparent accountability, & ongoing evaluation of the outcomes of care & nursing practice decisions.

The nursing practice decision flowchart illustrates the processes that a registered nurse would follow in making decisions about nursing practice, taking account of the guiding principles set out above.

Nursing practice decision flowchart narrative

Any activity intended to achieve desired/beneficial client outcomes is based on a comprehensive assessment of the client by a registered nurse and is determined, whenever possible, in partnership with the client. Practice changes may also arise from evaluations of services and a desire to improve access to or efficiency of services to groups of clients. The first decision that will need to be made is whether the activity is within the current contemporary scope of nursing practice as envisaged in professional practice standards and legislation.

If the **activity IS within the current contemporary scope of nursing practice**, the registered nurse would need to consider the organisation's quality and risk management framework as well as its capacity in terms of staffing, resources and access to other health professionals. If the organisational capacity is not sufficient to support the activity, further planning and consultation should be undertaken before proceeding and referral may be necessary in the meantime.	If the activity **is NOT within the current contemporary scope of nursing practice**, the registered nurse (1) will need to consider whether she/he (or another nurse) wishes to integrate the activity into their own nursing practice and/or whether the employer wishes to initiate a change within the organisation. If not, then the client will need to be referred to an appropriate health professional or health service provider, and the registered nurse will need to establish a collaborative relationship with that person/service to ensure the provision of ongoing nursing care for the client. (1) Current professional standards, such as the competency standards for the RN and EN, clearly give certain responsibilities exclusively to registered nurses, including making professional judgements about the scope of nursing practice and delegation of activities in a nursing plan to others.
The registered nurse will need to conduct a risk assessment to determine the appropriate person to perform the activity. Factors to be considered by the registered nurse in making this decision include whether a nurse should perform the activity because – • the client's health status is such that the activity should be performed by a nurse	If a nurse wishes to integrate the activity into their nursing practice, or an organisation wishes to initiate practice change, they will need to consider a number of factors, such as lawful authority, professional consensus, risk management, organisational support and the preparation and experience of the registered nurse, before proceeding. These factors include whether –

• the complexity of care required by the client indicates that a nurse should perform the activity, because specific knowledge or skill is needed • professional standards for nurses indicate that the activity should be performed by either a registered or enrolled nurse • any state/territory or Commonwealth legislation specifies that a nurse should perform the activity • any local or organisational policy, guideline or protocol requires a registered or enrolled nurse to perform the activity • the model of care mandates that the activity should be performed by a nurse • there is evidence that the activity is best performed by a nurse	• the activity can legally be performed by a nurse, with due consideration given to the need for the client to consent to the activity being performed by a nurse if at all possible • professional standards would support a nurse performing the activity • a risk assessment has found no risks indicating that the activity should be performed by another qualified person/service • consultation and planning with all relevant stakeholders has occurred • the organisation in which the activity is to be performed is prepared to support the nurse in performing the activity • the nurse has the education, authorisation, experience, capacity, competence and confidence to safely perform the activity.
If the registered nurse decides, on the basis of **any one** of the above factors, that the activity needs to be performed by a nurse, the competence and confidence of that registered or enrolled nurse will need to be determined, as will their understanding of their level of accountability in performing the activity. Whether further education, clinically-focussed supervision and support from a registered nurse is required will also need to be established, based on consideration of the support, education and competence assessment that may be needed and is available	Before new activities can be integrated into a nurse's practice, changes to legislation, community opinion, professional standards, public health policy, local/ organisational policies, educational opportunities, resource provision, levels of supervision, roles and responsibilities, and/or the individual's educational preparation and competence may be required. Nurses may need to identify whether there are any professional or industry standards or expectations for education and training to prepare for the new role, including accredited education programs leading to formal qualifications, and if not, may need to collaborate in the development of appropriate education and assessment pathways.
If **all** of these factors are positive, the activity may be performed by a nurse and the outcomes evaluated. If no competent nurse is available, or the desired education, level of supervision or support cannot be provided, the decision maker will need to refer the activity to a more experienced nurse to perform.	If **all** of these factors are found to be positive, then a nurse can perform the activity. However, if at any of the decision points a negative response occurs, the nurse would need to undertake further education, consultation or planning before proceeding, and/or refer the client to another health professional or service provider. In the latter case, the nurse would continue to collaborate to ensure provision of any ongoing nursing care.

If **the registered nurse decides that the activity can be performed by a non-nurse**, the registered nurse will need to consider, within a risk management framework, who the most appropriate person (eg nursing student, Aboriginal or Torres Strait Islander Health Worker, support worker, volunteer, family member, carer, other) is to perform the activity. In making this decision, the registered nurse will need to decide whether –

- performance of the activity by a non-nurse will achieve the desired client outcomes, and the client consents, if at all possible, to the activity being performed by a non-nurse
- there is organisational support in the form of local policies/guidelines/protocols for the performance of this activity by a non-nurse (for students, support from the educational institution for this activity to be delegated to students should also be established)
- there is professional consensus (ie support from the nursing profession or other experienced nurses) and evidence for the performance of this activity by a non-nurse
- the non-nurse is competent (ie, has the necessary education, experience and skill) to perform the activity safely
- the non-nurse's competence has been assessed by a registered nurse
- the non-nurse is ready (confident) to perform the activity and understands their level of accountability for the activity
- there is a registered nurse available to provide the required level of supervision and support, Including education.

If all of these factors are positive, then the registered nurse can delegate the activity and ensure that the appropriate level of supervision is provided.

If any of these factors is negative, the activity **should not be delegated**. In the absence of another competent non-nurse, or if necessary additional support (education, competence assessment, supervision etc) cannot be provided, the activity should either be performed by a nurse or referred to another service provider.

In the latter case, the registered nurse would continue to collaborate to ensure the provision of any ongoing nursing care required by the client.

Further consultation and planning may be necessary to achieve changes at the organisational or professional level to permit delegation in future, if this is considered appropriate.

Whatever the decision, documentation and evaluation of the outcomes of the decision must be completed.

All parties to the decision, including the client, the registered nurse, the person performing the activity, and other health care team members, should participate in the evaluation, if at all possible. The employer may also be involved in evaluation of an organizational change. The evaluation should consider outcomes for the client, for the person performing the activity, for the person delegating the activity and for any others affected by the decision.

Client's referred for Nursing Support – including those through DVA Nursing, Home Care Packages 3 and 4, NDIS will be assessed by a Registered Nurse.

A comprehensive assessment will be undertaken that includes nursing care requirements.

Many non complex tasks such as enema's, catheter bag care can be undertaken as part of personal care activities, and are often best placed to be provided with personal care activities.

The RN will assess the requirements of the client for specific nursing care and tasks, as well as personal care support needs within the client's lifestyle context and identify which aspects of care can be delegated to those staff that have the appropriate training, skills, competency and confidence to deliver them.

Using the principles, protocols and decision making points above the RN will determine if an aspect that would normally fall within the legal requirements to be provided by a RN can be delegated to a non nursing person.

The RN will ensure all plans are clear to staff, that staff have been assessed as competent in undertaking the task. Client has been included in decision making about delegation of tasks, and aspects of care.

The RN will undertake regular reviews (six monthly) or more frequently if there are any reports regarding change of client's health condition. A Client Focus Meeting will be held to discuss any changes with staff, develop strategies, retraining, and further assessment of skills.

All of CCO's support staff are provided with the following training by a Registered Nurse at Induction – Bowel Care, Enema's, Medication Management, Infection Control.

Additional 1:1 training is provided to staff working with high needs client's including manual handling, Autonomic Dysreflexia.

Schedule for Revision of Policy: Delegation of Clinical Care				
Policy Adopted	**Date**	**December 2020**		
Review	**1.12.21**		**Review/Evaluate**	
	January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**

3.17 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.

Aged Care Quality Standards
- ✓ *Standard 1 – Consumer Dignity and Choice*

National Disability Standards
- ✓ *Standard 1 – Rights*

NDIS Practice Standards
- ✓ *Core Module 1-4*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*

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**	**Comments**
July 2006	**New policy**	**R. Thompson**	**2008**	
August 2008	**Reviewed**	**R. Thompson**	**2011**	
November 2011	**Reviewed**	**D. Ryan**		
September 2014	**Reviewed**	**D. Ryan**	**2016**	
December 2016	**Updated**	**D. Ryan**	**2018**	
November 2018	**Reviewed**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

3.18 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.

Aged Care Quality Standards
- ✓ *Standard 1 – Consumer Dignity and Choice*
- ✓ *Standard 3 – Personal Care and Clinical Care*
- ✓ *Standard 8 – Organisational Governance*

National Disability Standards
- ✓ *Standard 1 – Rights*
- ✓ *Standard 3 – Individual Outcomes*
- ✓ *Standard 6 – Service Management*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

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**	**Comments**
July 2006	**New policy**	**R. Thompson**	**2008**	
August 2008	**Reviewed**	**R. Thompson**	**2011**	
November 2011	**Reviewed & Updated**	**D. Ryan**		
September 2014	**Reviewed & Updated**	**D. Ryan**	**2016**	
December 2016	**Updated**	**D. Ryan**	**2018**	
November 2018	**Reviewed**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Update**	**D. Ryan**	**2025**	

3.19 Dysphagia, Safe Swallowing and Mealtime Management

What is dysphagia?
Dysphagia is a medical term for any difficulty with swallowing. A person may have dysphagia if they show signs and symptoms such as –

- difficult, painful chewing or swallowing
- a feeling that food or drink gets stuck in their throat or goes down the wrong way
- coughing, choking, or frequent throat clearing during or after swallowing
- having long mealtimes e.g. finishing a meal takes more than 30 minutes
- becoming short of breath when eating and drinking
- avoiding some foods because they are hard to swallow
- regurgitation of undigested food
- difficulty controlling food or liquid in their mouth
- drooling
- having a hoarse or gurgly voice
- having a dry mouth
- poor oral hygiene
- frequent heartburn
- unexpected weight loss
- frequent respiratory infections.

A range of disabilities and medical conditions are associated with dysphagia, such as congenital syndromes, neuromuscular dysfunctions such as cerebral palsy, neurological disorders such as stroke, cancer, and chronic lung disease. Many people with disability are also prescribed medications on a long-term basis, which can increase risk of swallowing problems.

Risks associated with dysphagia
Because of the high rates of dysphagia in people with disability, they have an increased risk of respiratory problems or choking as well as poor nutrition. Swallowing problems can allow food, drinks or saliva to get into lungs rather than the stomach, which can cause aspiration pneumonia. Studies have found that aspiration pneumonia and choking were among the most common respiratory causes of death for people with disability in NSW, QLD and VIC. The risk of accidental choking can be reduced by following expert advice from speech pathologists and other specialists. Early identification and management of swallowing problems can minimise risks of health complications.

Provider obligations related to dysphagia
Staff must comply with the NDIS Code of Conduct when providing supports or services to NDIS participants with dysphagia or swallowing difficulties. The NDIS Code of Conduct requires all NDIS providers and workers who deliver NDIS supports to NDIS participants to, among other things –

- provide supports and services in a safe and competent manner with care and skill
- promptly take steps to raise and act on concerns about matters that might have an impact on the quality and safety of supports provided to people with disability.

Dysphagia Support

Context

A support plan for severe dysphagia management has been developed and is overseen by a relevant health practitioner, and each participant is involved in the assessment and development of their support plan. The support plan is up-to-date, readily available, clear and concise and clearly identifies and describes the support needs and preferences of the participant (such as for food, fluids, preparation techniques and feeding equipment).

Participants are supported to seek regular and timely reviews of their health status by an appropriately qualified health practitioner. Each participant's support plan is communicated, where appropriate and with their consent, to their support network, other providers and relevant government agencies.

NDIS providers should ensure that workers understand the support needs outlined in the support plan such as - required characteristics of textured food and drink; specific mealtime assistance techniques; what risks to look for and action required to respond to risks, incidents, and emergencies. Workers also need access to appropriate policies and procedures, timely supervision, support, equipment, and consumables required to provide severe dysphagia management supports.

Scope: This applies when supporting a participant assessed as having swallowing, biting or chewing difficulties that can present a risk for health outcomes including choking, aspiration, malnutrition and/or dehydration.

Training - In addition to general training in a range of different types of dysphagia and related support requirements, workers will be trained in the specific needs of each participant they support including the appropriate use of equipment. Training should be delivered by an appropriately qualified health practitioner with expertise in severe dysphagia management.

NDIS providers are responsible for ensuring workers have current skills and knowledge, and that the training of workers is documented and regularly audited. It is recommended that a worker's competency to provide dysphagia supports are reviewed annually to confirm the worker has current skills and knowledge required. Where a worker has not delivered this support for a period of more than three months, or if a participant's support needs have changed and/or they have an updated support plan in place, it is recommended the worker be reassessed before supporting the participant and undertake refresher training if required; this timeframe may vary depending on the nature of supports required and worker experience.

Recommended ways to support NDIS participants with dysphagia

There are a number of steps that can be taken to provide safe and competent supports to participants with dysphagia to try to avoid the risks of choking or aspiration pneumonia, which could lead to the participant's death or serious health complications. While every participant will have different support needs for their dysphagia, there are some recommended steps.

Ensure staff know dysphagia symptoms and risks
CCO staff have training to improve their knowledge and develop skills so they can support participants who may have dysphagia. Staff should understand how to identify and respond to early signs and symptoms of dysphagia and how to support the person to have safe and enjoyable meals.

Support participants with possible swallowing difficulties to be assessed for dysphagia
If a participant shows any sign or symptom of swallowing difficulty, this should be reported to the organisation. CCO will support the client to consult a GP and a speech pathologist promptly, so they can assess their swallowing and mealtime assistance needs as well as review their general health.

Support participants with dysphagia to have a mealtime management plan
Participant's with dysphagia should be supported to have a mealtime management plan written by a health professional. A speech pathologist can prescribe and recommend specific actions for a person to eat and drink safely and develop a mealtime management plan for their needs. They will also specify when plans need to be reviewed. A dietitian may contribute to the mealtime management plan by ensuring there is enough nutrition and hydration in the recommended modified meals.

Mealtime management plans may include recommendations to –

- improve the seating and positioning supports for a person's safe positioning during meals
- modify food textures to make the food easier to chew and swallow
- provide specific mealtime assistance techniques, including any reminders about a safe rate of eating, or a safe amount of food in each mouthful
- respond to coughing or choking and make sure risks are monitored while a person is eating or drinking
- use feeding equipment for people who have severe dysphagia, including assistive technology such as spoons, plates, cups and straws; and tube feeding equipment for those with severe or profound difficulty swallowing who require tube feeding.

Support people with dysphagia to eat and drink safely during mealtimes
CCO will ensure that –

- staff receive the necessary training and support to implement a mealtime management plan or other mealtime recommendations for swallowing safely and mealtime management
- meals for participants with dysphagia, and medication taken orally, are prepared as directed and mealtime supports and assistance are provided as recommended by health professionals.
- trained staff are available to monitor people with dysphagia during mealtimes
- staff know how to respond if a participant starts to choke during mealtimes, Including when they should call an ambulance
- mealtime safety issues for people with dysphagia are regularly considered in staff

meetings and addressed in day-to-day procedures, participants' documentation, and plans for transition to hospital.

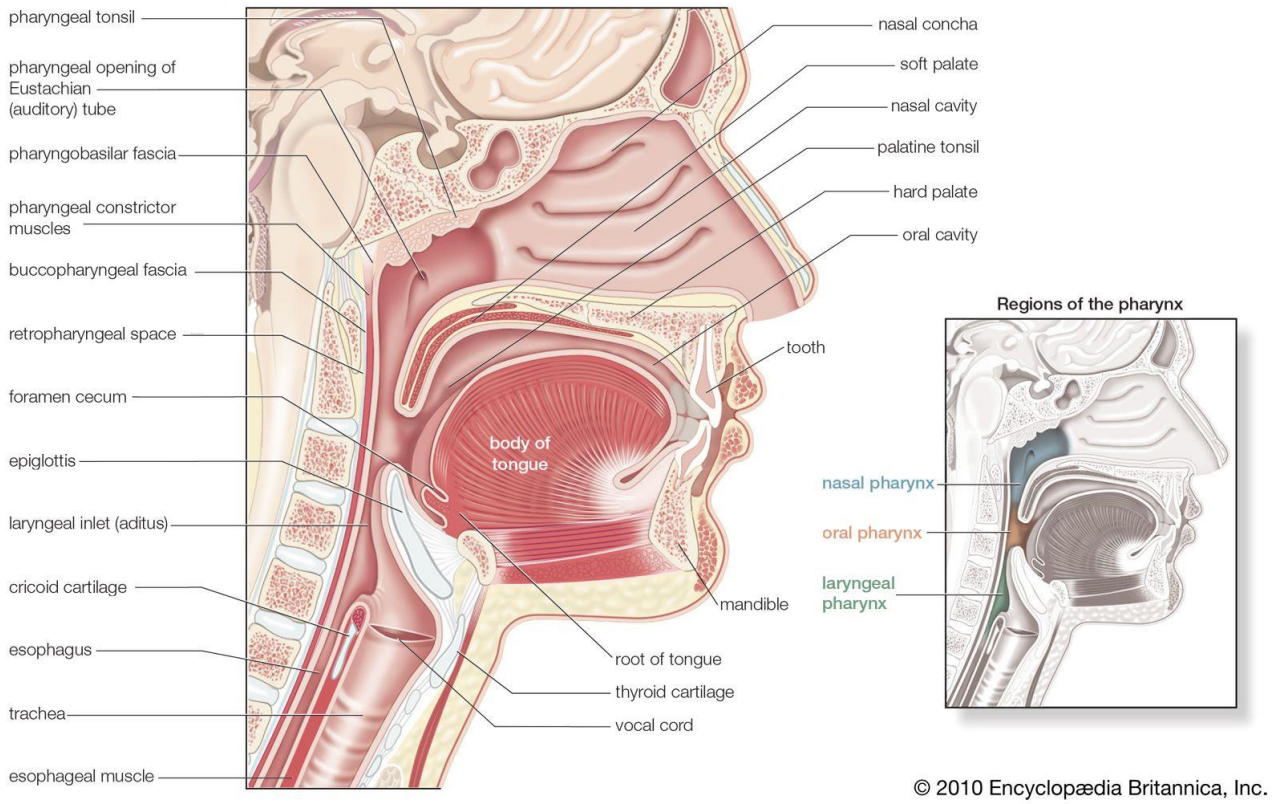
Ensure mealtime management plans are regularly reviewed
Mealtime management plans need to be reviewed regularly. CCO will support a participant with dysphagia to arrange this. The speech pathologist who develops a mealtime management plan will include how often it should be reviewed, and may specify the circumstances in which you should request a review.

Ensure medications are regularly reviewed
CCO will also support a participant with dysphagia to have their medications regularly reviewed by a GP, the prescribing medical practitioner, or a pharmacist to assess whether the medications may affect their swallowing. The review can also determine if the medications are suitable when managing risks around swallowing. Several medications have impacts on swallowing, particularly medications for epilepsy or mental health conditions.

Useful Resources – Nutrition and Swallowing Assessment

Schedule for Revision of Policy: Dysphagia Management				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
January 2022	**New policy**	**D. Ryan**	**2024**	
January 2023	**Reviewed & Update**	**D. Ryan**	**2025**	

<u>Pharangeal Anatomy</u>



Procedure for Assisting with Meals

Helping participants with meals takes time, understanding and patience. Avoid interruptions and don't rush. Some participants take a long time to eat their meals.

When assisting with meals –

- Review the Mealtime Management Plan if one is provided. It's important to read and understand the mealtime recommendations before assisting with meals.
- Wear a mask
- Wash/sanitise hands and wear gloves
- Provide a serviette to protect the participant's clothing, or wipe mouths
- Sit beside or opposite the participant
- Let the participant know that you will support them to eat their meal, if required
- If specified in their plan, position the participant for eating. The plan may specify the angle of the wheelchair, for example. It's important to follow these instructions.
- Assist with cutting food, as required. The size and texture of the food specified in the plan is important.
- Tell the participant what is on the plate – eg. if eating a puree diet, as food may not be instantly recognisable.
- Ask whether the participant wants any seasoning or sauces and has a preferred order in which they wish to eat the food.
- Ask how the participant would like to receive the food; some may prefer a fork, others a spoon. It is important to maintain the participant's autonomy during the mealtime.
- When participants have a small appetite, suggest that they try to eat a little of each course for a balanced nutritional intake.
- Offer sips of fluid after every couple of mouthfuls; this can help eating.
- When the participant has had enough of the main course, offer dessert in the same way. Make sure the spoon is the correct size, for example, using a teaspoon for a yoghurt.
- After the meal, ensure the participant is clean and comfortable and has had enough to eat and drink. Participants should be encouraged to eat but should not be pressured when they have indicated that they have had enough.
- At the end of the meal ensure the participant has a drink to hand but be aware that those who need help with eating may need help with drinking too and regular fluids should be offered.
- Remove your gloves, wash your hands
- Document the participant's food intake - if the participant refused a meal or didn't eat much.

Responding to coughing or choking/emergencies

If someone is choking and cannot breathe, call triple zero (000) and ask for an ambulance.

If the person becomes blue, limp or unconscious, call triple zero (000) and ask for an ambulance.

1. Try to keep the person calm. Ask them to cough to try to remove the object.
2. If coughing doesn't work bend the person forward and give them up to 5 sharp blows on the back between the shoulder blades with the heel of one hand. After each blow, check if the blockage has been cleared.
3. If the blockage still hasn't cleared after 5 blows, place one hand in the middle of the person's back for support. Place the heel of the other hand on the lower half of the breastbone (in the central part of the chest). Press hard into the chest with a quick upward thrust, as if you're trying to lift the person up. After each thrust, check if the blockage has been cleared.
4. If the blockage has not cleared after 5 thrusts, continue alternating 5 back blows with 5 chest thrusts until medical help arrives.
5. If the patient becomes blue, limp or unconscious, start CPR immediately.

3.20 Emergency Plan - Client not responding to scheduled visit

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. This policy applies to all CCO client's who live alone, and other's as need identified.

Position Statement
There is public concern that frail older people and people with complex needs 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 and people with a disability 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.

This response will also address **Emergency and disaster management -** the planning required by providers to prepare, prevent, manage and respond to emergency and disaster situations whilst mitigating risks to and ensuring continuity of supports that are critical to the health, safety and wellbeing of NDIS participants. Schedule 1 – Core Module, Part 3 – NDIS Practice Standards.

Aged Care Quality Standards
- ✓ *Standard 2 – Ongoing Assessment and Planning*
- ✓ *Standard 3 – Personal Care and Clinical Care*
- ✓ *Standard 4 – Services and Supports for Daily Living*
- ✓ *Standard 8 – Organisational Governance*

National Disability Standards
- ✓ *Standard 3 – Individual Outcomes*
- ✓ *Standard 6 – Service Management*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*
- ✓ *Emergency & Disaster Management*

DVA Notes for Community Nursing Providers
- ✓ Section 10.6

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 Coordinators/Care Managers 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 Critical Response Staff and others to advise Support Workers in the event of attendance and the client not responding, or in the event of a natural or other disaster situation.
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 Coordinator 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 Coordinator during office hours (8.30am – 4.30pm) and to Critical Response Service if outside of office hours. If the Support Coordinator is unavailable the SW should advise the Client Services Manager or CEO if CSM not available.

The Support Coordinator 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 the Critical Response Service if outside of office hours.

The Support Coordinator or Critical Response staff member 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 Coordinator 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 Coordinators 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.
Where a client's Emergency Response Plan has been activated this should be documented in the client's care plan notes.

If the client's emergency response plan is activated on 3 or more occasions in a three month period, the Care Manager or Support Coordinator should review with the client and suggest ways of reminding the client or their carer about service times and staff or adjusting service times if these are not working.

Community Care Options maintains a client high risk register which identifies the following – client's who live in flood affected areas, client's who live in rural/remote area, fire risks, client's who live alone, client's who have dementia or other high needs requirements. CCO also has Disaster Planning including Pandemic responses, strategies, policies and procedures.

All of CCO's client's have an Emergency Card in their home and home communication folders.

NDIS client's have in place Emergency & Disaster Management Plans.

Schedule for Revision of Policy: EMERGENCY PLAN – CLIENT NOT RESPONDING TO SCHEDULED VISIT				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
March 2011	New Policy	D. Ryan	2013	
September 2014	Reviewed & Updated	D. Ryan	2015	
December 2016	Updated	D. Ryan	2018	
November 2018	Reviewed	D. Shipman	2021	
March 2021	Reviewed & Updated	D. Ryan	2022	
January 2023	Reviewed & Updated	D. Ryan	2025	**Change to NDIS Practice Standards – Emergency & Disaster Management**

Community Care Options

Medicare No: _____
Health Care Card No:_____
Pension No: _____
DVA Number: _____
Private Health Insurance:_____

EMERGENCY CARD

In the event of an Emergency **DIAL 000**

(Ambulance, Fire, Police)

The following information may need to be provided:

Client's Name	
Client's Date of Birth	
Address	
Client's Phone number	
Nearest Cross Street	
Nearest town (rural clients)	
Directions to address from nearest town	

Description of entry gate/ mailbox/ rural addressing:
Side of road: left ☐ right ☐
Colour of: Gate: _ _____Mailbox: _____Fence: _____
Significant landmark/ feature:

Neighbours/ Friends/Relatives/Next of Kin/Guardian (Name & Contact No.):

1. _____
2. _____
3. _____
4. _____

Other Important Emergency/ Contact Numbers

State Emergency Service – 132500
(in the event of a flood or storm damage, or if you require temporary accommodation, food or clothing)

Country Energy 132080 **Poisons Information** 131126
Rural Fire Service 1800 049 933

Doctor and/or Other Medical Personnel (Name & Contact No. including After Hours if applicable):

1. _____
2. _____

Any Health Conditions: (including allergies, diabetes, epilepsy):

_____

Location of webster pack/medications -

_____

_____

Other important information: (hearing, vision impairment, communication ability) -

_____

_____

_____

FOR AMBULANCE:

Describe Accident, Illness or Injury –

Risk of further danger
Airway Clear/ blockage
Pulse/ no pulse
Burns
Patient responsive/ unresponsive
Breathing/ not breathing
Bleeding

- If possible/ required to meet the ambulance at the front gate
- Turn on outside lights/ car hazard lights if at night
- If required pack an overnight bag for the hospital – include client's medications.

FOR FIRE:

Actions to be considered on discovering a fire

Always be aware that fire can spread quickly and create very thick smoke – if inside a house when the fire starts – keep as close as you can to the floor, cover your nose and mouth and follow the walls until you come to a exit, close any internal doors/ windows to contain fire.

Always know the exits – keep same clear - and where any fire equipment is located

Location and Type of Fire Equipment:

1. _____
2. _____

R '**Rescue**' any person/s in immediate danger.
A Raise the '**Alarm**', dial 000 (or 112 for some mobiles if out of range)
C '**Contain**' fire by closing doors/ windows
E Attempt to '**Extinguish**' the fire only if you are trained and it is safe to do so.

3.21 Emergency and Disaster Management

Definition
An emergency is a life-threatening event that requires immediate action, but is usually contained. A disaster is a more widespread event, overwhelming entire communities. The United Nations International Strategy for Disaster Reduction defines a disaster as ‘a serious disruption of the functioning of a community or a society causing widespread human, material, economic or environmental losses which exceed the ability of the affected community or society to cope using its own resources.

Emergencies and disasters include a variety of hazardous situations that may occur inside or outside the organisation. These include, but are not limited to fire, natural disasters (eg floods, earthquakes), industrial accidents (eg train derailments), chemical spills, radiation exposure, threats of personal violence, acts of terrorism, and public health emergencies such as outbreaks and pandemics.

Position Statement
Catastrophic events aren’t exactly new. In recent times, though, their pace has clearly accelerated. Just take the case of weather and climate-related disasters: those have more than quadrupled since the 1970s.

Health services organization, such as Community Care Options play a vital role in responding to emergencies and disasters. Therefore, even when emergencies and disasters occur outside the organisation, CCO must be ready to respond to such events.

The processes for preparing for, responding to and recovering from both emergencies and disasters are similar. Emergency and disaster preparedness is defined as the organisation and management of resources and responsibilities for dealing with all aspects of emergencies, in particularly preparedness, response and rehabilitation.

Community Care Options recognises its responsibilities in ensuring the care and safety of our client’s and staff, during emergency events. Our clientele are vulnerable people due to aged and/or disability. Our staff and clientele are widely dispersed throughout the community.

Emergency management is the organisation and management of resources and responsibilities needed to deal with emergencies, or situations that pose immediate risks to health, life, property, or the environment.

CCO makes a commitment to **emergency and disaster management -** the planning required by providers to prepare, prevent, manage and respond to emergency and disaster situations whilst mitigating risks to and ensuring continuity of supports that are critical to the health, safety and wellbeing of NDIS participants and aged care clients.

Aged Care Quality Standards

- ✓ *Standard 2 – Ongoing Assessment and Planning*
- ✓ *Standard 3 – Personal Care and Clinical Care*
- ✓ *Standard 4 – Services and Supports for Daily Living*
- ✓ *Standard 8 – Organisational Governance*

National Disability Standards

- ✓ *Standard 3 – Individual Outcomes*
- ✓ *Standard 6 – Service Management*

NDIS

- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*
- ✓ *Emergency & Disaster Management*

DVA Notes for Community Nursing Providers

- ✓ Section 10.6

Operational Procedures

Community Care Options will maintain a High Risk Register which identifies client's who may live in at risk situations due to location, frailty, mobility, lack of informal supports, health and other factors.

These risk factors will be assessed at intake and updated on the high risk register.

Client review, incidents/hazards, feedback which identifies changes to the client's circumstance should instigate an update of the high risk register as required.

CCO staff to read this policy in conjunction with CCO's Emergency and Disaster Management Plan – located in staff and management policy manuals.

This policy addresses client care factors during a disaster or emergency.

<u>Preparing for an emergency/disaster</u>

CCO will assist client's to prepare for emergencies/disaster based on assessment of risk factors. eg if they live in a bushfire area - they have a fire safety plan.

Risk Factors	
Age/frailty	
Health, medical, medication	
Physical location – rural, remote, isolated	
Informal supports	
Lives alone	
Mobility – manual handling	
Flood Prone area	
Bushfire area	
Neurological deficit – Dementia, disability	
Hearing/Vision impaired	

Preventing an emergency/disaster

The best prevention comes through effective planning.
Service and support planning should include discussions with client's about emergency situations and plans of action.

Consider for each client risk the following plans –

Pet Care Plan – if they go to hospital,
Fire Safety Plan – including smoke detectors, and fire fighting equipment, clutter, access and egress
Futures Planning – wills, advanced care directive
Support Plan – neighbours, family, friends, access to lockbox
Mobility/transport plan – if need to evacuate location
Health Care Plan – list of medications, oxygen,
Communications – Day Manager to be emailed to Management and Critical Response each afternoon for access to staff and client contact details in case of IT failure.
Access to adequate food and water supply

CCO will assist client to consider and plan for emergency events – form

The safest option may often be to stay where you are, unless ordered to evacuate.

Managing an emergency/disaster

Community Care Options will enact its Emergency and Disaster Management Plan in the event of an emergency or disaster.

All CCO client's and staff will be contacted as prioritised in the high risk register and CCO's emergency and disaster management plan, depending upon type, location and length of emergency or disaster.

Community Care Options will notify police and emergency services of any client's known to be in disaster location or at risk as indicated in High Risk Register.

Responding to an emergency/disaster

In the Case of an Emergency/Disaster we agree to the following Emergency Response Plan:

Emergency: RING: 000

The Emergency response will be reviewed with clients a minimum annually and as required during emergency situations

EMERGENCY Response Plan Summary: eg: call appropriate emergency services: ambulance, SES, Fire Brigade, Community food banks etc trades such as electricity, plumbing, gas suppliers and emergency contact person (John Smith – phone number) and who will make calls ie: CCO staff, Carer etc

EMERGENCY	RING	
FIRE:	**000**	**John Smith 0412 345 678**
FLOODING:	**000**	**John Smith 0412 345 678**
DAMAGE – SEVERE STORMS:	**132 500–SES-**	**John Smith 0412 345 678**
HOME INVASION**:**	**000**	**John Smith 0412 345 678**
MEDICAL:	**000**	**John Smith 0412 345 678**
POISONING:	**131126** (Poisons Information Centre)	**John Smith 0412 345 678**
PANDEMIC RESPONSE:	**6652 0000 (CCO)** for services and the **Carer/Next of Kin** to confirm service arrangements	
ELECTRICAL/FAULTS/OUTAGES:	**132080** (**Country Energy) John Smith 0412 345 678**	

EMERGENCY CONTACTS TRADES:

Electrical: Reg Latter Electrical : **(02) 6651 8499**

Plumbing: Emerald Beach Plumbing: **(02) 66500 642 or (02) 66500 544**

or Nambucca Plumbing**:** **(02) 6569 4400**

Council/burst mains etc: **(02) 6648 4000 (Coffs Harbour) (02) 6655 7300 (Bellingen)**

EMERGENCY CONTACTS CARER/NEXT OF KIN:

Name: John Smith

Phone: 0412 345 678

Email:

Fire	In the event of a fire the client's family/SW's (if in attendance) will support the client's removal from the house by the safest exit (client can identify exits and uses lifter, wheelchair) and go to a safe place ie: next door neighbours, across the road – ring 000
Flooding	If flood waters are encroaching on the residence the client will call 000 or SES to arrange evacuation, call Carer and/or CCO to assist with evacuation to a safe area
Severe Storms/Tornado's	In the case of a storm/tornado the client will remain in the home and seek assistance from ringing 000, Contact Carer, SES and/or CCO

Medical Emergency	Client to ring **000, if staff are present -** ring **000**
Pandemic	CCO to contact client to discuss next steps appropriate to the specific circumstances, re-arrange services if required and confirm arrangements with carer/ next of kin (with client consent)
Food Shortage /assistance	**Bellingen,** 64 HYDE ST, LifeHouse Care Shop, 02 6655 2279 Tue: 10 – 12, Fri: 10 -12 **Toormina,** 4 MINORCA PL, LifeHouse Care Shop, 02 6658 1899 Thur: 10 -12 **Coffs Harbour,** 169 ORLANDO ST, LifeHouse Care Shop, 02 6658 0055, Tue: 10 -12
Services Requiring Trade qualified persons	**Phone numbers located above**

High Risk Register

Name	Client Code	Location	Lives alone	Rurally isolated	Tank Water & Electric pump	flood zone	fire zone	Restricted mobility in fire	manual handling	Specific Staff	challenging behaviour	falls risk	High medical needs	Hearing Impaired	Vision impaired	memory loss	Oxygen in use
Joanne	7020	Sandy Beach						●	●	●	●	●	●				
Pat	7004	Coffs Harbour	●					●	●	●		●	●				
Norman	7013	Port Macquarie						●	●	●			●				

http://www.coffsharbour.nsw.gov.au/moving-around/Pages/emergency-road-closures.aspx

3.22 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.

Aged Care Quality Standards
- ✓ *Standard 3 – Personal Care and Clinical Care*
- ✓ *Standard 4 – Services and Support for Daily Living*

National Disability Standards
- ✓ *Standard 3 – Individual Outcomes*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

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 by Board	**Outcome**	**Author**	**Next Review**	**Comments**
May 2007	**Approved**	**R. Thompson**	**2010**	**New Policy**
November 2011	**Updated**	**D. Ryan**		
September 2014	**Reviewed**	**D. Ryan**	**2016**	
December 2016	**Updated**	**D. Ryan**	**2018**	
December 2018	**Reviewed**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

3.23 Exit from the Organisation

Aged Care Quality Standards

- ✓ *Standard 2 – Ongoing Assessment and Planning with Consumers*
- ✓ *Standard 3 – Personal Care and Clinical Care*
- ✓ *Standard 4 – Services and Supports for Daily Living*

National Disability Standards

- ✓ *Standard 5 – Service Access*

NDIS

- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *NDIS Rules 2018*

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
- client choice of other preferred provider

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 Coordinator 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**
May 2007	**Approved**	**R. Thompson**	**2010**	**New Policy**
November 2011	**Reviewed & Updated**	**D. Ryan**		
September 2014	**Reviewed & Updated**	**D. Ryan**	**2016**	
December 2016	**Updated**	**D. Ryan**	**2018**	
November 2018	**Reviewed**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

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.

Aged Care Quality Standards
- ✓ *Standard 1 – Consumer Dignity and Choice*
- ✓ *Standard 2 – Ongoing Assessment and Planning with Consumers*

National Disability Standards
- ✓ *Standard 1 – Rights*
- ✓ *Standard 2 – Participation and Inclusion*
- ✓ *Standard 3 – Individual Outcomes*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

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**
July 2006	**New policy**	**R. Thompson**		
July 2007	**Amended**	**D. Vaughan**	**2009**	
March 2009	**Reviewed**	**D. Ryan**	**2012**	
November 2011	**Updated**	**D. Ryan**		
September 2014	**Reviewed & Updated**	**D. Ryan**	**2016**	
December 2016	**Updated**	**D. Ryan**	**2018**	
November 2018	**Reviewed**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

3.25 Freedom from Abuse

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

Aged Care Quality Standards
- ✓ *Standard 8 – Organisational Governance*
- ✓ *Serious Incident Response & Reporting*

National Disability Standards
- ✓ *Standard 1 – Rights*
- ✓ *Standard 6 – Service Management*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*
- ✓ *Reportable Incidents*

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.

Community Care Options has a Serious Incident Response System that sets out

arrangements to manage and take reasonable action to prevent incidents with a focus on the safety, health, wellbeing and quality of life of clients.

All people have the right to feel safe and live dignified, self determined lives free from exploitation, violence and abuse of all kinds.

All staff of the organisation are expected to abide by the Aged Care and NDIS Code of Conduct.

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.

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 abuse will be managed in accordance with the aged care Serious Incident Response process and the NDIS Reportable Incident process. Staff of the organisation will utilise the Serious Incident Response decision support tool to assess the priority of all serious/reportable incidents.
- Prioirty 1 reportable incidents must be reported to the Commission – Aged Care or NDIS, within 24hrs of CCO becoming aware of the incident. Priority 2 reportable incidents to the Commission within 30 days of becoming aware of the incident.
- 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.
- Ensuring all organisational staff are aware of and comply with the Code of Conduct and Serious Incident Reporting requirements.

Indentification

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 Coordinator or Client Services Manager and document their concerns on the organisation's hazard/incident report form.

Support Coordinators 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, and or a Serious Reportable Incident lodged.

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 abuse

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 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 Coordinator will ensure coordinated provision of appropriate services for clients and carers who are victims of abuse. The Support Coordinator 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);
- Notification to the appropriate authorities regarding abuse of a person with a disability
- 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 Group
People with Dementia and their Carers
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.

Aboriginal and Torres Strait Islander People

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.

<u>People with a Disability</u>
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; Serious Incident Response and Reporting and Reportable Incidents. 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.
- Report Serious and Reportable incidents to the Aged Care of NDIS Commission.

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.

- Operate within the Aged Care and NDIS Codes of Conduct.
- 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**
August 2003	**New policy**	**R. Thompson**		
November 2006	**Amended**	**A. Vaughan**	**2009**	
December 2008	**Reviewed**	**D. Ryan**	**2012**	
August 2010	**Reviewed**	**D. Ryan**		
November 2011	**Reviewed and Updated**	**D. Ryan**		
September 2014	**Reviewed & Updated**	**D. Ryan**	**2016**	
December 2016	**Updated**	**D. Ryan**	**2018**	
November 2018	**Reviewed**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**		**SIRS implementation**

3.26 Health and Well Being

Definition
Health and well-being can be described as the absence of physical illness, disease and mental distress. This is a negative definition of health and well-being. - health and well-being can be described as the achievement and maintenance of physical fitness and mental stability.

Legislation
The policy is consistent with the objects and principles of the Disability Inclusion Act 2014 (the Act), and the Aged Care Act. The objects and principles of the Acts require organisations to support people with disability and older people to exercise their rights, choice and control in pursuing their goals, to promote their independence and social and economic inclusion, and to realise their physical, social, sexual, reproductive, emotional and intellectual capacities.

The policy embodies the objects and principles of the Act by supporting people to be actively involved in achieving the best possible health and wellbeing outcomes throughout their lives. The policy's person centered guiding principles align with the principles of the United Nations Convention on the Rights of Persons with Disabilities (ratified by Australia in 2008) relating to health and wellbeing outcomes.

Aged Care Quality Standards
- ✓ *Standard 1 - Consumer Dignity & Choice*
- ✓ *Standard 3 - Personal Care & Clinical Care*
- ✓ *Standard 4 - Services and Supports for Daily Living*
- ✓ *Standard 6 - Feedback and Complaints*
- ✓ *Standard 8 – Organisational Governance*

National Disability Standards
- ✓ *Standard 1 - Rights*
- ✓ *Standard 2 - Participation and Inclusion*
- ✓ *Standard 3 - Individual Outcomes*
- ✓ *Standard 4 - Feedback and Complaints*
- ✓ *Standard 5 - Service Access*
- ✓ *Standard 6 - Service Management*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

Purpose
The policy applies to all CCO supports and services and aims to streamline the health and wellbeing support system. Under the policy framework the existing CCO health, nutrition, medication, epilepsy, palliative care and death policy principles, are assembled to reflect the health and wellbeing support continuum for people with short and long term health conditions.

A Practice and Procedures Manual, founded on evidence-based best practice, accompanies the policy, and includes procedures, guidelines, tools, templates, and other resources. The purpose of the Manual is to streamline the policy framework by reducing the duplication and recording of health and wellbeing information that has previously been imposed by the separation of health related policies. The procedures are a requirement for CCO services and staff to follow when they are applying the principles of the policy.

This Health and Wellbeing policy consolidates all health related policies, including health planning, nutrition, medication, chronic disease, epilepsy, advance care planning and decision making, under one overarching assembly.

Specific guidelines and procedures for each health area are contained in the Health Practice and Procedures Manual for use by Support Workers when implementing the policy.

The Health and Wellbeing policy (the Policy) embodies the principles of legal and human rights found in the NSW Disability Service Standards, the NDIS Practice Standards (the standards), aged care standards and the commitment to deliver culturally responsive services to Aboriginal and Torres Strait Islander people.

The policy defines how people with disability, older people and their families exercise their rights and entitlements, under the standards, to make informed decisions about health services, including health promotion opportunities, treatments, therapy and rehabilitation.

The policy presents a basis for planning, to achieve the best possible health and wellbeing outcomes for all people supported by Community Care Options.

The policy highlights the importance of identifying symptoms of illness and changes in health status early, and of communicating and recording health information. The policy recognises that establishing clear pathways for referral is fundamental to achieving the best possible health and wellbeing outcomes, and requires the development of key partnerships between the person, family, carers and health professionals.

Partnerships with health providers in the mainstream health system are key elements of the NSW Ministry of Health's response to the Service Framework to Improve Health Care of People with Intellectual Disabilities as well as the tenet's of the National Disability Insurance Scheme (NDIS) that health supports are best provided by health services.

Tools and templates are provided as aids for gathering and recording information, and other resources support health planning and other policy activities.

Person centered guiding principles

Health, nutrition, chronic disease, medication, epilepsy, end of life care planning and death.

1. **Person at the centre**

The person is central to health planning and is supported to understand health related discussions and to make healthy lifestyle decisions.

2. **Considering culture**

Health planning and management takes culture and religion into account as they relate to health and wellbeing.

3. **One health plan**

Every person has one health plan which incorporates all health and wellbeing assessments, reports, plans and recommendations.

4. **Health assessment**

Every person has an annual health assessment, conducted by a medical practitioner, which informs the health plan.

Health planning advice is provided by the medical practitioner during the annual health assessment with input from other health and wellbeing practitioners.

Health planning includes at least an annual dental and oral health check, conducted by a health professional, which informs the health plan.

5. **Regular review**

Health and related plans are reviewed every three months with the person and support workers, and with input from the family, others important to the person and other health and wellbeing practitioners where it is required.

6. **Communication**

The person is encouraged to self-advocate, and is supported to communicate health needs and treatment preferences to health care professionals.

Health care professionals are supported to understand the person's health and wellbeing needs, and given the means to communicate health information in a way the person understands.

7. **Inclusion of others**

In accordance with the person's wishes, health planning and support is provided wherever it is required by the family, person responsible or guardian, health professionals and support workers.

8. **Service access**

Every person is supported to access mainstream health services of their choice, as well as disability specific or aged care specialist health services where they are needed.

9. **Continuity of care**

Relationships are established with health care professionals and providers to promote continuity of care and to enhance mutual understanding of people's health care preferences and needs.

10. Access to skilled supports

Each person receives services that optimise their health, wellbeing and quality of life.

Services are delivered by a range of support workers and health professionals who have, or will acquire, the necessary skills.

11. Nutrition

Every person has access to good quality and nutritious food, and is supported to enjoy long-term health and wellbeing.

Each person has an annual assessment to identify risks associated with nutrition and swallowing.

Risks identified in the assessment are addressed using mealtime management plans developed by a qualified health professional.

Any person who requires a special diet has it prescribed by a qualified health professional.

Mealtime management plans and diets are reviewed regularly as part of health planning.

Food preferences and mealtime support are documented in a nutrition profile and reviewed as part of health planning.

Nutritional support is provided in the context of a person's health needs, culture, religion and personal preferences, and includes family and other people important to the person.

Each person is encouraged and supported to engage in good nutritional practices through participation in social and physical activities that promote good eating and a healthy lifestyle, and include regular exercise.

Support is provided to access mainstream nutrition promotion strategies to reduce the risk of developing some common chronic health conditions.

12. Medication

Medical needs are determined by a treating practitioner, and prescribed medications are administered according to the practitioner's orders.

Medication reviews are conducted during regular health assessments and include medications prescribed by other health providers.

Predicted risks and benefits of prescribed medication are explained to the person in a way that meets her or his communication needs.

A record of prescription and non-prescription medications is documented in a medication chart by the treating practitioner or is supplied by the pharmacist using medication management software.

Suitably skilled workers are available to support people with disability and older people to administer their own medications independently, or to manage and administer medications and maintain accurate and current medication records.

Processes are in place to ensure that all medications are administered safely, and stored securely.

Systems exist for auditing medication supplies, and for recording and managing any irregularities in medication supply, administration and consumption.

13. Chronic disease

Annual health assessments identify and monitor long term physical and mental illness.

Referrals are made to appropriate mainstream chronic disease management programs or specialist disability services.

People are supported to access mainstream or disability-specific/aged care specific specialist disease management programs as appropriate.

14. Epilepsy

The person with epilepsy is supported to access quality health care and to have full involvement in decision making and exercising choice about support and treatment.

Each person with epilepsy has a plan that records the type of epilepsy, seizure description, treatments, management and risks associated with the condition, and is reviewed during regular health assessments.
Each person with epilepsy is supported by workers who are appropriately trained and skilled in seizure response and management.

Management of chronic health conditions such as epilepsy requires regular auditing of environmental and other risks to the person with epilepsy, and identification of triggers that can prompt a seizure.

A person with epilepsy with ongoing seizures is supported to understand how ‘duty of care’ is considered before ‘dignity of risk’ around activities involving water.

Attempts to reduce risk for the person with epilepsy should avoid compromising other aspects of safety and dignity, or impairing quality of life, as much as possible.

Monitoring and supervision of the person with epilepsy is as discreet as possible, minimising disturbance to the person, and promoting the person's health and safety.

15. End of life care planning and death

Planning for the person's health and wellbeing support needs towards the end of life is a positive process that represents the person's values, beliefs and choices, and guides future decision making if the person is unable to communicate a preference.

Each person who has a life-threatening illness is supported to plan for the treatment or illness management that reflects their own end of life support wishes.

The support plan is reviewed regularly to align with changes in the person's care and support needs for the duration of the illness.

The person's wishes about advance care planning, end of life support, death and post-death, are recorded in the health plan and followed, with the involvement of the family, person responsible or guardian.

Application of principles

The policy's person centered guiding principles are the basic requirements when planning with people to achieve good health and wellbeing. CCO does not have responsibility for 24 hour care of our clients in most instances. Person centered health planning is provided in the context of the level of assistance each client wants or needs for our support and services. CCO staff will encourage and promote the person centered principles with all client's where we are assisting them with their health and wellbeing goals.

Aboriginal and Torres Strait Islander people

Cultural sensitivity is fundamental in a person centered approach to health and wellbeing, and without it, health and wellbeing outcomes of Aboriginal and Torres Strait Islander people are compromised.

The traditional Aboriginal perspective of health is holistic, and encompasses land, environment, physical body, community, relationships and law. Health is connected to the social, emotional, and cultural wellbeing of the whole community, and the sense of being indigenous.

In addition to the person centred health principles featured in the policy, the following culturally sensitive matters should be considered when supporting Aboriginal or Torres Strait Islander people to manage their health and wellbeing –

- recognising the person's culture is a way of acknowledging and valuing the person's identity
- acknowledge the history of difficult relationships with government services
- recognise family, kinship and friend relationships and the person's connection to community and the land
- determine who in the family or community should be approached for decisions and consent about health support and treatment

- ask how and where the person would prefer to receive services
- confirm whether the person or family would prefer to work with the health system through an Aboriginal Liaison Officer
- determine which health issues or practices are sensitive or taboo and who to refer to if they are.

Cultural and linguistic diversity

People bring their values, beliefs and experiences with them when they relocate to another country. The person and family's behaviour, attitude, preferences and decisions about health and wellbeing, are influenced by culture and religious practices.

A person's cultural and religious preferences for health and wellbeing should be ascertained early in support planning. Demonstrate respect and sensitivity by considering –

- the person and the family's perspective on health and illness
- the person and the family's perspective on health management and treatment.
- the person and the family's views about Western health care practices and their use of alternative traditional practices
- the role of spiritual and religious beliefs and practices in health care
- how the person and the family communicate, for instance, through an interpreter
- the person's own role in the process of problem solving and decision making.

Schedule for Revision of Policy: HEALTH & WELLBEING				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
March 2019	**Approved**	**D. Ryan**	**2021**	**New Policy**
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

3.27 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.

Aged Care Quality Standards
- ✓ Standard 4 – Services and Supports of Daily Living

National Disability Standards
- ✓ Standard 2- Participation and Inclusion
- ✓ Standard 3 – Individual Outcomes

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

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 Coordinators 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**
June 2011	**New policy**	**D. Ryan**		
September 2014	**Reviewed & Updated**	**D. Ryan**		
December 2016	**Updated**	**D. Ryan**	**2018**	
October 2018	**Reviewed**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

3.28 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.

Aged Care Quality Standards
- ✓ *Standard 1 – Consumer Dignity and Choice*
- ✓ *Standard 2 – Ongoing Assessment and Planning with Consumers*
- ✓ *Standard 3 – Personal Care and Clinical Care*
- ✓ *Standard 4- Services and Supports for Daily Living*
- ✓ *Standard 8 – Organisational Governance*

National Disability Standards
- ✓ *Standard 1 – Rights*
- ✓ *Standard 2 – Participation and Inclusion*
- ✓ *Standard 3 – Individual Outcomes*
- ✓ *Standard 5 – Service Access*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

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 Coordinator, and other relevant information. The Support Coordinator 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;
- Service Quotation
- needs assessment.

The Agreement is signed and dated by the client or carer and the organisation's Support Coordinator/Care Manager.
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 Support Coordinator role is supporting client's to access information in a mode they understand, 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 Coordinators/Care Managers 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**		
November 2011	**Amended**	**D. Ryan**		
September 2014	**Reviewed & Updated**	**D. Ryan**	**2015**	
December 2016	**Updated**	**D. Ryan**	**2018**	
October 2018	**Reviewed**	**D. Shipman**	**2021**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

3.29 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 abuse and neglect to government authorities.

This specific policy relates to Mandatory Reporting of suspected child abuse or neglect.

As an Aged and Disability Service Provider we are also mandatory reporters of suspected abuse and neglect of older people and people with a disability. These responsibilities and operational responses are identified in CCO's Reportable Incidents Policy.

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 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 Child Protection Helpline [phone 132 111] 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 Child Protection 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 Child Protection Helpline 132111 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
NDIS 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**
January 2007	**New Policy**	**A. Vaughan**	**2009**	
July 2009	**Reviewed & updated**	**D. Ryan**	**2012**	
November 2011	**Reviewed & Updated**	**D. Ryan**		
September 2014	**Reviewed & updated**	**D. Ryan**	**2015**	
December 2016	**Updated**	**D. Ryan**	**2018**	
October 2018	**Reviewed**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

3.30 Medication Management 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
- ✓ *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*

Aged Care Quality Standards
- ✓ *Standard 1 – Consumer Dignity and Choice*
- ✓ *Standard 2 – Ongoing Assessment and Planning with Consumers*
- ✓ *Standard 3 – Personal Care and Clinical Care*
- ✓ *Standard 4- Services and Supports for Daily Living*
- ✓ *Standard 8 – Organisational Governance*

National Disability Standards
- ✓ *Standard 3 – Individual Outcomes*
- ✓ *Standard 5 – Service Access*

NDIS

- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

DVA Notes for Community Nursing Providers

- ✓ 7.3.2.2. Medication Administration – Clinical Care
- ✓ 7.4.2. Assistance with Medication
- ✓ 5.3.4 Delegation of Care
- ✓ 8.1.7. Day Review

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 –

<u>Guiding Principle 1 – Information Resources</u>

All clinical 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.

Care Managers/Support Coordinators 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 Care Manager/ Support Coordinator requires further information about the client's medicine(s) they may with the client's consent, consult the client's pharmacist and/or doctor. Care Managers/Support Coordinators will ensure that direct care staff are resourced with information and procedures for the provision of medication assistance to the client if

this is required. 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 Care Manager/Support Coordinator 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 Care Manager/Support Coordinator 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 Care Manager/Support Coordinator 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 Care Manager/Support Coordinator 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. Care Managers/Support Coordinators 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.

Guiding Principle 4 – Administration of Medicines in the Community
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.

Role of Clinical Care staff in supporting the administration of medicine
Some of CCO's client's may be classified under a Clinical Care Schedule – (DVA, NDIS, Home Care Packages 3 & 4) and therefore care must be provided by an RN or EN (with an approved qualification in administration of medications) if the client requires the administration of –

- Prescribed medications (schedule 4 and above)
- Schedule 8 drugs if dispensed from a bottle/packet, including Schedule 8 transdermal patches
- Cytotoxic drugs or creams
- Prescribed medicated eye drops (Schedule 4 and above) and/or
- Prescribed creams

It may not always be possible for an RN to directly provide all nursing services, and some of these tasks may be delegated to others as part of personal care routines. CCO has a delegation of care policy that all staff, and particularly clinical care staff, need to be familiar with in terms of being able to delegate some tasks of care to others.

Community Care Options needs to ensure that all Community nursing services delivered by an EN and/or Support Worker are assessed, planned, delegated, supervised and documented by and RN. All delegated care must be appropriately documented in clinical records and kept on the client's file.

CCO's Registered Nurses must recognise the differences in accountability and responsibility between themselves, EN's and unlicensed support workers. An RN must delegate aspects of care to others according to their competence and scope of practice. This includes –

- Delegation of aspects of care according to role. functions, capabilities and learning needs;
- Monitoring aspects of care delegated to others and provides clarification/ assistance as required;
- Recognising own accountabilities and responsibilities when delegating aspects of care to others; and
- Delegation to and supervision of others consistent with legislation and CCO policy.

Client's can be physically assisted with self –administered medication by a Support Worker under the following circumstances –

- The person's medical conditions/are stable; and
- There is an established medication regime; and
- There is a comprehensive care plan in place which includes medication contraindications (interactions and side effects) and emergency contacts; and
- There is a blister pack filled by a registered Pharmacist; or it is over the counter medication, or prescribed/non prescribed cortisone cream.

The RN (or an EN with an approved qualification in administration of medication) conducts a face to face visit and reviews the client on a weekly basis if assistance with the self administration of Schedule 8 drugs are involved.

Client requests for assistance with medications should be referred to the Care Manager 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 Care Manager. The Care Manager 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.

Care Managers 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.

Care Managers 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
Support staff may be required to assist clients to self administer medications.

A trained and competent Support Worker can help when a client or their carer requires physical assistance to administer the client'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.

A trained and competent Support Worker has completed the required (Certificate 111) assistance with medication administration competencies; adheres to the National and Territory/State Drug Acts; and adheres to CCO's Medication Management policy and procedures, including delegation of care principles requiring any change in health status be reported immediately to the RN.

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 Care Manager 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 Care Manager 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.

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 Care Manager 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 Care Manager 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 Care Manager immediately. eg. Client has too much medication at home if using more than the Webster pack.

Support staff **will not** assist with the following procedures unless they have been specifically trained to do so, assessed as competent, by a CCO RN or other health professional; 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 Care Manager/Support Coordinator before applying.
- Herbal supplements are considered to be medications and must not be dispensed.

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, Care Managers/Support Coordinators, 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, Care Manager/Support Coordinator 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.

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/Support Coordinators.

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 Care Manager/Support Coordinator 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 Care Manager.

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.

Staff Training

All CCO staff receive training in medication management (Cert 111) and administration by a RN at Induction. Competency assessment by RN.

Schedule for Revision of Policy: MEDICATION POLICY				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
October 2005			**2007**	
April 2009	**Draft policy developed**			**For consultation**
November 2011	**Reviewed & Updated**	**D. Ryan**		
September 2014	**Reviewed & Updated**	**D. Ryan**	**2015**	
December 2016	**Updated**	**D. Ryan**	**2018**	
November 2018	**Reviewed**	**D. Shipman**	**2021**	
March 2021	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

3.31 Person Centred Support Planning

Definition
A 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 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.

Aged Care Quality Standards
- ✓ *Standard 1 – Consumer Dignity and Choice*
- ✓ *Standard 2 – Ongoing Assessment and Planning with Consumers*
- ✓ *Standard 4 – services and Supports for Daily Living*
- ✓ *Standard 8 – Organisational Governance*

National Disability Standards
- ✓ *Standard 1 – Rights*
- ✓ *Standard 2 – Participation and Inclusion*
- ✓ *Standard 3 – Individual Outcomes*
- ✓ *Standard 6 – Service Management*

NDIS Practice Standards
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*

DVA Notes for Community Nursing Providers
- ✓ *Section 10.2*

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

Care Managers/Support Coordinators 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 and community organisations.

Care Managers/Support Coordinators 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 Coordinators will undertake a comprehensive assessment of client needs as a basis for the support planning process. Home Care Package 3 & 4 clients; DVA clients and NDIS Clinical care clients will have a care plan developed by a Registered Nurse, which will include a focus on health outcomes.

CCO utilises its own comprehensive assessment tool including a WH&S risk assessment tool.

Following the assessment, the Care Manager/Support Coordinator together with the client and/or the client's representative, will develop a plan of support – the Support Plan/Care 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, health, 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 review, 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 care management, and clinical care management where required. Care 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 care 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 Care Manager/Support Coordinator 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 Care Manager/Support Coordinator is to be responsible for gathering relevant data, information and assessment results for the meeting.

The Care Manager/Support Coordinator 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 Care Manager/Support Coordinator, 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 Care Manager/Support Coordinator, 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/Care Plan/Nursing Care Plan
The Care Manager/Support Coordinator 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 Care Manager/Support Coordinator 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 Care Manager/Support Coordinator support and supervision processes.

The support plan will include –

- the agreed goals of care – desired outcomes
- the short, medium and long-term objectives of the client and carer;
- the services to be provided – activities identified from assessment – including

clinical and personal;
- nursing interventions, a nursing plan (where required);
- the frequency of service provision;
- delegation of care arrangements and support staff;
- medication information and chart (if assistance required);
- a behaviour support plan where required
- 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 if applicable (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, Care Managers/Support Coordinators 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 plans 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. Care Managers/Support Coordinators 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 care 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 CENTERED SUPPORT PLANNING				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
July 2006	New policy	R. Thompson		
January 2007	Amended	A. Vaughan	2009	
March 2009	Reviewed	D. Ryan	2012	
November.2011	Reviewed and Updated	D. Ryan		
September 2014	Reviewed & Updated	D. Ryan	2016	
December 2016	Updated	D. Ryan	2018	
December 2018	Reviewed	D. Shipman	2021	
March 2021	Reviewed & Updated	D. Ryan	2022	
January 2023	Reviewed & Updated	D. Ryan	2025	

3.32 Privacy, Dignity and Confidentiality

Documentation and Record Keeping

Definition

'Privacy' is 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.

Aged Care Quality Standards

- ✓ *Standard 1 – Consumer Dignity and Choice*
- ✓ *Standard 4 – Services and Supports of Daily Living*
- ✓ *Standard 8 – Organisational Governance*

National Disability Standards

- ✓ *Standard 1 – Rights*
- ✓ *Standard 6 – Service Management*

NDIS

- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

Legislation

- ✓ *Human Rights and Equal Opportunity Commission Act 1986*
- ✓ *NSW Freedom of Information Act 1989*
- ✓ *Commonwealth Privacy Act (1988) and the amended Commonwealth Privacy Amendment*

(Private Sector) Act 2000.
- ✓ *Australian Privacy Principles 2014*

Operational Procedures
Implementation of Australian Privacy Principles

APP 1 – Open and transparent management of personal information
Program Managers and Support Coordinators 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 Coordinators 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 Coordinators 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 Coordinator 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.

See CCO Data Breach Response Plan.

Schedule for Revision of Policy: Privacy, DIGNITY AND CONFIDENTIALITY				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
January 2002	New policy	A. Vaughan		
May 2006	Revision	A. Vaughan	2008	
July 2008	Reviewed & Updated	D. Ryan		
August 2010	Reviewed & Updated	D. Ryan	2012	
November 2011	Reviewed & Updated	D. Ryan		
March 2014	Reviewed & Updated	D. Ryan	2015	
December 2016	Updated	D. Ryan	2018	
November 2018	Reviewed	D. Shipman	2021	
December 2020	Reviewed & Updated	D. Ryan	2022	
January 2023	Reviewed & Updated	D. Ryan	2025	

3.33 Reportable Incidents – Serious Incident Response

Position Statement
Senior Australians and people with a disability have the right to feel safe and live dignified, self determined lives free from exploitation, violence and abuse.

Reportable incidents can threaten the health, safety or wellbeing of people with disability, and older Australians and can have a significant impact on people with disability, older people, workers, families, carers, community members and CCO.

Reportable incidents provide an opportunity for CCO to review our operational practices to improve the quality and delivery of supports and services to NDIS and aged care participants and prevent future harm.

CCO are committed to the following objectives promoting -

- timely and effective responses to reportable incidents to address the safety and wellbeing of people with disability, and older people.
- effective and appropriate monitoring and investigation of reportable incidents.
- learning from reportable incidents and patterns of incidents, to reduce the risk of harm to people with disability, and older people, and improve the quality of supports and services.
- accountability of CCO to people with disability, and older people.

Legislation
NDIS (Incident Management and Reportable Incident Rules) 2018
Aged Care – Serious Incident Response Scheme (SIRS)

CCO is required by law to have appropriate systems in place to respond to any incidents that occur or are alleged to have occurred in connection with the provision of supports or services to it's clients – people with disability and older people. The law also requires that we notify certain types of incidents to the NDIS Commission or Aged Care Commission. These incidents are referred to as 'reportable incidents', or Serious Incidents.

Principles
CCO adheres to the following principles in dealing with reportable incidents.

Centred on the person	Management of an incident is respectful of, & responsive to, a person with disability's, or older person's preferences, needs & values while supporting the person's safety & wellbeing.
Outcome focussed	Management of an incident should reveal the factors which contributed to the incident occurring, & seek to prevent incidents from reoccurring, where appropriate.
Clear, Simple and Consistent	The process for dealing with reportable incidents is easy to understand, accessible & consistently

	applied.
Accountable	CCO are responsible for appropriately managing the response to reportable incidents. Everyone involved in the management of a reportable incident understands their role & responsibilities, & will be accountable for decisions or actions taken in regard to an incident.
Continual improvement	The incident management process facilitates the ongoing identification of issues & implementation of changes to improve the quality & safety of NDIS and aged care supports & services.
Proportionate	The nature of any investigation or actions following an incident will be proportionate to the harm caused & any risk of future harm to the client.

Definition
Section 73Z(4) of the NDIS Act defines a *reportable incident* as –

- the death of a person with disability
- serious injury of a person with disability
- abuse or neglect of a person with disability
- unlawful sexual or physical contact with, or assault of, a person with disability
- sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity
- unauthorised use of a restrictive practice in relation to a person with disability.

Operational Procedures
For an incident to become a reportable incident it must satisfy the following requirements –

- the incident must involve an act, event or omission defined in section 73Z(4) of the Act and section 16 of the NDIS (Incident Management and Reportable Incidents) Rules 2018.
- the incident must have occurred or is alleged to have occurred in connection with the provision of supports or services by CCO.

CCO must notify ***all*** reportable incidents (including allegations) to the NDIS Commission, even where we have acted and responded appropriately.

A failure to comply with the requirement to notify, investigate and manage reportable incidents is a breach of our conditions of registration and may lead to compliance and enforcement action by the NDIS Commission.

Roles and Responsibilities
All CCO staff are responsible for work health and safety. It is everyone's responsibility. CCO's incident management system sets out the roles and responsibilities of all workers in identifying, managing and resolving incidents and in preventing incidents from occurring.

All staff who are advised that a Reportable Incident may have occurred are to contact the CEO immediately.

The CEO will retain responsibilities for notifying the NDIS Commission that a reportable incident has occurred. The CSM or Operations Manager may report in the CEO's absence.

Categories of Reportable Incidents
The definition of *reportable incident* captures not only confirmed incidents that have occurred, but also allegations of incidents.

In connection with the provision of supports or services
The phrase *'in connection with'* is broad. It covers reportable incidents that may have occurred during the course of supports or services being provided, altered or withdrawn. However, an incident does not necessarily have to occur at the time that the supports or services are being provided to meet the '*in connection with*' requirement.

While not exhaustive, the type of incidents that will be considered to have occurred *in connection with* the provision of supports or services include –

- when a person with disability is receiving a support or service (for example, where a person with disability is receiving care from a worker).
- when a person with disability attends the premises of CCO, or where the support or service is 'off-site', and an incident occurs at the location where those supports or services were provided.
- where a person is receiving funded supports at home.
- where a person with disability is in residential care.

CCO's Incident Management Policy identifies the action steps to be taken in assessing the severity of any reported incident/hazard. The same immediate response is required.

CCO's Response Plan for Incident Management is as follows -

Immediate Action	
Office Staff Member receiving call is to ascertain & record the following -	
Names	That all people present are safe.
	If the staff member is injured.
Injuries	If the client or other parties are injured.
First Aid	If First Aid or Emergency Medical Attention is required
	Whether the staff member left the situation or are still present
	What assistance the staff member may need
	If there are any immediate risks to others because of the incident
	If so who -

Description of incident to be recorded as reported, on CCO's Hazard/Incident Report Form
Other details as per form – date, time, location, witnesses, action taken by the CCO employee

ACTION	Where the incident fits within the criteria identified as critical in this policy the Receiving staff member will report the situation/incident immediately to a Senior Manager – Client Services Manager, Operations Manager, CEO, Program Managers.
	Reportable incidents are to be advised to the CEO immediately. The CEO, CSM & Operations Manager have delegations for reporting to the NDIS Quality & Safeguards Commission & will complete this action.

Remedial Action	Both corrective & preventative
Manager receiving Incident /Hazard advice will ensure the following -	
	Follow up with client regarding their health, safety and wellbeing by the CSM, Program Manager, Care Manager, Support Coordinator or Service Coordinator as appropriate & available – **same day**. Ascertain if any additional supports or services required.
	Follow up with the staff member regarding their health, safety and wellbeing by the Operations Manager, Support & Development Manager, Service Coordinators Support & Development as appropriate & available – **same day**. Action W/Comp notification if required due to lost time Action any roster changes
	Ascertain any further details that may be required for mitigation of future risks
	Process Hazard/Incident Form for registration, action

Supporting participants in the period after a reportable incident
CCO will play an important role in helping clients after a reportable incident occurs. Workers need to be aware of the impact of trauma on clients, and help to link them to the additional support services they may need. It is important that alleged victims are not repeatedly questioned or told that the impact of their disclosure is that the worker or participant will get into trouble.

Many jurisdictions have Charters or Declarations that set out the rights of all victims of crime, and how government agencies and providers should support victims.

Therapeutic supports
Trauma can be caused by one incident or many incidents. It can result in clients continuing to feel unsafe, even long after the event. Many people with disability experience trauma due to many events over their lives. This includes life-long

discrimination and bullying; separation from their family; lack of control over their life; and experience of abuse and/or neglect. If the person has difficulty communicating, it can be harder to deal with trauma.
Responses to trauma can include that the client –

- is less able to control their emotions and urges, such as anger
- self-harms
- has chronic guilt or embarrassment
- has difficulty trusting others
- is less able to do things for themselves
- increases showering, and
- has more incontinence and smearing.

It is important that CCO delivers support that is 'trauma-informed'. This includes providing a safe environment; communicating openly and respectfully; helping clients to have maximum choice and control; and linking them to trauma services, such as counselling.

CCO Managers will be responsible for finding an appropriate counsellor who has the skills to work with the person. It is important to remember that not all counsellors have experience in working with people with intellectual disability.

Support for participants in the criminal justice system
People with disability are vulnerable in the legal system. They often have limited access to protection and justice as victims and offenders.

While legislation differs in each jurisdiction, when police take someone into custody who they suspect is a vulnerable person, a support person should be contacted. People with intellectual or physical disability are generally considered to be 'vulnerable persons' by police.

One role of the support person is to help them to get legal advice. It is the right of a participant, whether they are a victim, witness or alleged offender, to decline a police interview. You should know which organisations can provide criminal justice support, including giving free legal advice to suspects with intellectual disability.

Record Keeping
CCO must keep records of all reportable incidents that occur or are alleged to have occurred for a period of seven years from the date of notifying the NDIS Commission. A completed reportable incident notification form is sufficient for this purpose, but CCO is aware that we may have other obligations under Commonwealth, state or territory law to keep records about reportable incidents, particularly if they relate to an alleged crime or an incident under work health and safety laws, and so will maintain all records in relation to all reportable incidents.

CCO will also retain records of investigations (including records of interviews, evidence collected, any relevant correspondence, investigation reports and outcomes).

Key personnel, managers or other people specified in CCO's incident management system are the individuals that will be responsible for creating and maintaining incident records, while CCO will be required to retain them.

Minimum requirements for reporting/record keeping include –

- a description of the incident, including the impact on, or harm caused to, any person (including a person with disability, an older person, a staff member, other)
- whether the incident is a reportable incident
- if known, the time, date and place at which the incident occurred or if not known, the time, date and place at which the incident was first identified
- the names and contact details of the persons involved in the incident and any witnesses to it
- the actions taken in response to the incident, including action taken to support or assist a client (person with disability or older person) impacted by the incident
- if an investigation is undertaken by CCO in relation to the incident —the details and outcomes of the investigation, and
- the name, position and contact details of the person making the record of the incident.

Additional data and information may be required in undertaking an investigation/ assessment of a reportable incident. Other parties may be involved and have priority in investigating the situation eg police, coroner. Staff members to ensure that all details recorded accurately.

Categorising for management reporting
Staff Members receiving Hazard/Incident Reports are to assess incident severity eg is it a reportable/critical incident? to identify priority of reporting to Senior Management including CEO.

Any incidents falling into a reportable incident category are to be notified to the CEO immediately on the day of occurrence/notification.
The CEO or delegated Manager will provide advice to staff involved in the incident with regard to the following -

- **notification of police or emergency services if they have not already been advised**
- **notification of next of kin, family, carers, guardian**

Incidents resulting in an injury to a CCO employee are to be notified to the Operations Manager immediately on the day of occurrence/notification.

Where the identified Manager is not available for reporting via phone, email or in person, then the staff member is to report the incident to their immediate Manager eg CEO, or another Manager, if the CEO is unavailable.

Notifying the NDIS Commission of a reportable incident
If a worker becomes aware of an incident, they have a duty to notify one of the following as soon as possible –

- a member of CCO's key personnel
- a supervisor or manager of person
- the person specified in the incident management system who is responsible for reporting incidents that are reportable incidents to the NDIS Commission.

This person is the CEO – Deb Ryan.
In her absence the Client Services Manager and Operations Manager may carry out this function. The CEO has a duty to take all reasonable steps to notify the NDIS Commission.

Notification Timeframes
All reportable incidents, except for the unauthorised use of a restrictive practice, must be notified to the NDIS Commission within 24 hours of CCO becoming aware of the incident.

Any unauthorised use of restrictive practices must be notified within 5 days.

CCO will be taken to have become aware of an incident once a person employed or otherwise engaged by CCO has notified one of the following -

- a member of CCO's key personnel
- a supervisor or manager of the person
- the person in the incident management system who is responsible for reporting incidents that are reportable incidents to the NDIS Commission.

Notifications
The notification should be made in writing, by completing a form approved by the NDIS Commission and returning it to the NDIS Commission via email. The Department of Social Services has also commenced the development of an online system for notifying the NDIS Commission of reportable incidents.

Information Required by the NDIS Commission
The CCO reporting officer must provide the following information to the NDIS Commission where it can be collected –

- the name and contact details of – CCO
- the person making the notification
- the name and contact details of – the persons involved in the incident (alleged victim and alleged offender)
- a description of the reportable incident – including the nature of any injuries sustained, and details such as time, date and place it allegedly occurred
- a description of the impact on, or harm caused to, the person with disability
- (Note: where the reportable incident is a death this does not need to be provided)
- the immediate actions taken by CCO in response to the reportable incident including – any actions relating to the health, safety and wellbeing of the client, involved in the incident including medical treatment provided, or whether the incident has been reported to the police or any other body.

If particular information described in the form is not available within 24 hours of relevant personnel becoming aware that a reportable incident has occurred, remaining information may be provided to the NDIS Commission within five business days.

CCO has **five business days** to notify the NDIS Commission of –

- the names and contact details of any witnesses to the reportable incident (including workers, participants or third parties)
- any further actions proposed to be taken (by CCO) in response to the reportable incident.

The NDIS Commissioner will acknowledge receipt of the notification within 24 hours of receiving the additional information.

Police or other Sensitive Matters
While a report of an incident is required by the NDIS Commission, CCO is not required to notify the NDIS Commission of certain information if collecting that information would, or could reasonably be expected to, prejudice a criminal or investigation into the reportable incident, or cause harm to a person with disability.

Registered providers are required to investigate reportable incidents
Registered providers are required to appropriately assess and/or investigate all incidents having regard to the views of any person with disability impacted by an incident and including the following –

- whether the incident could have been prevented
- how well the incident was managed and resolved
- what, if any, remedial action needs to be undertaken to prevent further similar incidents from occurring, or to minimise their impact
- whether other persons or bodies need to be notified of the incident.

The nature and extent of this investigation will differ depending on the circumstances of the incident or allegation.

A police investigation takes priority over a reportable incident investigation. CCO must obtain clearance from police before taking any action that might compromise the investigation. CCO are required to manage any ongoing risk and should maintain an open dialogue with police about any investigation they are conducting.

Investigating reportable incidents is a complex process. Internal and external investigators **must be appropriately trained** in conducting serious workplace investigations, including investigating serious incidents that may involve a criminal element. The CEO will determine the appropriate person (including external sources) to investigate based on individual circumstances.

Providing the NDIS Commission with a final report
CCO will be required to give details to the NDIS Commission in connection with any internal or external investigation or assessment that has been undertaken in relation to the reportable incident, including –

- the name and position of the person who undertook the investigation
- when the investigation was undertaken
- details of any findings made
- details of any corrective or other action taken after the investigation
- a copy of any report relating to the investigation
- information about whether persons with disability impacted by the incident (or their representative) have been kept informed of the progress, findings and actions relating to the investigation or assessment
- any other information required by the NDIS Commission.

The details outlined above should be included in the final report to the NDIS Commission which must be provided within 60 business days following the initial notification. The NDIS Commission may extend the period for providing the final report - eg if there is a concurrent police investigation, the reportable incident will be justifiably delayed.

Corrective action
Corrective and restorative measures may be taken following a reportable incident, regardless of whether or not an investigation has occurred.

At a minimum, CCO will consider whether any corrective action would reduce the risk of future reportable incidents. It is acknowledged, that there may be certain incidents that will not require further action, such as the death of a person with disability from natural causes, so long as there were no additional contributing factors (for example neglect or poor quality of care).

Corrective measures may include, but are not limited to –

- disciplinary action
- training or education of workers
- modification of the environment
- development or amendment of a policy or procedure
- changes to the way in which supports or services are provided
- other practice improvements.

Where appropriate, the NDIS Commission may require CCO to take corrective measures. The NDIS Commission will work with CCO to implement the measures, and monitor progress.

Restorative measures may include, but are not limited to –

- providing ongoing support to people with disability impacted by a reportable incident

• giving an apology
• providing compensation - for example, through an enforceable undertaking.

Action by the NDIS Commission
The NDIS Commission can take action or require CCO to do one or more of the following in response to receiving a notification of a reportable incident –

- give information in relation to the reportable incident to police
- refer the reportable incident to another person or body with relevant responsibilities in
  relation to the reportable incident (eg child protection authorities)
- require or request CCO to undertake specified remedial action in relation to the reportable incident within a specified period, including remedial action to ensure the health, safety and wellbeing of the person with disability affected
- carry out an internal investigation in relation to a reportable incident
- engage to an appropriately qualified and independent expert, at the expense of the provider, to carry out an investigation in relation to the reportable incident
- conduct an inquiry
- take any other action considered appropriate in the circumstances.

The NDIS Commission may provide, or can require CCO to provide, information on the progress or outcome of an investigation to the following people –

• the participant who was involved in the incident (or their representative)
• any person nominated by the participant (or their representative) to receive the information.

Information will be provided to the client in a form that is accessible to them.

In addition, the NDIS Commission can carry its own investigation or inquiry in relation to the reportable incident as it sees fit.

- pattern of behaviour that is harassing or harmful to a person with disability.
- Verbal abuse, including where it is intended to intimidate, threaten or belittle, gain power and control or where the intent is to cause emotional pain or is demeaning or insulting.

A ‘pattern of abuse’ occurs where there is repeated physical abuse, ill treatment and/or harassment of a participant.

Abusive conduct includes the following, alone or in any combination:

- abuse of a sexual or non-sexual nature
- physical force or inappropriate physical contact
- threats of physical force or threats of inappropriate physical contact
- conduct that causes physical harm or emotional distress to the person with disability impacted by the incident
- financial abuse.

Financial abuse includes:

- withholding money belonging to a person with disability or using money for purposes not authorised by a person with disability, including NDIS funds
- coercion or misleading behaviour to obtain money or property from a person with disability.

Description of the categories of reportable incidents
Death of a person with disability

Specific and more detailed policy and procedures for responding to deaths can be found in CCO Policy Manual: Service Access – 3.9 Death and Dying and Safe Work Manual: Incident Management Policy 5.1

All deaths of people with disability that occur in connection with the provision of supports or services must be notified to the NDIS Commission. This includes –

A death that occurs while a support or service is being provided (for example, in a person's home or supported disability accommodation).
A death that occurs as a result of, or, in connection with the provision of supports or services.

There are specific requirements in each state and territory in relation to the obligations on providers to notify a death to bodies such as coroners and police. Coroners are responsible for determining the cause of death. Coroners are also responsible for making decisions about whether there will be an autopsy or an inquest in relation to a death. The NDIS Commission will work alongside state and territory coroners and other bodies to examine the circumstances of deaths.

The NDIS Commission's jurisdiction is limited to oversighting deaths that occur in connection with the provision of supports and services by an NDIS provider. The NDIS Commission does not have a function to inquire into the provision of other services, for example, health services and/or other mainstream systems the responsibility of states and territories.
The NDIS Commission will establish strong working relationships and information sharing arrangements with state and territory bodies.

It is a condition of registration that all registered NDIS providers have an incident management system in place which sets out for workers the procedures for identifying, managing and resolving incidents, including a reportable death of a person with disability. For this reason, providers are strongly encouraged to have a dedicated policy and related procedures with clear instructions for workers about how to respond to a death including who is responsible for notifying the NDIS Commission.

Serious injury of a person with disability
The serious injury of a person with disability must be notified to the NDIS Commission if it occurs or is alleged to have occurred in connection with the provision of supports and services.

In determining, whether an injury is 'serious', consideration should also be given to the level of harm caused. A serious injury includes, but is not limited to –

- fractures
- burns
- deep cuts
- extensive bruising
- concussion
- any other injury requiring hospitalisation.

Abuse or neglect of a person with disability
All incidents of abuse of a person with disability that occur or are alleged to have occurred in connection with the provision of supports and services must be notified to the NDIS Commission. There are many different types of abuse.

The focus is on the nature of the incident or allegation itself, and the impact on the person with disability. Abuse may include:

behaviour management that is seriously inappropriate or improper
making excessive and/or degrading demands of a person with disability
hostile use of force towards a person with disability
a pattern of seriously inappropriate, degrading comments or behaviour towards a person with disability.

In making a determination regarding abuse, it is important to consider relevant codes of conduct that outline the nature of professional conduct and practice by workers which should occur when working with people with disability.

Psychological abuse includes -

A pattern of behaviour that is harassing or harmful to a person with disability.
Verbal abuse, including where it is intended to intimidate, threaten or belittle, gain power and control or where the intent is to cause emotional pain or is demeaning or insulting.

A 'pattern of abuse' occurs where there is repeated physical abuse, ill treatment and/or harassment of a participant.

Abusive conduct includes the following, alone or in any combination -

- abuse of a sexual or non-sexual nature
- physical force or inappropriate physical contact
- threats of physical force or threats of inappropriate physical contact

- conduct that causes physical harm or emotional distress to the person with disability impacted by the incident
- financial abuse.

Financial abuse includes -

- withholding money belonging to a person with disability or using money for purposes not authorised by a person with disability, including NDIS funds
- coercion or misleading behaviour to obtain money or property from a person with disability.

Neglect of a person with disability
Neglect includes an action, or a failure to act, by a person who has care or support responsibilities towards a person with disability. In determining neglect, the nature of the worker's care responsibilities provides the context against which the incident or allegation needs to be assessed.

Neglect can be a single significant incident where a provider or worker fails to fulfil a duty, resulting in actual harm to a participant, or where there is the potential for significant harm to a participant. Neglect can also be an ongoing pattern of repeated failures by a provider or worker to meet a participant's physical or psychological needs.

All incidents of neglect of a participant that are alleged to have occurred in connection with the provision of supports and services must be notified to the NDIS Commission.

Neglect includes grossly inadequate care that involves depriving a participant of the basic necessities of life, such as food, drink, shelter, clothing, medical care/treatment. It also includes more specific categories which are discussed below.

Supervisory neglect
An intentional or reckless failure to adequately supervise or support a participant that *results* in the death of, or significant harm to, the participant, or

An intentional or reckless failure to adequately supervise or support a participant that also -

- involves a gross breach of professional standards
- has the potential to result in the death of, or significant harm to, the participant.

Failure to protect from abuse
An obviously unreasonable failure to respond to information which strongly indicates actual or potential serious abuse of a participant.

A reckless act/ failure to act
A reckless act, or failure to act, that -

- involves a gross breach of professional standards
- results in or has the potential to result in the death of, or significant harm to, a participant.

Unlawful sexual or physical contact with, or assault of, a person with disability
Unlawful sexual contact
Any unlawful sexual contact or assault of a person with disability that occurs, or is alleged to have occurred, in connection with the provision of supports or services must be notified to the NDIS Commission.

'Unlawful sexual contact or assault' encompasses any behaviour of a sexual nature that is an offence under any criminal statute of a state, territory or the Commonwealth.
Sexual offences include, but are not limited to -

- sexual assault
- indecent assault
- acts of indecency.

Sexual assault
The term *sexual assault* refers to -

- Specific offences involving a person having sexual intercourse with another person without their consent (sometimes referred to as rape, depending on the language of the relevant state or territory legislation).
- A situation where a person is forced, coerced or tricked into sexual acts against their will or without their consent.

Indecent assault
Indecent assault usually involves touching (or threatening to touch) a person's body in a sexual manner without the consent of the other person. For example, it can include unwanted touching of a person's breast, bottom or genitals.

Unlawful physical contact
Any unlawful physical contact with, or assault of, a person with disability that occurs, or is alleged to have occurred, in connection with the provision of supports or services must be notified to the NDIS Commission.

Physical assault
A physical assault includes any act by which a person intentionally inflicts unjustified use of physical force against a person. An assault can also occur if a person causes another person to reasonably fear that unjustified force will be used against them.

Even if a person who inflicts, or causes, the fear of, physical harm does not intend to inflict the harm or cause the fear, they may still have committed an assault if they acted recklessly (i.e. the person ought to have known that their actions would cause physical harm or the fear of such harm).

Assaults can include hitting, pushing, shoving, spitting, throwing objects, or making threats to physically harm a participant.

When physical contact does not need to be notified to the NDIS Commission
The Rules specify when unlawful physical contact does not need to be notified to the NDIS Commission and that is in circumstances where the contact with, and impact on, the person with disability – is in all the circumstances – negligible.

It is important to consider the context in which physical contact/force is used against a participant to determine whether it is unlawful. For example, where there is use of necessary and reasonable force in the following circumstances:

- restraining a participant when it is in accordance with an approved behaviour support plan authorised by a Restricted Practices Authorisation mechanism
- taking reasonable steps to disarm a participant seeking to harm themselves or others
- separating participants who are fighting
- moving a participant out of harm's way
- restraining a participant from causing intentional damage to property
- self-defence, or the defence of others.

CCO requires that all incidents are recorded and managed in accordance with CCO incident management system, and mandatory reporting requirements. See Policy Manual 3: 3.18 Freedom from Abuse Policy, Safe Work Manual: 5.1 Incident Management

Sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity

Sexual misconduct
For sexual misconduct to constitute a reportable incident: the alleged misconduct must have been committed against, with, or in the presence of a participant by a person, including a worker or another participant, in connection with the provision of NDIS supports or services.
The term sexual misconduct is designed to address conduct of a sexual nature that can, but does not have to, amount to a criminal offence.

Unlawful sexual conduct
Sexual crimes which do not involve physical conduct will constitute sexual misconduct.
For example, acts of indecency are sexual offences where a person commits an indecent act with or toward another person, but does not have any physical contact with them.
There are a range of non-contact sexual offences in each jurisdiction, which involve conduct that must be notified to the NDIS Commission. These include but are not limited to:

- grooming a child for sexual purposes

- filming a person without consent
- a pornography offence or an offence involving child abuse material.

Some jurisdictions also have specific sexual offences that are designed to prevent the sexual exploitation of people with a cognitive impairment by their carers, or by anyone else who has knowledge of the person's impairment and enters into a sexual relationship with the intent of taking advantage.

Crimes which involve encouraging another person to commit a sexual offence against a person with disability (such as offences involving aiding, abetting, counselling or procuring) would also constitutes sexual misconduct.

Crossing professional boundaries

The support relationship between a worker and a person with disability relies on a high degree of trust. All forms of sexual misconduct constitute a breach of this trust and a breach of the NDIS Code of Conduct.

It is important to distinguish between sexual misconduct and legitimate conversations around a participant's sexual support needs, family planning or that serve to meet a worker's duty of care.

Sexual misconduct includes behaviour that can reasonably be construed as involving an inappropriate and overly personal or intimate relationship with, conduct towards, or focus on, a participant or group of participants.
The crossing of professional boundaries can only occur in the context of a worker-participant relationship.

In the area of 'crossing professional boundaries', particular care should be exercised before making a finding of sexual misconduct. For example, a worker who, on an isolated occasion, 'crosses professional boundaries' in a manner that involves no more than poor judgement could not be said to have engaged in sexual misconduct. Also, in cases where a worker has 'crossed boundaries' in terms of their relationship with a participant, this would not constitute sexual misconduct if there is evidence which shows that the worker did not seek to establish an improper relationship with the involved participant.

However, a single serious 'crossing of the boundaries', or a course of less serious breaches of this type, may constitute professional misconduct – particularly if the worker either knew, or ought to have known, that their behaviour was unacceptable.

The NDIS Code of Conduct as well as CCO Code of Conduct outline the expectations of workers in respect of their relationships with participants.

Sexually explicit comments and other overtly sexual behaviour

Sexual misconduct includes a broad range of sexualised behaviour with or towards participants. While it is not possible to provide a complete and definitive list of unacceptable sexual conduct involving participants, the following types of behaviour give strong guidance:

- sexualised behaviour with or towards a participant (including sexual exhibitionism)
- inappropriate conversations of a sexual nature
- inappropriate comments relating to sexual acts
- unwarranted and inappropriate touching of a participant
- personal correspondence and communications (including emails, social media and web forums) with a participant concerning the worker's romantic, intimate or sexual feelings for the participant
- inappropriate exposure of participants to sexual behaviour of others
- watching participants undress in circumstances where supervision is not required and it is clearly inappropriate.

Grooming behaviour

Behaviour should only be seen as 'grooming' where there is evidence of a pattern of conduct that is consistent with grooming a participant for sexual activity, and there is no other reasonable explanation for that pattern.

The types of behaviours that may lead to such a conclusion include, but are not limited to -

Persuading a participant or group of participants that they have a 'special' relationship with the worker, for example by -

- inappropriately giving gifts
- inappropriately showing special favours to them but not other participants, or
- asking the participant to keep the relationship to themselves.

Testing boundaries', for example by -

- 'undressing in front of a participant
- encouraging inappropriate physical contact (even where it is not overtly sexual)
- 'accidental' intimate touching.

Extending a relationship with a participant outside of work (except where it may be appropriate, for example, where there was a pre-existing friendship with the participant's family, or as part of regular social interactions in the community).

Inappropriate personal communication (including emails, telephone calls, text messaging, social media and web forums) that inappropriately explores sexual feelings or intimate personal feelings with a participant.

A worker or another person in the context of NDIS support provision requesting that a participant keep any aspect of their relationship secret, or using tactics to keep any aspect of the relationship secret, would generally increase the likelihood that grooming is occurring.

Unauthorised use of restrictive practice
Restrictive practices involve the use of interventions and practices that have the effect of restricting the rights or freedom of movement of a person with disability. These can include restraint (chemical, mechanical, social or physical) and seclusion (keeping someone in isolation).

The NDIS Commission aims to reduce and eliminate the use of restrictive practices in the NDIS state and territory authorisation arrangements are intended to protect participants from being inappropriately treated or controlled. The NDIS (Restrictive Practices and Behaviour Support) Rules also regulate the following restrictive practices through behaviour support plans -

Seclusion, which is the sole confinement of a person with disability in a room or a physical space at any hour of the day or night where voluntary exit is prevented, or not facilitated, or it is implied that voluntary exit is not permitted.

Chemical restraint, which is the use of medication or chemical substance for the primary purpose of influencing a person's behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition
.
Mechanical restraint, which is the use of a device to prevent, restrict, or subdue a person's movement for the primary purpose of influencing a person's behaviour but does not include the use of devices for therapeutic or non-behavioural purposes.

Physical restraint, which is the use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person.

Environmental restraints, which restrict a person's free access to all parts of their environment, including items and activities.

The use or alleged use of a restrictive practice in relation to a participant, other than where the use is in accordance with an authorisation (however described) of a state or territory in relation to the person with disability must be notified to the NDIS Commission. This includes the emergency use of a restrictive practice.

In addition, the following use of a restrictive practice is reportable -

the use of a restrictive practice in relation to a person with disability where the use is in accordance with an authorisation of a state or territory but is not in accordance with a behaviour support plan for the person with disability.

The use of a restrictive practice in relation to a person with disability is not a reportable incident if -

- the use is in accordance with a behaviour support plan for the person with disability
- the state or territory in which the restrictive practice is used does not have an authorisation process in relation to the use of the restrictive practice.

For further information please refer to guidance material on behaviour supports and the use restrictive practices**.** ***(Restrictive Practices and Behaviour Support) Rules 2018*** **(NDIS Rules)**

Schedule for Revision of Policy: REPORTABLE INCIDENTS				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
March 2019	New policy	D. Ryan	**2021**	
December 2020	Reviewed & Updated	D. Ryan	**2022**	
January 2023				

3.34 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.

Aged Care Quality Standards
- ✓ *Standard 1 – Consumer Dignity and Choice*
- ✓ *Standard 2 – Ongoing Assessment and Planning with Consumer*
- ✓ *Standard 4 – Services and Support for Daily Living*

National Disability Standards
- ✓ *Standard 1 – Rights*
- ✓ *Standard 2 – Participation and Inclusion*
- ✓ *Standard 3 – Individual Outcomes*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

Legislation
- ✓ *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 Coordinator know, when they are not happy with their service;
- let the Support Coordinator 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	**Outcome**	**Author**	**Next Review**	**Comments**
May 2007	**Approved**	**R. Thompson**	**2009**	**New Policy**
May 2009	**Reviewed & Updated**	**D. Ryan**		
August 2010	**Updated**	**D. Ryan**		
November 2011	**Updated**	**D. Ryan**		
February 2012	**Updated**	**D. Ryan**		
September 2014	**Updated**	**D. Ryan**		
December 2016	**Updated**	**D. Ryan**	**2018**	
December 2018	**Reviewed**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

3.35 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.

Aged Care Quality Standards
- ✓ *Standard 2 – Ongoing Assessment and Planning with Consumers*
- ✓ *Standard 3 – Personal Care and Clinical Care*
- ✓ *Standard 8 – Organisational Governance*

National Disability Standards
- ✓ *Standard 3 – Individual Outcomes*
- ✓ *Standard 6 – Service Management*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

Operational Procedure
To ensure that service is effective, fulfils the organisation's duty of care and is satisfactory to clients, the Support Coordinator/Care Manager will review the support plan. Reviews will be conducted regularly with clients. Reviews may be conducted by phone.

The Support Coordinator 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 Coordinators 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 our own Comprehensive Assessment Tool to assess clients. This tool enables the Support Coordinator/Care Manager to continually update information in line with client changing needs. Support Coordinators will update this tool as changes are noted.

Nursing reviews for Level 3 & 4 client's will be conducted as agreed to between the nursing staff and the Support Coordinator or as identified by the Support Coordinator, 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 Coordinator to achieve optimum service outcomes; will have a new support plan explained to them by the Support Coordinator.

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 Coordinator, 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 Coordinators 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 client's assessment 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 Coordinator, 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 Coordinators 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 Coordinator 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 AND SERVICE USER REASSESSMENT				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
May 2007	**Approved**	**R. Thompson**	**2009**	**New Policy**
May 2009	**Reviewed & Updated**	**Deb Ryan**		
August 2010	**Updated**	**Deb Ryan**		
November 2011	**Updated**	**D. Ryan**		
February 2012	**Updated**	**D. Ryan**		
September 2014	**Updated**	**D. Ryan**		
December 2016	**Updated**	**D. Ryan**	**2018**	
December 2018	**Reviewed**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

3.36 Service User Referral - Across Agency Coordination

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.

Aged Care Quality Standards
- ✓ *Standard 2 – Ongoing Assessment and Planning with Consumers*
- ✓ *Standard 3 – Personal Care and Clinical Care*
- ✓ *Standard 4 – Services and Supports for Daily Living*
- ✓ *Standard 7 – Human Resources*

National Disability Standards
- ✓ *Standard 1 – Rights*
- ✓ *Standard 2 – Participation and Inclusion*
- ✓ *Standard 3 – Individual Outcomes*
- ✓ *Standard 5 – Service Access*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

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 Aged Care Meetings, 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.

Support Planning Procedure

The Support Coordinator/Care Manager 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 Coordinator 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 Coordinator/Care Manager will make a referral to the appropriate organisation on their referral form.

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

The other agencies, the client and the CCO Support Coordinator 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 Coordinator 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 Care Managers/Coordinators 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 Coordinator will, with the client's consent, work closely with the other Case Manager to ensure optimum outcomes for the client. The CCO Support Coordinator 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 Coordinator

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 Coordinator will –

- exercise judgment in determining effective monitoring arrangements, who will be involved, how often and by what method. For Level 3 & 4 Home Care Packages, the role of monitoring clients' nursing needs will be agreed between nursing staff and Support Coordinators;
- 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.

Where required the following applies –

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

Coordination with General Practitioners (GPs)

If a client gives consent, the following will apply –

- Support Coordinators will inform GPs of clients' relevant health issues and seek their assistance where appropriate;
- Support Coordinators 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 to the client's GP with a covering letter.

Schedule for Revision of Policy: SERVICE USER REFERRAL- CROSS AGENCY COORDINATION				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
July 2006	**New policy**	**R. Thompson**		
January 2007	**Amended**	**A. Vaughan**	**2007**	

April 2009	**Reviewed & Updated**	**D. Ryan**	**2012**	
November 2011	**Reviewed & Updated**	**D. Ryan**		
September 2014	**Reviewed & Updated**	**D. Ryan**	**2016**	
December 2016	**Updated**	**D. Ryan**	**2018**	
December 2018	**Reviewed**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

3.37 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 older people and people 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 the elderly and people with a disability. As such CCO provides or facilitates opportunities that contribute to the acknowledgement of the valued status of each person.

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.

Aged Care Quality Standards
- ✓ *Standard 1 – Consumer Dignity and Choice*

National Disability Standards
- ✓ *Standard 2 – Participation and Inclusion*
- ✓ *Standard 3 – Individual Outcomes*

NDIS
- ✓ *Core Module 1-4*
- ✓ *High Intensity Daily Personal activities*
- ✓ *Support Coordination*
- ✓ *Implementing Behaviour Support Plans*
- ✓ *NDIS Rules 2018*

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 and older people 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, Aged Care Standards and comply with all relevant legislation.

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 Coordinators/Care Managers 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**
January 2007	**New Policy**	**A. Vaughan**	**2010**	
August 2011	**Reviewed**	**D. Ryan**	**2013**	
September 2014	**Reviewed & Updated**	**D. Ryan**	**2015**	
December 2016	**Updated**	**D. Ryan**	**2018**	
December 2018	**Reviewed**	**D. Shipman**	**2021**	
December 2020	**Reviewed & Updated**	**D. Ryan**	**2022**	
January 2023	**Reviewed & Updated**	**D. Ryan**	**2025**	

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 individual's 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**
May 2007	**Approved**	**R. Thompson**	**2008**	**New Appendix**

Dec 2016	**Reviewed**	**D. Ryan**	**2018**	

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

Schedule for Revision of Policy: PRINCIPAL ASSUMPTIONS UNDERLYING CASE MANAGEMENT				
Date Adopted	**Outcome**	**Author**	**Next Review**	**Comments**
May 2007	**Approved**	**R. Thompson**	**2009**	**New Appendix**

Dec 2016	**Reviewed**	**D. Ryan**	**2018**	