CHCCCS006
Facilitate individual service planning and delivery

Release 2

Learner Guide

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Aspire
Learning Resources

CHCCCS006 Facilitate individual service planning and delivery, Release 2

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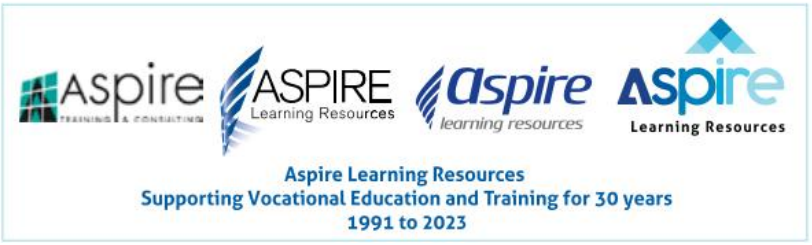


Contents

Aspire acknowledges the homelands of all Aboriginal and Torres Strait Islander peoples and pays our respect to Country

Before you begin

This Learner Guide is based on the unit of competency *CHCCCS006 Facilitate individual service planning and delivery*, Release 2.

Your trainer or training organisation must give you information about this unit of competency as part of your training program.

How to work through this Learner Guide

This Learner Guide contains a number of features that will assist you in your learning. Your trainer will advise which parts of the Learner Guide you need to read, and which Practice Tasks and Learning Checkpoints you need to complete.

Feature of the Learner Guide	How you can use each feature
Learning content	Read each topic in this Learner Guide. If you come across content that is confusing, make a note and discuss it with your trainer. Your trainer is in the best position to offer assistance. It is very important that you take on some of the responsibility for the learning you will undertake.
Examples	These highlight learning points and provide realistic examples of workplace situations.
Practice Tasks	Practice Tasks give you the opportunity to put your skills and knowledge into action. Your trainer will tell you which Practice Tasks to complete.
Callouts	Callouts reiterate key learning points to help students revise for their assessments.
Weblinks	Weblinks provide learners with additional content to contextualise their learning and develop their understanding.
Videos	Videos provide a visual reference of key concepts to aid comprehension and guide learner exploration. Each video is accessed by a QR code in the Learner Guide (or a button in the eBook version) for ease of access. 
Glossary/margin definitions	Key terms are defined where they first appear to help consolidate understanding. A glossary of terms is provided at the end of the Learner Guide to assist learner revision of key concepts.
Summaries	Key learning points are provided at the end of each topic.
Learning Checkpoints	There are Learning Checkpoints at the end of each topic. Your trainer will tell you which activities to complete. These activities give you an opportunity to check your progress and apply the skills and knowledge you have learnt.
Case studies	Case studies are interspersed throughout the learning content to provide a workplace setting that contextualises key concepts.

Foundation skills

As you complete learning using this guide, you will be developing the foundation skills relevant for this unit. Foundation skills are the language, literacy and numeracy (LLN) skills and the employability skills required for participation in modern workplaces and contemporary life.

These skills are listed below:

Foundation skill area	Foundation skill description
Reading	• Understanding how documents are presented and being able to navigate through documents • Understanding industry and job-specific terminology • Interpreting key information in relevant documents • Understanding routine workplace checklists and documentation
Writing	• Planning, drafting and writing reports and documents • Communicating through written letters, email and online • Recording progress; reporting incidents
Oral communication	• Clarifying instructions • Providing information • Supporting others through encouragement, negotiation and conflict resolution • Using body language to model desired behaviour and responding to others' body language
Numeracy	• Calculating costs, weights, measurements of height and distance • Interpreting measurements
Learning	• Understanding your job role, organisational procedures and legal responsibilities • Managing your work and seeing how well you are going • Making goals for yourself at work • Seeking professional development opportunities for continuous improvement
Problem-solving	• Identifying problems • Working out how to fix a problem using problem-solving processes. • Reviewing the outcome
Initiative and Enterprise	• Recognising opportunities to develop and apply new ideas • Generating ideas by thinking of new ways to do something • Making suggestions to improve work
Teamwork	• Working well with other people by cooperating, collaborating, encouraging and building rapport
Planning and organising	• Planning your workload and commitments • Implementing tasks • Completing work on time • Knowing how to deal with hazards and risks

Foundation skill area	Foundation skill description
Self-management	• Understanding and applying decision-making processes • Reviewing your behaviour and the impact of your decisions
Technology	• Efficiently using digitally based technologies and systems correctly and safely • Accessing, organising and presenting information • Using equipment correctly and safely

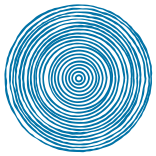
Note: Not every unit of competency will contain all foundation skills.

What do you already know?

Use the following table to identify what you may already know. This may assist you to work out what to focus on in your learning.

Topic	Key outcome	Rate your confidence in each section
Topic 1 Establish and maintain relationships	1A Building positive relationships	❑ Confident ❑ Basic understanding ❑ Not confident
	1B Privacy and confidentiality protocols	❑ Confident ❑ Basic understanding ❑ Not confident
	1C Supporting multifaceted needs	❑ Confident ❑ Basic understanding ❑ Not confident
	1D Supporting client interests and rights	❑ Confident ❑ Basic understanding ❑ Not confident
Topic 2 Prepare for planning	2A Physical and psychological factors that influence service delivery	❑ Confident ❑ Basic understanding ❑ Not confident
	2B Planning processes and service options	❑ Confident ❑ Basic understanding ❑ Not confident
	2C Determine readiness for plan development	❑ Confident ❑ Basic understanding ❑ Not confident
	2D Include others in the planning process	❑ Confident ❑ Basic understanding ❑ Not confident
	2E Preparing and distributing information	❑ Confident ❑ Basic understanding ❑ Not confident

Topic	Key outcome	Rate your confidence in each section
Topic 3 Plan service delivery	3A Planning tools to promote participation	❑ Confident ❑ Basic understanding ❑ Not confident
	3B Using a collaborative process to establish goals	❑ Confident ❑ Basic understanding ❑ Not confident
	3C Planning for interrelated needs	❑ Confident ❑ Basic understanding ❑ Not confident
	3D Identifying and addressing risk	❑ Confident ❑ Basic understanding ❑ Not confident
	3E Managing conflict	❑ Confident ❑ Basic understanding ❑ Not confident
Topic 4 Review service delivery implementation	4A Consult, address and report on quality and satisfaction with service delivery	❑ Confident ❑ Basic understanding ❑ Not confident
	4B Work in collaboration to adjust plans	❑ Confident ❑ Basic understanding ❑ Not confident
	4C Identify areas to improve the quality of service delivery	❑ Confident ❑ Basic understanding ❑ Not confident
Topic 5 Complete reporting requirements	5A Follow organisational requirements for recording and documenting	❑ Confident ❑ Basic understanding ❑ Not confident
	5B Incorporate findings into continuous improvement processes	❑ Confident ❑ Basic understanding ❑ Not confident



Topic 1: Establish and maintain relationships

1A Building positive relationships

1B Privacy and confidentiality protocols

1C Supporting multifaceted needs

1D Supporting client interests and rights

1A Building positive relationships

Connecting with clients and demonstrating a genuine passion for helping others contributes to successful outcomes.

People working in aged care, disability and other community and health service settings have a high level of responsibility. They often work with highly vulnerable people who may need to rely on others for things many of us take for granted. Some clients put up barriers that challenge your ability to gather information about them. As a service worker, it is your task to overcome any barriers and collect the information you need from clients so it can be used to build an individualised plan that improves their quality of life.

Roles and responsibilities

Responsibilities will vary because of the different needs and variations in levels of support required. Some of your clients may need low-level care. You could simply assist with simple daily activities, such as catching a bus, shopping or attending a social activity. Clients with complex need requirements may have a different set of needs, such as assistance in personal care, daily living activities, medical aid and mobility support.

A significant part of a support worker's role is communicating effectively and adapting communication skills to the person's level of understanding and ability to communicate.

As a professional, it is expected that you can form and maintain positive working relationships with your clients and their support networks. Support networks can consist of other carers, family members, health care professionals, and stakeholders from other services.

Provided here is a general outline of the roles and responsibilities of individuals and services involved in client care.

Carers and support workers
Carers and support workers assist the people they care for. Responsibilities require a level of trust and a relationship with clients, families and other caregivers. Clients may require support with daily activities such as personal care, mobility, general home duties and management of medication. Carers and support workers have a duty of care to protect people they assist from any foreseeable harm.

Health professionals
Qualified health professionals oversee medical treatments. These people include GP's, physiotherapists, occupational therapists, in-home community nurses and other medical or allied health specialists. With consent from their patients, the health professionals provide information to the service about the types of treatments the person is receiving. In addition, health professionals guide support workers and carers in ways they can monitor the person's progress with their treatments.
Service delivery workers
Sometimes this term is used interchangeably with a support worker. However, in addition to providing care, they often perform administrative duties as part of service delivery. Examples of these people include community development officers, case managers, client intake officers, youth workers, and employment officers. Typical tasks carried out by a service worker include managing client intakes, working with other services to ensure support does not overlap or create service gaps, conducting community needs analysis to identify service gaps, handling public relations, applying for tenders and government funding, and implementing public education programs.
Client assessor
A suitably qualified person who evaluates a person's ability to manage their daily activities. They are usually not employees of the service organisation but are contracted to perform their duties independently from the service. They determine the level of support a person is eligible to receive and assist in identifying the strengths and capabilities of the person.
Services and agencies
Services and agencies provide care, support and resources to service users. It is the responsibility of the service to ensure that it adheres to all relevant legislation and that this are reflected in the policies and procedures of the organisation. Services need to develop strong and trusting relationships with external services, their clients and support networks, ensuring that the quality of care delivered is of a high standard. Services must source resources, employ suitably qualified workers and upskill as necessary. They must participate in local networks and collaborate with other services to effectively address the multifaceted needs of their clients and look for ways to improve how their services are delivered.

Relationship building

The quality of care given and the ability to communicate effectively influences client outcomes. Therefore, you must establish respectful working relationships, build trust, and promote the client's rights. This means acting in a professional manner with other health care and service providers.

Relationships you have with your clients are based on trust. A client must feel they can communicate with you openly and honestly. They must feel safe. Remember that many clients are vulnerable and need to feel they can share their concerns. Many of your clients will have a history of interactions with services: some of these will be negative experiences.

In your initial meeting, provide your client with information about yourself and about your service. This ensures the client can give informed consent.

Listed below are a few examples of the types of information you will provide to a person when you first meet.

Examples of information to be provided to clients new to a service
• The support worker's role in providing care and support and the name of the service they represent. • Information about the services offered by the organisation. • Information on the organisation's rights and responsibilities. • Information on their code of conduct including the client's rights and responsibilities. • Privacy and disclosure information including security and access. • Consent to share the client's personal information with other services. • Information about the purpose of client assessments. • Financial costs to the person and any funding they may be entitled to.

Interpersonal exchanges

Part of the support worker's role is to gather information from clients and others in their support network. This can include information about their needs and wants, medical history, barriers that make daily life challenging, goals, interests and aspirations. You also need to exchange information with people outside your organisation, such as other service providers or health professionals.

Here are some actions you can take to build a trusting relationship with clients:

Action	Strategies
Professionalism	• Introduce yourself. Say your name, the name of the service you work for and your job title. • Show a genuine interest in people. • Ensure you present with a neat, tidy appearance. • Participate in professional development opportunities to keep up to date with current practices. • Be respectful of professional boundaries. • Do not make promises you cannot keep, and always act ethically. • Represent your service professionally in interactions with other services and health professionals.
Demonstrate Respect	• Be non-judgemental. • Communicate openly and focus on the speaker. • Show a genuine interest and care for others. • Be polite. • Be approachable. • Show empathy by placing yourself in another person's situation and try to see life from their point of view.

Using clear communication

Whether communicating to have a conversation, share information or ideas, give or receive a direction or resolve a conflict or issue, your communication must be clear.

Here are some tips for communicating effectively using active listening and questioning:

- Make sure you have the person's attention and ignore distractions.
- Provide a suitable, quiet environment, and a private one if needed.
- Use words that the person can understand, by considering their age, language, abilities or culture.
- Use clear, specific and relevant words, and avoid slang or abbreviated terms.
- Speak to the person directly.
- Use sentences that are easy to follow and interpret.
- Ask if the person needs more information and explain yourself in different ways.
- Don't speak for the person or fill in words for them without their consent.

Active listening

Active listening involves actively interpreting the information being communicated and participating in the conversation. For example:

Active listening
Concentrated listening and non-verbal encouragement indicating an understanding of what is being said.

- acknowledging what a person is saying with short utterances, such as 'uh huh' and 'ok'
- using positive body language, such as nodding, smiling, leaning in towards the speaker, uncrossing arms and legs
- repeating back to the person to clarify what you have heard by asking a clarifying question, such as 'Have I got that right?' or 'So, what I hear you saying to me is that...'
- not interrupting the person and allowing them time to answer.

Questioning

Questioning is the basis of identifying and understanding a client's needs. A question helps show the client that you are genuinely interested and want information to be able to support them. For example, a probing question can encourage the person to provide more information, such as, 'I agree the community house is a nice place to visit. What else did you like?'

Questions can include open and closed styles. The following table explains both in further detail.

Open questions	Open questions allow the person to speak in their own words and encourages thinking and reflecting. They normally begin with, or use key words, such as: • Who • What • Where • When • Why • How Examples of open questions include: • "What type of house are you looking for?" • "Why would you like to visit the hospital?" • "Where have you seen this service used?" • "How do you feel about having a different assessor?" • "When are you looking to have this completed by?"
Closed questions	Closed questions require the person to make a choice between a few limited options. They can be in the form of probing questions and normally begin with, or use key words, such as: • Can • Does • Would • Could • Which • Are • Have • Do Examples of closed questions include: • "Do you have a preference between X and Y?" • "Do you want to have a look for yourself?" • "Would you like to speak to my manager?" • "Would you like me to see if this can be fixed?" • "Have you had this issue before?"

Demonstrate goodwill

When clients see your good intentions, it helps build strong relationships. It also reflects well on the service you work for and demonstrates a willingness to go the extra mile. Most support workers have a genuine passion for helping others, so giving a little extra is personally rewarding. Taking the time to build rapport will help build trust and confidence in the relationship.

Video: Building positive relationships

Watch this video to hear people who receive support describe what they want in a support worker: aspirelr.link/creative-support-ltd

How do the comments made by the people in the video reflect a person-centred approach to support?

Example

Promoting trust and goodwill

Sharon is a support worker for a home care service provider. Sharon is making a house visit and will be helping with household duties. She arrives for her first shift with Dinesh, who is a new client to the service. Before she starts her tasks, she notices Dinesh is a little shy and is standing well away from the door. To help him feel at ease, Sharon asks Dinesh if she can make them both a cup of tea and they sit and have a chat at the table with their drinks.

Sharon uses this opportunity to see how Dinesh feels the service is going and make sure his needs are well met. During the conversation, Dinesh reveals he is feeling low as he doesn't have the mobility he would like and cannot work in his garden. Dinesh tells Sharon about his partner and how he used to care for the roses in the garden. Sharon offers to walk with Dinesh in the garden and to speak to coordinator about adding garden maintenance in Dinesh's service plan.

Consider the reasoning behind developing trust with somebody you support.

Practice Task 1

Question 1

Which of the following are communication strategies that build trust and goodwill? Tick all that apply.

- ❑ Speak loudly in the hope the person will understand you better.
- ❑ Use body language that shows you have a genuine interest in what the person is saying.
- ❑ Use clarifying questions to be certain of what you have heard.
- ❑ Use probing questions to find out more information.
- ❑ Interrupt the person when it is taking them too long to respond.
- ❑ Fill in words for the person when they need help.

Question 2

Provide four reasons why establishing and maintaining trusting relationships is a support worker's priority.

Question 3

Match each of the roles and responsibilities to the people involved in the planning process.

Services and agencies	These people provide support and have a duty of care to protect people they assist from any foreseeable harm.
Service delivery workers	With consent from clients, these people provide information to the service about the types of treatments the person is receiving.
Carers and support workers	In addition to providing care, these people often perform administrative duties as part of service delivery such as managing client intakes.
Health professionals	These people evaluate a person's ability to manage their daily activities and use this information to determine the level of support.
Client assessor	Organisations who provide care, support and resources to service users.

1B Privacy and confidentiality protocols

Respecting a client's right to privacy and confidentiality helps build trusting relationships.

Support workers in a community service setting need access to sensitive client information to perform their job. When working with other service workers, you may need to share information.

The following table explains two key considerations when handling personal information:

Consent	• The client must give their permission to have their information collected. • Before giving consent, the client must be fully informed and understand the conditions they agree to. • This is often done during the client intake process. Consent also includes photographic images, such as uploading an image to the organisation's social media or webpage.
Disclosure	• A disclosure form provides the service with permission to share their personal information with a third party. For example, for a referral to new services. • However, there are certain circumstances where data does not have to be shared, such as when a mandatory report has to be lodged, a police investigation or when the courts request information for legal proceedings.

Read more about privacy, confidentiality and disclosure: aspirelr.link/fairwork-workplace-privacy

Privacy principles

The Australian Privacy Principles (APPs) outline thirteen national privacy principles that apply to the collection, use and storage and disposal of people's information. Organisations base their privacy policy and procedures and protocols on these principles.

People receiving support services have a right to expect that their personal and health information will be protected. Personal records, such as case notes, should be private and secure. These are considered legal documents and must be collected and stored according to your workplace's policies and procedures.

Detailed information about privacy principles can be found at: aspirelr.link/oaic-privacy-principles

Acting ethically

Acting in an ethical manner means behaving with honesty, fairness and equity. The way you manage confidential information can have a significant impact on a person's dignity, rights and choices, opportunities, access and self-image, self-esteem and wellbeing.

Confidentiality restricts an individual or organisation from using, storing and disclosing information (written or verbal) about a person that is outside the scope for which the information was collected. You must have a reasonable purpose for collecting, storing, accessing and distributing information about a person. Organisations and workers must not collect generalised information without an implicit reason.

Maintaining confidentiality is part of respecting a person's privacy and individual rights. In practice, confidentiality means not discussing an individual's personal information unless they have given their consent for this to happen.

You can read more about the Privacy Act at: aspirelr.link/oaic-privacy-act

Sharing and disclosing information

A client (or their representative) must give consent before any information is shared with or accessed from another agency. Most community organisations gather this consent using a specific form. Consent is given for access to information for a particular purpose.

Some organisations require staff to sign a confidentiality agreement stating that employees will not divulge any information acquired during or after their involvement with clients unless legally required to do so.

You can view an example of the 'Authority to request or disclose personal information to external parties' form developed by the Queensland government at: aspirelr.link/personal-information-form

Organisational policies and procedures

When you start working for a community or health service, you will be inducted into how its employees carry out the tasks relative to their job descriptions. In addition, you will be shown how to access workplace policies and procedures and maintain and protect the privacy and confidentiality of your clients and other sensitive information that you may encounter.

Policies outline the organisation's principles. Procedures give you instructions on how you store information securely. This includes electronically stored information. For example, lockable filing cabinets for hard copies and a secured computer server for electronic files. All devices must be password protected, and any documents downloaded must be saved in the appropriate location and deleted from the downloads file every day.

Policies and Procedures
• Privacy and confidentiality • Codes of conduct • Rights and responsibilities • Collecting personal information • Storing of paper-based information • Email communication • Image consent policy

You can read an example of a privacy policy used by the Aged Care and Quality Safety Commission, for the way they handle personal information: aspirelr.link/aged-care-privacy-policy

Consequences of breaching privacy and confidentiality

Breaching confidentiality may have serious consequences for the person you are providing services to, for you as a support worker or for your employing agency. It may have serious effects on the working relationship between you and your client, leaving the person to doubt trusting others. This can lead to limited options and opportunities for receiving the services they need.

Breaching privacy legislation can be a criminal offence, depending on the nature and seriousness of the breach. If the breach is serious, you may be disciplined. If a service worker witnesses a breach in the privacy and confidentiality procedure, then the breach must be reported to their supervisor immediately. Your organisation's policy will provide you with clear instructions on how to initiate the reporting process.

If the person has suffered harm or loss because of your actions, you or your employer may be sued. If you step outside an important policy, you may lose the protection of vicarious liability and could be sued personally.

Some exceptional circumstances enable you to disclose private information, but this is generally only when you become aware that the person is at risk of harming themselves or others (or that they are being harmed). For example, if the person is being referred for medical treatment, the hospital, specialist or doctor needs to know the person's history, allergies and personal details.

Here are some other situations where you may be required to disclose confidential information:

- If compelled by law; for example, if the person has a reportable disease or the information is requested by a court of law.
- If a person's interests require disclosure and there is a serious risk which justifies breaching confidentiality; for example, risk of suicide, self-harm or harm to others.
- If there is a duty to the public; for example, there is a public threat or concern.

Here are some ways to safeguard confidential information:

- Keep personal information safe and secure.
- Be aware of work practices and never leave files open.
- Ensure that only authorised people have access to personal information.
- Do not pass on information about a person without their permission.
- Never discuss a person receiving a service in public.
- Be discreet on the telephone.
- Do not discuss someone receiving a service unless it is essential for providing a service.
- Make sure that information that is no longer required is returned or destroyed/deleted.
- Dispose of confidential information securely and carefully.
- Make sure you do not reveal names and other identifying information.

Example

Organisation policy and protocols in practice

Tina has been a support worker for Julio for quite some time. He has shared with her that he is interested in carpentry and has asked her if their service has any activities that will allow him to use his woodworking skills. Unfortunately, the service does not provide this type of activity, but Julio has been able to find another community service that has a men's group. Once a week, they get together and share carpentry skills and make items to give away. Before Julio can attend he needs a referral and has to consent to provide the new service with his personal information. For this purpose, she will need to get a signed disclosure agreement.

Think about how you would approach a similar situation. Why must you follow organisational policies when organising extracurricular activities?

Practice Task 2

Read the case study, then answer the questions that follow.

Case study

Rita is one of the support workers for a care team that provides in-home assistance for May, a client with high care needs. Staff keep files containing information about May and other residents' daily personal care, medications, physio schedule, and other important health care information. This is stored on a tablet device kept in the residence. The application allows the team to access the information and each day staff add to the notes and communicate about May's care. On the weekend, May has a friend who visits and they try to access information about the residents on the tablet.

Question 1

List three strategies Rita can use to ensure May's information remains private.

Question 2

Identify at least one situation where confidential information may be disclosed.

1C Supporting multifaceted needs

Many clients have multiple needs that require a number of services working together.

Community and health services assist a broad range of people. This includes culturally and linguistically diverse (CALD) clients.

Likewise, you will find a diverse range of services within the sector because of the broad range of clients. This includes refugees and migrants, Aboriginal and Torres Strait Islander peoples, individuals with mental health issues, people with a disability and the aged – just to name a few.

For this reason, culturally relevant services must be included in the client's planning session. Services must promote an inclusive and diverse work environment and employ workers from all backgrounds. In addition, organisations should ensure that service information is provided in other languages and collaborate with other services to ensure all aspects of the client's life can be met.

Cultural awareness
Being aware of cultural difference and diversity and developing a sensitivity and respect for difference.

Diversity
A wide range of different personal characteristics, including culture, gender, sexual orientation and ethnicity.

Stereotyping
Judging an individual based on particular characteristics, then applying that belief to all members of that group.

Bias
A feeling of liking or disliking a person or group of people due to a preconceived opinion or prejudice.

Working with diverse people

Cultural awareness is an essential skill for support workers to develop.

People requiring support from community and health services organisations are as **diverse** as the general population is. They come from different cultural and socioeconomic backgrounds, are of different ages and genders, and have varying levels of support from their families, friends, and the wider community. This means that the needs of these individuals are also diverse.

It can be particularly challenging for some workers to overcome their **stereotypes** and personal **bias** as we all tend to see the world through our own cultural perspective. To work effectively and meet the needs of their clients, care workers must reflect on their own biases and prejudices and overcome them. Without this reflection, the quality of service offered to clients will be negatively affected.

Support workers and other stakeholders must acknowledge and understand their clients' diverse needs and respect the varying backgrounds that underlie these needs. Workers should never rely on stereotypes but should use a range of strategies to overcome any barriers the person may face to meet the individual needs of each client.

Communicate with people from diverse backgrounds

Where cross-cultural communication can pose a challenge for the person and support worker, a cultural interpreter can be helpful in this area, as they interpret for both cultures doing their interactions from a cultural perspective, interpreting not only language but body language and other social cues. For example, you may need to greet a person a certain way or need an interpreter to assist in language interpretation. Cultural interpreters and Aboriginal Liaison Officers can help avoid cross-cultural miscommunication and help build positive working relationships with clients and other staff. Here are some other examples:

- Find out how people from diverse backgrounds may come across barriers that challenge their ability to access the same opportunities as others.
- To improve your cultural knowledge, research and learn how communication is practised in other cultures.
- Engage with local multicultural services that can provide you with cultural information and other forms of learning.
- Arrange for professional development training on cultural awareness and cultural safety.
- Arrange for an interpreter to attend a meeting if required.
- Speaking to a colleague of the same background as your client can be useful, especially for clients you are meeting for the first time.
- Offer written information that has been translated into the person's first language
- Refresh your knowledge on anti-discrimination legislation, workplace policies, and procedures related to bias and inclusion.

Multifaceted needs of individuals

A client with **multifaceted** needs requires several targeted supports based on their characteristic or environmental needs. For example, seeking employment for a person with a disability or long term unemployed person, requires not just getting the actual job but also the social skills, support needs to maintain the position, and the education/training to do the work.

Multifaceted
Something involving several different aspects or containing many features.

To make the employment more successful, the employer or workplace may need to be viewed in terms of their disability awareness, accessibility and access to transport.

Holistic refers to the whole person's needs being supported such as their cultural, mental health, physical, emotional and spiritual needs. Examples of multifaceted or holistic needs include:

- a person experiencing homelessness often also has dental, physical and mental health needs those services need to address
- an unemployed person may have financial problems, mental health issues, and education and training needs
- an older people may have mobility or health issues that exist side by side with grief and loss, nutritional concerns, or mental health issues
- a person with an intellectual disability may require employment support and help to build social relationships, with sexuality, accommodation, etc.

Some clients require support to identify their needs. This may mean seeking permission to speak with carers, family members, health professionals or looking at care notes where support programs have been provided by other services. Needs will change, so the worker needs to check in with the person to determine if their needs are being met appropriately.

Collaborate with other service providers

It is uncommon for a client to only require support in one area. Support workers work alongside other community service workers and health professionals to ensure all clients' needs are met.

While some large community service organisations may have the resources and programs for most client needs, the likelihood is that you will need to collaborate with other service providers to gain specialist support on behalf of your clients. Collaborating with other service providers can help you understand individuals' experiences and gain new knowledge and skills.

It is important to remember that no one service can meet the needs of every client. This is referred to as meeting the limits of service.

Here are examples of a variety of support services that can be used to help meet a range of diverse and multifaceted needs of different groups of people:

LGTBQIA+ Services	• Mental health services • Emergency and share house accommodation • Social groups and events • Health services • Support groups

Aged Care Services	• Medical management • Advocacy • Meals and home care services • Support with personal care • Grief support • Social activities • Health services • Assistance with transportation
Disability Services	• Medical management • Advocacy • Social activities • Education and training • Housing to support independent living • Health services
Social housing and emergency accommodation services	• Provision of safe housing and mobile phones • Crisis accommodation and relocation • Legal aid and counselling services • Financial counselling • Mental health services • Child protection
Family services	• Parenting education • Child protection • Home support services • Financial hardship • Community integration programs for migrant and refugee families • Support with education and training
Employment Services	• Career counselling • Financial support • Mental health issues • Literacy and numeracy • Education and training
Mental health services	• Home support • Mental health management • Social activities • Support groups
Translation and interpreter services	• Over-the-phone translation services • Access information translated into diverse languages • Cultural interpreters

Aboriginal and Torres Strait Islanders support services	• Culturally appropriate health services • Culturally appropriate legal services • Employment services • Education and training • Counselling services

Example

Respect the diverse and multifaceted needs of the individual with others

Kim works at a residential aged care facility and is new to the role. Margaret has recently moved to the facility as her dementia has advanced, and she needs 24-hour care. Kim has observed that Margaret doesn't want to interact with other residents and prefers to stay in her room. Kim sits with Margaret to get to know her and Margaret reveals she feels sad and doesn't feel confident about walking in case she falls. She also says that she misses not going to church.

Kim speaks to her supervisor and her supervisor suggests she speak with the client support officer as she can suggest some activities that Margaret may enjoy.

The information she shows Margaret include pictures of different activities offered by the centre and bus trips including gardens and wildlife centres they regularly visit. Margaret agrees to walk with Kim around the facility. Kim introduces her to some people and the spend some time getting to know them. Kim then arranges for Margaret to meet the Chaplin. They walk around the chapel and Margaret seems pleased to be in the church and asks questions about the times of the services.

Consider why you must respect the individual needs of those you support. How might this inform your care?

Practice Task 3

Question 1

Match the beginning of each sentence about providing service delivery to the correct ending

Cultural awareness	A wide range of different characteristics, including culture, gender, sexual orientation and ethnic background
Bias	Involves targeting several different aspects of a client's characteristics or environmental needs
Diversity	A feeling of liking or disliking a person or group of people due to characteristics that are beyond their control
Multifaceted needs	Being aware of cultural difference and diversity and developing a sensitivity and respect for difference

Question 2

Which of the following statements relate to collaborating with other service providers to support a client? Tick all that apply.

- ❑ One service provider should be able to provide support for the holistic needs of their clients.
- ❑ Collaborating with other service providers means access for specialist support.
- ❑ Clients with multifaceted needs require several targeted supports.
- ❑ Clients from CALD backgrounds have needs that will also be diverse.

1D Supporting client interests and rights

Support workers play an important role in ensuring a client's rights are protected.

An important aspect of the trust that develops between a worker and their client is that the worker will advocate for them and help them achieve their basic rights. When people feel in control of their lives, they are more likely to take an active role and contribute to decisions being made about them. Their outlook can improve and accessing quality support can boost confidence and willingness to try other things.

As a support worker, you play a significant role in this process. Your ability to connect people with economic, social and cultural supports, provide accurate information, assist in decision making, and build trusting relationships all contribute to a clients' self-determination.

Providing service information

Providing clear and accurate information to people who are using services from your organisation is very important. It is the person's right to be fully informed before deciding if the services are suitable for them. The volume of information can be overwhelming, particularly for clients where communication is a barrier. When clients do not know or understand what is happening or what they are being asked to do, they can become quite distressed, anxious, and even aggressive.

The table below gives you a few examples of the types of information a client will need to understand.

Types of information
• Information about the services and programs provided by the organisation • Information contained in service contracts • Boundaries of worker roles and responsibilities • Eligibility criteria for accessing a service • Privacy and confidentiality policies of the organisation • Information in their plans • Rights and responsibilities of the client • Rights and responsibilities of the service • Financial information about payments • Codes of acceptable behaviour

Using effective communication

Service information must be presented and explained in a way that meets each person's individual needs. Here are some examples:

Barrier	Strategies
Verbal Communication	• Speak slowly • Speak clearly • Use plain English • Check the person understands you • Arrange for an interpreter • Use non-discriminatory language
Written Communication	• Provide information that has been translated into the persons' first language • Use pictures and images to support written content • Ensure information is not too wordy or uses complex industry vocabulary or acronyms • Use plain English for printed information

Supporting the interests of clients

An individualised plan outlines personal information about the client. The client's plan will provide information about the person's history, the type of care, goals and aspirations, and describe the type and level of supports. Clients should be involved in the development of a plan, so it reflects their strengths and abilities, not just their problems or issues. They are provided with the opportunity to voice the goals and services they want to interact with. They can make changes at any time when they feel it is not helping them progress or not meeting all their needs.

- Ask the client what they are good at.
- Ask them if they would like to learn anything new.
- Ask the client about past achievements.

Concerning consent from the client, talk to family members, other caregivers, health professionals and service providers. They may tell you what the person's strengths are.

Supporting clients' rights

Support workers can uphold the rights of the client by helping them to make decisions that are right for them. Supporting their rights can also mean supporting or representing them in complaints processes and attending meetings – depending on your job role. Rights also extend to upholding your service's responsibilities for privacy and confidentiality, treating people fairly and equally and with dignity and respect.

Some of the rights of the client are encapsulated in law such as legislation regarding child or elder abuse, privacy, or anti-discrimination, and work health and safety. Other rights, known as human rights, are outlined in international treaties and conventions, such as the Conventions on the Rights of Persons with Disabilities and the Universal Declaration of Human Rights.

You can read more about human rights at the following sites:

- aspirelr.link/crpd
- aspirelr.link/udhr

Decision making

When deciding on services, the client, the support worker, and representatives of other services must all work together. The person will explain what they need, want to achieve and the support that could help them. Using this approach will help the person feel supported and make decisions that will benefit them.

Your role will sometimes require you to support clients to make decisions. As discussed, the greater client's contribution in developing their plan, the greater their chances of achieving their goals. For some clients, making decisions can be challenging, particularly for those with cognitive impairments. You may have to provide extra information or ask questions in different ways to find out their needs and goals. Any decisions related to consent or services fees, must be communicated clearly and the person given time to consider their responses and be encouraged to ask questions.

You can support the person in their decision-making capacity by doing some of the following things:

Provide Information
Clients need to be given accurate and current information relevant to them. Written information can be read to them, or you can read along with them. You can answer questions and clarify information they don't understand.
Explore Options
Once you know your clients' goals and strengths, you can suggest the appropriate programs and services. Then you can research with the client different service options and make the referral together, if the client is happy to do so.
Implications
You must consider costs and travel when sourcing a service. Your client may want to use local services. Some services offer home visits, or you can arrange for a visit to the service so the client can meet the workers and get a feel for the place before they decide.

Support network

With the client's consent, they can choose to have other people to support them in decision making. The client can consider alternatives, and they can also give you feedback.

Example

Supporting the rights and interests of the individual

Read the following example to learn about supporting an individual's rights in a care capacity.

Samira's husband recently passed away. She now lives alone, but the house is too big for her to maintain. She has been thinking about moving into an independent lifestyle village because they offer security, and the units are easy to maintain. Samira meets with Julio from a local support service to discuss her needs. In addition to finding a place to live, she needs support with transport to community activities.

Julio suggested different accommodation options for Samira to visit and arranges to take Samira to tour the facilities. Samira asks lots of questions so make sure she understands. Julio explains the offers, costs, and eligibility criteria for each option and offers to write up the information so Samira can read it again and show her son and daughter.

Julio has found several transport services options for Samira, including one that will take her in a private car to appointments and other places she needs to go for a fee.

Practice Task 4

Read the case study, then answer the questions that follow.

Case study

Lillian and her family are from South Sudan. They have recently migrated to Australia with help from a refugee program and don't speak much English. It is unknown how much schooling Lillian or her children have had. Joseph is meeting with the family to identify their support needs and to begin the process of access to services for Lillian and her children to help them integrate into their community.

Question 1

Suggest three ways to ensure Lillian will be provided with clear and accurate written information on the service to enable her to give informed consent.

Question 2

Which of the following statements relate to supporting the interests, rights and decisions of a person? Tick all that apply.

- ❑ The client can explain what they need, want to achieve and the support that could help them.
- ❑ Plans cannot be changed if the plan is not helping them achieve their goals.
- ❑ The support worker can ask the person's support network and health team to identify their likes and dislikes.
- ❑ Supporting the rights of the person involves upholding the service's responsibilities to the client.
- ❑ Supporting the person to make decisions means providing accurate and current information on service options and fees.

Summary

- A significant part of a support worker's role is communicating effectively and adapting communication skills to the person's level of understanding and ability to communicate.
- Effective communication, and the use of strategies that will enhance understanding such as active listening and questioning, is essential in building a relationship of trust.
- Support networks can consist of other carers, family members, health care professionals, and stakeholders from other services.
- Showing empathy and kindness to others is a demonstration of goodwill and helps build strong relationships.
- Protecting a client's right to privacy and maintaining confidentiality is a legislative requirement.
- The way support workers manage confidential information can impact on a person's dignity, rights and choices, opportunities, access and self-image, self-esteem and wellbeing.
- People needing support from community and health services organisations are as diverse as the general population.
- A client with multifaceted needs requires several targeted supports based on their characteristic or environmental needs.
- Collaboration with other services is essential to meet the needs of people from diverse backgrounds and those with multifaceted needs.
- Information provided to people interested in using services must be clear and accurate and support their decision making.
- A support worker's ability to connect people with economic, social and cultural supports, provide accurate information and assist in decision making all contribute to a clients' self-determination.

Learning Checkpoint 1

Establish and maintain relationships

Part A

1. It is the support worker's responsibility to ensure that they can establish positive working relations with their clients. List four communication strategies a support worker can use to demonstrate genuine interest in the person they are supporting.

2. Match each term about organisational requirements for privacy and confidentiality to its definition.

Privacy	The service has permission to share personal information with a third party.
Ethical	The right to expect personal and health information will be protected, i.e. private and secure.
Consent	Information is shared with others without permission being given.
Breach	The client gives their permission to have their information collected.
Disclosure	Acting in a way that demonstrates honesty, fairness and equity.

3. You overhear a colleague talking on the phone to a friend. During the conversation, your colleague shares personal information about one of her clients. What is your duty of care in this situation?

4. Which of the following statements relate to role and responsibilities of different people in the planning process? Tick all that apply.

- ❑ Carers have a duty of care to protect their clients from any foreseeable harm.
- ❑ Health professionals monitor the person's progress with their treatments.
- ❑ Support workers look for ways to improve how their services are delivered.
- ❑ Assessors determine the level of support a person is eligible to receive.
- ❑ Service providers check that staff adhere to relevant legislation and that laws are reflected in their service policies and procedures.
- ❑ Service delivery workers provide information to the service about the types of treatments the person is receiving.

Part B

Read the case study, then answer the questions that follow.

Case study

Gloria is an Indigenous Elder who has come to live at an aged care facility. She has several medical conditions that require her to attend regular medical appointments, but her family cannot always help with transport. Nicola is the worker asked to gather information from Gloria so they can develop a support plan to meet Gloria's needs.

1. Suggest three ways Nicola can interact with Gloria to help build trust and goodwill.

2. List at least two reasons why Nicola should maintain Gloria's confidentiality and privacy.

3. Suggest two of Gloria's multifaceted needs and identify three types of services that Nicola could suggest to Gloria to help support these needs.

4. List three ways Nicola can explain information about service delivery to Gloria and her family.

5. Which of the following statements about supporting Gloria's interests, rights and decision-making are correct? Tick all that apply.

- ❑ Determining a person's strengths is not part of service delivery and must be done by a psychologist.
- ❑ Some of Gloria's rights are upheld by legislation.
- ❑ One way to identify Gloria's interests and strengths is to ask her what she is good at.
- ❑ Gloria must check any decisions with her support team to ensure she is making the right choice.

Topic 2: Prepare for planning

2A Physical and psychological factors that influence service delivery

2B Planning processes and service options

2C Determine readiness for plan development

2D Including others in the planning process

2E Preparing and distributing information

2A Physical and psychological factors that influence service delivery

Understanding a person's life stage will ensure the support provided is best for the person's progression.

The starting point for developing an individualised plan for a client is to identify the person's life stage. From birth to death, we transition through phases of physical and psychological development and growth. During these phases, a person will achieve several milestones. Life stages can be separated into:

- childhood
- adolescence
- adulthood
- older adulthood.

The person's plan must be customised for their level of development and consider other factors that can impact on progression through life, such as medical needs, disabilities, and mental health issues.

Life stages

However, ages, stages and marked milestones will vary from person to person. Milestones can be tracked and monitored and appropriate actions and planning need to reflect the progress of each individual person.

For example, if an infant or child requires medical treatment, the adult caregivers will decide about health care. Once a child reaches adolescence, from the age of 16, they can choose their own medical care needs either independently or with support from others.

In the later years of life, an adult may have a medical condition that affects their ability to make sound decisions. Sometimes, another person will be authorised to make medical decisions on their behalf. This is called a medical power of attorney. This only gives that person the right to make decisions that relate to medical treatments.

Physical factors

As we move through life's stages and age, our physical needs change. Information on a person's physical abilities will influence service delivery. Everyone's physical development is different but follows a similar pattern. The support one person may need will not be the same as another but generalisations can be made about milestones that will be reached in each life stage.

Examples of physical milestones that may need to be considered when developing a person's plan are outlined in this table:

Stage	Physical factors
Early childhood	• Long, slow physical growth • Behavioural challenges • Rapid cognitive development • Development of speech
Adolescence	• Rapid growth spurt increasing height and size • Increased risk of injuries from risk-taking behaviour • Puberty
Middle adulthood	• Deterioration of the senses, e.g. Eyesight and hearing • Weight gain • Muscle strength begins to decline • Menopause for women
Late adulthood	• Deterioration of mobility and muscle strength • Increased health and medical conditions • Dental health needs • Increased likelihood of a fall

Psychological factors

Psychological factors can have a significant influence on service delivery options. For example, psychological and mental health needs can affect a person's ability to make decisions, judge situations, regulate their emotions and interact with others. For an older person who may be experiencing the onset of dementia, they will start to show signs of memory loss, which can affect their level of independence and their ability to perform daily activities. Again, these are only milestones but can be used as a measure of psychological and emotional growth and development.

Examples of psychological factors affecting planning include:

Stage	Psychological factors
Early childhood	• Delayed speech • Communication skills • Ability to form healthy attachments • Ability to trust
Adolescence	• Mental health • Ability to develop strong and intimate relationships • Brain development to solve problems and predict consequences • Transition to independence

Stage	Psychological factors
Adulthood	• Mental health • Transition to an empty nest • Obtainment of career goals • Information processing begins to decline
Late adulthood	• Loss of memory • Sleep and behaviour disorders • Cognitive deterioration • Process of grief • Need for social interaction

Example

Factors relevant to an individual's life stage

Tom is 62 years old and recently had a stroke. The stroke has affected the language centre in his brain. Before he became unwell, Tom owned a small car repair business. He lives with his wife and his children are grown and have children of their own.

Since the stroke, Tom has not been able to run his business as he used to. He is unable to speak fluently and finds it difficult to use the right words to communicate.

Tom is still enthusiastic about life, but has had to find other ways to communicate effectively. He also sometimes finds it difficult to manage his emotions. Tom enjoyed running his own business as it gave him a sense of satisfaction to be able to employ others and support his family. Tom is considering his future – selling his business, working part-time and taking up volunteer work.

Tom's support worker will need to consider all of the factors and changes in Tom's life, when working with him to develop and plan suitable services to meet his needs.

Think about factors you might need to consider in your workplace when clients' needs change.

Visit this website to find out how physical, psychological (and social) factors relevant to the person's life stage will influence service delivery: aspirelr.link/assessment-process

Practice Task 5

Read the case study, then answer the question that follows.

Case study

William is 85 years old, and you have recently been asked to support him in the planning process of his individualised plan. He lives in his own home but has had complications due to his diabetes, including having to have both legs amputated. He needs supported accommodation and is now using a wheelchair. He misses being able to do many of the activities he used to enjoy such as lawn bowls.

Question 1

Which of the following factors relate to William's service needs at his stage of life? Tick all that apply.

- ❑ Need for social interaction
- ❑ Increasing confusion
- ❑ Serious medical condition
- ❑ Lack of mobility
- ❑ Need to play a sport
- ❑ Rapid physical growth

Question 2

Match each stage of life to its description of either physical or psychological factors.

Children have a long, slow growth period	Psychological
Children learn to form healthy attachments	Psychological
Adolescence is a period of rapid growth	Physical
Adolescence is the time for transition to independence	Psychological
Adulthood is when eyesight and other senses begin to diminish	Psychological
Adulthood involves transition to an 'empty nest'	Physical
Older adults have an increased risk of a fall	Physical
Older people can have dementia with confusion	Physical

2B Planning processes and service options

The key to an effective individualised plan is to encourage and support the person to make decisions.

Individualised plans are formal documents that outline the type of services to be provided to the person. The structure and information included in a plan will vary depending on the service that develops the plan.

For example, a family and domestic violence support service will develop safety plans with the families who use the service. Employment services will develop job plans that outline the person's mutual obligations for receiving income support, and aged care and disability services will develop care plans. They should be used as tools to help achieve outcomes.

An effective plan can be followed by all stakeholders and the client. Thorough planning can help ensure the effectiveness of the planning process. Stakeholders, including the person receiving services and their significant others, are more likely to support the planning process if they understand its purpose, so you must explain the process to them.

Strengths-based approach for plan development

Individualised plans focus attention on the person's strengths and capabilities.

A **strengths-based approach** helps people feel more satisfied with their life and recognises that all people can succeed. For a person to achieve their goals, building on their strengths using appropriate tasks and activities will increase successful outcomes. Placing attention on what the person is unable to do will affect their confidence.

Strengths-based approach
Recognises that all individuals are resourceful and resilient experts in their lives, and can progress in a way that enhances their quality of life.

This approach is not about fixing the person. Instead, it is about drawing attention to what the person can do and what they enjoy and using this information as the baseline to move and progress.

For this process to work effectively, the support worker must work collaboratively with the client, support people, health professionals and other service providers to create a supportive network. The network of people supporting the person can then ensure the person has access to the necessary resources to meet their goals. This will give the person the confidence to work with their plan.

The following table outlines the characteristics of the strengths-based approach:

Purpose of the approach	• Builds on a person's strengths and capabilities to make positive and meaningful choices • Promotes the person's wellbeing by providing resources that enhance quality of life and independence • Uses motivational strategies with the person that will drive them to goal achievement
Role of the support network	• Carers, family members, support workers, and other stakeholders work with the person • The person is acknowledged as the expert and must be the centre of all decision making. Decisions are not made for them • Provide the information to support the person in making informed decisions • Empower the person, so they have the confidence to decide what is right for them
Areas of focus	• Goal achievement • Outcomes focused • Recognises the barriers a person may have in what they can do, their strengths and their resources • Avoids making assumptions about the person • The person is seen as a valued person in society who has something to offer.

Video: Strengths-based approach

Watch this video for a description of how a strengths-based approach underpins support, and interventions used in the community services and support services: aspirelr.link/strengths-based-approach

- Listen for information on how to respond to the following questions:
- How does a strengths-based approach provide more than meeting a person's needs?
- How does an outcome focused approach provide a better life for the person?
- How does moving away from an approach where workers focus on questions on a printed form to having a conversation and asking, "What does a good day look like?" provide a better outcome?

Purpose of the planning process

The person should be part of the planning process so they can make decisions for themselves and build a sense of self-worth and empowerment.

Some clients find the planning process stressful, so you must explain this carefully before any scheduled appointments. Provide written information ahead of time. The person may be unaware of the volume of information they are expected to give and receive. By explaining the process for planning, they are being informed in advance, leaving no surprises.

A welcome pack is a good introduction to a service that is given to the person. This may contain information about the service, such as brochures, important contact numbers, information on other services in the organisation's network, and any financial assistance they may be eligible for.

The purpose of the planning meeting is to assist the person in establishing their goals, determine the person's status and create a strategy that will help the person achieve what they need or desire. This information will form part of the individualised plan.

The planning process has three major parts to it:

1. Establish the person's goals
Gather information about the client including about the person's health status, review other case notes and any other information you have consent to access. You need to talk to the person and their support people and find out their goals.
2. Determine the person's status
Check the currency of the information gathered with the person to determine if their condition is stable, getting worse or improving. From the conversation, you then have a clear picture of the person's situation.
3. Develop a strategy
A strategy is a resource offered to the person to meet their needs. Consider the holistic needs of the person such as physical, financial, and cultural needs. You may need to source external services to help meet any gaps not provided by your service. This may involve checking for eligibility and waiting lists. If the person has to be placed on a waitlist, you can use another strategy in the interim if the person believes it will benefit.

Discuss different service options

As a support worker, you must be aware of the services available in your organisation and other organisations in the area where you work. Many clients need to access services close to where they live to allow for transport needs. For those confident in using public transport, a bus timetable or journey planner can be used. If the person speaks English as a second language, then find out what services are on offer for the meeting such as an interpreter.

You will need to discuss the different service options available to the person. Make sure they understand the process, any eligibility criteria and any costs involved. When you work with other services, you must invite the presentative of that organisation/service, to the planning meeting. This will allow the client to meet with their support network, and a relationship can begin to be formed.

Attendant care and support work services	Attendant care services help the person to manage everyday living. They may offer support for personal care, domestic and gardening duties, home medical care, community engagement, and assistance in their rehabilitation plans.
Recreation, leisure, community access	Recreation, leisure, and community access services provide people with access to recreational and leisure activities, such as low-impact sports, computer classes, art, music and cultural community groups.
Community nursing services	These services provide in-home care to manage medical issues, such as wound care. Other medical assistance can be offered, such as monitoring medications, taking blood pressure and performing other medical treatments.
Complex support coordination	Due to the number of services involved in providing multifaceted care for the person's complex needs, this style of care is referred to as case management.
Positive behaviour support services	Provide support for persons who display challenging behaviours using specific positive reinforcement strategies.
Respite services and short-term stays	These services offer carers some time away from their caring duties to attend to their own needs which often get neglected. Respite services can occur in a person's home when another support person will take over the caring duties for the person, or the person requiring support may move to another location for a short time.
Emergency support	A variety of supports are available when a physical or psychological emergency occurs. These range from ambulance or transport services to telephone or online helplines and visiting emergency experts such as 1800RESPECT for information and referrals for support for sexual assault, domestic or family violence.

Brokerage services	Brokerage services have different purposes. For example, they can specialise in the provision of support staff. This can be for temporary solutions or more permanent arrangements, with a wide range of expertise levels. They can act as the link between two organisations when referring clients to government-funded programs where referrals by brokers are a contract requirement.
Healthcare planning	A service to plan and implement health care, as needed.
Supported accommodation services	Provides accommodation staffed by support staff. Support can differ dependent on the person's needs and goals. The types of accommodation include group/shared housing, transition, respite, and independent living arrangements.

Example

Purpose of the planning process

Hugh is a coordinator for a disability support service. He uses a number of creative ways to encourage the clients to contribute to the planning process. For example, Hugh is working with a young man named Darren. Darren has a cognitive impairment resulting from an accident.

To help Darren understand the planning purpose, Hugh adapts his communication style for Darren. He slows down his rate of speech and uses simple words. He uses diagrams to explain Darren's options on a sheet of paper, Hugh draws a circle captioned "You are here". They add arrows with words that describe Darren's strengths and weaknesses.

On the other side of the sheet of paper is another circle designed like a target. With some prompting by Hugh, Darren identifies his goals and where he would like to be living in the future.

This diagram helps Darren provide the information they need to begin the planning process.

What creative ways can you think of to plan with clients?

Practice Task 6

Question 1

Briefly describe one benefit of informing the person and their support people about the planning process.

Question 2

Outline what a strengths-based approach involves.

Question 3

Which of the following statements relate to the purpose of the planning process? Tick all that apply.

- ❑ Tell the person what their goals need to be.
- ❑ Have a conversation to clarify the person's current circumstances.
- ❑ Consider the holistic needs of the person.
- ❑ Clearly explain the service options available.
- ❑ Arrange for an interpreter if the person has a disability.

2C Determine readiness for plan development

For an individualised plan to work successfully, clients must be able to participate actively.

Service standards make it clear that any community service organisation and staff must take reasonable steps to ensure the person is the 'driver' of the care plan. The plan is used to enhance the person's quality of life; therefore, three main factors that impact the person's readiness to plan include:

- their ability to understand what the plan is for and make fully informed decisions
- their ability and obligations to fulfil their responsibilities in a plan
- the support services and people available to provide the support they require.

Assess for plan readiness

A person's ability and life experience will determine how well they will be able to plan. Therefore, identify the factors that affect a person's ability to plan to determine whether they are ready to help prepare it. These factors are explained below:

Capacity to make decisions
A range of factors can limit a person's decision-making ability in the context of medical care and treatment. For example, cognitive impairment, intellectual disability, brain injury, mental health and substance misuse can prevent making decisions that best meet their needs. These factors also act as a barrier to informed consent.
Capacity to understand the planning process
A person has the right to be fully informed and understand why they are providing consent. You need to make sure they understand what is being said and not just nodding in agreement. Capacity to understand the process varies significantly between individuals. People from CALD backgrounds or who do not speak English, may have other barriers to communication for reasons such from an acquired brain injury or intellectual disabilities. You may need to use the services of an interpreter, augmentative and alternative communication systems, or adjust your communication style to be understood so the person knows what is expected of them.
Capacity to participate in the plan
A person's capacity to participate can be affected by their impairments, confidence, and sense of self-worth. You will focus on their strengths which will help them develop confidence and self-esteem to give them the courage to try new things and want to improve on or reach their goals.

Involvement of an advocate

An advocate is an individual who promotes the interests of the person and ensures the person's human rights are respected and they can participate fully in the community. An advocate can assist the person in understanding their rights and the choices that are available to them and can represent the person when their rights have been breached or violated and need to be defined.

Choosing service options

The most suitable service options need to support the person's circumstances and preferences effectively. A person-centred approach means acknowledging a person's choices and their right to make their own decisions. Every person will have their own set of likes, dislikes, experiences and background, so options that may suit one person may not work for another.

A range of other factors need to be considered including:

- their financial resources
- support of family, friends and the community
- their physical and psychological factors
- their specific situation or circumstances
- their ability to access services.

The selected options should then be updated and documented in the person's plan.

Principles for the person-centred approach

- Show respect and understanding to the person.
- Support the person to make decisions about their own lives.
- Give priority to the wishes and choices of the person.
- Acknowledge the person is an expert in their life and give attention to what they can do well and their past achievements.
- Provide the person access to resources in their communities.
- Work with the person to envision the future and formulate creative strategies that will assist them in achieving their goals.
- Ensure the person feels empowered and supported.

Example

Determine readiness for plan development

Belinda is working with Archie to assess his readiness to develop an individualised plan. Archie has been struggling to make decisions since his partner died.

Belinda has explained to Archie the planning process and has confirmed that he understands the process. It takes several meetings and some support for Archie to decide on service options. Archie says he feels comfortable working with Belinda, as she reminds him of his daughter and because she has not rushed him into making any decisions he feels he may regret. Archie's identified goals are to join a widowers' group, connect with others, and build his support network.

Think about how you might determine if somebody you support is ready to be involved in developing their individual care plan?

Practice Task 7

Question 1

Briefly explain how to determine a person's readiness for the planning process.

Question 2

Match the beginning of each sentence to the correct ending.

The capacity to participate	is making sure the person understands so they can make informed choices and give consent based on their understanding.
The capacity to understand	is an approach where the person that leads the planning process.
The capacity to make decisions	ensures the person has the confidence to focus on improving their life and making changes or trying new things.
Person-centred planning	is the person's ability to make choices that are best for them to meet their needs, interests and goals.

2D Including others in the planning process

Knowledge of other support providers allows for continuity of services and prevents supports being duplicated.

To access personal information and records, the person will need to give their consent for their information to be shared with others. Once this has been received, you will be able to access and use information that has been gathered for other purposes.

It is not uncommon for clients to have had experience with other services, especially individuals with chronic or complex conditions. Health professionals that are familiar with the client's history can provide you with information during the planning process. They can provide background on the person's strengths, weaknesses and suggest strategies to give the person the best support.

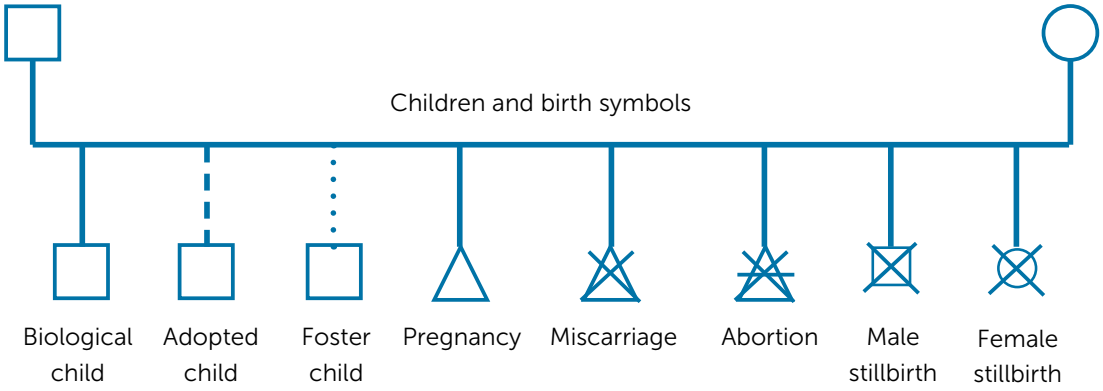
Other people, including those from other services, can offer valuable insight into the person's strengths and weaknesses, as can family members and friends. These people can also support the implementation of an updated or new plan.

It can be a difficult task to identify all the relevant stakeholders, particularly for clients who have been receiving supports over a long time or those that have complex or multifaceted needs. Access to referral letters, doctors and other reports can help you determine who can provide you with advice about the person's needs; they also help you select the appropriate strategies based on what has been tried, tested and what has been successful.

Furthermore, sometimes it can be quite challenging for clients to identify the people in their life who they can rely on for support. For example, this may be due to little or no contact with family or friends, experience with violence or if they have never had support from their family. There are some tools that can be useful to assist the person in identifying the significant people in their lives.

Genograms

Genograms are a visual tool used by people in the community services sector to map relationships. They look like a family tree and are a visual way of looking at the relationship patterns of the person.



Genogram symbols for child links and special births

Ecomaps

Ecomaps are useful for CALD clients and can help build a detailed picture of support people and the connections they have to the person, other significant people, and their community.

Instructions on how to draw an ecomap can be found on the internet including instructions developed by Jesuit Social Services: aspirelr.link/ecomaps

Participation in the planning process

For a plan to be effective, you need to understand the role of others in the planning process. People who might be involved may be the assessor, the carer, support workers, health professionals and other service providers. Other significant people, family members, friends, neighbours, or community and religious leaders may also be included.

The person needs to agree for each of these people to be involved and agree to their roles and responsibilities in the process. Different roles can be providing reports, attending planning meetings, or acting as a support person during the process but not attending the meetings.

Family and other carers

Carers can be professionals or family members and friends. Carers will understand the person's needs, strengths and abilities and provide information about care requirements. If carers are going to be involved in implementing the individual plan, they should be involved in its development. Discuss the involvement of carers with the person to confirm they are comfortable with who is involved in the planning and what level of input they will have during the process.

Other service providers

It is not unusual for the support provided to be in the form of a care team with people representing different services that offer resources to the person. For example, people who have complex care requirements may require high-level care using a range of services for clients with paralysis, acquired brain injury (ABI) or with a psychotic mental disorder.

The roles and responsibilities of health professionals depend on their involvement and the services they provide.

Role	Roles and responsibilities
General practitioner	A general practitioner, often referred to as a doctor, may have a long-term relationship with the person. They will have access to medical records with information on health issues and chronic illnesses and will know about all medical treatments the person is receiving.
Physiotherapist	Physiotherapists have a specialisation in the structure of the human body. They often work across a range of health settings which include residential care with older people. Physiotherapists assess, plan and oversee treatments that relate to the gross motor skills of a person who has medical conditions, which include stroke, diabetes, physical injuries, osteoarthritis and palliative care.
Occupational therapist	Occupational therapists work the fine motor skills of a person. This includes gripping small items, balance, strength, and speech. These are skills that will enhance the daily living experience for people who require their services.
Psychiatrist/ psychologist	A psychiatrist or psychologist has information regarding the person's mental health and ability to participate in the planning session and plan implementation. A psychiatrist can issue prescribed medication. They will have information on the person's mental health treatments and may share information regarding the person's strengths and abilities.
Community nurse	Community nurses support the person by meeting their medical needs outside a hospital environment. They can provide medical assistance such as wound care, conducting medical observations and they work collaboratively with medical experts. In addition, community nurses can provide valuable information regarding medical treatment and identify the person's strengths and abilities before the planning session.

Prepare for planning meetings

Review your organisation's procedures for the planning meeting, as there may be several people who need to know the arrangements. This includes details of where the meeting will happen and what type of room is required. Specific resources may be needed, such as a computer for Zoom or Teams meetings if not everyone can be in the room at the same time, or augmentative communication devices, such as large print or communication devices.

Here are some practicalities you should consider to ensure the meeting runs smoothly:

Procedure for organising a planning session

- Find a suitable time and date that works for everyone.
- Share information about date, time and how to log in if relevant.
- Book an appropriate venue like a meeting room at your organisation or meeting in the person's home.
- Ensure that the venue is accessible by everyone attending.
- Make sure that the person you are supporting has access to transport to attend.

Example

Including others in the planning process

Barbara, an aged care worker, has concerns regarding one of her clients, Mrs Jonas, who has made an appointment to see her GP for a mental health assessment. Barbara has not received any feedback from the GP about the appointment which occurred two weeks ago. She checks with Mrs Jonas, who reassures her that she attended the appointment and provided her consent for the clinic to provide Barbara with a copy of her mental health plan. Barbara phones the clinic and explains the situation. The GP confirms Mrs Jonas attended her appointment and sends through the report.

What are some of the other professionals that may be involved in the planning process for your clients?

Practice Task 8

Read the case study, then answer the questions that follow.

Case study

Simon has mild cerebral palsy and is about to move out of the family home and into a shared house with other young people. This will be the first time Simon has lived away from home, but it has been his goal for some time. He is excited but knows he will miss his family. For two years, Simon's family has been working closely with the NDIS local area coordinator, and David's GP, to arrange for Simon to have an independent living arrangement. Arrangements have been made for David, a support worker, to work with Simon to develop an individualised plan to support his needs and goals.

Question 1

Identify a role and responsibility for each member of Simon's support network:

- Simon's family
- The GP
- Local area coordinator
- Support worker

Question 2

List three responsibilities of the support worker when ensuring Simon can work effectively with his plan.

2E Preparing and distributing information

Distributing information before a planning meeting ensures all stakeholders can be prepared in advance.

Before planning can occur, ensure you have all the necessary information. The plan starts with identifying basic daily needs such as meeting nutritional and accommodation needs, to more complex activities, such as making friends, obtaining work and building confidence. In addition to personal details and contacts, the documentation may include assessment, consent and referral forms.

Gather and prepare information

Service providers will often require staff to use templates to record information to prepare for a planning meeting. These might include meeting agendas, assessments and individual plans. A template is a document that has been specifically formatted for the organisation's purposes. Using a template ensures consistency across the organisation because it is a standardised format. Best practice means making sure you are familiar with the form's layout and know what information is required.

Standard inclusions in templates

- Document control information – creation date, who created it, and version number
- Personal details, including emergency contacts
- Any conditions that may become a barrier to the implementation of the plan
- The person's goals and desired outcomes
- Strategies that will be used to support the person
- A list of people responsible for implementing the plan and their responsibilities
- Resources required to implement strategies
- Plan review date

Distribute information to stakeholders

Once you have collated all the necessary information, share it with the relevant stakeholders before the planning session, and confirm it has been received. Stakeholders can then prepare by familiarising themselves with the information about the person's health history and personal goals, and consider the support they can offer, eligibility criteria and any financial costs.

When email is used to distribute information, consider potential issues with privacy and confidentiality. Take care to ensure that only the people who have been given consent receive the personal and sensitive information. A disclosure statement in the email signature will instruct the recipient to delete the email, not share the

information contained in the email and inform you of any error. You can also set up to receive an alert when the email has been delivered or follow up with a phone call to confirm the information was received.

You can keep a record of who has been contacted and the method used to provide the information and if they will be attending. These records can be stored in the person's file, or in the online database with notes, as required. This is evidence that you have made contact.

Below are some methods you could use to distribute information.

- Email
- Internal mail to a colleague
- Post
- Hand deliver
- Phone

Example

Corresponding with stakeholders

Kimberly is a care supervisor for an in-home care service. She has finalised the documents for Emmanuel's planning meeting.

Here is a copy of her email sent to the stakeholders who will attend the meeting.

To: a.brown@health.au, j.williams@homehelp.com
Cc: m.y.manager@carecentral.com.au
Subject: Client – Emmanuel Brown
Good Afternoon Please find attached information regarding our new client Mr Emmanuel Brown to assist in your preparation for the planning meeting scheduled for 12 June 2023. Shortly, you will receive a calendar invitation. If you have any questions, please do not hesitate to contact me. Kind Regards Kimberly McDonald *Care Central Community Service* This e-mail is intended for the use of the addressee only and may contain confidential information. If you are not the intended recipient, you are hereby notified that any use or dissemination of this communication is strictly prohibited. The sender disclaims liability for any errors, omissions, viruses, loss and/or damages arising from using, opening or transmitting this email. If you receive this transmission in error, please notify Care Central immediately on (03) 1300 1300 then delete this email.

Documenting planning sessions

Before the planning session commences, a person is delegated to be a notetaker. It is standard practice to convert notes from meetings into minutes. These are then distributed to all attendees following the meeting. If a stakeholder was not able to attend, their name will be documented in the apologies section of the minutes. They can read the minutes and stay informed of what occurred during the meeting.

Meeting minutes outline the discussion points and tasks people must complete and time frames within which those tasks need to be completed. Meeting minutes become a record of the meeting and are a reminder to all the participants.

Here is an excerpt of completed meeting minutes:

Meeting Minutes	
Date	10 February 2023
Time	11.00am
Location	Meeting Room 2
Notetaker	Jackson Smith
Attendees	Benjamin Woods (client), Jackson Smith, Michael McLeod, Rebecca Burbridge.
Apologies	n/a

Key Discussion points

- Identifying Ben's strengths, interests
- Goal setting using a MAPs goal setting tool
- Service providers discussed service options; Benjamin was encouraged to identify suitable options.

Item	Action Taken	Due by
Benjamin to tour the recreation centre	Michael McLeod	15 March 2023
Copies of finalised client plan to be distributed to participants	Jackson Smith	17 March 2023

Liaise with the assessor

Most people receiving services will require their eligibility assessed for access to government services.

Assessors are qualified experts and include rehabilitation counsellors, social workers, nurses, and registered psychologists and use standardised assessment tools to assess a person's capabilities. Registered NDIS providers and aged care services use assessors to ensure that the person is allocated the correct amount of funding and receives the appropriate level of support.

Assessors are used when funding is being provided from government sources. An assessor has the required skills, knowledge, and qualifications to assess the client's medical condition and health status. Without an assessment, the service will be unable to provide the support needed for the person.

Information provided to the assessor about the client will be needed so they can determine the appropriate services to support plan outcomes. The assessor will need information about the person's strengths and capabilities, any medical information, and the level of support the person is currently receiving. The assessor will explain medical information, so you have a good understanding of the challenges the person is experiencing. The assessor will recommend support and services and you can make recommendations based on your knowledge of working with your client.

Your role may be to make sure the assessor has the information they need before the planning session and to present the person with a list of service options that they might like.

For more information, visit these links about assessments in disability and aged care services:

- aspirelr.link/ndis-independent-assessors
- aspirelr.link/aged-care-quality-assessors

Assessment tools for individualised plans

The assessment process must be documented carefully so there can be no confusion when other stakeholders refer to the assessment records. During the consultation with the assessor, take notes of what was discussed. Ask your supervisor who can offer advice and examples of how the organisation wants information documented and where it should be stored.

Information about different assessment tools used to identify a client's needs is outlined below:

Personal detail forms
Personal details and referral documentation will provide background information about the client, allowing you to assess the person's eligibility to access the services. Specific details you will find on these forms are contact details, emergency contacts and a summary of the current state. Personal details and referral forms are standard documents that all services use for commencement of service and when the client needs to access external services.
Functional capacity evaluation forms
A functional capacity evaluation form is a tool used to assess the person's ability to manage daily activities and the level of dependence required for tasks they may need assistance with. This document is completed by the health professional who is conducting the assessment prior the individualised plan being developed. This includes daily living activities such as transport, continence, bathing and showering, grooming and dressing. The Bartle Index and Katz Index are examples of how a person's ability to perform daily activities are assessed.
Health assessment questionnaire
The health assessment questionnaire is designed to build on the medical information that has been provided in the person's personal information or referral forms. It allows the person to self-assess their own health and wellbeing. These forms are written in plain language, making it easier for non-health professionals to understand the questions.
Mental health forms
Mental health and wellbeing forms ask the person to disclose their sense of satisfaction, energy levels, fears, general outlook, optimism or pessimism, and engagement in daily activities. The person's responses may show an indication that they are presenting mental health issues that will require management. A general practitioner usually carries out a mental health assessment. Upon completing this assessment, it is determined if the person is experiencing a mental health issue. The GP will then complete a mental health plan that outlines the person's diagnoses and treatments provided to them. If the person must seek other professional services, this document is sent through with a referral.
Mini-mental status examination (MMSE)
A mental status examination assesses a person's level of cognitive impairment. The assessment is a questionnaire that general practitioners and other health professionals use to evaluate cognitive function, including a person's short-term and long-term memory, attention and concentration, language and communication skills, ability to problem-solve, and understand instructions.

Example

Liaise with the assessor

Jeremy is a young adult who was born with cerebral palsy. Jeremy and his support planner are preparing for the arrival of an assessor who will discuss and review his care plan. The assessor arrives at Jeremy's home and ask questions about his strengths, capabilities, needs, and goals. The assessor asks about his fine motor skills as he was having trouble holding a pen. Jeremy says he likes to write stories and it is becoming more difficult for him to write with a pen and type on a keyboard. The assessor explains how an occupational therapist could help and this was added to Jeremey's care plan review notes.

Consider why constant communication is vital to monitoring the effectiveness of a care plan.

Practice Task 9

Question 1

Which of the following statements relate to gathering and distributing information to stakeholders? Tick all that apply.

- ❑ It allows participants to identify the support they can offer
- ❑ It allows participants to gather service information relevant to the person
- ❑ It gives time for invoices to be printed
- ❑ It makes the best use of time when everyone is busy and has limited time
- ❑ It gives the person a chance to prepare for the meeting

Question 2

List two measures that ensure client information is sent to and received by the correct person.

Case study

Peter is 13 years of age and is living with his grandparents Terrence and Grace. He has a vision impairment and is looking forward to going to secondary school and meeting other young people and making new friends. An assessor has made a home visit and suggests a number of services that Peter may enjoy.

Question 3

Provide three examples of the type of information the assessor may need before service options for Peter are discussed.

Summary

- The physical and psychological factors related to the person's life stage will influence service delivery.
- The strength-based approach recognises that all individuals are experts in their lives, have talents and can progress in a way that enhances their quality of life.
- The purpose of the planning meeting is to assist the person in establishing their goals, determine the person's status and create a strategy that will help the person achieve their needs.
- The planning process involves developing or updating the person's individualised plan.
- Determining readiness for the development of a plan includes examining their capacity to make decisions, capacity to understand the planning process and to participate in the plan.
- Notifying and organising practicalities for the planning process includes booking rooms, sending out information and preparing an agenda.
- It is important to gather and prepare information for the planning process and distribute it to relevant stakeholders.
- Meeting with the assessor before the meeting ensures they have some time to research funding and eligibility as well as identify suitable support options and resources to support plan development.

Learning Checkpoint 2

Prepare for planning

Part A

1. Match each term about life stages to its description.

Late adulthood	Behavioural challenges
Middle adulthood	Ability to develop peer relationships
Early childhood	Transition to an empty nest
Adolescence	Loss of memory

2. Provide three examples of ways to explain the purpose of the planning process using a strengths-based approach.

3. List examples of two ways to determine a person's readiness for the development of their plan.

4. Which of the following need to be organised for the planning process? Tick all that apply.

- ❑ Find out if family, friends or carers can offer insight into the person's strengths
- ❑ Arrange for a learning ability assessment
- ❑ Access referral letters, reports to find advice about the person's needs
- ❑ Discuss service options with the person and others in their support network
- ❑ Distribute the organisation's code of conduct
- ❑ Email the person's medical history to everyone involved in the planning process

5. Explain how consultation with the person's assessor supports a strengths-based planning process.

Part B

Read the case study, then answer the questions that follow.

Case study

Dang is 25 years old. Two years ago, he was in a car accident that left him with paraplegia. Since the accident, Dang has participated in a rehabilitation program and is progressing well. He receives personal care in his home and attends a support group with other people who have had similar experiences as a result of a car accident. Dang would like support to be able to participate in volunteer or part-time work.

1. Identify two physical and two psychological factors relative to Dang's life stage, that will be considered when selecting service options for Dang's individualised plan.

2. Identify at least one factor that indicates Dang is ready to develop a plan.

3. Number each step from 1 to 5 in the order you would follow to arrange Dang's planning meeting.

	Book a meeting room and send calendar invitations.
	Gather information.
	Confirm with participants scheduled time is suitable for them.
	Distribute information.
	Send a reminder two days before the meeting to all participants.

4. List at least three service options that may be suitable for Dang to help him meet his goals.

Topic 3: Plan service delivery

3A Planning tools to promote participation

3B Using a collaborative process to establish goals

3C Planning for interrelated needs

3D Identifying and addressing risk

3E Managing conflict

3A Planning tools to promote participation

Organisations in the community and health services sectors have their own ways of delivering services and supporting clients.

Although services delivery can differ from organisation to organisation, the aim is always to achieve several core functions:

- To provide services to clients in need of those services
- To connect clients with resources
- To ensure that services are delivered to a high standard
- To ensure that the support and resources provided meet the needs of the individual and the community
- To network with other organisations to share skills, expertise and other resources

Levels of service

Organisations offer services according to the level of support required by their clients. Assessors determine the level of support based on funding models and eligibility criteria.

The tables below provide examples of levels of service and the resources offered to service users in the aged and disability sector.

Level 1: Basic care needs	This home care package provides 2.5 hours of support per week and includes the following services: gardening and maintenance, domestic cleaning, social support, personal care, transportation and meal preparation.
Level 2: Low care needs	The person is eligible for up to 4.5 hours a week of support. Services are the same as Level 1.
Level 3: Intermediate care needs	The person is entitled to receive 9 to 10 hours of assistance per week which will include: clinical nursing, medication management, allied health support, help with shopping, home help, personal care, and support with changes to cognitive functioning and behaviour.
Level 4: High care needs	High needs clients can receive 14 to 15 hours of support per week. In addition to the supports provided from Level 1–3, Level 4 clients are usually clients with Dementia or Parkinson's Disease. Support workers qualified to work with people with these diagnoses provide the care and support.

In the disability sector, the NDIS program supports children, young adults and mature adults in three categories (NDIS, 2021).

Core	Assistance and resources provided to the person are to help the person complete daily living tasks
Capital	Technology, equipment, home and vehicle modification and accommodation are provided
Capacity building	Support and resources provided to the person aim to build independence and skills

For further information, visit: aspirelr.link/ndis-supports-services

Organisational processes

Some organisations focus on one or two areas of support for clients with particular needs. For example, domestic and family violence support services will only focus on the needs of those affected by violence and abuse. Larger organisations can offer a much broader range of services.

Every workplace has its own set of processes for how and when different tools and documents must be used for planning and implementing service delivery. Processes allow for consistency in the information provided to clients and how the information must be collected and collated. Workers must be familiar with the requirements of their organisation so the organisation can meet their responsibilities to report to government, board of directors or other funding bodies.

For example, when a referral is needed, workers need to know how and when it should be used and what documentation is required to be recorded such as meeting notes, phone calls and which are the correct referral documents to be used. In some cases – like referrals to drug and alcohol services and some mental health services – services only accept self-referrals, which means the person must complete the referral themselves.

Promote participation

During the planning process, your role will be to develop a working relationship where the person feels comfortable and is confident to express their views. Respecting and valuing the person's opinions and perspective is the foundation of the planning process.

When the person's **strengths** and capacities are identified and used to drive decisions, the person feels empowered because they have some control in decisions that affect their life.

Strengths
A person's positive personal attributes, character traits or skills available to that person.

Some examples include perseverance, resourcefulness, honesty and kindness.

Showing respect for the person's perspective is to:

- focus on the person's abilities, what they can do and what they do well, i.e. a strengths-based approach
- identify the person's skills, competencies and strengths to help the person feel a sense of accomplishment
- recognise the supports a person needs for growth and development
- identify the strategies that support the person to cope and manage stress
- identify factors that contribute to the person's positive relationships with family, friends and members of the community
- acknowledge that support impacts not only the person but also their family and other people in their support network
- establish positive expectations for the future
- avoid focusing on the person's weaknesses, such as what they cannot do or what their issues are.

The success of the planning process relies on your ability to acknowledge what is important to the person now and in the future. If the client can see that you understand their perspective, they will be encouraged to participate in the planning process and work towards individual goals.

Video: Support worker roles in a strengths-based approach

Watch this video as a reminder of the principles of a strengths-based approach in the work of a support worker: aspirelr.link/bvs-training

Example

A process to plan service delivery

At Technotron Consulting, staff use this process when planning service delivery for their clients.

1. Establish the person's goals.
2. Determine the level of support required.
3. Identify the resources required.

4. Develop actions and strategies that support goal achievement.
5. Determine the indicators for success and progression.
6. Track and monitor progression.
7. Review the plan intermittently and make adjustments as necessary.
8. Transition the person to other services.
9. Exit the service.

Practice Task 10

Question 1

Provide three reasons why processes are useful during the planning process.

Question 2

Which of the following will encourage client participation when planning service delivery? Tick all that apply.

- ❑ The person's strengths and capacities drive decisions.
- ❑ The person's opinions and perspective are respected and valued.
- ❑ Health professionals lead the planning process.
- ❑ The family leads the discussion on their needs and wants.
- ❑ The person feels confident to express their views.

3B Using a collaborative approach to establish goals

Goal-setting should be a collaborative experience where the person gets the opportunity to explore what is important to them.

The basis of a service delivery plan is to establish what the person wants to achieve now and in the future. Goals need to be practical and achievable, otherwise the person will lose motivation. Goals that are too difficult to reach can lead to disappointment and set the person up for failure. Larger goals should be broken down into smaller goals to make them more realistic and increase the chances of success. Collaborating with the person to develop goals requires the worker to:

- demonstrate a positive regard for the person
- use active listening skills
- be patient
- encourage input from the person and other stakeholders (if required).

There are many tools that can be used to help a person identify their goals. You can work with your client to identify the best tool they feel they can work with.

SMART goals

SMART goals cover the following areas:

- Specific – What actions will you take?
- Measurable – How will success be measured?
- Achievable – Do you have the necessary skills and resources?
- Realistic – Is it important to your life?
- Time framed – What is the time frame for achieving the goal?

For more information on how to use SMART goals, visit this link: aspirelr.link/smart-goals

MAPs

MAPs stands for Making Action Plans. This tool supports the person, their family and the support worker to build a plan for the person's future.

Personal history	• Achievements • Abilities and capabilities • Strengths

The person's aspirations	• Goals • Dreams and aspirations
The person's challenges	• Possible barriers • Identify what makes the person feel powerless • Identify what makes the person feel uncomfortable
The person's strengths	• People providing support now • Other people who can give support
Identifying resources	• Resources the person already has access to e.g. transport • Physical resources the person needs to achieve their goals • Services and programs that can help the person achieve their goals
Agreement	• Develop an action plan • Determine if the person agrees to the action plan

PATH

PATH stands for Planning Alternative Tomorrows with Hope. It is a person-centred process where the client is encouraged to develop reflective and action skills to help them realise their goals.

Future Vision	• Ask the person what they want from life. Encourage them to identify how this vision makes them feel • Ask the person what is most important to them • Ask the person how they imagine their life to look for themselves (and their loved ones) • Find out what the person's passions are • Find out what a good life looks like for them
The person's gifts	• Identify what the person enjoys • Identify the person's strengths • Identify who their support people are • Identify how their strengths and passions make them feel
The person's needs	• Identify what the person needs to learn • Identify what skills the person would like to improve on • Identify any behaviours and habits they would like to change
Resources	• Identify the resources the person already has: physical and human • Identify the resources the person will need: physical and human
Timeframes	• Encourage the person to visualise what their life would like if they could achieve anything • Identify which goals are ideal to be short-term and which long-term • Identify strategies that will help them achieve their goals • Allocate time frames to achieve goals

Personal futures planning

Personal futures planning tools are used by organisations who support young people with disabilities. They are commonly used to support them to prepare for the transition from schooling to work to identify how they can achieve their goals.

Here is a link to an example of how a disability organisation uses personal futures planning when working with people they support: aspirelr.link/valued-lives

Individual outcomes and resources

Resources provided by service agencies must align with the person's goals. Resources can be friends, family, community groups, health professionals or other service workers who provide general support or specific services. Resources can also be physical resources such as money, time, transport, technology, or education. You will need to work with the person to identify the necessary resources needed to fulfil the strategies.

Individual service delivery planning is most effective when the support worker and the person know what the outcomes will be and what success looks like. Here are some examples of goals linked to outcomes and the resources required to help meet those outcomes:

Goal	Strategies	Resources	Outcomes
To be in paid work in customer service	Explore volunteering opportunities to gain experience	Receive assistance from a support worker for one to two hours per week until opportunity is gained	With my support worker, I am looking for volunteer work to learn retail skills. I have spoken to the manager at a local op shop and arranged a meeting next week
I want to learn how to budget and save money	Attend a financial literacy workshop	Complete financial literacy training and develop my budget	I have learned how to budget and created one of my own. I am saving $20 a week. When I start paid work, I will increase my weekly savings amount

Example

Process requirements of service planning tools

Tanya has been working hard to manage her drug and alcohol addiction. She feels her life lacks focus and has recently been in trouble with the law for driving with an expired licence. Tanya meets with her support worker, and together they develop the following PATH to help Tanya focus on her goals and improve her health and well-being.

Now	• Drinking alcohol and taking drugs • Unemployed • Receiving income support • Relying on assistance for food • Has outstanding fines to pay • Broken relationships with friends and family
Dreams	• To live a drug and alcohol-free life • To find a job and hold down that job • Own her own home
What I need to do	• Participate in a drug and alcohol rehabilitation program • Develop a career pathway plan • Enrol in formal training • Pay off fine • Meet with family
People who can help me	• Drug and alcohol services • My family • Employment services • Counsellor
The first step	• Contact your local drug and alcohol service, and register for a rehabilitation program • Arrange a meeting with my family • Participate in personal counselling • Create a personal budget
Medium-term plans	• Contact employment services and arrange for career counselling • Enrol at the local training centre • Participate in relationship counselling
Long term plans	• Apply for jobs • Review personal budget and save for a home deposit

Example

Sample individualised plan

Tammy has just completed an individualised support plan with Agnes May. Tammy places the plan in Agnes's case file, kept in a locked filing cabinet and an electronic version stored in the organisation's database. Here is an excerpt from Agnes's plan.

Individual Plan			
Participant details			
First Name	Agnes	Surname	May
Date of Birth	13/05/1941	Gender	Female
Residential address			
Address	21 Ranchford Ave	Suburb	Box Hill
State	Victoria	Postcode	3128
Phone	0488 659 363	Email	angnusmay@gmail.com
About me			
I am 82 years of age and live in the family home. I have no medical conditions that require monitoring but do require some home care due to aging. My daughter and son help me with shopping, take me out on weekends for lunch, and to see my family. I am able to make my own decisions.			
My goals			
My Goals	• Maintain full autonomy and choice in all aspects of life • Stay in my own home • Continue participating in all activities • Maintain overall health	Timeframe	Ongoing
My support timetable			
Task/Service	**Day**	**Equipment**	**Comments**
Personal care	Daily	Commode	

Task/Service	Day	Equipment	Comments
Cleaning	Tuesday and Friday	Vacuum, mop and bucket, disinfectant, wipes, multipurpose spray, glass cleaner, toilet cleaner	PPE: latex gloves
Laundry		Laundry powder, washing basket, washing machine, pegs	
Garden maintenance	Once a month	Lawnmower, rake, and grass bin	
Last review	15/02/2023	Next review	15/08/2023
Created by	Wendy Miller	Date created	10/02/2023

Practice Task 11

Question 1

Develop a service plan using the PATH approach for yourself, someone at your workplace, or with a family member or friend.

Now	To go to the recreation centre and talk to the people there about what they have on offer
Dreams	To win a trophy
What I have to do	Think about what I am good at
People who can help	Feeling lonely, I don't have any friends
The first step	To be a part of a team
Medium-term plans	I need to find out what activities in my community I can participate in that are not too challenging
Long-term plans	My mum, my brother, my support worker

Question 2

Which of the following statements are correct? Select yes or no for each one.

a. Collaboration means demonstrating a positive regard for the person and encouraging input from the person and their support network.	Yes / No
b. Reasonable goals motivate the person to move forward and to work towards achieving them.	Yes / No
c. Setting goals that are too difficult to achieve will lead the person to failure.	Yes / No
d. Larger goals help motivate the person because they have more to look forward to.	Yes / No

Question 3

List three examples of human resources and three examples of physical resources required to meet a person's goal of moving out of home and into an independent living arrangement with friends.

3C Planning for interrelated needs

Many people who access community services have several needs that they need support to manage.

Imagine that a person has physical and mental health issues as well as no access to transport. These issues are **interrelated needs**. The person's physical challenges have affected their mental health because they cannot do what they enjoy. Poor access to transport is a barrier for the person wishing to access appropriate health care and visit local community services, significantly affecting their sense of independence and interaction with the community.

Interrelated needs
A combination of issues that a person experiences at the same time.

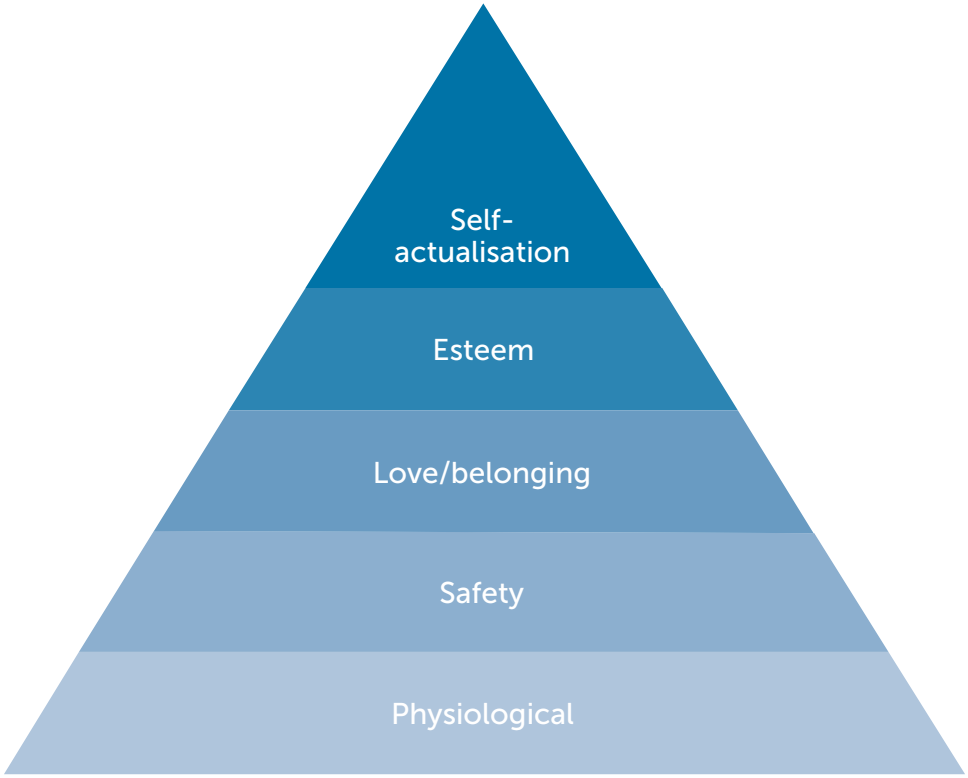
As a support worker, you will need to consider each of the needs and prioritise the services they need to access.

Identifying different needs

Abraham Maslow developed the motivational theory known today as Maslow's Hierarchy of Needs. The theory suggests that for a person to be motivated to reach their maximum potential, some needs must be met for this to be achieved. Maslow identified five stages of needs that must be satisfied for a person to self-actualise or, in other words, achieve the goals they desire.

The five stages are shown in a pyramid, and the needs start from the bottom tier and move upwards. The hierarchy is a valuable tool to use when considering a person's interrelated needs. Work from the bottom of the pyramid and determine if they have stable housing, can afford food, and generally meet their own basic needs. If you identify that these needs are currently not being met, you can set up adequate supports to satisfy the person's basic needs. Continue up the pyramid to identify barriers that may inhibit the person's chance of achieving their goals.

Below are the stages of Maslow's hierarchy of needs starting from the bottom of the pyramid.



Video:
Watch this video for an overview of Maslow's hierarchy of needs: aspirelr.link/maslows-hierarchy-needs

Integrated approach

Clients with multifaceted needs can feel like the services they receive are fragmented. Receiving services from multiple providers can result in services working in isolation from each other. This approach is inefficient and results in poor health and well-being outcomes for clients.

An effective way is for services to work with each other.

This benefits the person because they can access the resources they need and reduces the need to interact with various services, sometimes in several locations. An **integrated approach** reduces duplication of service delivery, and the person is less likely to miss out on receiving a service due to a 'service gap'.

Integrated approach
An approach to care where there is a high degree of collaboration among involved health professionals, ensuring improved outcomes for the person.

Service providers build a network with other services within the sector or area. Each service provider has a commitment to a shared vision to meet the diverse needs of service users. Integrated services can be together at the same facility for example in a 'health hub' where services refer back and forth to each other to meet their clients' holistic needs. In some models, specialist services can be provided alongside generalist services. For example, 'Headspace', a youth mental health service provides services relating to mental health, physical health including sexual health, study support and drug and alcohol services.

You can read more about the services of Headspace at this link: aspirelr.link/headspace

The following table outlines different types of integrated care services:

Community-focused integrated care	A strategy used to improve Indigenous communities, and to address the specific needs of a community. Once needs are identified, services in aged care, health, and social services work together and establish partnerships that connect community members to a wide range of services. For example, health and legal and employment services are operated by Indigenous people to meet their specific needs.
Culturally specific services	Integration of cultural services, such as refugee and migrant services, provide care across several types of support. Services join together through shared values and may rely on volunteer services, support by church groups and community donations to operate.
Multipurpose services	Integrated acute care, aged care, and community health services work together in urban, regional, rural and remote areas. Some of these services have scope to support volunteers and are used to promote health activities such as diabetes awareness, mental health awareness, smoking and alcohol use.
Community health services	Residential home care, health services, and services that target social disadvantage in the community. Funding comes from Government initiatives

Read more about integrated care at this link: aspirelr.link/integrated-care

Example

Health hubs

Examples of health hubs can be found across Australia with information available by searching the web. Here is the vision statement from the Ballarat Community Health (BCH).

> Our vision is that all people within the communities we support achieve the best possible health and wellbeing. From primary care to community wellbeing programs, we work to ensure a holistic approach is taken to better health. We know everyone is different and we work with the community wherever possible to create consumer-led and informed services, ensuring more effective care for individuals and their needs.

Practice Task 12

Question 1

Match each type of integrated care service to its description.

Community health services	Specific services for a group of people, operated by the people
Multipurpose services	Partnerships between service providers based on shared histories, values and beliefs
Community-focused care	Services that provide a broad range of resources for clients, such as promoting healthy activities in rural and remote areas
Culturally specific services	Collaborative network of services funded by the government that provide residential home care and health services

Question 2

Briefly describe an example of an integrated approach to service delivery.

3D Identifying and addressing risk

A strong risk assessment process ensures the personal safety of clients and of the people who provide care and support.

Support workers have a **duty of care** to take all reasonable steps to prevent, identify, assess and eliminate risks, while ensuring the person's right to **dignity of risk**. As a support worker, you need to balance ensuring personal safety with some exposure to risk. This is the person's right and promotes personal growth and development.

Here are some definitions and examples of duty of care and dignity of risk:

Duty of care	The legal and moral responsibility to promote and protect the safety and well-being of others from all foreseeable harm. Foreseeable harm is any predictable risk. Failure to do so results in negligence to the service user, and you could face disciplinary action for your inactions.
Dignity of Risk	A support worker's adherence to duty of care works alongside dignity of risk. This means a person has the right to make their own choices and participate in activities that have some risk. Dignity of risk does not ignore duty of care; workers must evaluate the level of risk to the person.

Duty of care
A moral or legal obligation to ensure the safety and wellbeing of other persons.

Dignity of risk
A person's right to dignity and choice, upheld in legislation and service standards, to ensure that duty of care or safety is not used as a reason to limit a person's freedom of personal choice.

Risk assessment

People who access community services have their own individual needs, interests, goals and abilities. Therefore, the level of risk for each person will vary; what may be high risk for one person may not be for another, so you need to use a case-by-case approach.

When selecting strategies, you need to keep in mind work health and safety legislation, industry standards and your organisation's policies and procedures. The requirements for complying with the law, guidelines, regulations, standards and organisational policies and practices, all underpin the operations in workplaces and include service delivery to clients. It is the service workers responsibility to ensure the safety of the clients accessing the service.

Risk management is the process of assessing and evaluating the level of potential harm a risk has and putting in place strategies that will reduce the risk of injury to a person.

Collaborate to minimise risk

Health and safety discussions must involve the person, caregivers and families (if applicable). For clients who participate in activities with some level of risk, remind them of the potential risk they are taking and suggest strategies to reduce the risk to themselves and others. For example, if a client wants to cook a BBQ for lunch but has not used a gas BBQ before, you will need to discuss the correct way to use the equipment before they begin.

Helping a person understand hazards and ways to minimise risk means they take some ownership for the risk. They can be part of the solution and responsible for the safety of themselves and others. It can also mean that when you are not present, they know how to recognise and report risks.

People who have experienced acquired brain injury, a mental illness, cognitive impairment or intellectual disability may have difficulty understanding the risks they are exposed to or can create. In these circumstances, it may be appropriate to discuss risks with the whole family or carers so everyone understands the risks and ways they can be minimised.

Conducting a risk assessment

Risk assessment Determining the likelihood a hazard will cause harm, injury or ill-health and determining its possible consequence.

A **risk assessment** is a five-step process used to identify and manage risks. For example, you may have to complete a risk assessment when a person first commences a service, or when changes have occurred to the person's circumstances, or when new equipment is introduced into the person's home. Your organisational policies and procedures will outline the requirements and frequency of risk assessments. The following table summarises the risk assessment process:

Identify hazards	Inspect the area and identify what could cause harm. Hazards are not always obvious.
Assess risk	Understand the nature of the harm that could be caused by the hazard, how serious the harm could be and the likelihood of it happening. This step may not be necessary if you are dealing with a known risk with known controls.
Control risk	Implement the most effective control measure that is reasonably practicable in the circumstances and ensure it remains effective over time.
Monitor and review risks	Review hazards and control measures to ensure they are working as planned.
Complete documentation	Refer to the hazard reporting processes for documenting hazard inspections, identified levels of risk, the likelihood of the risk occurring, and control measures No hazard is too small to report. If a hazard will cause harm and cannot be controlled to a satisfactory level or is beyond the scope of your job role, then it must be reported immediately to a supervisor or workplace health and safety officer.

Read more about the risk assessment process here: aspirelr.link/swa-identify-risk

link broken

Risk matrix

A risk assessment matrix is used to assess the level of risk and the seriousness of the harm that the risk could cause. Using a risk assessment matrix is like using a grid on a map; you estimate the likelihood of the risk and the impact of the risk. The intersection of the two points gives a risk rating level. The higher the risk rating, the more serious the potential for harm to a person.

Likelihood	Impact				
	Insignificant	Minor	Major	Critical	Catastrophic
Almost certain	HIGH	HIGH	EXTREME	EXTREME	EXTREME
Likely	MODERATE	HIGH	HIGH	EXTREME	EXTREME
Possible	LOW	MODERATE	HIGH	EXTREME	EXTREME
Unlikely	LOW	LOW	MODERATE	HIGH	EXTREME
Rare	LOW	LOW	MODERATE	HIGH	HIGH

Hierarchy of control

Risk controls are measures to manage the hazard and reduce the level of risk. An example is replacing a lightbulb or repairing a door lock to prevent a burglary compared to installing a personal security alarm in a home and garden. Both strategies will control the risk, but one will control the risk whereas installing a home security system will be to closer to eliminating the risk.

A ranking system of controls and strategies is used to reduce harm. The following table gives you examples of different types of level of control over risk:

Level of Control	Explanation
1. Elimination	Remove the risk; for example, mopping spills, removing unsafe objects, repairing or replacing equipment.
2. Substitution	Substitute the hazard with one that is of less risk. For example, use a less hazardous chemical to clean, or dilute chemicals with water.
3. Engineering controls	Make physical changes, such as installing handrails, altering doorways, repair floorings.
4. Administrative controls	Implement controls, such as participating in safety training, or updating policies and procedures, so they better represent current standards of practice.

Level of Control	Explanation
5. PPE	Use protective equipment, such as eye protection, safety boots, aprons, latex gloves and facemasks.

Indicators of risk

Not all clients can, or will, tell you that they are at risk; however, there are signs to look out for. Here are a few examples:

- Their physical appearance changes or deteriorates
- Behaviour may be erratic, aggressive or the person may be withdrawn
- An increase in risk-taking behaviours
- Self-harming or self-injurious behaviours
- Sleeping or eating problems

When preparing an individual plan, assess the risks relative to your client's activities or environment and develop appropriate strategies to minimise or reduce the risk. Risk assessment involves observing the environment and checking for issues or items that may cause danger to the person or worker. A checklist is commonly used to identify and check off aspects of the home environment to ensure they are safe and equipment is in good working order.

Discuss with the person any potential risks they may have identified themselves and add these to the notes as part of your assessment. Risks can be categorised but the person is always the centre of the assessment.

Environmental risks
Risks related to the design and layout of a person home, business, or facility. A risk assessment involves scanning the person's environment looking for hazards that may cause harm. For in-home care services the worker can be looking hazards that may place them or the client at risk. For example, bathrooms where assistance is needed for showering such as checking the height of the step and room to reach in. Checking kitchen benches are suitable for preparing foods and with cupboards where the client can reach food and cooking utensils. For an immobile person, modifications may be required to allow the person to manoeuvre around the home in an electric chair or a wheelchair and to access their garden or outdoor area.
Physical risks
The client's home must be well maintained to prevent injury or harm to clients, support workers, and other visitors. This includes the cleanliness and tidiness of the house, checking paving in outdoor areas and floor coverings are not damaged, there is adequate lighting, ensuring door handles, taps, and shower doors are in working order, smoke alarms batteries are working and checked regularly, and equipment used to support the person works has regular maintenance checks. Physical risks to workers includes awareness of manual handling such as moving clients from a bed to the toilet or showering techniques or assisting them in and out of a car.

Physiological risks
Physiological risk factors are biologically related. If the person experiences sudden or unexpected changes in health, including the loss of vision, hearing or balance, these can be a sign of a medical conditions that needs to be attended to. In emergency situations this would mean an ambulance to hospital. Other physical risks to look out for may be weight loss or gain, skin integrity, risk of infection, inadequate self-care, a person's ability to regulate temperature, impaired judgement, and impaired cognitive functioning.
Safety and security
Everybody needs to feel safe. Vulnerable clients such as people who identify as being homeless, are at a higher risk of danger while sleeping rough. Clients need to feel safe at home such as windows that shut and doors that lock. Deadlocks can be installed on doors, window locks, outdoor security lighting, personal security alarms, gates, and the locked key boxes. Emergency services need to have access in the case of an emergency and the worker can discuss an emergency evacuation plan with their clients.

Consequences of risk

Manual handling	Using incorrect lifting devices or improper lifting techniques can cause serious physical harm to the body with the potential to cause long-term damage and rehabilitation.
Mould and damp	Environments that are damp or not cleaned properly or there is poor ventilation can cause breathing problems, allergies and respiratory infections.
Clear access	Hallways, living areas and passageways should be free from clutter and tripping hazards. Access to the person mean correct manual handling techniques can be used to avoid physical injury to both the person and worker.
Staircases	Stairs are a significant barrier to access. Handrails must be secured, and flooring on the stairs be in good condition and non-slip to prevent falls. Gates can be installed top and bottom of the staircase to prevent access, particularly with young children.
Challenging behaviours	Violent and aggressive behaviours put both the person and support worker at risk of physical injury. Support workers should be offered training in de-escalation and managing people in crisis.
Memory problems	People with a loss of memory may forget to turn appliances off, become confused and wander, or incorrectly take their medications. Make sure all exits are secure, unused appliances put away, and medication is stored correctly and managed.
Infections caused by cross-contamination	Unsafe food preparation and poor cleanliness can lead to infections such as gastroenteritis. Food preparation areas must be frequently clean and well maintained. Food storage beyond its due date must be managed and potentially unsafe food removed and destroyed.

Other risks

Challenging behaviours Behaviours that can place the person or others at risk of physical and psychological injury.

Other risks include self-harming behaviours, violence, abuse, or drug and alcohol misuse. For the less experienced support worker, this can be difficult to manage.

To assess the risk of **challenging behaviours**, work with your supervisor to review the client's history, identify any triggers that bring on an unwanted behaviour, speak to experienced support workers who know the person, and ask for additional training if you feel this would be helpful. An understanding of your client is the best way to de-escalate challenging behaviours and reduce the likelihood of harm to yourself and others.

Abuse and neglect

Abuse happens when a person is deliberately hurt or harmed either physically, sexually or psychologically.

This can occur to vulnerable people at any age or life stage but has been identified in several royal commissions to be prevalent in the aged, disability and childcare sectors.

For details about child abuse and neglect, visit: aspirelr.link/child-abuse-neglect

Video: Elder abuse

Listen to this video from the Australian Attorney-General's Department on elder abuse. aspirelr.link/older-australians-rights

Make a list of the different types of abuse described in the video.

For information on mandatory reporting, visit: aspirelr.link/mandatory-reporting-child-abuse-and-neglect

Risks to support workers

A risk assessment must also consider risk to yourself and other workers. Support workers often accept an element of risk as part of their job in order to offer effective and valuable support to their clients. Here is a list of several risks and suggested strategies to reduce that risk.

Risks	Strategies
Shift work schedules including night shift and long days	• Encourage teamwork.
Inadequate training	• Research suitable professional development opportunities online and make some suggestions to your supervisor or in a team meeting.
Managing challenging client behaviours	• Request coaching and mentoring. • Keep a journal.
Workplace stress	• Make sure you have a work-life balance and participate in an enjoyable activity or hobby in your free time. • Debrief with your supervisor or colleagues after a difficult day. • Take advantage of the employee assistance program (EAP). This service provides free access to a qualified psychologist.

For more information on workplace health and safety guides for community support services, visit this link to WorkSafe Victoria: aspirelr.link/worksafe-community-support

Example

Conduct a risk assessment specific to the person's circumstances

Daniel is a local area coordinator for a disability service. Part of his job requires him to do a risk assessment during the induction of new clients.

Jeremy is a new client who was recently referred to the service. He was in a car accident and is learning to walk again, and his short-term memory has been affected.

Daniel used a checklist to walk around the house looking for hazards that might be a risk to Jeremy and the support workers who will support Jeremy in his home.

He identified a few hazards and discussed the assessment results with Jeremy and his partner.

Daniel noticed that a corner of a floor rug in the lounge room was curled at one end. They discussed replacing the rug with a flat piece of carpet or having the area glued or fastened in some way to keep it flat. They discussed the potential trip hazard for Jeremy while he needs a walking frame. Daniel also noticed that the security lighting at the front door does not work, and the security flyscreen door has no key. In addition, there is mould in the bathroom, and a power point in the kitchen is not fixed to the wall properly.

Jeremy agrees to allow a home maintenance team in to do some repairs to make his house safer for him.

How might you conduct a risk assessment as part of your role? What factors would you need to pay particular attention to?

Practice Task 13

Question 1

Match each term related to risk to its correct description.

Risk matrix	Identify what could cause harm.
Hazards	Evaluate the potential risk that a person may be undertaking.
Duty of care	Assess the level of risk and the seriousness of the harm that the risk can cause.
Risk assessment	Set control measures to manage hazards and reduce the level of risk.
Hierarchy of control	Legal and ethical responsibility to protect the safety and well-being of others from all foreseeable harm.

Question 2

Which of the following statements relate to managing different risks? Tick all that apply.

- ❑ Using correct lifting equipment when moving a client to prevent straining a muscle
- ❑ Using a checklist to scan the home of a client for trip hazards
- ❑ Asking the client to cook a meal and watching to see if they use spoiled food
- ❑ Opening a window to allow fresh air into a room with poor ventilation
- ❑ Arranging for locks to be installed on the door so the client feels safer at home

Question 3

Identify three reasons why minimising risks should be discussed with the person you support.

3E Managing conflict

Conflict is not unusual and often occurs with clients who are vulnerable, marginalised or have difficulties regulating their emotions.

As a support worker, it is your responsibility to prevent conflict from escalating.

Some groups of people always focus on agreeing with one another. They may do this to be courteous, or they may not have confidence in their ideas. This is known as 'groupthink' and often occurs in groups where there is a dominant person or personalities. Groupthink results in members of the group feeling pressured to support the dominant view and they don't have the confidence to voice their own opinions. It tends to prevent alternative ideas being put forward. When groupthink is used, the person's needs may be overlooked because creative ideas to overcome barriers are not discussed.

Building strong and positive relationships is helpful for preventing conflict situations from escalating. If conflict, such as violence or aggression towards you or others, occurs and is beyond your scope or job role, you will need to speak with your supervisor. Remember to document these incidents as a way of monitoring the person's plan.

Manage conflict

Conflict is not always negative; it can prompt the need to make improvements.

Many people deal with conflict in unproductive ways due to personality differences and insufficient coping strategies.

To resolve conflict effectively, always remain calm. Use active listening skills and positive body language to try to identify the root cause of the conflict. Acknowledging a problem or issue for a person validates and confirms to the person that they have been heard and understood, and often results in the person becoming more relaxed. For example, once the person has explained what is bothering them, you can ask them what they would like to see happen.

Conflict resolution training is a good way to improve skills, and some techniques are outlined below.

Avoid conflict
Avoiding conflict is ignoring the people we are in conflict with or simply withdrawing from the situation. This is a passive approach and very ineffective for resolution because the problem can escalate and, when it finally comes out, it can be worse. This strategy can be used to allow a heated situation to calm down before you work towards resolution.

Competing ideas
People can have competing ideas. The outcome is that one person will get their way and different perspectives are not considered. It is not the most effective way of resolving issues because it is a win-lose outcome and the losers are often left feeling dissatisfied.
Accommodating
This is a cooperative strategy and requires one person to make a sacrifice for a resolution to occur. Sometimes stepping back and away is the best course of action because the work required to find a resolution is not worth the effort.
Compromising
When both parties compromise, it means that they both make a sacrifice of some kind. No one person gets their way.
Collaboration
Collaboration is a cooperative way to resolve conflict. Both parties are listened to and have input into how the conflict can be resolved. This strategy is a powerful way to resolve problems.

Example

Manage any conflict or differences with regard for the person's perspective

Dianne is a support worker for a mental health service. Kristy is her client and has come to the office to attend an appointment. Kristy is visibly upset and angry. During the appointment, Dianne appears calm, making sure her body language is not defensive as she listens to what Kristy says. Once Kristy has finished explaining her frustrations, Dianne acknowledges Kristy's reasons for being upset. Dianne documents the incident in Kristy's case notes.

The next day Dianne telephones Kristy to make sure that she is okay. Kristy sounds much better and tells Dianne she will be there for her next regular appointment.

Reflect on the reasons behind managing conflict immediately. How might this inform a resolution?

Practice Task 14

Question 1

Which of the following statements are correct? Select yes or no for each one.

a. Collaboration is an effective way for resolving conflict.	Yes / No
b. Conflict can lead to positive outcomes.	Yes / No
c. Avoiding conflict will prevent problems from getting out of hand.	Yes / No
d. Accommodating in a conflict makes the person feel like they lost the fight.	Yes / No
e. Resolving conflict when a client is angry and aggressive is part of a support workers job role.	Yes / No

Question 2

Briefly explain how collaboration can be an effective strategy to resolve conflict.

Summary

- Organisations offer services according to the level of support required by their clients.
- Assessors determine the level of care required based on funding models and eligibility criteria.
- To develop an effective plan, you need to respect the person's perspective, foster their strengths and capacities, and promote participation.
- Each workplace will have its own set of processes for how and when different tools and documents must be used for planning and implementing service delivery.
- Developing goals that are achievable will motivate the person to move forward and to work towards meeting them.
- Collaboration with the person means consistently demonstrating a positive regard for the person, using active listening skills, being patient and encouraging input from the person and other stakeholders (if required).
- You can establish practical goals by identifying and confirming key aspects of individualised service delivery in collaboration with the person and other stakeholders.
- An individual service delivery plan is most effective when the support worker and the person know what the outcomes will be and what success looks like.
- Resource requirements provided by service agencies must align with the person's goals for them to be purposeful. If they do not, the person will not be motivated to participate.
- Consider the interrelated needs of the person and plan an integrated approach to service delivery.
- You will need to conduct risk assessments specific to the person's circumstances, discuss this with the person and work collaboratively to minimise risk.
- Conflict is not always negative; it depends on how you manage it.

Learning Checkpoint 3

Plan service delivery

Part A

1. Briefly outline how a strengths-based approach encourages the person to be proactive in the planning process.

2. Provide at least one reason why processes are used in service delivery.

3. Provide one example of when a process would be important in the planning process.

4. Which of the following statements relate to motivating the person to establish goals? Tick all that apply.

- ❑ Learn about what is important to the person.
- ❑ Introduce the person to another client who is more motivated.
- ❑ Encourage the person to take risks to meet goals.
- ❑ Allow the person to try again another time when they are feeling up to it.
- ❑ Encourage input from the person and other stakeholders.

5. Match each term about different modes of delivery to its definition.

Maslow's Hierarchy of Needs	A holistic view of the person and collaboration of services in service delivery.
Integrated approach	A combination of issues that coexist at the same time.
Interrelated needs	A tool to use when considering a person's interrelated needs.

6. Identify three benefits of using the integrated approach.

7. Explain how duty of care must also recognise the person's right to dignity of risk.

8. When a support worker has conflict with a client, how is it best managed?

Part B

Read the case study, then answer the questions that follow.

Case study

Chen is 76 years of age. Due to his failing health, he decides he needs help with his mobility as he is finding it difficult to walk around the home and get in and out the car to get to medical appointments. His wife suggests he contact a local service provider so he can be assessed and be given the appropriate advice on the type of mobility aid he needs. Chen has not made contact with this type of service before and is unsure about what to do.

1. Identify three ways a support worker at the local service could help Chen to feel at ease about the planning process.

2. List two resources Chen already uses and two resources the service provider may be able to provide to Chen in the future.

3. Identify three risks to Chen's current safety, considering his poor mobility, and suggest a strategy to manage each of the risks.

4. Number each step from 1 to 5 in the order support staff would conduct a risk assessment of Chen in his home.

	Control risks
	Complete documentation
	Identify hazards
	Assess risk
	Monitor and review risks

Topic 4: Review service delivery implementation

4A Consult, address and report on quality and satisfaction with service delivery

4B Work in collaboration to adjust plans

4C Identify areas to improve the quality of service delivery

4A Consult, address and report on quality and satisfaction with service delivery

At each stage in the planning process, stakeholders can be reminded of the importance of feedback.

From a service perspective, monitoring the quality of service delivery allows for evaluation of staff performance, identification of gaps in the service and other issues that, when identified, can help improve processes and services for clients.

The client, their family, carers and other support people need to know that feedback is valued and taken seriously. Feedback can come from external providers, contractors and health professionals involved in the support of the client.

Client dissatisfaction with services they have been receiving leads to their progress being affected. The client may not participate actively in their plan or may look for another service.

Formal methods for gathering input from stakeholders into the quality of services are listed below:

Questionnaires or surveys	• A set of questions where the person can provide responses to questions on the quality of service. • Questions can be written or verbal/hard or soft copy. Responses can be anonymous, and this can increase the likelihood of honest answers. • Information gathered from a survey can come from observations of the effectiveness of a plan or from records and notes on client outcomes. • Questions can be designed as a checklist or be open questions requiring details and an explanation in a response. • When the survey or questionnaire has been completed, the information needs to be analysed and areas of concerns identified.
Customer complaints and compliments	• Questions in a complaint register or compliments register allowed the service to identify strategies that work well and those that did not. • A complaints processes allows the service some insights into the client's perception of the quality of customer service. • Information can be collated and reviewed to look for patterns in areas or services that are not meeting quality standards. • If breaches in policy are identified, then staff may require additional or refresher training, or procedures may need to be reviewed to improve practices.

Online feedback	• Online feedback allows clients to respond to questions accessible on the organisation's website. This may be a questionnaire or a form on the website for submitting complaints or compliments. • This is a convenient way of getting feedback as it can be completed anytime and anywhere. It can also be anonymous.
Shift reports and progress notes	• Support workers document daily interactions with clients and keep a record of their interactions with clients. • These notes include observations on client successes and issues, barriers and challenges. • This information can help determine if any problems for the client stem from the service, service workers, or other factors.
Inductions and planning meetings	• Feedback can be collected from clients during an induction to a service, during the planning process and/or when they leave or transition from one service to another. • This information can provide insights into the client's changing perception of the service as they move through and engage with the service organisation.

Example

Consultation to determine plan effectiveness

Mr Lopez has been receiving support from the service for three months. His support worker has asked him to complete a questionnaire giving feedback about his satisfaction with the quality of service he has received. Here is an extract of his feedback:

Client Feedback Form

Clients Full Name: Mr Samuel Lopez

Date: 03/02/2023

- ☑ I am always encouraged to make my own decisions
- ☑ My needs are always considered
- ☑ I am always asked if I want to give my consent for others to access personal information
- ☑ My care needs are being met
- ☑ I feel safe
- ☑ My cultural and/or religious needs are always considered
- ☑ I am treated with dignity and respect by staff
- ☑ I receive the information I need about my supports
- ☑ I am encouraged to work towards my goals
- ☑ My needs are regularly reviewed
- ☑ I communicate with staff when there is a change affecting my level of support
- ☑ I trust the service to keep my personal information confidential
- ☑ My support team understand me

Report and address issues

Issues with service delivery need to be documented and reported directly to your supervisor or reporting manager. Procedures are provided to staff, so they know how and when to report and document issues raised by the people they support. Documenting may be required in the client's file and should include details of the problem and follow up notes on how it was addressed.

Feedback can be received from written complaints, during an exit interview, directly from interactions or through observations of a client's interactions with resources. For example, a client may be disappointed that specialist support is not available or there is a waiting list to access services.

Most client complaints will be able to be resolved soon after the problem or incident has occurred. Support workers need to use their discretion and follow procedures when considering how issues need to be managed. If you are unsure, discuss this with your supervisor or manager.

Taking action

Any concerns raised must be addressed as soon as possible. Serious problems must be addressed immediately. The client and all relevant stakeholders need to be involved in a discussion to find a resolution. Resolution to a problem or issue may require:

- asking the client or their family what they suggest should/could have happened
- making an adjustment to the service plan to meet client needs more effectively
- providing additional training to staff to improve quality-of-service delivery
- providing opportunities for staff to attend buddy shifts and learn from more senior workers
- requesting additional information to gather more details on the issue.

Below are some questions to consider when addressing problems:

Service issue considerations
• Has there been a breach of the person's human rights or rights as a service user? • Have there been any changes to their personal circumstances? • Is the service plan meeting the needs of the person? • Are there issues in the staff's skills and knowledge that need to be addressed? • Are the activities or tasks in the service delivery plan too challenging or not enjoyable for the person? • Are additional resources required to improve service delivery?

If a breach of personal or human rights has occurred, the organisation needs to report it to the proper authorities, such as a regulator or governance board.

Making a complaint

With permission from the client, the worker can advocate on behalf of the person and complete feedback or complaint documentation. The client may be reluctant to explain their experience for fear of having resources withdrawn or upsetting people in their support network. If there is an incident being reported, the report must be the person's direct experience. However, if you are a witness to any events related to a complaint, you can write your own account to support the complaint being lodged. Always discuss with your supervisor or manager before taking this step.

1. Lodge the complaint
Complaints must be documented. Explain to the person their right to complain, and if the person is unable to complete the complaints form, you can assist with consent.
2. Assess the complaint
Ask the person what result they are seeking. Information is gathered from case notes, interviews and discussions with support people and other stakeholders, and witness statements. Statements must include consent from the person giving the service permission to gather and share information.
3. Manage the complaint
Complaints are managed case by case. The type of complaint determines how the complaint is addressed. Firstly a meeting will be required to gather the facts. Next, the person will be asked what they would like to see happen to resolve the problem. The person must be kept up to date with the progress of the complaint such as actions being taken, including if it will be escalated to a manager or senior person in the organisation.
4. Report the outcome
Once a decision or action has been determined, the person must be informed of how the issue has been managed and asked if they are satisfied with the outcome. If they are not, then they can be offered other options for further escalation or reporting such as to a regulatory body or Ombudsman or other body.

For more information on the complaint process for discrimination and a breach of human rights, visit this link: aspirelr.link/complaint-process

Example

Report and manage issues

Luksung Bao pays for support through his NDIS plan. He has become frustrated because his support worker never arrives on time and then has to leave early to get to his next client. As a result, they never get to do the activities outlined in his plan.

One afternoon the care team coordinator drops by to visit Luksung Bao and see how he is going. Wang Lei tells him that he is not happy with the service and would like to make a complaint. The coordinator acknowledges his concern and explains their complaint process, which involves lodging a complaint on their website. He then sends Luksung Bao an email with the link to the complaint's web page. The co-ordinator follows up with Luksung Bao a few days later after he has read the details included in the complaint Luksung Bao lodged.

Why is it important to manage complaints in order to achieve a resolution?

Practice Task 15

Question 1

Identify at least three ways a support service may receive feedback about the quality of service delivered.

Question 2

Briefly describe how a support worker should use their professional judgement when a complaint is made.

Question 3

Which of the following statements relate to addressing and reporting issues? Tick all that apply.

- ❑ All relevant stakeholders can be invited to discuss a resolution.
- ❑ Serious problems must be addressed immediately.
- ❑ Resolving a problem may require asking the client what they think should have happened.
- ❑ A common way to address a problem with a delivery plan is to simplify goals and lower the expectations of the person.
- ❑ A breach of a person's human rights must be reported directly to the regulator without input from a supervisor.

Question 4

Number each step for making a complaint from 1 to 4.

	Gather information and ask the person what they would like to see happen to resolve the problem.
	Inform the person about how the issue has been managed and ask if they are satisfied with the outcome.
	Manage the complaint by keeping the person up to date with the progress of the complaint and the actions being taken.
	Document the complaint or lodge it on behalf of the person according to the organisation's procedures.

4B Work in collaboration to adjust plans

Sometimes strategies need adjustments and improvements.

As soon as a need to adjust an individual plan has been identified, the service must take the necessary steps to amend the plan to improve outcomes for the person. If the plan needs immediate attention, the client has a right to expect progress reports about changes that will be implemented. Procedures outlining how this should occur will vary from organisation to organisation.

Support workers play an essential role in the tracking and monitoring of a person's individualised plan. Monitoring a person's plans occurs in the following ways:

- By observation
- Through conversation
- Daily shift reports and progress notes
- Feedback from other service providers
- A formal review process conducted at certain intervals; for example, every 3 or 6 months

In your daily interactions with the person, you may note how the person feels they are progressing. When the person or other person in their support network raises a concern about the progression of the plan, these must be documented and a supervisor consulted.

Identify the need for adjustments

Ask the person how they feel the plan is working. Do they feel they are moving forward and progressing?

A person's plan needs to be a working document as needs and goals change. For this reason, the document, once developed and implemented, must be monitored to ensure it is still working for the person.

The need for adjustments to the service delivery plan is often identified by observing the person engaging in activities or tasks outlined in the plan. You will often be able to tell if they are progressing or struggling. If there is consistency in your observations over a period of time, you will be able to identify adjustments to help with issues or barriers to success.

There are many reasons why plans evolve and no longer meet the needs of the client such as service gaps, changes to services, medical conditions, and achievement of goals. Support workers, health professionals, and, most importantly, the person and their family can provide information on the need for change.

Here are some examples of a change in a person's situation or circumstances:

Living arrangements	• Transportation arrangements • Availability of support people • Home modifications • Level of home care support
Financial position	• Employment or unemployment • Retirement • Eligibility to receive Centrelink payments • Receive an inheritance or divorce settlement
Changes in health status	• Level of support • Returning mobility equipment • Eligibility for health care services • Source in-home care • Include a community nurse and other health support into the person's plan • Make transport arrangements • Install medical equipment into the home • Relocate the person into a facility

Some of the actions you may need to take to adjust a person's plan are listed below:

Additional Services	You may need to offer additional services. For example, a client has been receiving home help for the last 12 months, but recently their health has deteriorated and a support worker is required every second day.
Modifying services	Current services may need to be modified. For example, a client has shown improvement in managing their disability. The current services are longer necessary and the level of support provided to the client can be scaled back.
Changing the type of support	You may need to offer different services. For example, a client has been receiving one-to-one counselling for depression. As a result, the client feels ready to participate in a support group. The plan will need adjusting to include this activity.
Changing services	Due to service limits, the client needs to access support from a different service. For example, a client needs to see a dietitian as they have been diagnosed with diabetes. The person will have to transition to a new service that provides this support and exit from the service they are currently registered with.

Support self-determination when adjusting plans

Services providers and their staff must recognise all people receiving services are experts in their own needs. If the person's expertise about themselves is not acknowledged, they can feel disempowered. For example, a person with a disability should not be excluded from discussions about what they need to be more independent and should be supported with resources to achieve independence.

Self-determination
A person's right to have control over their own life, able to make independent choices about decisions that affect them.

Four fundamental principles to **self-determination** are provided below:

Principle	Explanation
Freedom	Everyone has the right to decide how they want to live their lives, make decisions, and have the freedom to make mistakes.
Authority over resources	Everyone has the right to control their own finances and have access to resources needed to live a fulfilling life.
Support	Everyone is entitled to have access to formal and informal supports to assist them to live independently.
Responsibility	Society accepts that everyone has value and is entitled to opportunities that enhance their quality of life.

Read more about self-determination as a human right at this link: aspirelr.link/self-determination

Documenting changes to a plan

When a person is satisfied with the new arrangements in their plan, details of the adjustments must be recorded according to the organisation's procedures. Like all inclusions in the individual plan, the changes must be communicated to all stakeholders responsible for the plan.

Here is an example procedure for changing an individual plan:

Plan adjustment procedures
1. Seek feedback from the person to determine the need for adjustments. 2. Research alternative opportunities and activities. 3. Brainstorm alternatives with the person. 4. Complete a draft of the changes to the plan. 5. Discuss the draft with the person and their advocate or significant others. 6. Formalise the new individual plan. 7. Implement the new personal plan. 8. Monitor and review the new individual plan. 9. Make further adjustments if required.

Example

Work in collaboration to adjust plans

Monica has Down Syndrome. She is 18 years of age and lives at home with her parents and two younger brothers. Two months ago, she met with her support worker and representatives from the local recreation centre and supermarket, who supported her to develop her individualised plan. The activities included in her plan are her swimming lessons and paid work at a local supermarket.

After seven weeks working at the supermarket, Monica found working in a team environment very challenging. It affected her self-confidence and caused her some anxiety about going to work.

Monica decided she was not ready for paid work and would like to try something else. She contacted her support worker and together they meet with her family to discuss alternative ideas.

Her support worker makes a few suggestions including a local training program for young adults ready to enter the workforce. Monica liked the idea of the short course and felt it would be a good way for her to improve her communication skills needed for future work opportunities.

Consider the reasoning behind collaborating with the person you support and others to adjust individualised plans.

Exiting one service and transitioning to another

During the transition process, the person needs clear and accurate information about the new service and how the transition will occur. Some clients like to see the new service, meet the people who work there and get a feel for the place. Some services invite the new user to the service to introduce them to staff to make them feel welcome.

The transition process can be challenging for some clients, especially if the person does not want to change services. Listen to any concerns and support the person through these changes.

Keep the person informed of their progression on a waiting list as this gives the client certainty there will be a change of service. Once the transition has occurred, you can follow up with the client a week or two later to check they are settling in well with the new service.

Here are some things to consider when a person is exiting a service:

Procedure to exit clients from current services

1. Obtain their reasons in writing for leaving the service (if it was voluntary).
2. Source an appropriate service that meets the needs of the person.
3. Identify referral requirements of the new service.
4. Lodge the referral with the new service.
5. Obtain consent from the person to share information with the new service.
6. Provide written confirmation that the client has now been withdrawn from the service.
7. Follow workplace procedures, close the client's file and archive.

Example

Service transition

Read the following example to learn more about applying the principles of service transition in a workplace setting.

Abasi works for a service that provides transitional care. The purpose of outpatient transition services is to assist people to regain their independence after they have undergone a medical procedure. After an assessment process has determined the patient's eligibility, Abasi supports the person in developing a short-term plan. He helps his client define their goals, and together they form a support plan that will assist the person during recovery and back to independent living.

Practice Task 16

Question 1

Match each term about types of adjustments to its description.

Changing services	A client has been receiving home help for the last 12 months. However, his support worker can see that he needs assistance with personal care and gardening.
Changing the type of support	Due to the COVID-19 pandemic, a client has been visiting family once a month. Now the lock-down has lifted, they can visit once a week.
Additional Services	A client can no longer volunteer at the community op-shop and but still wants to do some volunteer work in the community.
Modifying services	A client has reached their goal of learning to drive and is looking for some other challenges.

Question 2

Identify three examples of why a person's plan may need to be adjusted.

Question 3

List at least three principles of self-determination and provide an example of a strategy a service worker can use to promote self-determination in their clients.

Question 4

Number each step from 1 to 7 in the order you would follow to transition and exit a client from a service.

	Identify referral requirements of the new service.
	Provide written confirmation that the client has now been withdrawn from the service.
	Source an appropriate service that meets the needs of the person.
	Obtain their reasons in writing for leaving the service.
	Follow workplace procedures, close the client's file and archive.
	Obtain consent from the person to share information with the new service.
	Lodge the referral with the new service.

4C Identify areas to improve the quality of service delivery

Organisations that strive to deliver quality services have a positive presence in the communities they support.

Evaluation of existing strategies helps the organisation identify what is being done well and where there is a need for improvement to service delivery. If problems are not addressed, poor quality of service can negatively affect a client's ability to achieve their outcomes, their physical and their psychological well-being. The consequences can be significant from a community perspective as the organisation will not effectively meet the community's needs. Reducing the quality of life for clients, and the inability to address community needs can increase social problems in a community.

Identification of improvement areas

Evaluating the implementation of services across the organisation can be done using feedback from clients, other stakeholders, other services, health professionals and staff. Organisations can use internal evaluations using various feedback methods discussed earlier in this topic such as surveys and by examining complaints registers.

External consultants are sometimes used to conduct an organisation wide evaluation of services of their overall customer service and business operations. Other areas for examination include effectiveness of policies and procedures, safety records, relationships with external service providers, the organisation's ability to address the community's needs, and hiring staff processes.

A final report may reveal the strengths and weaknesses of the organisation with recommendations of how improvements can be implemented. Staff can be given an opportunity to hear the recommendations and offer their own comments. For example, improvements might include providing staff with training, improving procedures to daily work tasks, and suggesting business growth improvements.

Critical factors for effective service delivery

Many critical factors affect service delivery quality and provide a starting point to identify areas for improvement. Below are some of these critical factors:

Cultural awareness
Organisations must ensure that cultural diversity and inclusion are considered when implementing services. • Are staff trained in cultural awareness? • Are there staff members from diverse cultures in the organisation? • Do the team have access to interpreter services and translated materials? • Does the organisation have a reconciliation action plan in place? • Is the organisation welcoming to diverse people?
Service workers knowledge and skill level
The worker's knowledge and skill levels will influence the quality of service. Support workers must have knowledge on the challenges that impact their clients and have the skills support them effectively. Training should be on offer and built into part of each staff members professional development and requirements of the job.
Strengths-based approach
Consider whether the organisation is genuinely providing strengths-based services to individuals. For example, is there still a focus on deficits and problems of individuals receiving services? Are individuals encouraged to identify and build on their strengths and interests?
Privacy and confidentiality
Does the organisation meet legislative and industry standards to protect individuals' privacy and provide them with confidential services? Are the policies and procedures of the organisation adequate to ensure all staff understand their responsibilities in this area?
Person-centred approach
Does the organisation place focus on the person receiving services? Does the organisation support self-determination and provide the person opportunities to grow through taking managed risks and making their own decisions?

Here are examples of barriers to effective service delivery:

Barriers to effective service include:
• Staffing barriers, such as limitations in skills, experience or knowledge • Funding barriers, such as insufficient funding to provide quality services or adequate staffing • Organisational culture barriers, including staff cultural understanding and not promoting an inclusive and diverse workgroup • Providing services that inadequately address the needs of service users • Partnership barriers, such as inadequate collaboration with other services, communication challenges or differences in vision

Example

Improve the quality of service delivery

Ferndale Mental Health Services have employed an external consultant to review and evaluate the effectiveness of service delivery processes. The consultant talks to staff, management, individuals receiving services, and other stakeholders, including family members and other service providers.

The consultant identifies the organisation's strengths. The team's ability to provide person-centred services to individuals who focus on stability and promote self-determination in their services' users has shown to be outstanding. The consultant also recognises that the organisation provides excellent services to people from diverse cultural backgrounds and employs First Nations Australians and culturally and linguistically diverse staff. However, the consultant notes that family members are not satisfied with the organisation's services. Several families have commented on being excluded from the planning process and don't feel informed.

The management team at Ferndale Mental Health Services begin discussing ways to include more family-inclusive services. Staff are asked to attend some training and a schedule of meetings is developed to review relevant policies and procedures to ensure that family-centred practices become part of the way the organisation operates and delivers services.

Reflect on this example and determine why it's important to improve the quality of service delivery.

Practice Task 17

Question 1

List five barriers that can affect the quality of service.

Question 2

Which of the following statements are correct? Select yes or no for each one.

a. Staff should be able to comment on recommendations for improvements.	Yes / No
b. The knowledge and skills of workers is essential for the delivery of quality of service.	Yes / No
c. Cultural diversity and inclusion should be part of the implementation of quality services.	Yes / No
d. Focusing on the problems of people receiving services can lead to improvements in service.	Yes / No
e. Outdated policies and procedures lead to staff not fulfilling their responsibilities and the quality of care will be affected.	Yes / No

Summary

- Monitoring the quality of service delivery allows for the evaluation of staff performance, identification of gaps in service and other issues that, when identified, can help improve processes and services for clients.
- The client, their family, carers and other support people need to know that feedback is valued and taken seriously.
- Consult with individuals receiving services and other stakeholders to assess the quality of, and satisfaction with, service delivery.
- A standard complaints process includes lodging the complaint, assessing the complaint, managing the complaint and reporting the outcome to the people involved.
- Work with all stakeholders to identify and adjust individualised plans to meet needs.
- Support the person's self-determination when making adjustments to service delivery plans.
- During the transition process, the person needs clear and accurate information about the new service and how the transition will occur.
- Staff can be asked to make suggestions about how to improve the quality of service delivery.

Learning Checkpoint 4

Review service delivery implementation

Part A

1. Identify three reasons why service organisations review their service delivery.

2. List at least four groups of people who can be consulted when reviewing quality and satisfaction with service delivery.

3. A client feels their plan is not helping them meet their goals. Which of the following statements relate to making adjustments to their plan? Tick all that apply.

- ❑ Concerns about plan progression must be documented and a supervisor consulted.
- ❑ A person's needs and goals can change, and the plan must reflect the new circumstances.
- ❑ Observations over time can indicate an issue or adjustment is needed.
- ❑ The family must be consulted and give approval before changes are made to a plan.
- ❑ Changes must be communicated to all stakeholders responsible for the plan.

4. Explain two principles of self-determination and how they need to be considered when changes are needed in a person's plan.

5. Outline the process for transitioning and then exiting a client from a service.

Part B

Read the case study, then answer the questions that follow.

Case study

Fatima has been receiving in-home care from a local support service for the past three years. Her current support worker has been finishing her shift half an hour earlier than previous helpers and Fatima has mentioned this to her daughter, Melissa. Melissa noticed on a recent visit that the bathroom had not been cleaned properly and she asked her mother about the last time it was cleaned. She also noted that her mother was wearing odd matching clothes and shoes.

Melissa arranged to be at her mother's home at the same time as the support worker so she could see for herself the type of support being given to her mother. When she arrived, her mother was cleaning the bathroom while the support worker was vacuuming the lounge room. Her mother was standing dangerously on the edge of the bath trying to wipe the tiles.

Melissa rang the co-ordinator of the service to tell her what she has seen. The co-ordinator took notes during the phone call and assured Melissa she would follow up and be back in touch with her with a response within two days. The co-ordinator also asks Melissa to fill out the online complaints form that she will send in a follow up email.

1. The co-ordinator has been receiving complaints from other clients and their families. Suggest two things the co-ordinator can do to identify if this is a problem across the organisation.

2. List two strategies the organisation can implement to ensure Fatima receives the support she is entitled to receive.

Topic 5: Complete reporting requirements

5A Follow organisational requirements for recording and documenting

5B Incorporate findings into continuous improvement processes

5A Follow organisational requirements for recording and documenting

Accurate record keeping is essential to avoid clients receiving incorrect support and services.

There are legal requirements for organisations to document client details, outcomes of staff meetings and program information. Auditors can refer to documentation for evidence that the organisation is providing the types of service expected under relevant legislation and standards. For example, confidentiality and record management systems must meet legislative requirements for privacy.

Documents also provide evidence of the actions that comply with industry standards in the event of an incident or accident such as a fire or car accident. Requirements for recording information will be detailed in organisational policies and procedures.

Support workers are required to record their meetings with clients, adjustments and notes in the individualised plans, and other service delivery materials. Here are some examples of the types of information they may be required to report:

- Personal information
- Health assessments
- Individualised planning meetings
- Case documentation
- WHS reports
- Service data
- Organisational reports
- Human resources reports

Your organisation will have policies and procedures that outline the way they want this done as well as procedures for storing, sharing, and archiving information. Speak to your supervisor or manager if you have questions about recording client information.

Clear and accurate recordkeeping

Progress notes and shift reports that include observations must be validated by factual events. Relying on memory can increase the risk of incorrectly recalling an event. Information lacking accuracy or currency about a person's status, or the issues affecting them, may mean the person could receive incorrect care or disjointed services.

Professional standards require that reports and documents use objective language based on fact and observations. The record taker should record what each person said rather than their interpretation of events. Objective language describes what has been observed or heard, while subjective language may be based on feelings, emotions or opinions. Objectivity is essential for accuracy and accountability and ensures individuals are described in ways unaffected by judgments, stereotypes, assumptions or opinions.

Objective versus subjective language
Objective: Mrs Smith stated, 'I am feeling depressed'. **Subjective:** Mrs Smith seemed depressed.
Objective: Alex rose quickly, slammed the door and raised his voice. **Subjective:** Alex acted aggressively.
Objective: Mark uses heroin regularly. **Subjective:** Mark is a drug addict.
Objective: Mr Thompson requires full physical assistance with meal preparation. **Subjective:** Mr Thompson is unable to cook for himself at home.

Language must also suit the audience. For example, a report to a manager will contain a different style of language compared with a report for families or sent to a client. For example, expressions, acronyms or abbreviations used by staff need to be used with consideration when communicating with people outside the sector.

Spelling is critical for the accurate recording of information. Misspelling a person's name may cause confusion with another person's information such as duplication of records. Incorrect spelling of medical terms can also create problems leading to incorrect treatments or referrals.

Handwriting must be legible and understandable. Reading information back to the person to confirm accuracy can take longer, but helps prevent mistakes that may take considerable time and effort to rectify later.

For more information on the importance of record keeping, visit the following link: aspirelr.link/record-keeping

Strengths-based approach to documenting

Using a strengths-based approach requires you to ensure that documentation reflects the strengths and capacities of the person. This means that planning and service delivery documentation, like case notes, refer to the person's strengths and what can be achieved rather than their deficits (what they cannot do).

Follow requirements to prepare reports

Reporting requirements will differ depending on the situation, consent for sharing information, and your organisation's policies and procedures.

Here are some organisational requirements that need to be considered when preparing reports:

Meet timelines	• The purpose of a report or document, along with the organisation's expectations, will determine the timelines for its completion. • For example, funding submissions or statistical reports to the government have time frames set externally. • Your organisation will have procedures for when documents need to be completed and for reporting incidents and accidents.
Maintain confidentiality	• Case notes, programming and incident reports often include interactions that involve events with other people. • Therefore, the confidentiality of a person's receiving services, and others, must be maintained when writing notes or reports recorded in the person's file or records.
Use forms and templates	• Forms provide consistency in the way information is collected and reported. • Use the appropriate form or report template, as this helps other workers identify the required information. • Make sure you have completed all sections and entries and that they make sense.
Obtain authorisation	• Records should be signed and dated by the person completing them. • Computer-based records may require a log-in for access to identify the author. • For reports, show drafts to another authorised person for feedback; some organisations require that a manager sign off any outgoing reports.
Storage of records	• Information must be retrieved by authorised personnel. Information should always be kept in safe and secure areas. • For example, storing hard copy files in a lockable cabinet is common, with files stored alphabetically by surname with personal information at the front, progress notes next, assessments behind that and payment records at the back. • For electronic files, detailed information is recorded in a specific form or field. • Systems need to be password-protected, which limits access to authorised staff only.

Updates and adjustments	• Updates to service delivery plans or other documentation can be necessary if there is a change in the person's circumstances that lead to plan adjustments. • Completed documents generally must not be changed. Errors or alterations should be identified in an additional note or new record, clearly explaining the reason for the change. • Correction fluid to change any written document is never used. • Computer-based records may not allow changes to saved information.
Archiving information	• Most organisations use a version control process to ensure the currency of documents. • The general rule is that past work records are stored and maintained, even if they no longer appear relevant or are superseded by more recent information. • Your workplace will have procedures and guidelines about how and when documentation is to be maintained.

Here are some examples of the types of information a support worker may be required to report on after a planning meeting:

Information to document
• The people attending the meeting • How the person participated in decision making • How the person was supported during the session and by whom • The goals the client has chosen to work towards • Strategies and actions selected • Progress of the person • Reasons for making adjustments • Any issues raised and other feedback on service

Checking currency of documentation

When facilitating individualised plans, ensure all documentation is up to date and readily accessible by all parties involved in the person's care. For example, before a meeting with a client, check that no personal details have changed, and always ensure that case notes are completed immediately after the appointment. The best practice is to take notes as you work with your clients.

Notetaking is an important skill that allows you to record information as you hear it and not rely on memory. It is best practice to ask permission to take notes in a meeting and to explain why you need to take notes. Keep notes as brief as possible: you can write them in full immediately after the appointment.

Example

Maintain currency of documentation

Ava is a support worker in a care team that provides 24 hours around the clock care for a client who has complex and multifaceted needs. At the start of the shift, she signs an attendance sheet as evidence of her attending the shift. Several documents used to show proof of care are provided on each support worker shift in the client care file. This includes personal care, meals, and medication management. Once Ava has completed the task, she signs and dates the document.

Consider why you must maintain current documentation in your role. What might the implications be if you fail to do so?

Practice Task 18

Question 1

List three reasons why all documentation must be accurate and current.

Question 2

Which of the following statements relate to the strengths-based approach to the recording of information? Tick all that apply.

- ❑ Reporting on successes
- ❑ Reporting on progression towards goals
- ❑ Recording who was present in the meeting
- ❑ Recording consent given by the client
- ❑ Documenting past failure strategies

Question 3

List two reasons for using objective language in workplace documents.

Question 4

Match each of the requirements for documentation with its example.

Archiving	Statistical reports sent to a government authority
Meeting timelines	Personal information stored securely in the person's file
Storing records	Documents used for consistency across an organisation
Using templates	A sign off of outgoing reports by a manager
Updating and making adjustments	Information retrieved by authorised personnel
Maintaining confidentiality	Errors or alterations identified in an additional note
Obtaining authorisation	Version control process used to ensure currency of documents

Case study

Charlotte is a support worker who has met with Liam to review his individualised plan. During the planning session, Liam explained to Charlotte that he felt like he was progressing well and was making friends in the indoor soccer team, but that he does not like the library group he has been attending. He finds it boring and wants to do something a bit more exciting.

Question 5

Charlotte and Liam have updated his plan and necessary changes have been made. Charlotte has completed a final draft. List three tasks she must do now with Liam's plan document.

Question 6

List one thing Charlotte must do to file the plan to keep it secure.

Question 7

Suggest one reason why Charlotte should complete the documentation straight away and not leave it until later.

5B Incorporate review findings into continuous improvement processes

The goal of continuous improvement is to improve the overall quality of service to both the users and the community.

Identifying problems in service delivery ensures that improvements will close service gaps and improve standard of service. Making **continuous improvement** a part of evaluation demonstrates a proactive approach to improving the service.

Continuous improvement
An iterative process that involves an ongoing cycle of identification, planning, implementation and review.

Support workers can use continuous improvement as a daily activity. It means reflecting on what is done well and what areas can be improved. Personal reflection involves identifying what aspects of work can be improved, such as communication skills, conflict management skills, and hands-on task performance.

Continuous improvement processes

Continuous improvement should be systematic and ongoing. An effective process will ensure that communication and analysis of current work practices are carried out regularly to ensure service users receive a high standard of service and representation. Improvement is achieved through a series of planned steps based on monitoring and evaluating current practice and progress.

Organisations, businesses and services use a cycle of continuous improvement. The Plan-Do-Check-Act method is one of the most efficient models used, and the steps are easy to follow. The table below explains how the process works.

Plan	The organisation will review its current standards of practice, staff performance and seek feedback from service users, staff and external services to identify areas of improvement. The team will then brainstorm suitable activities to improve level of service.
Do	The improvement strategies generated in the planning phase are trialled. This can be by changing the way tasks are carried out, improving the skills and knowledge of staff, predicting problems that may arise and having strategies to manage them effectively.
Check	Feedback is gathered from staff, clients and other stakeholders using evaluation tools to determine if the new approaches are practical and work. The feedback from the evaluation is then analysed.
Act	If the trialled improvements work effectively, procedures will be amended to incorporate the new activities. This can be done by updating the organisation's guidelines on how activities are carried out and adjusting policies. The activities become the official way of delivering services.

Video: Continuous improvement

For more information on how to include continuous improvement in daily practice, watch this video: aspirelr.link/continuous-improvement-practice

Here are a tips for things to consider in during the CI process:

Continuous improvement strategies
• Consider the needs of clients receiving services and involve them, where possible, in improvement activities. • Involve other stakeholders like family members, staff, carers, advocates and others. • Be part of a review system to assess how well service delivery implementation is working. • Raise issues in team meetings so decisions on actions are shared. • Measure improvements in terms of observable outcomes.

For more information on continuous improvement in the aged care sector, visit: aspirelr.link/aged-care-quality-continuous-improvement

Practice Task 19

Question 1

Briefly explain whose responsibility it is for continuous improvement.

Question 2

Number in order each stage of the continuous improvement process.

	Evaluate feedback
	Review current standards of practice
	Amend organisation policies and procedures
	Predict issues that may occur

Summary

- Accurate recordkeeping is critical to avoid clients receiving incorrect support and services.
- There are legal requirements for organisations to document client details, outcomes of staff meetings and program information.
- Follow your organisation's requirements to record all planning activities and prepare reports and documentation.
- Professional standards require that reports and documents use objective language based on fact and observations.
- Spelling is critical for the accurate recording of information and language must suit the intended audience.
- Notetaking is an important skill that allows you to record information as you hear it and not rely on memory.
- Currency of documentation can be maintained by making appropriate updates to version controls and file naming protocols
- Apply continuous improvement practices to your work practices through reflection.
- Incorporate findings of reviews into continuous improvement processes to ensure exemplary service delivery.

Learning Checkpoint 5

Complete reporting requirements

Part A

1. Which of the following statements relate to the responsibilities of a support worker when writing reports? Tick all that apply.

- ❑ Check that information is current
- ❑ Write information using plain English
- ❑ Develop documents so they are suitable for the purpose
- ❑ Use objective language based on fact and observations
- ❑ Use acronyms and abbreviations so clients understand the language used in the sector.

2. Suggest one risk to clients if their plans contain errors and outdated information.

3. List two things an organisation can do to ensure that staff use only current forms.

Part B

Read the case study, then answer the questions that follow.

Case study

Judith has recently attended an individualised plan meeting with her client Ethan. Although she wrote down the proposed plan changes during the meeting, Judith now needs to produce a final plan and ensure her client, and other relevant stakeholders, receive a copy.

1. Judith tries to access the plan template, but she can't find the document she is familiar with. Explain what Judith should do now.

2. Judith is taking notes during her meeting with Ethan. List at least three responsibilities for notetaking and preparing Ethan's plan.

3. Judith's supervisor asks her to tell the rest of the team about the problems she had finding the correct template. Identify the steps the organisation could take to improve the process.

Glossary

Active listening

Concentrated listening and non-verbal encouragement indicating an understanding of what is being said.

Bias

A feeling of liking or disliking a person or group of people due to a preconceived opinion or prejudice.

Challenging behaviours

Behaviours that can place the person or others at risk of physical and psychological injury.

Continuous improvement

An iterative process that involves an ongoing cycle of identification, planning, implementation and review.

Cultural awareness

Being aware of cultural difference and diversity and developing a sensitivity and respect for difference.

Dignity of risk

A person's right to dignity and choice, upheld in legislation and service standards, to ensure that duty of care or safety is not used as a reason to limit a person's freedom of personal choice.

Diversity

A wide range of different personal characteristics, including culture, gender, sexual orientation and ethnicity.

Duty of care

A moral or legal obligation to ensure the safety and wellbeing of other persons.

Integrated approach

An approach to care where there is a high degree of collaboration among involved health professionals, ensuring improved outcomes for the person.

Interrelated needs

A combination of issues that a person experiences at the same time.

Multifaceted

Something involving several different aspects or containing many features.

Risk assessment

Determining the likelihood a hazard will cause harm, injury or ill-health and determining its possible consequence.

Self-determination

A person's right to have control over their own life, able to make independent choices about decisions that affect them.

Stereotyping

Judging an individual based on particular characteristics, then applying that belief to all members of that group.

Strengths

A person's positive personal attributes, character traits or skills available to that person.

Strengths-based approach

Recognises that all individuals are resourceful and resilient experts in their lives, and can progress in a way that enhances their quality of life.