CHCCSM004 Coordinate complex case requirements

Release 1

Learner guide

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Aspire version 1.4

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Version control and modification history

Version	Release date	Modification
Release 1, version 1.1	July 2017	First release
Release 1, version 1.2	November 2017	Update to QR code destinations. Minor corrections as part of our continuous improvement program
Release 1, version 1.3	July 2019	Updated to reflect the new Aged Care Quality Standards
Release 1, version 1.4	November 2019	Updated in line with changes to the Home and Community Care (HACC) program.

Aspire is committed to developing quality resources that meet the needs of our customers. However, occasionally Aspire finds, or is notified of, errors. Please refer to our website at www.aspirelr.com.au to see if there are any updates that may be relevant to you.

CHCCSM004 Coordinate complex case requirements, Release 1

Level 1, 464 St Kilda Road
MELBOURNE VIC 3004 AUSTRALIA
Phone (03) 9820 1300

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Contact details

Participant

Name:

Start date:

Phone number:

Email:

Work location

Name:

Address:

Postal address:

Workplace supervisor name:

Phone number:

Fax:

Email:

Registered Training Organisation (RTO)

Name:

Address:

Postal address (if different):

Phone number:

Fax:

RTO contact name:

Mobile:

Email:

Contents

Before you begin

This learner guide is based on the unit of competency *CHCCSM004 Coordinate complex case requirements*, Release 1. Your trainer or training organisation must give you information about this unit of competency as part of your training program. You can access the unit of competency and assessment requirements at: www.training.gov.au.

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. The features of this learner guide are detailed in the following table.

Icon	Feature	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 key 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.
	Video clips	▶ Where QR codes appear, you can use a smartphone or other device to access video clips relating to the content. For information about how to download a QR reader app or accessing video on your device, please visit our website: www.aspirelr.com.au/help
	Summaries	▶ Key learning points are provided at the end of each topic.
	Learning checkpoints	▶ There is a learning checkpoint at the end of each topic. Your trainer will tell you which learning checkpoints to complete. These checkpoints give you an opportunity to check your progress and apply the skills and knowledge you have learnt.

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.

The following table outlines specific foundation skills noted for your learning in this learner guide.

Foundation skill area	Foundation skill description
Learning	▶ Understanding your job role, organisational procedures and legal responsibilities ▶ Managing your work and seeing how well you are going and making goals for yourself at work ▶ Seeking professional development opportunities for continuous improvement
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
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
Making decisions	▶ Understanding and applying decision-making processes ▶ Reviewing the impact of your decisions
Problem-solving	▶ Identifying problems ▶ Working out how to fix a problem using problem-solving processes and reviewing the outcome
Innovation and creation	▶ Recognising opportunities to develop and apply new ideas ▶ Generating ideas by thinking of new ways to do something ▶ Making suggestions to improve work

Foundation skill area	Foundation skill description
Technology and digital literacy	▶ Efficiently using digitally based technologies and systems correctly and safely ▶ Accessing, organising and presenting information ▶ Using equipment correctly and safely

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 outcomes	Rate your confidence in each section
Topic 1 Understanding case management	1A Case management and coordination	☐ Confident ☐ Basic understanding ☐ Not confident
	1B Regulations, codes and legislation	☐ Confident ☐ Basic understanding ☐ Not confident
Topic 2 Understanding the client	2A Assessing the client	☐ Confident ☐ Basic understanding ☐ Not confident
	2B Client dynamics	☐ Confident ☐ Basic understanding ☐ Not confident
	2C Cultural considerations	☐ Confident ☐ Basic understanding ☐ Not confident
Topic 3 Coordinating care	3A Developing a client plan	☐ Confident ☐ Basic understanding ☐ Not confident
	3B Arranging services	☐ Confident ☐ Basic understanding ☐ Not confident
	3C Role responsibilities	☐ Confident ☐ Basic understanding ☐ Not confident

Topic 1

In this topic you will learn about:

Understanding case management

Case management is a process in which a case coordinator or case manager assesses a client and assists them to access options and services.

Case management is a collaborative process of assessment, planning, facilitation, advocacy and coordination of options and services to meet an individual's holistic needs. This is achieved by using efficient communication and accessing available resources to promote high-quality, cost-effective outcomes.

Watch the unit introduction video here.

1A Case management and coordination

A case management framework is one in which a client accesses multiple services, usually predominantly publicly funded, which are coordinated by a suitably qualified professional.

Service provision in a case management framework is ideal for people with complex needs. This is because multiple services can be accessed to address multiple needs in this framework. These services are coordinated by the case coordinator or case manager, or by another professional who performs the case management function.

The main aim of delivering services in a case management framework is to facilitate targeted, holistic, high-quality service delivery, and to address all of the client's needs. This approach also aims to reduce the likelihood that co-existing needs snowball into greater issues, and to minimise the adverse effects of these co-existing needs.

A case management framework involves working with the client through an integrated process of assessment, planning, monitoring and review, which aims to provide the best services to meet clients' complex needs, and to ensure that the services remain effective. Depending on the context of case management, the terms 'case management framework' and 'service coordination framework' may be used interchangeably.

Models of case management

There is a wide range of case management models and service/care models.

Although there are differences in the ways in which the models are implemented, there are significant similarities across these models. For example, they are all outcome-focused, person-centred and evidence-based. The differences are largely due to various organisational practices, sector-specific requirements and funding issues.

The following models may be used when coordinating care for a client.

Brokerage model

- In the brokerage model, the case manager does not provide any direct services to the client. Instead, they act as a conduit, facilitating and arranging access to services to meet needs that can range from personal care through to social and psychological support.

Clinical model

- The clinical case management model is an extension of the brokerage model, in that the case manager facilitates and arranges access to services. However, the clinical case manager also provides services. The case manager must be appropriately qualified to provide services. Examples of personnel qualified to provide clinical case management services include social workers and nurses.

Assertive community treatment model

- In the brokerage and clinical case management models there is usually a single case manager. Assertive community treatment involves a team approach. There is no single case manager, but a team in which all members contribute.

Rehabilitation model

- Rehabilitation case management focuses on outcomes. The key aim of this model is to restore clients to their previous level or optimal level of functioning. This model can be effective because it helps the client to focus on their goals and achievements.

Consumer-directed care model

- This model is used to give the consumer (the client) as much control and choice over their care and services as possible. If case management is provided as part of a Commonwealth-funded Home Care Package, this model will enable the client and their carers to have more choice, flexibility and support through a collaborative approach to wellness and enablement.

Example

Brokerage model of case management

Stanley is 77 years old. He has been living alone in his own home since his wife passed away three months ago. Stanley has diabetes and now self-administers his insulin injections. Stanley has had both legs amputated below the knee due to the effects of his diabetes, and he uses a wheelchair for mobility. Due to muscle de-conditioning, Stanley's upper body strength has diminished, and he is struggling to push himself in his wheelchair.

Due to his physical status, Stanley struggles with activities of daily living (ADLs), such as cooking. Stanley is grieving the loss of his wife, whom he was married to for 52 years. His doctor recently diagnosed him with depression. Stanley has become increasingly isolated since his wife's death. He often feels lonely and because he cannot drive, going out is difficult for him. However, he wants to keep living at home. Stanley is referred to My Aged Care (MAC) by his doctor and is assessed as being eligible for a range of funded support services.

Diane is a case coordinator. After conducting a multi-disciplinary initial needs assessment, she meets with Stanley to look at service options to address his needs. Diane considers the assessment outcomes and Stanley's personal goals, and puts the following suite of services in place:

- local service providers to support Stanley
- arrangement of service inputs within the range of allocated funding
- Red Cross volunteers to transport Stanley to his appointments
- a physiotherapist to administer a physiotherapy plan for his treatment
- a homecare agency to provide staff to support Stanley with self-care.

Approaches to case management

Standards and codes of practice underpin approaches used to address client needs in the best and most appropriate manner.

Approaches to case management can overlap and complement each other. They may include:

- person-centred approach
- strengths-based approach
- evidence-based practice approach
- early intervention and proactivity approach.

The following outlines the different approaches to case management.

Approach	Description
Person-centred approach	▶ Based on the assumption that the client, rather than the professional, should have the greatest say over their own life. ▶ The client is placed at the centre of decisions about their life and the support they receive. ▶ The client is supported to identify and work towards their own goals and aspirations, rather than goals someone else has determined to be appropriate. ▶ Self-determination and choice are optimised. ▶ The client's family, friends and significant others become partners in the process of planning and support. ▶ The priorities of service delivery are driven by the needs of the client, not by the interests of the organisation. ▶ The client and/or their advocate or representative are encouraged to identify services that best align to their goals and aspirations. ▶ Uses the client's natural/informal supports (such as family and friends) to facilitate sustainable support for the client, which is aligned with how the client chooses to live their life.

Approach	Description
Strengths-based approach	▶ Empowerment and capacity-building are central to this approach. ▶ The underpinning philosophy or approach of the organisation should always be strengths-based. ▶ Focuses on what clients can do and what motivates them, rather than what they cannot do. ▶ Aims to build on existing skills and interests, and seeks to set people up to experience success. ▶ Aligns with a person-centred approach in that the client's self-determination is optimised, and value and respect are at the forefront of all interactions. ▶ The client is supported to set goals based on their aspirations and interests, which build on their existing skills and capabilities. ▶ Areas of motivation form the basis of support strategies so the client remains interested and motivated. ▶ The client is more likely to experience success, which is a strong motivator to continually strive to reach new and existing goals. ▶ Encourages the client to access the range of services that best suit their existing strengths and interests, and to build on these so that the client will be more likely to reach their potential.

Evidence-based practice approach	▶ Used to assess needs, and determine, monitor and review services for effectiveness.
	▶ Integrates input and information from a range of sources to determine and deliver the best service options.
	▶ Ensures that decisions about client support have been informed by the relevant evidence.
	▶ The assessment and care coordination process uses industry-endorsed assessment tools and screening methods, client feedback and service provider feedback. This informs the plan of care/support, and reflects current best practice support strategies.
	▶ Requires decisions to be made about client support based on:
	    ▶ professional judgment and expert assessments, diagnoses and conclusions of relevant clinical specialists
	    ▶ stakeholder input and client/family/service provider feedback
	    ▶ research and scientific evidence relating to the area of service needed
	    ▶ organisational data, such as client observations and documentation, and organisational policies and procedures.

Approach	Description
Early intervention and proactivity approach	▶ Addresses needs or issues earlier, which is better for the client because it means that risks and problems can be identified and addressed before they become more complex. ▶ Beneficial from an economic perspective because managing multiple needs holistically often prevents issues from worsening, which would lead to greater need for services and increased cost to the public purse. ▶ Requires that organisations have processes in place to identify and respond to needs, risks and barriers as early as possible, in preference to a reactive approach to issues that could have been prevented or minimised.

Practice task 1

Click icon to open online version

Check your understanding of case management models and approaches.

Match the case management model or approach with its description.

* Early intervention and proactivity approach	* The case manager acts as a conduit, facilitating and arranging access to services to meet needs that can range from personal care through to social and psychological support.
* Evidence-based practice approach	* The case manager facilitates and arranges access to services, and also provides services.
* Brokerage model	* Decisions made about client support are based on professional judgment – the expert assessments, diagnoses and conclusions of relevant clinical specialists relating to the individual client.
* Clinical model	* This approach involves systematically identifying and addressing needs or issues at the earliest possible point to prevent snowballing of issues.
* Strengths-based approach	* Client self-determination is optimised, and value and respect are at the forefront of all interactions.

Principles and practices of case management

The principles of service coordination and case management must be built into organisational policies, procedures, protocols and practices.

To facilitate effective and seamless service provision across multiple services, there is a range of considerations, principles and approaches that you should use as the case coordinator. The principles link to and stem from the standards, legislation and regulatory requirements that govern the various sectors of the industry. It is important to follow these principles so that you always operate within the parameters of your role.

The following principles of case management reflect those that most community services organisations adhere to.

Logical and systematic
Case coordination requires a logical, structured, step-by-step approach, commencing with intake, undertaking full needs assessment, and involving well-considered planning, monitoring and review.
Sound assessment
A robust assessment process is undertaken to assess the full range of client needs, priorities and preferences.
Collaboration and partnership focus
Case coordinators build partnerships and collaborative relationships with clients, their families and significant others, formal networks of government and non-government service providers, and the community. Collaboration and inclusion are central features, and partnerships benefit the client by facilitating optimal opportunities for service provision.
Outcomes-driven
All services and inputs are focused on supporting clients to achieve agreed outcomes, and undertake the monitoring and reviews required to ensure outcomes are being met.
Advocacy
Service providers support clients to understand, access and claim their legal rights and entitlements.
Accountable
Service providers hold themselves accountable to provide high-quality services, and take responsibility for implementing processes and policies to facilitate this. Complaints are dealt with fairly.
Holistic
Services are planned and delivered to support the whole person.

Dynamic
Revision of goals, strategies, resources and outcomes is ongoing throughout the process of case management, facilitating responsiveness to the individual's changing circumstances.
Competent
All services and support activities are carried out by appropriately trained and qualified staff. The scope of roles is managed, and staff are supported through supervision, training and mentoring.
Transparent
All processes are open and applied equally to all.
Inclusive
Client diversity is respected and valued. Clients receive services on the basis of eligibility, assessed need and priority. There is no discrimination on the basis of clients' personal characteristics. Services are planned and delivered so that client diversity is supported.

Example

Approaches and models of case management

David has schizophrenia. Susan has been his case manager at Didsbury Mental Health Services (DMHS) for the past 18 months. Before he was diagnosed, David had been experiencing severe psychotic symptoms, including auditory hallucinations and paranoia. As David's symptoms worsened he was unable to hold onto his job, and his relationships with friends and family broke down. He also developed a significant dependence on alcohol, as he found relief from his symptoms when he was drinking.

David becomes homeless, and is eventually referred to DMHS by a GP. After the intake process, Susan is appointed as David's case manager. David explains that he would like to have a secure place to sleep and wants to eventually reconnect with his family and friends.

Susan commences the needs assessment process, and with David and his psychiatrist, develops a client plan to address some of David's co-existing needs. Susan coordinates the services David accesses, some of which are internal to DMHS, and some of which are provided by other organisations. She uses the brokerage model to acquire services for David that address his needs holistically.

David accesses the following supports and service inputs:

- Psychiatric treatment: a psychiatrist who works at DMHS monitors David and oversees his medication regime
- Outreach support: a mental health worker (MHW) who visits David twice weekly in his home, and supports him with appointments and shopping
- Subsidised housing: @HomeSafe provide affordable housing for clients with mental health issues
- Outpatient alcohol and other drugs (AOD) support: a local drug and alcohol service that supports David to beat his dependence on alcohol
- In-home support: assists David with home care tasks and meal preparation
- Social support: a local non-government organisation (NGO) that specialises in supporting clients with recreation and social activities

David's case plan is reviewed at regular intervals to see how he is progressing towards his goals.

1B Regulations, codes and legislation

Case coordinators must work within the legal and ethical parameters of the standards, codes of conduct and legislation that apply to the organisation and the specific sector.

This ensures that laws are not breached, obligations are upheld and best practice is demonstrated. The legal and ethical framework is created through adherence to obligations such as:

- organisational standards, policies and procedures
- regulatory standards
- codes of conduct
- legislation.

Organisational standards

Organisational standards, policies and procedures outline the way in which an organisation conducts business and the organisation's expectations of how staff will behave.

Organisational standards are underpinned by a code of conduct and a code of ethics. A code of conduct outlines the organisation's expectations and rules for staff behaviour, dress and professional conduct. An organisation embeds the ethical requirements into workplace policies and procedures so that staff will demonstrate ethical practice by following those policies and procedures. A new employee should always be given access to an organisation's documents so that they have direction for their work role and tasks.

Ethical codes of conduct

As well as organisational ethical codes of conduct, there are ethical codes of conduct that apply to specific sectors of community services.

For example:

- Australian Association of Social Workers (AASW) Code of Ethics outlines values and ethical responsibilities that must be upheld.
- Code of Ethics for Nurses in Australia includes standards from the United Nations' Universal Declaration of Human Rights. The Code supports commitment to respect, promote and uphold the fundamental rights of people receiving care.
- National Code of Ethics for Case Management outlines case management values, principles, ethical decision-making, and the practice and conduct expected of a person in a case management role.

Client rights and responsibilities

Clients of all community services organisations have service user rights and responsibilities.

These are specific to each sector, and are drawn from the wider legislation and standards that govern each sector. They form part of the legal and ethical framework used by case coordinators when supporting clients in various sectors.

Two examples of sector-specific client rights and responsibilities are:

- Charter of Care Recipients' Rights and Responsibilities – Residential Care
- Charter of Care Recipients' Rights and Responsibilities – Home Care

Understand your role

It is critical to understand the requirements and limitations of your role as a case coordinator.

Role requirements

The requirements and responsibilities that apply to a case coordinator's role are outlined in the position description. This details the scope of the role, the duties and activities that a staff member is legally able to perform. This might include not exceeding the authority of their position and staying within professional boundaries. It is vital that case coordinators undertake only the activities and duties that are specified by their role. Performing duties outside the job description may have legal implications for the organisation and the person involved.

Boundaries of role

Professional boundaries are stipulated in industry or organisational codes of conduct.

Boundaries can become blurred when they are not clearly defined and understood by both the case coordinator and the client. It is important that the client understands the ethical and legal boundaries that the case coordinator must work within. As the case coordinator, you must not only understand these boundaries, but also work within them.

Watch this video to learn about the key requirements of your role.

Regulatory standards

Various industry standards specify the level and quality that organisational services, processes and practices must meet.

Organisations' adherence to the standards that govern them is monitored by the state/territory and Commonwealth regulatory bodies that oversee the specific industry sector.

Regulatory bodies conduct regular accreditation audits to determine whether an organisation is meeting the standards. If so, the organisation will be granted accreditation, usually for a period of no more than three years.

Standards are legally binding, and if organisations are found to be non-compliant with the standards they are required to meet, a range of sanctions can be applied, including withholding funding until the organisation makes the required rectifications.

Examples of regulatory standards for community service sectors:

- The Aged Care Quality Standards apply to services delivering aged care and applies to all residential aged care facilities.
- The Human Services Quality Standards apply to Queensland Government service provision.
- Child Safe Standards apply to organisations in Victoria that provide services or facilities for children.
- National Standards of Practice for Case Management outline minimum requirements for case managers.

Legislation

Legislation is a set of laws passed by parliament at a state/territory or Commonwealth level.

All organisations in the community services sector must ensure that they operate in compliance with the relevant governing legislation.

Examples of legislation that apply to case coordination:

- *Privacy Act 1988* (Cth)
- anti-discrimination law
- *Equal Opportunity Act 2010* (Vic.)
- *Australian Human Rights Commission Act 1986* (Cth)
- health and safety legislation
- child protection legislation.

The Privacy Act

The Privacy Act contains 13 privacy principles that apply to organisations providing case management.

The Privacy Act protects personal information, including a person's name, signature, address, phone number, date of birth, medical records and bank account details. Clients and their representatives must be fully informed of the reasons the organisation needs to collect their personal information, and the type of information required. Organisations must only collect information that is required to facilitate service delivery.

The following outlines how case coordinators can meet their privacy obligations.

Storing and securing personal information

- Paper-based information must be stored in locked facilities.
- Electronically stored information must be stored with password controls.
- Records (paper or electronic) that need to be taken out of the office into the homes of clients must be transported safely and securely.

Sharing personal information

- Information must not be shared between organisations without the written, informed consent of clients or their representatives.
- Information can only be discussed with people who are authorised to know about it.

Anti-discrimination law

In Australia it is unlawful to discriminate on the grounds of age, disability, race or sex.

Anti-discrimination law means that case coordinators must ensure that services are provided to clients on the basis of assessed need and eligibility. There must be no preferential or discriminatory treatment based on the client's personal characteristics. Non-judgmental practice must be applied, and services must be delivered in a respectful manner.

Case managers and service coordinators may need to advocate for clients in the event of potential or actual discrimination.

Federal anti-discrimination laws are outlined in the following table.

Age Discrimination Act 2004 (Cth)

This Act makes it illegal to discriminate against someone on the grounds of age and age-specific characteristics.

Disability Discrimination Act 1992 (Cth)

This Act makes it illegal to discriminate against someone on the grounds of:

- disability (all types)
- diseases and disorders, including that affect thought processes, perception of reality, emotions or judgment, or result in disturbed behaviour
- the presence in the body of organisms causing or capable of causing disease or illness (e.g. HIV virus).

Racial Discrimination Act 1975 (Cth)

This Act makes it illegal to discriminate against someone on the grounds of:

- race
- colour
- descent
- national or ethnic origin
- immigrant status (in some cases).

Racial hatred is also made illegal under this Act. Racial hatred is defined as a public act likely to offend, insult, humiliate or intimidate on the basis of race.

Sex Discrimination Act 1984 (Cth)

This Act prohibits sexual harassment and makes it illegal to discriminate against someone on the grounds of:

- sex
- marital or relationship status
- pregnancy or potential pregnancy
- family responsibilities
- breastfeeding
- sexual orientation
- gender identity and intersex status.

***Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Act 2013* (Cth)**

This amendment inserted new grounds into the Sex Discrimination Act, making it illegal to discriminate against a person on the grounds of their:

- sexual orientation
- gender identity
- intersex status.

Same-sex couples are also protected from discrimination under the definition of 'marital or relationship status' (previously 'marital status').

***Equal Opportunity Act 2010* (Cth)**

This Act aims to eliminate discrimination, sexual harassment and victimisation. It also protects clients who require an assistance dog. The Act states that there must not be discrimination in the provision of goods and services, including:

- refusing to provide goods and services to the other person
- the terms on which the goods or services are provided
- subjecting the other person to any other detriment in connection with the provision of goods and services.

Human rights law

The Australian Human Rights Commission Act 1986 (Cth) enforces human rights law in compliance with various international instruments.

Those that relate to community services are:

- Convention on the Rights of Persons with Disability
- Conventions on the Rights of the Child
- Declaration on the Rights of the Child
- Declaration on the Rights of Disabled Persons
- Declaration on the Rights of Mentally Retarded Persons
- Declaration on the Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief

These may be read in full at http://aspirelr.link/humanrightslaw

Health and safety legislation

In 2011, Safe Work Australia developed a single set of work health and safety (WHS) laws, which have been implemented in most states and territories across Australia.

These are known as 'model' laws. For the model WHS laws to become legally binding, the Commonwealth, states and territories must separately implement them as their own laws. Acts and regulations require that all organisations have robust policies, procedures and systems in place to keep staff safe when they are carrying out their duties.

Case coordinators can meet their WHS obligations by:

- identifying and reporting hazards (physical and psychological)
- conducting risk assessments and devising risk control strategies in response to client-related and other workplace risks
- attending training, e.g. emergency response and personal safety
- completing incident reports and other documentation
- conducting in-home safety assessments to ensure a safe workplace for direct care staff attending clients in their homes
- ensuring the safest strategies and rosters are in place for staff who are delivering direct care support services
- monitoring the safety of direct care staff when they are working with clients
- arranging training for direct care staff
- minimising risks through policies and procedures that identify hazards, and assess and control risks.

Practice task 2

Click icon to open online version

Check your understanding of legislation, standards and policies that apply to case coordination.

Question 1

Standards are legally binding, and if organisations are found to be non-compliant with the standards, a range of sanctions can be applied.

☐ True

☐ False

Question 2

The Privacy Act supports service policies and procedures that encourage shared information between service organisations without the written, informed consent of the clients or their representatives.

☐ True

☐ False

Question 3

WHS obligations require case coordinators to conduct in-home safety assessments prior to direct care staff attending clients in the home.

☐ True

☐ False

Question 4

An organisation embeds ethical requirements into workplace policies and procedures so that staff will demonstrate ethical practice by following them.

☐ True

☐ False

Duty of care

Duty of care is part of common law; it requires you to do whatever is fair and reasonable to prevent harm or injury to a person or their property.

Duty of care describes the legal obligation that individuals and organisations have to anticipate and act on possible causes of injury and illness that exist in their work environment or come about as a result of their actions. There are serious implications if duty of care is not upheld.

Negligence

Negligence occurs when duty of care has been breached and harm to a person or property ensues. It is the legal and ethical obligation of any community worker, supervisor or organisation to ensure that people using services are not exposed to unnecessary or unreasonable risk.

Dignity of risk

The rights of people to dignity and choice, upheld in legislation and service standards, state that duty of care and safety concerns must not be used as a reason to limit a person's freedom or personal choice. A case coordinator must respect the concept of dignity of risk, which means that a person has the right to make their own choices and to take certain risks as part of their personal freedom.

Duty of care responsibilities

All staff must diligently uphold their duty of care to clients.

Clients with complex needs may experience a range of risks in relation to their physical, psychological and psychosocial safety. Addressing the actual and potential effects of harm becomes imperative in organisational duty of care obligations.

Identifying and responding to areas of complex risk requires involvement from qualified professionals as well as services with capacity and expertise to respond. Case coordinators who have any reason to suspect that clients are at risk must respond and report according to relevant organisational protocols.

Watch this video to learn about your duty of care responsibilities.

As a case coordinator you must manage risks and uphold your duty of care responsibilities to:

- children and young people
- people experiencing domestic violence
- people at risk of suicide
- people experiencing or at risk of elder abuse
- people at risk of harming themselves or others.

Children and young people

Children of parents with substance use issues (alcohol and other drugs) are at elevated risk of a range of adverse effects, due to substance-affected parents being unable to carry out responsibilities, and also from abusive behaviours arising from substance use.

Common risk contributors for children and young people are:

- parents with AOD issues
- parents with diminished parental capacity (DPC)
- homelessness
- mental illness.

Your duty of care and risk management responsibilities include:

- working with families according to the terms of court orders
- carrying out mandatory reporting obligations
- supporting supervised access visits
- enabling family mediation
- monitoring children for indicators of abuse
- monitoring families for risk factors for child abuse.

People experiencing domestic violence

Common risk contributors to domestic violence are:

- mental illness
- AOD issues
- history of abuse/trauma
- extreme financial strain.

Your duty of care and risk management responsibilities include:

- providing immediate first aid or medical treatment
- following mandatory reporting as per organisational obligations and protocol
- referring the client to appropriate services
- relocating the client to a ‘safe house’
- reporting to police or other regulatory authorities as required.

People at risk of suicide

Common risk contributors to suicide are:

- mental illness, especially if there is more than one co-existing mental health issue
- being recently discharged from an acute mental health facility
- AOD issues
- history of abuse/trauma
- recent significant changes to circumstances, e.g. divorce or separation
- complex custody battles
- gender – men are three times more likely than women to commit suicide
- social isolation
- age, e.g. adolescents who experience bullying may have elevated risk status
- personal characteristics, such as being a member of the LGBTI community or the Australian and Torres Strait Islander community
- bereavement, a sense of being a burden to others, declining health and social isolation
- extreme financial strain.

Your duty of care and risk management responsibilities include:

- providing immediate mental health first aid, physical first aid or medical treatment
- following mandatory reporting requirements
- referring the client to appropriate services for treatment.

People experiencing or at risk of elder abuse

Many elderly clients with complex needs are at risk of elder abuse. Elder abuse occurs when:

- there is improper use of the person’s finances or property
- pain or injury is intentionally inflicted
- sexual activity occurs without permission
- verbal intimidation occurs
- the necessities of life are withheld.

Common risk contributors for elder abuse are:

- physical frailty
- diminished independence
- dementia
- isolation
- loneliness.

Your duty of care and risk management responsibilities include:

- responding according to service protocols
- increasing service, if possible
- developing a safety plan.

Manage risks of self-harm and harm to others

As a case coordinator, you have a duty of care to persons at risk of self-harm and harm to others.

Case coordinators who have any reason to suspect that clients may fall into these risk areas must respond and report according to the relevant organisational protocols.

Self-harm

Common risk factors include:

- mental illness
- AOD issues
- history of abuse/trauma
- poor body image
- low self-esteem
- a belief that they should be punished
- unmanageable strong emotions.

Signs of imminence:

- escalating moods
- recent perceived crisis, leading to intensifying emotion
- increased AOD use
- worsening mental health symptoms.

Possible indicators:

- scars or cuts on arms, wrists or legs
- cigarette burns on skin
- hair pulled out (trichotillomania)
- scars from rubbing sharp objects into the skin
- bruises
- ripped skin.

Duty of care management:

- mandatory reporting as per organisational obligations and protocols
- ongoing monitoring by the appropriate agencies
- referral to the appropriate service/s for treatment
- accurate and timely reporting and documentation
- positive engagement with the client
- debriefing for staff.

Causing harm to others

Common risk factors include:

- mental illness
- AOD issues
- history of abuse.

Signs of imminence:

- perceived rejection or injustice
- increased sense of powerlessness
- escalating moods
- recent perceived crisis leading to intensified emotion
- increased AOD use
- worsening mental health symptoms.

Possible indicators:

- people fearful around the person
- people avoiding the person
- marks or bruises on significant others with varying explanations given.

Duty of care management:

- immediate first aid or medical treatment
- mandatory reporting as per organisational obligations and protocols
- ongoing monitoring by the appropriate agencies
- referral to the appropriate services
- accurate and timely reporting and documentation
- reporting to police or other regulatory authorities as required
- debriefing for staff.

Dignity of risk

Dignity of risk is a concept which acknowledges that life experiences come with risk.

It is necessary to find a balance between the need for duty of care and the right and capacity of people to decide what level of risk they are comfortable with.

The rights of people to dignity and choice, upheld in legislation and service standards, also require that duty of care or safety is not used as a reason to limit a person's freedom or personal choice. A case coordinator's adherence to duty of care and safety must be coupled with the concept of dignity of risk, which means that a client has the right to make their own choices and take their own risks.

Practice task 3

Click icon to open online version

Check your understanding of your duty of care obligations.

Read each scenario and select yes or no to indicate whether duty-of-care obligations have been upheld.

Question 1

Karen is assessing Jessie, who is 8 years old and has a single parent with diminished parental capacity. Karen notes that Jessie is not sure of her address because they have to keep moving. She realises that Jessie has an elevated risk of homelessness and abuse.

Karen completes mandatory reports and works with services to care for Jessie's immediate needs.

Has Karen upheld her duty of care obligations?

☐ Yes

☐ No

Question 2

Jeremy is coordinating care for Sarah, who is experiencing domestic violence. He organises immediate first aid, completes mandatory reports and contacts services to provide Sarah with a safe house.

Sarah's son calls the service and asks to speak with Sarah's case coordinator. The receptionist tells him that Jeremy is with Sarah at the safe house, gives him the address and says he can meet Jeremy there to talk with him.

Has the receptionist upheld her duty of care obligations?

☐ Yes

☐ No

Question 3

Alison is a case coordinator for Jackson, who is socially isolated and involved in a bitter custody dispute over his two children. Jackson's distress over his situation has escalated. The financial strain of continuing the custody battle is increasing. Jackson says, 'I don't know what to do any more'.

Alison immediately refers Jackson to a mental health service because he is at risk of suicide or self-harm and completes reports in accordance with service requirements.

Has Alison upheld her duty of care obligations?

☐ Yes

☐ No

Question 4

Kendal is the case coordinator for Shirley, who is 84 years old. Kendal notices that Shirley is having trouble reading, and asks if she has forgotten her glasses. Shirley reluctantly takes her glasses out of her purse. They are broken.

Kendal asks if everything is okay at home, and Shirley starts to cry. 'Sometimes my son loses his temper with me over money, but I don't want to get him into trouble,' she says.

Kendal immediately organises for Shirley to get her glasses replaced and develops a safety plan for her.

Has Kendal upheld her duty of care obligations?

☐ Yes

☐ No

Question 5

Shelly is a case coordinator for Sean who has a history of self-harm. He hates his body and is trying to save up for sex reassignment surgery. He often takes his anger and frustration out on his mother, who he lives with. Shelly monitors Sean for signs that suggest his mental health is worsening and his frustration and rage is building up.

When the indicators are apparent, Shelly reports his condition immediately, and refers Sean to a mental health specialist who can assist with self-harm issues. Shelly also puts plans in place to ensure Sean's mother is safe.

Has Shelly upheld her duty of care obligations?

☐ Yes

☐ No

Australian child protection legislation

Australian child protection legislation varies between states and territories.

Case coordinators must be familiar with legislation that applies in the state or territory where they work. Legislation and mandates include laws relating to a range of child safety issues, including:

- child protection responses
- court orders
- out-of-home care system
- registration and quality assurance of community services and carers
- maintaining vulnerable Aboriginal children in their communities
- promoting stability in care arrangements and beyond
- mandatory reporting requirements for known or suspected child abuse.

The following provides examples of relevant Acts that apply in various states and territories.

Victoria

Principal Act:

- *Children, Youth and Families Act 2005* (Vic.)

Other relevant legislation:

- *Working with Children Act 2005* (Vic.)
- *Child Wellbeing and Safety Act 2005* (Vic.)
- *Family Law Act 1975* (Cth)
- *Commission for Children and Young People Act 2012* (Vic.)

Tasmania

Principal Act:

- *Children, Young Persons and their Families Act 1997* (Tas.)

Other relevant legislation:

- *Family Violence Act 2004* (Tas.)
- *Family Law Act 1975* (Cth)
- *Children, Young Persons and their Families Amendment Act 2009* (Tas.)

Australian Capital Territory

Principal Act:

- *Children and Young People Act 2008* (ACT)

Other relevant legislation:

- *Adoption Act 1993* (ACT)
- *Human Rights Commission Act 2005* (ACT)
- *Public Advocate Act 2005* (ACT)
- *Family Law Act 1975* (Cth)

New South Wales
Principal Act: ▶ *Children and Young Persons (Care and Protection) Act 1998* (NSW) Other relevant legislation: ▶ *Child Protection (Offenders Registration) Act 2000* (NSW) ▶ *Commission for Children and Young People Act 1998* (NSW)
Queensland
Principal Act: ▶ *Child Protection Act 1999* (Qld) Other relevant legislation: ▶ *Child Protection Reform Amendment Act 2014* (Qld) ▶ *Family Child and Commission Act 2014* (Qld) ▶ *Commission for Children and Young People and Child Guardian Act 2000* (Qld)
South Australia
Principal Act: ▶ *Children's Protection Act 1993* (SA) Other relevant legislation: ▶ *Children's Protection Regulations 2006* (SA) ▶ *Family Law Act 1975* (Cth) ▶ *Family and Community Services Act 1972* (SA)
Northern Territory
Principal Act: ▶ *Care and Protection of Children Act 2007* (NT) Other relevant legislation: ▶ *Disability Services Act 2004* (NT) ▶ *Criminal Code Act 2006* (NT) ▶ *Family Law Act 1975* (Cth)
Western Australia
Principal Act: ▶ *Children and Community Services Act 2004* (WA) Other relevant legislation: ▶ *Family Court Act 1997* (WA) ▶ *Family Law Act 1975* (Cth) ▶ *Child Care Services Act 2007* (WA)

In Victoria, the *Crimes Amendment (Protection of Children) Act 2014* (Vic.) created a new offence for 'failure to disclose child sexual abuse'. The new offence requires that any adult (aged 18 and over) who holds a reasonable belief that a sexual offence has been committed in Victoria by an adult against a child (aged under 16) must disclose that information to police (unless they have a reasonable excuse). Previously, only selected professionals were legally mandated to report child abuse.

On 1 July 2015 a 'failure to protect' offence also came into effect in Victoria. This applies to people in organisations who knew of a risk of child sexual abuse by someone in the organisation and had the authority to reduce or remove the risk, but negligently failed to do so.

Example

Duty of care and dignity of risk

Alice is an aged care case coordinator for Stella, who is 83 years old. At their case review meeting, Alice notices that Stella is unsteady on her feet and suggests that an assessment may provide her with strategies to improve her strength and mobility. Stella becomes agitated and anxious that she may no longer be able to go for walks with her carer.

Alice suggests a cup of tea and sits with Stella and her carer in the kitchen. She explains the assessment process and her duty of care to provide the best care possible and minimise the risk of Stella coming to harm. Alice knows that she has to balance her duty of care responsibilities with Stella's right to dignity of risk. Alice explains that the assessment will focus on helping Stella to keep doing the things she enjoys.

Alice tells the carer she has an important role to play and that she can encourage Stella in the strategies to improve her strength. Stella seems to be comfortable with the support she will be getting from her carer. She now says she is looking forward to learning how to strengthen her ability to walk and increase her confidence.

With Stella's consent, Alice says she will talk to other health professionals to decide which assessment would be the most suitable.

Summary

- Case management is a process in which a client is assessed and facilitated to access options and services by a case coordinator or case manager.
- The main aim of delivering services in a case management framework is to facilitate targeted, holistic, high quality service delivery, and to address clients' co-existing needs so that each specific need is addressed.
- This case management approach also aims to reduce the likelihood that co-existing needs snowball into greater issues, and to minimise the adverse effects of these co-existing needs.
- To facilitate effective and seamless service provision across multiple services, there is a range of considerations, principles and approaches that you should use as the case coordinator.
- Organisations providing case management must develop policies and procedures that are based on high-quality, ethically sound and legally compliant principles.
- A code of conduct outlines the organisation's expectations and rules for staff behaviour, dress and professional conduct.
- Clients of all community services organisations have service user rights and responsibilities.
- The Privacy Act protects personal information, including a person's name, signature, address, telephone number, date of birth, medical records and bank account details.
- Duty of care describes the legal obligation that individuals and organisations have to anticipate and act on possible causes of injury and illness in their clients that may exist in their work environment or come about as a result of their actions.

Learning checkpoint 1

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This learning checkpoint allows you to review your skills and knowledge in understanding case management.

Part A

1. Briefly describe **two** different approaches to case management.

2. Briefly describe risk contributors to children and young people, and a case coordinator's duty of care responsibilities and risk management strategies in relation to this.

3. Briefly describe risk contributors to people experiencing domestic violence, and a case coordinator's duty of care responsibilities and risk management strategies in relation to this.

4. Briefly describe risk contributors to people at risk of suicide, and a case coordinator's duty of care responsibilities and risk management strategies in relation to this.

5. Briefly describe **two** principles or practices of case management.

6. List **two** indicators of imminent self-harm or harm to others.

7. Briefly describe and provide an example for each of the following:
   a. Standards
   b. Statutory mandates (such as mandatory reporting)
   c. Policies and procedures
   d. Legislation

8. Why is it important for a case coordinator to keep within their role and professional boundaries?

Part B

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

Case study

Edward is 83 years old and lives at home with his daughter, Brenda, who is his main carer. Edward accesses support for home and personal care. Home care workers who assist Edward have reported there are a number of bills on the table that have are overdue and are concerned that essential services may be disconnected. When Jenny, the case coordinator, speaks with Edward, he is surprised that the bills are overdue because he has been giving Brenda money to pay them.

Jenny asks Brenda about the bills and she turns and yells at Edward, saying, 'What have you been telling them? You're just a crazy old man!' Brenda tells Jenny she has no right to ask questions about Edward's money and it is none of her business. She says she had to give up full-time work to care for Edward in his home, so it is about time he paid the bills. She says he has gone without hot water for a few days before and it didn't kill him. Jenny immediately calls her manager and together they develop a safety plan for Edward.

1. List one indicator that Edward is experiencing elder abuse.

2. List one way Jenny managed Edward's risk of harm and upheld her duty of care to Edward.

Topic 2

In this topic you will learn about:

Understanding the client

To help a client, you will need to understand the physical, mental, social and cultural factors that shape their needs.

Clients presenting with more than one need or diagnosis are said to have co-existing or complex needs. These co-existing needs have the potential to adversely interact with each other.

Clients with complex needs have complex case requirements. They require multiple services, which the professional who is managing their case must coordinate effectively.

2A Assessing the client

Health and medical conditions may be acute or chronic.

Acute conditions

Acute conditions are rapid in onset and last for a short period of time. Here is an example of an acute condition.

Elsie is 68 years old and recently had a fall and fractured her leg. Until the fall, Elsie managed all her daily living and self-care activities. She was hospitalised after the fall, and required rehabilitation as an in-patient from her local health network. Elsie receives multiple services from a range of organisations, coordinated by a home care provider. The plan is to reduce and eventually cease these services when Elsie's rehabilitation is complete.

Chronic conditions

Chronic conditions are conditions that are persistent or long-lasting, or that develop and worsen over time. The term 'chronic' is usually used when the condition or disease lasts for more than three months.

Examples of common chronic diseases/conditions are:

- arthritis
- asthma
- diabetes
- hepatitis C
- chronic obstructive pulmonary disease.

Conditions that contribute to complex needs

A client with complex needs may have chronic or acute conditions, or a combination of both.

Clients with complex case requirements have predominantly chronic conditions. However, some clients need to access multiple services to address acute conditions, which may complicate chronic conditions, or which may have a significant effect on the client's health or lifestyle for a short period of time.

Co-existing complex needs include:

- chronic physical health issues
- acute medical conditions that significantly affect the client in the short term
- mental health issues
- issues related to ageing
- issues related to disability (intellectual, physical, sensory, cognitive or neurological)
- alcohol and other drug (AOD) issues
- gambling addiction
- homelessness
- domestic/family violence
- multicultural and ethno-specific services
- issues related to refugee status
- issues related to past trauma and/or abuse
- involvement with the criminal justice system.

Practice task 4

Click icon to open online version

Check your understanding of conditions that contribute to a client's complex needs.

Read each statement and select true or false.

Question 1

Chronic conditions are conditions that are persistent or long-lasting.

☐ True

☐ False

Question 2

Complex needs are rapid in onset and last from a few days to a few weeks.

☐ True

☐ False

Question 3

Acute conditions can complicate chronic conditions.

☐ True

☐ False

Co-existing needs

If not managed effectively, single needs can accelerate into more complex needs, and become much more difficult to control.

Case coordinators need to understand the relationship between the client's co-existing needs and attempt to reduce the likelihood that the presenting needs will interact to create additional issues.

Read Merv's story about his co-existing needs.

Merv's story

Merv, 79, lives in a residential aged care facility and has osteoarthritis in both knees. He needs help to stand up and walk. He has Type II diabetes, which is controlled through his diet, and he relies on facility staff for dietary support.

Care staff are busy, and can take a long time to respond when Merv calls for toileting assistance. This has caused episodes of urinary incontinence. Staff have encouraged Merv to wear a continence aid, telling him it will help if they can't get to him in time. Merv has complied reluctantly, but his skin has become chafed due to urine in the continence aid.

Merv has become depressed and anxious. He says his dignity has been compromised by this avoidable situation. He has stopped attending afternoon activities and is reluctant to go to the dining room for his meals because he is fearful he will 'have an accident'. His appetite has declined, and he is eating less, which has an adverse effect on his blood glucose levels. Merv's self-imposed isolation is increasing his loneliness and depression, and he is no longer motivated to get up for his morning shower. With his decreased movement and physical activity, Merv is in more pain because the muscles around his knees have de-conditioned due to diminished use.

A review of Merv's care needs indicates that he now requires interventions to address the following multiple needs:

- functional incontinence
- depression
- self-isolation
- decreased mobility
- increased pain and swelling of the knees, requiring additional pain relief and physiotherapy
- diabetes management and dietary issues
- chafing of the skin around the groin.

If appropriate interventions had been put in place, ensuring the response times to Merv were faster, Merv's original co-existing needs would not have reached this level of complexity.

Watch this video of Merv's story.

Address client issues

Many clients face a range of issues when accessing multiple services.

As a case coordinator, you need to work with the client and other stakeholders to address each of these needs and issues. Issues that need to be considered when planning and coordinating support services include:

- disempowerment
- implications for family and unpaid carers
- client confusion, concerns and barriers
- generational abuse
- welfare dependency.

Watch this video to learn about addressing client issues.

Disempowerment

Disempowerment is a common experience for clients accessing multiple services.

Many clients' lives are full of appointments for therapies and services, with little time or opportunity for recreation. Often their complex issues reduce their quality of life (QOL) and they may be worn out trying to cope. Clients may feel that they have little control over their lives. Multiple staff coming into their home to provide services can lead to feelings of invasion of privacy.

Working with the aim of empowerment is important. At all times, respect must be shown to the client. Case coordinators and staff should ensure they do not work in an authoritarian manner, which will further disempower the client.

Implications for family and unpaid carers

When clients have to access multiple services, this can adversely affect their family members.

The presence of support staff in the home may be an issue. Additionally, much of the focus of the family may be on the client's needs, such as attending appointments, leaving little time for family activities, or for other members of the family to have their needs met.

Case coordinators can help clients' families to address these issues by informing them about support services. For example, a family may be able to access respite services, or funding for recreational activities/camps for children to attend. Case coordinators must be careful not to blur the boundaries of their role, remembering that their primary focus is to coordinate the case requirements of the client.

Client confusion, concerns and barriers

Accessing multiple services can cause confusion for clients.

Clients with complex needs may have a disability that affects their cognitive ability to understand processes and remember information. This could be an intellectual disability, a neurological condition, an acquired brain injury (ABI) or mental health issues.

Clients could also be affected by fatigue, pain, side effects from medication, poor sleep or stress arising from trying to manage their symptoms and personal situation.

Accessing multiple services, even if the services are necessary and effective, may create confusion for clients. They may not be able to fully understand the need for some of the services. Clients with AOD issues may experience confusion when accessing multiple services due to the effects of the alcohol and drugs on their cognition and awareness.

Confusion may also arise from the processes involved in accessing multiple services. Bureaucratic processes and paperwork can be confusing even to staff involved in sourcing and coordinating services for clients. Service eligibility and funding nuances can be complicated, and many clients struggle to understand these.

Prevent and manage client confusion

Some issues that cause client confusion also present barriers to the client attaining desired outcomes.

Here are six common issues that can cause confusion for the client, and actions that you can take to reduce confusion.

Jargon and abbreviations

Actions to reduce confusion:

- Use terms that can be understood by a layperson.
- Use active and reflective listening to check client understanding.
- Provide a fact sheet or glossary that explains terminology clients need to know.

Funding complexities

Actions to reduce confusion:

- Provide as much information as necessary in a format that is suitable for the client.
- Use active and reflective listening to check client understanding.
- Refer clients to websites of funding bodies or encourage clients to ask you questions at any time.
- Source user-friendly or plain English versions of information.
- Focus on clarifying critical information.

Service eligibility requirements

Actions to reduce confusion:

- Provide as much information as necessary in a format that is suitable for the client.
- Use active and reflective listening to check client understanding.
- Refer clients to relevant websites or encourage them to ask you questions at any time.
- Source user-friendly or plain English versions of information.
- Focus on clarifying critical information.

Multiple appointments

Actions to reduce confusion:

- Help clients to keep a diary, calendar or reminder system in their phone to keep track of in-home or community appointments, dates and locations.
- Send reminders using the client's preferred method, such as a text message, email or phone call.
- Minimise changes to appointment times.
- Enlist a friend or family member to remind the client about appointments.

Case coordination process

Actions to reduce confusion:

- Provide as much information as necessary in a format that is suitable for the client.
- Use active and reflective listening to check client understanding.
- Explain why there are meetings, assessments and forms to be filled in, focusing on the meaning or outcome for the client.
- Refer clients to relevant websites or encourage them to ask you questions at any time.
- Source user-friendly or plain English versions of information.
- Focus on clarifying critical information.

Staff changes and turnover

Actions to reduce confusion:

- Give the client plenty of notice of any staff changes, such as staff members being on sick leave or holidays.
- Provide clients with rosters showing which support staff will be attending.
- If a key support staff member is leaving or being taken off the client's services, give the client as much notice as possible and begin introducing the replacement.

Generational abuse

Generational abuse is abuse which is passed on from one generation in a family to future generations.

The abuse may be physical, sexual or emotional. Statistics have shown that a child who witnesses or experiences domestic or family violence is at greater risk of becoming a victim or perpetrator of abuse as an adult.

Some of the complex issues facing case coordinators when they are coordinating services for clients with complex needs stem from generational abuse that has become cyclical in the family. Multiple generations of the same family may have accessed services, and been in contact with the criminal justice system and welfare system in connection with intergenerational abuse.

Breaking the cycle of abuse is complex, and a multifaceted approach is required. Usually, results are not seen in the short term, because significant changes in familial patterns may not be revealed until the next generation.

Always monitor for indicators of abuse. Report and respond to suspected abuse by following organisational procedures and mandatory reporting requirements.

Effects of generational abuse include:

- behavioural issues
- increased risk of committing abuse as an adult
- hyper-vigilance
- anxiety and depression
- normalisation and increased risk of substance abuse
- poor educational outcomes
- post-traumatic stress disorder (PTSD).

Welfare dependency

When a household or person relies on social security as their income for a prolonged period of time, welfare dependency may occur.

Families who have been dependent on welfare benefits for up to three generations experience a downward-spiralling poverty cycle, as well as the normalising of reliance on benefits.

Other flow-on effects of multi-generational welfare dependence include:

- low self-esteem
- low confidence
- minimal ambition or aspiration
- poor educational outcomes
- limited employment prospects.

Support clients with generational welfare dependency

Case coordinators who are supporting clients in a generational welfare reliant situation will face challenges with client motivation to break free of the cycle.

Case coordinators may also experience a phenomenon in which some clients have mastered the ability of navigating ‘the system’ and maximising the services and benefits they can access. Such clients may have little or no aspiration to change their situation by taking advantage of support services.

An early intervention approach targeting the youngest members of multi-generational welfare dependent families could be effective. Encouraging young people to pursue education and training outcomes could help them to break the cycle of dependency.

Practice task 5

Click icon to open online version

Check your understanding of the issues that can affect a client who needs to access multiple services.

Match the beginning of each sentence to the correct ending.

* Generational abuse can	* contribute to client confusion.
* Minimal ambition or aspiration and low self-esteem can	* be passed on from one generation in a family to the next.
* Funding complexities, such as eligibility criteria and multiple appointments, can	* contribute to welfare dependency.

Example

Understanding the client

Simone is 19 years old, and has been homeless for several years. She left home at age 15, due to severe family violence towards herself and her mother. When Simone left home, she began 'couch surfing' with friends. She dropped out of school and by the age of 17 had developed a heroin addiction. With no income, she began to take money for sex to pay for drugs, and to secure a place to stay for the night. She contracted hepatitis C from sharing needles and is now sleeping on the streets.

Simone is technically malnourished. Her dental health is poor because of poor oral hygiene and drug use. Due to her early departure from school, she has minimal employment opportunities. Simone has become increasingly depressed, and wishes to do something to change her circumstances. She has few friends, and her life has become a daily quest for heroin. She often wishes she could reconnect with her mother.

Simone has been referred to a community services agency. An initial needs assessment indicates that Simone has complex needs, including needs for services to address:

- safe accommodation – immediate and long term
- drug detoxification/rehabilitation
- mental health assessment and possible treatment for depression
- medical assessment and treatment for hepatitis C, malnutrition and other medical issues
- dental assessment and treatment
- education and training to increase employment possibilities
- help to access welfare benefits
- social and emotional support
- family reconnection.

If early intervention had occurred when Simone's stepfather began to physically abuse her and her mother, Simone's issues and needs may not have escalated.

2B Client dynamics

Family structure, and the dynamics in that structure, can affect communication and decision-making processes when coordinating services and care for the client.

Family dynamics affect the way members of the family relate, communicate and interact. The dynamic will affect the client and the case coordinator when planning and providing a case plan.

Roles and functions in the family

The dynamics in a family are influenced by personalities, family relationships, the number family members and the mix of family members.

When a family member requires case coordination, the ease with which coordination is accomplished will depend on the way that family works. For example, decisions may be made as a group or by a single person who is considered the head of the family.

Family structure and roles vary. In patriarchal cultures, the most senior man is the head of the household and is responsible for the family and decision-making. In matriarchal cultures, the grandmother or mother is the head of the family. In some families, the parents or guardians make the decisions; in other families, all members are consulted.

Be aware of which family member you may need to contact about a client. Ensure you don't breach Australian laws and service standards when doing this. You will need to be respectful of family members while asserting the right of the client to express their own views and direct their own care.

In the past, people made the assumption that the nuclear family (a male and female parent plus children) was the norm. Today, we acknowledge that families come in all shapes and sizes.

Family structures include:

- blended families
- single-parent families
- foster families
- multi-generational families
- LGBTI families
- families in which the primary care-giver is a grandparent or other relative.

Decision-making

When deciding what services and care need to be offered and coordinated, the client must be encouraged and enabled to participate in decisions and choose the services and care they prefer.

The consumer-directed care (CDC) model of case coordination states that each care recipient has the right to make decisions and participate in the decision-making process relating to their care. The client also has the right to have their representative participate in decisions. Including the client in this process empowers them, contributing to a level of self-determination when setting goals and making decisions about their life.

The decision-making process may be affected when the client's cultural background requires:

- decisions about support to be made by male members of the family
- a male health professional to liaise with a male family member about decisions relating to support.

Communication

To fully and meaningfully participate in the process of planning their support needs, clients must be assisted to understand the processes involved.

Communication needs will be identified at the intake and initial needs assessment stages. However, some needs are not disclosed or discovered at those points for various reasons. One example of this is language, literacy and numeracy (LLN) issues, which clients may be embarrassed to disclose.

In all client contacts, you should make reasonable attempts to identify and address communication needs as early as possible, and use the communication methods that are most appropriate to the client.

Communication requirements may include:

- using alternative or augmentative communication, such as communication boards or tablet-based communication apps
- using family members or others to support clients with diminished expressive and/or receptive communication ability
- engaging with a client's guardian (a person who is appointed to make decisions on behalf of the client)
- inviting a chosen family member to facilitate emotional or cultural safety
- providing information about the client's rights and responsibilities in audio, braille, plain English or another accessible format
- addressing issues involved in obtaining a client's signature, and verifying informed consent if needed
- organising interpreting services for clients who speak English as a second language (ESL) or use sign language.

Practice task 6

Click icon to open online version

Check your understanding of how family dynamics affect the client.

Select yes or no for each statement.

Question 1

Family structures vary. When coordinating care you must adhere to the rules of the family's culture.

- [ ] Yes
- [ ] No

Question 2

The CDC model of case coordination states that the client has the right to make decisions and participate in the decision-making process.

- [ ] Yes
- [ ] No

Question 3

It is a communication requirement to engage with a client's guardian if the client is unable to make decisions due to disability.

- [ ] Yes
- [ ] No

Example

Client dynamics

Susan is coordinating services for Mariah, aged 19, who has an intellectual disability. Susan has accessed support services to help Mariah become more independent and self-sufficient. In the care plan review meeting Mariah, her parents and Susan discuss Mariah's progress.

Mariah wants to move into her own flat, but her father, Franz, is opposed to the idea. Franz has always been the decision-maker in the family. He says that they don't need social workers meddling in their affairs, or putting ideas into Mariah's head. He says that they have always looked after Mariah at home and they will continue to do so – end of story.

Susan manages the family dynamics carefully by explaining to Franz that Mariah's wish to move out on her own does not reflect on the wonderful care that he and his wife provide for Mariah. Mariah has developed skills that enable her to live independently.

Mariah hugs her dad and says, 'It's okay, Dad, I just want to have my own space and you can come and visit me all the time!' Giselle, Mariah's mother, speaks up and says 'We just want you to be safe.'

Susan asks Mariah and her parents to look at some information together about support options for young people with intellectual disabilities who want to move out of home. They agree to meet again in a fortnight. Susan restates the aim of Mariah achieving the independence she wants in a secure and monitored environment.

2C Cultural considerations

Legal obligations are enshrined in a range of anti-discrimination legislation.

There are legal obligations on all service providers to uphold access and equity principles. This means organisations must provide services to clients based on assessed need, regardless of any personal characteristics such as race, ethnicity, culture or religion.

Cultural competence

A case coordinator must work effectively and respectfully with clients from a range of backgrounds.

The ability to express cultural traditions and needs is a key factor in maintaining emotional and psychological wellbeing. It is vital that clients receive support services that are culturally appropriate to facilitate holistic wellbeing.

Anti-discrimination laws and regulations make it illegal to discriminate against anyone because of their cultural, religious or racial background.

Community services organisations must have policies and procedures that result in the provision of culturally competent support. These include needs identification and assessment processes that identify the client's cultural and spiritual needs, and services that recognise and accommodate these needs. Cultural competence is more than simply accepting differences.

Cultural competence begins with:

- genuinely valuing diversity, resulting in clients experiencing cultural and emotional safety
- factoring cultural needs into support services in a genuine and meaningful way
- not expecting clients to relinquish their cultural beliefs and practices in order to receive support services
- not stereotyping people based on their cultural backgrounds
- practising self-reflection in relation to your own attitudes, biases and prejudices.

Self-reflection

Identify areas in which you require support or mentoring as a case coordinator in order to be able to work in a culturally competent manner.

This is to ensure care is provided in a non-biased, non-judgmental manner, and should be done through self-reflection and by examining your own values and biases. If there are issues, you should be able to access programs to promote cultural competency through your organisation.

Demonstrate cultural competence

The capacity to practise and celebrate cultural traditions and practices is often pivotal to a person's sense of identity.

Often, there is some cross-over from cultural to religious or spiritual expression and the client's spiritual needs must be treated with the same respect as their cultural needs. Culturally competent case coordinators are flexible and can work with the key cultural requirements of their clients. Significant cultural needs can form part of the overall picture of a client's 'complex needs'.

English as a second language (ESL)

Family members or friends are often able to translate on behalf of a client who does not speak English well, but an independent interpreter is required in certain situations. This includes when discussing legal or medical matters that require a specialist vocabulary, or when the client wishes to discuss a matter in private.

An independent interpreter also removes the possibility of a family member trying to influence the client, or incorrectly relaying information.

It is important to determine who bears the costs of interpreters, and whether there are budgetary considerations.

A non-hearing client may use AUSLAN signing, and need an AUSLAN interpreter when planning services or attending case meetings.

The case coordinator will need to:

- arrange an assessment process to identify specific needs
- provide for an interpreter to be present during planning and delivery of services
- embed communication requirements into service delivery
- monitor whether these arrangements are working.

Food

Clients may have dietary requirements of cultural or religious significance, such as halal, kosher or vegetarian meals.

The case coordinator will need to:

- arrange an assessment process to identify specific needs
- ensure that service providers understand and accommodate needs when providing or preparing foods
- embed dietary requirements into service delivery
- monitor client satisfaction with this provision.

Dress and adornments

Clients may have cultural or religious/spiritual needs relating to modesty, such as women wearing a hijab, niqab or burqa or men wearing a head covering. Some faiths require specific jewellery or adornments to be worn.

The case coordinator will need to:

- arrange an assessment process to identify specific needs
- ensure staff respect and honour the client's dress requirements
- embed dress requirements into service delivery
- monitor client satisfaction with this provision.

Gender of staff

Clients may have a preference for male or female staff for direct service provision.

The case coordinator will need to:

- arrange an assessment process to identify specific needs
- ensure staff respect and honour clients' preferences and requests
- embed requirements into service delivery
- undertake ongoing self-reflection to monitor and manage own attitudes
- monitor client satisfaction with this provision.

Religious and cultural observances

Clients may observe festivals or sacred days such as Ramadan or the Sabbath. They may spend time praying, fasting, avoiding certain activities or visiting a place of worship.

The case coordinator will need to:

- arrange an assessment process to identify specific needs
- change service/appointment times to accommodate religious and cultural practices
- embed requirements into service delivery
- undertake ongoing self-reflection to monitor and manage own attitudes
- monitor client satisfaction with this provision.

Prayer times

Clients may wish to pray at certain times; this could take the form of multiple daily prayer times, morning and night prayers, or prayers before eating.

The case coordinator will need to:

- arrange an assessment process to identify specific needs
- change service/appointment times to accommodate prayer times
- arrange a private space for prayer when the client is attending communal activities
- embed requirements into service delivery
- provide non-judgmental practice
- undertake ongoing self-reflection to monitor and manage own attitudes
- monitor client satisfaction with this provision.

Decision-making protocols

Clients may have cultural preferences to liaise or communicate with male personnel in regard to decision-making, or giving or receiving information. Some cultures and faiths require that a senior male family member make decisions regarding medical treatment.

The case coordinator will need to:

- try to accommodate requirements
- arrange an assessment process to identify specific needs
- embed requirements into service delivery
- monitor to ensure that no disempowerment occurs, e.g. other family members being forced to relinquish their rights to make decisions due to this protocol
- consult with cultural experts and arrange cultural mediation if needed
- provide non-judgmental practice
- undertake ongoing self-reflection to monitor and manage own attitudes
- monitor client satisfaction with this provision.

Refugee or forced migration status

Clients who arrived in Australia as refugees or forced migrants need specialised support to adjust to a new culture and deal with the experiences they have been through in getting here. You may need to support a client who:

- has or is applying refugee status
- has been in detention
- has experienced trauma
- has culture shock
- has been separated from their family
- faces discrimination or ostracism.

The case coordinator will need to:

- arrange an assessment process to identify specific needs
- embed requirements into service delivery
- foster links to local cultural and community groups
- provide cultural and ESL support
- organise services to address trauma
- help the client to understand laws and acceptable practices in Australia to prevent engagement with the criminal justice system
- connect the client with training and educational opportunities
- consult with cultural advisers and interpreters
- provide non-judgmental practice
- monitor client satisfaction with this provision.

Diversity of family structures

Clients may come from non-nuclear family structures, such as:

- single-parent families
- blended families
- foster families
- multi-generational families
- LGBTI families
- families in which the primary care-giver is a grandparent.

All family structures must be respected – except in situations that breach Australian law, such as underage marriage. If you are concerned about the legality of a situation or a person's safety, follow organisational procedures and mandatory reporting requirements to alert the appropriate authority.

The case coordinator will need to:

- respect and honour the family structure
- arrange an assessment process to identify specific needs
- provide non-judgmental practice
- undertake ongoing self-reflection to monitor and manage own attitudes
- monitor client satisfaction with this provision.

Australian Indigenous cultures

Australia has two Indigenous cultures: Aboriginal and Torres Strait Islander culture.

Aboriginal culture is complex and diverse. Aboriginal people come from mainland Australia, Tasmania and other islands such as Stradbroke Island and Groote Eylandt. Torres Strait Islanders live between the top of Queensland and Papua New Guinea.

All case coordination processes and activities must be undertaken in a culturally appropriate manner. To do this, case coordinators need to understand the history, protocols and systems of Aboriginal culture and Torres Strait Islander culture.

Acknowledging the history of Aboriginal and Torres Strait Islander peoples, particularly the effects of colonisation, gives non-Indigenous people an insight into the contemporary, physical, mental, social, economic and political situations of Indigenous peoples. This helps to reinforce the importance of empowering Aboriginal and Torres Strait Islander clients.

Post-colonisation history

- White settlers robbed Aboriginal and Torres Strait Islander peoples of much of their connection to the land, their spirituality and their culture. Conflict with settlers, forced relocation and introduced diseases such as smallpox dramatically reduced the population.
- The European way of managing Indigenous peoples was to remove them from their traditional lands and force them to live on reserves, stations or missions. Assimilation was a government policy that saw forceful attempts to absorb Aboriginal people 'not of full blood' into white culture. These actions left long-lasting emotional and cultural scars.

The stolen generation

- The term 'stolen generation' refers to the implementation of the Aboriginal Child Welfare Policy from the 1930s, most notably during the 1950s. Over this period up to 100,000 Aboriginal children were forcibly removed from their families in the mistaken belief that they would be better off living in a white community. The children were raised by church organisations, fostered or adopted by white parents, or placed in state institutions. Because they were so young when they were taken, many grew up not knowing who their parents were, and were denied their heritage and culture.
- The legacy of the stolen generation has had an enormous impact on the Aboriginal community. In 2007, the Australian Government formally apologised for past events as a first step in reconciliation leading to the social, economic and political inclusion of Aboriginal people in Australian society.

Citizen rights

- From around the time of settlement, Australia was considered a Crown dominion; therefore, all inhabitants, including Aboriginal people, were regarded as British subjects and had the right to vote. However, under the new Commonwealth of Australia, Indigenous peoples were not included as citizens of Australia and could therefore not vote. It was not until a 1967 referendum that citizen rights were returned to Aboriginal and Torres Strait Islander peoples.

Cultural protocols

Case coordinators require awareness of Aboriginal history and the effects of European contact to better understand Aboriginal and Torres Strait Islander clients' needs, health and wellbeing.

Here are some cultural protocols that must be considered.

Referral protocols

- Referring Indigenous peoples to other services may take time. Indigenous peoples have complex kinship relationships and may want to consult with other members of the family regarding the referral. Case coordinators need to respect clients' wishes and allow them time to do this.

Communication protocols

- Indigenous clients may be anxious and not assertive when making inquiries for themselves or for other relatives. It may be more effective to focus on recognising cultural protocols, breaking down barriers and opening lines of communication as a first step towards dealing with an inquiry.
- You will need to recognise that clients have different approaches to seeking assistance. Act in a culturally appropriate manner, following nonverbal protocols such as eye contact and facial expression.

Cultural systems

Cultural systems are overarching frameworks that contain rules, behaviours, values and beliefs that are unique to a specific group.

Cultural systems vary between tribes, countries and ethnicities. Challenges can arise when collaboration between different cultures occurs. Coordinating care for clients from a different cultural system to your own can be challenging. You must understand the nuances and protocols of the client's cultural system. For example, when coordinating care, the Australian Aboriginal kinship system may affect group discussions and conference meetings because a mother-in-law and son-in-law require a social distance, and may not be able to be in the same room.

Community service, health and welfare, and justice systems may be quite different culturally from the systems experienced by the client. You must be aware of this and be able to provide service with respect and consideration.

Example

Cultural considerations

Ashleah is the case coordinator for Jimmie, an older Indigenous man. Jimmie is accessing a respite care centre for the first time because his daughter, Sue, has to go to hospital for a few weeks. When Sue takes him to the respite centre, Jimmie is frightened and visibly shaking. Sue is worried about her father and is very reluctant to leave him at the centre.

Sue telephones Ashleah and explains her own distress and the distress of her father. Ashleah contacts Jennie at the centre to organise a carer who has an Indigenous background to help Jimmie settle in and provide support for him. Jennie tells Ashleah there are other Indigenous men at the centre and will ask Jimmie if he would like to meet them.

Ashleah relays this information to Sue, who is very relieved. They discuss Jimmie's need for family and cultural contact, and the kind of activities he can participate in to make his stay in the centre more enjoyable.

Practice task 7

Click icon to open online version

Check your understanding of how cultural competence should be demonstrated.

Read each scenario and select yes or no to indicate whether the case coordinator has demonstrated cultural competence.

Question 1

Carla is coordinating support for Ming. Ming has limited English and often has difficulty understanding the information that Carla is explaining. Carla speaks slowly, but feels frustrated when Ming still can't understand her. Carla organises an interpreter, which eases the communication problem between Carla and Ming.

Has Carla demonstrated cultural competence?

☐ Yes

☐ No

Question 2

Maria is a case coordinator, and is very religious. Maria is coordinating services for Lillian, a Torres Strait Islander woman. Maria tells Lillian about her religion and tries to convince Lillian that she should believe in God instead of her own cultural beliefs.

Lillian is too polite to say anything, but is angry because her mother was taken from her family and placed in a church-run home.

Has Maria demonstrated cultural competence?

☐ Yes

☐ No

Question 3

Dave is the case coordinator at a residential aged care facility, and notices that several of the Indigenous Australian clients stay with their families for days at a time. Some have dementia and others experience mobility difficulties, but they all have a need to maintain their connection with their heritage and values. The process of getting their older relatives to the community and looking after them is very demanding.

To help families overcome transportation, care and accommodation difficulties, Dave applies for funding to provide transport to the remote community. This enables the older people to participate in family gatherings and significant community events without having to stay for long periods.

Has Dave demonstrated cultural competence?

☐ Yes

☐ No

Summary

- A client with complex needs may have chronic or acute conditions, or a combination of both.
- Part of the challenge in managing complex needs is understanding the relationship between co-existing needs, and attempting to reduce the likelihood that the presenting needs will interact to create additional issues.
- Clients face a range of issues when accessing multiple services, such as disempowerment, the effects on their unpaid carers, and confusion about service provision.
- Family structures, and dynamics in the family structure, can affect communication and decision-making processes when coordinating services and care for the client.
- There are legal obligations on all service providers to uphold access and equity principles, and to provide services to clients based on assessed need, regardless of any personal characteristics.
- Identify areas in which you require support or mentoring as a case coordinator to be able to work in a culturally competent manner by using self-reflection and examining your own values and biases.
- Cultural systems are overarching frameworks that contain rules, behaviours, values and beliefs that are unique to a specific group.

Learning checkpoint 2

Click icon to download this in Word format

This learning checkpoint allows you to review your skills and knowledge in understanding the needs of the client.

1. Briefly describe how different family structures and dynamics affect how you interact with a client.

2. How can you identify and address a client's communication needs?

3. What steps can you take to help you avoid client confusion?

4. List **two** issues that can cause clients confusion or concern, or present a barrier to clients understanding their service provision.

5. Briefly describe **two** issues faced by clients and/or their family and carers that need to be considered when planning and coordinating support services.

6. Provide a brief description of one of the following:

   - The post-colonisation history of Aboriginal and Torres Strait Islander peoples
   - The stolen generation
   - The history of Aboriginal and Torres Strait Islander peoples' citizen rights

7. Briefly describe how cultural protocols can affect case provision.

Topic 3

In this topic you will learn about:

3A **Developing a client plan**

3B **Arranging services**

3C **Role responsibilities**

Coordinating care

Coordinating care involves putting the information you have gathered about your client and your professional skills together to get the client the services they need to have a good quality of life.

Once the complex needs of the client and the legal and ethical parameters have been identified, services to meet their needs can be agreed upon and coordinated. Depending on the complexity and nature of the needs, service care may be multi-disciplinary.

3A Developing a client plan

Developing the client plan calls on all the skills and knowledge of the case manager.

Planning services and support strategies and interventions should be a collaborative process, involving the client, others who are significant to the client, any advocate, representative or substitute decision-makers who choose or need to be involved, and relevant stakeholders from organisations who will be providing services.

Planning should occur at a formal planning meeting (or series of meetings). These meetings must be person-centred and client-driven.

Assessment outcomes and information gathered during the assessment phase are used to develop client plans. Depending on the organisation and sector of the community services industry, the client plan may be referred to by another name.

Common names used for client plans include:

- care plan
- case plan
- person-centred plan
- support plan
- service agreement
- National Disability Insurance Scheme (NDIS) plan
- individual service plan (ISP).

Determine service needs

Determining the service provision requirements of a client usually begins at the point of intake.

This is the point at which the client has been accepted into the service, and has been allocated a case coordinator.

Read Alex's story to see how his needs were determined.

You can also watch a video of Alex's story here.

Alex's story

Alex has not seen his daughter Susan for 8 years. Susan broke contact with her father when his excessive alcohol use affected their relationship. Alex has recently been referred to a community service organisation to address his complex needs, which include:

- homelessness
- depression
- unemployment and minimal job prospects
- fractured family relationship
- need for family mediation and therapy
- poor physical health.

In discussion with his case coordinator, Alex disclosed that part of his depression stems from not having contact with his daughter. Alex says that restoring his relationship with Susan is more important to him than finding a home.

The service providers have a duty of care to address the range of client needs, but they also have an ethical obligation to balance this with client self-determination and choice.

With Alex's consent, his case coordinator shares this priority with the organisations that will be providing support services, and this is factored into Alex's support service strategies. As well as addressing his physical health needs immediately, Alex is referred to a family counselling agency to assist him to reconnect with his daughter.

The prospect of having his daughter back in his life is a motivator for Alex to address his alcohol use and to begin to make long-term plans to find accommodation so that his daughter would be able to visit him.

Intake and initial needs assessment

It is important to start building a good relationship from the first time the potential client or someone acting on their behalf contacts the organisation.

Initial contact may be made by the client or via a referral from another professional. A staff member must inform the potential client of the process to enter the service, any costs, and any waiting periods that might apply.

Intake

This is when the potential client meets the eligibility requirements for the organisation and is accepted into the service. The specific services they will receive have not yet been worked out in detail at this stage. The initial intake process will depend on the sector of the community service industry and the protocols of each organisation.

Here are some examples:

- Clients accessing funded home support services through the Commonwealth Home Support Programme (CHSP) and disability services through the NDIS are required to make initial contact with the centralised intake and assessment services for each of these areas.
- Clients accessing services through the NDIS first need to be assessed as eligible in the NDIS intake process. The initial contact and the intake processes begin at this central point, which the client (or their representative) must contact.
- My Aged Care (MAC) is the point of entry for subsidised aged care services in Australia, including CHSP services. A potential client, their family member or representative, or another professional may contact MAC. This may include a hospital, the client's doctor or another health practitioner. The person's initial eligibility will be established.

Initial needs assessment

The finer points of this process depend on organisational protocols. This process is ideally in a face-to-face meeting with the client and their significant others or a representative. The case coordinator my access client histories from other services or assessment information from central assessment teams such as MAC or NDIS. Depending on the situation, other stakeholders may also be present.

This phase involves an initial screening process to determine the areas of client need. It is a holistic look at the areas of the client's presenting needs, risks, and the level of urgency with which they require services. This phase gives a picture of the client's eligibility and service provision requirements.

The case coordinator must work with the client to begin to understand their needs, preferences, priorities and aspirations. They need to understand what the client hopes to accomplish through the services they will receive.

Once this has been established, a deeper assessment process is undertaken to gain a more thorough picture of each of the client's presenting needs.

Read part 1 of Madeline's story about her intake and initial needs assessment.

Madeline's story, Part 1

Madeline has been accepted to receive services from South Eastern Community Services (SECS). Madeline has a severe alcohol addiction. She has been staying with a friend since recently leaving a long-term de facto relationship with an abusive partner. Madeline experiences anxiety and depression, and is scared that her ex-partner will find out where she is living and come to harm her. Madeline is scared to leave her friend's house, and only ventures out to buy alcohol.

Madeline has no access to money because her ex-partner controlled the couple's finances. Madeline has not been receiving Centrelink benefits, and is not sure she will be able to.

An initial needs assessment indicates the areas of Madeline's short- and medium-term needs, which include:

- assessment for alcohol usage (detoxification/rehabilitation service)
- mental health support
- emergency accommodation (immediate)
- subsidised housing (medium term)
- financial help
- health assessment (GP).

Planning for long-term interventions would also be required.

Funding options

This phase involves a detailed assessment of the client's needs and looks at funding options that can be used to plan for services.

As the case coordinator you are required to arrange assessments in consultation and collaboration with the client. You must make sure the client understands why the assessments are required, and ensure that the client does not become overwhelmed by the process. Only the specialists who are relevant to the client's situation should be involved in the assessment process.

Two funding bodies that clients may need to access are the National Disability Insurance Scheme (NDIS) and My Aged Care (MAC).

NDIS

If a person is assessed as eligible for NDIS funding, a National Disability Insurance Agency (NDIA) representative will contact the client or their nominated representative and commence the planning process. The first plan will usually be determined over the phone. The client's first plan will identify the reasonable and necessary supports required to meet their immediate needs and start to identify their goals for the future.

Once completed, the first plan will provide the client with individualised funding that they control and choose how to use. The client will have a support coordinator allocated to support the implementation of the NDIS plan and to coordinate the process of sourcing and accessing services. NDIS plans will be reviewed annually, unless the client's circumstances change significantly before that time, in which case, a review will occur earlier.

MAC

There are variances in the intake and assessment process across Australian states and territories. Initial information is taken by the MAC operator and the person will receive a home support assessment from the Regional Assessment Service (RAS) to look at their needs, level of function, services required, services currently received and natural supports.

The RAS assessor will work with the person and their family to develop a home support plan, to identify their strengths, difficulties and personal goals. The RAS can support the person to identify service providers who can address their complex needs, and prepare a referral. If the client requires a greater level of support, the RAS assessor will organise for the client to receive a comprehensive assessment.

Multi-disciplinary assessment

Clients may require clinical assessments to help determine how best to manage their complex needs.

Clinical assessments are those relating to medical, psychiatric, psychological, allied health or other specialty areas. These must be undertaken by appropriately qualified personnel in an organisation, or by professionals external to an organisation that a client has been referred to. This may include:

- physiotherapist to assess a client's mobility needs
- psychiatrist to assess a client's mental health
- audiologist to assess a client's hearing.

Read part 2 of Madeline's story below.

Madeline's story, Part 2

As Madeline is now a client of SECS, her case coordinator discusses the areas of service she requires, and she is referred to each service. Each of the practitioners then conduct their assessments with Madeline.

The practitioners use assessment tools and diagnostic methods that reflect current best practice in each discipline. When Madeline presents at the alcohol and other drug (AOD) service, the relevant practitioner will assess her alcohol usage and its effects on other life and health areas using the appropriate assessment tools and screening methods.

Madeline will be referred to a GP who will assess her health, or supported to see her own GP if she has one she trusts. From the assessment, a treatment plan will be determined.

Evidence-gathering

Through the assessment process, a base of evidence about the client's situation, needs and preferences is gathered.

Evidence is verifiable data and information from which conclusions can be drawn and action can be planned. Evidence proves or disproves something. It reveals the facts about a client's needs, which then informs their service provision requirements.

Medical evidence

Medical evidence includes the outcomes of medical tests, clinical assessments, and records of interventions that have been implemented and their effectiveness.

Client feedback

Evidence includes client histories from other services, client feedback, and feedback from other stakeholders, including clients' families or representatives.

Client needs

Evidence includes the client's experiences, perspective, journey, aspirations and needs, all of which must be taken into account when planning for services to address complex needs.

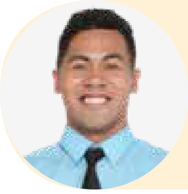
Types of evidence

A sound assessment process takes into account the full range of quantitative and qualitative evidence in relation to clients.

When collecting and analysing evidence in the assessment process, it is important to collect quantitative and qualitative evidence. The case coordinator needs to understand not only what the client's assessed needs are, but also how they feel about their situation and how they experience their circumstances. The case coordinator uses evidence to identify the full range of services that are required by the client.

Mark is a case coordinator who is collecting evidence to help him create a client plan for Lisa. Mark asks his colleague Sandra to help him refresh his knowledge of quantitative and qualitative evidence. Read the discussion between Mark and Sandra.

Mark



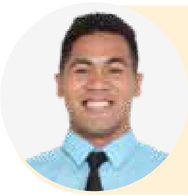
Hey Sandra, I've been trying to remember the difference between quantitative and qualitative evidence. Can you refresh my memory? I can't seem to get it straight.

Sandra

Sure, Mark. Evidence that is quantitative can be counted, weighed or measured, and is given as a numerical value.

If the evidence tells you 'how much' or 'how many', then it is quantitative evidence.

An example of this is Lisa's weight. If her weight-loss program is working, there will be an amount of weight lost, like 10 kilograms. You can measure this when you weigh her. The numerical data – 10 kilograms – makes the evidence quantitative.



Oh, thanks Sandra,that makes more sense now. So what is qualitative evidence?

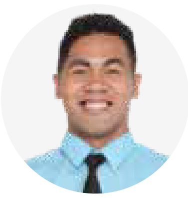
Qualitative evidence is about types, categories and degrees. Qualitative evidence often measures people's perceptions, experiences and feelings about something. It can be gathered from facts collected in interviews, direct feedback or observation.

Considerations when gathering evidence

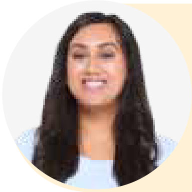
Using effective interpersonal skills when gathering evidence from the client is imperative to building a trusting and respectful relationship.

Sandra continues to talk with Mark about collecting evidence during Lisa's assessment. He wants to make sure that Lisa feels comfortable during the assessment.

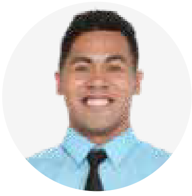
Mark, there are three important things to remember when you are interviewing Lisa. The first thing is to make sure she feels emotionally safe.



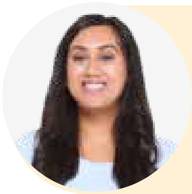
What does emotionally safe mean?



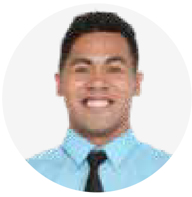
Well, when Lisa is talking with you, she needs to feel comfortable sharing information with you. Some information may be difficult for her to share and she may feel vulnerable and unsure about sharing certain information with you.



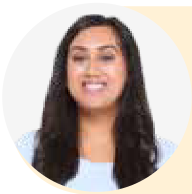
How can I make sure Lisa feels emotionally safe? I don't want Lisa to feel intimidated or insecure during the assessment.



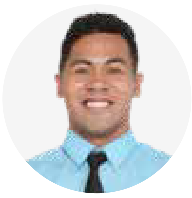
Create an environment where Lisa feels comfortable. Ask her if she would like a support person or a family member she trusts to sit in with her. You can reassure Lisa about your confidentiality responsibilities so she feels safe to disclose information.



Oh, good points, I will make sure I do that. What is the second thing I need to remember?

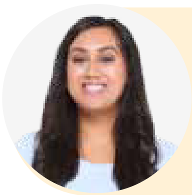


Make sure you take a non-judgmental approach. This is critical. There may be aspects of Lisa's personal history that she feels embarrassed about or ashamed of. She must be reassured that you will not judge her on what she discloses.

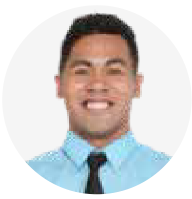


Right, I will make sure that my personal feelings of what is right or wrong do not come into the conversation and are not conveyed when I am speaking with her. I need to watch my body language too. I need to reassure her that nothing she says will be judged or criticised.

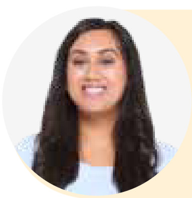
So what is the third thing I need to be aware of?



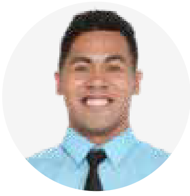
Respect. You must respect Lisa and make sure she feels valued. This is called respectful and inclusive engagement. This will help you develop a relationship that is meaningful and trustworthy.



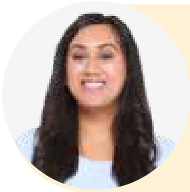
How can I demonstrate respectful and inclusive engagement when assessing Lisa?



You can make sure you use a manner that encourages Lisa to contribute and assists her to engage with you. You can show respect by acknowledging Lisa's contributions in the assessment, and by recognising any cultural needs she may have.



Thanks, Sandra, you have been a big help to me. I will take all of this on board.



To sum up, the three critical aspects to remember when gathering evidence are facilitating emotional safety, not being judgmental, and enabling respectful and inclusive engagement.

Practice task 8

Click icon to open online version

Check your understanding of preparing to develop a client plan.

Read each statement about the early phases of case coordination and select true or false for each one.

Question 1

The intake phase is when the potential client meets the eligibility requirements of the service.

- [ ] True
- [ ] False

Question 2

The client's initial needs assessment is a single diagnostic assessment that involves a screening process to determine the areas of client need.

- [ ] True
- [ ] False

Question 3

A multi-disciplinary assessment may include areas such as medical, psychiatric, psychological and allied health.

- [ ] True
- [ ] False

Question 4

Evidence is gathered, read and analysed to inform the case coordinator of the client's needs and their service provision requirements.

☐ True

☐ False

The client plan

Client goals are set as part of the client plan and specific services are chosen to support the client to meet their goals.

After the initial needs assessment, the multi-disciplinary assessment phases, and collaborative discussion with the client and stakeholders from other service providers, the process of case planning can begin.

Clients with complex needs may require multiple services to address their various needs. Goals and strategies must be established to manage these appropriately. You must explore the full range of services and supports that are available to the client to ensure the client receives holistic care. This includes using local support services where possible to provide easy access for the client. A range of other support services may be needed to ensure the client plan meets the client's complex needs.

Components of an effective plan

There is no single right way to create client plans, although there are legal requirements involved in the process.

Goals and strategies to address one area of need should not undermine progress in other areas. Funding limitations and service eligibility must also be key determinants when setting client goals and strategies for support. The likelihood of service duplication must also be minimised. This should be considered in the planning stage.

Organisations use a range of protocols and systems to coordinate complex case requirements. Regardless of the specific planning type, the components of an effective plan include setting:

- SMART goals
- strategies
- roles and resources
- time frames and review dates.

Plans that do not have these components risk:

- lacking clarity
- increasing confusion
- causing service duplication, poor service and poor outcomes for the client
- non-compliance with legislative and funding obligations.

SMART goals

Goals are the outcomes that the client wishes to achieve.

Referrals should be made to the most appropriate organisations to support clients to reach their identified goals.

Goals should be set using a 'SMART' format, as explained below.

Specific

This means that goals must be well defined and clear to the client and everyone involved in the client plan. For example:

- Alan will put aside $1,000 in his savings account by 1/8/2018.
- Daniel will reduce his alcohol intake over the next six months to reach a goal of no more than one standard drink per day.
- Sophie will stop smoking cigarettes by 10/10/2017.

Measurable

There must be clear and specific outcome indicators to track progress towards the goal. For example:

- the target dates
- how much must be achieved
- how to determine when the goal has been achieved.

Attainable

Goals must not be set that exceed the client's capabilities. The client must be able to participate in the goal-setting and decision-making process so you can agree on achievable aims.

Realistic

Goals must be realistic. For example:

- The goal must be within the capacity of the service provider to support.
- The resources must be available.
- The time must be available.
- Costs must be within budget.

Time frame

Goals must have a time frame. For complex or long-term goals, setting key milestones on the time frame will help you and the client track their progress.

Goals that are hard to measure

There are some issues that seem difficult to set goals for in the SMART goal framework.

For example, if you are trying to set a goal relating to a client's depression, it seems difficult to set a SMART goal for improvement. It is hard to know how the client will respond to treatment, or quantify how much better they will feel with the supports you can offer.

It is also difficult to measure improvement in how the client feels overall. However, quantitative indicators can apply. For example, a client who was not eating properly due to depression could experience an increased appetite and reach a healthy weight as their depression dissipates.

Goals that are not set in the SMART goal framework are difficult to monitor. 'Getting fit', 'paying off all my debts' or 'being happy' will not help a client. You and your client will need to think laterally about correlated outcomes, or set goals that are actions.

Here are examples:

- John will see a psychologist each fortnight for the next six months to work on managing his depression. At the end of this time, he will review this arrangement with his psychologist, case manager and GP.
- John will enrol in a 10-week weight-training class at the community centre with a group of friends. His goal is to attend every session. A friend will pick him up from home to help him stay motivated.
- John will meet with a financial counsellor and contact utility companies to negotiate a manageable payment plan for his debts by 1 June.

Strategies

Strategies are the actions that will be taken to support the client to work towards their goals.

All client plans should specify what each service, the client and any natural supports will do in relation to reaching the goals.

Strategies to help clients work towards their goals include:

- creating a plan that identifies all tasks
- determining who is responsible for each task
- defining when the tasks need to be completed by
- supporting the client to have a high level of self-determination when setting goals and making decisions
- ensuring the client is actively participating in their support activities
- valuing all input and efforts by the client
- encouraging the client to take responsibility for their own progress.

Specify roles and resources

The roles of other services/organisations and staff who will be involved in the support strategies must be specified and defined.

Resources – such as the human, material and financial resources required to support the goal – must be determined. It is vital that funding opportunities and limits are clear, so that you can manage the costs involved with services from the client's individual funding package or other funding source.

Monitor the plan

At the time of formal service planning, it is also important to establish how the plan will be monitored.

Monitoring is vital to see whether the client is making progress towards their goals and to find out whether any issues or concerns have arisen.

The plan needs to stipulate:

- the outcome or evidence indicators and how progress towards goals will be measured
- how will it be evident that the goals have been met
- indicators that review is required
- who is responsible for collecting and analysing the indicators and monitoring the plan.

You will need to discuss the following questions with the client and stakeholders:

- How will the plan and progress towards the goals be monitored?
- What documentation and reporting requirements are there?
- How will feedback be collected from the client and other stakeholders?
- Will meetings be held; if so, how often and when?

Read the following example to learn how SMART goals can be applied in various client plans.

Example

Applying SMART goals

Diabetes

Goal

- To help the client maintain blood glucose levels (BGL) in the following range:
  - 4–6 mmol/L before meals
  - 4–8mmol/L two hours after starting meals

Strategy

- Take BGL measurement three times a day.
- Client to self-administer insulin.
- Client to access Meals-on-Wheels diabetic diet for lunches and dinners.
- Client to choose from a list of diabetic menu options for breakfasts and snacks provided by dietitian.

Responsibilities and time frames

- Client's self-management: ongoing.
- Client to access GP and community health centre: once a month.
- Client to meet with dietitian from the community health centre: once a month.
- Meals-on-Wheels specialised meals service: reviewed once a month.

Reduced mobility due to bilateral leg amputation, reduced upper body strength

Goal

- To optimise the client's mobility

Strategy

- Client to use manual wheelchair for mobilising.
- Submission for electric wheelchair.

Responsibility and time frame

- Case coordinator to prepare submission to Gov-Equip and submit by 10 October.

Reduced upper body strength due to de-conditioning

Goal

- To increase the client's upper body strength by 10%

Strategy

- Client will attend physiotherapy sessions weekly.

Responsibilities and time frames

- Client to attend physiotherapy sessions: once a week
- Appointment with physiotherapist from Get Fit Community Physiotherapy: once a month
- Transport to appointments will be provided by volunteers from the Red Cross: once a month

Social isolation

Goal

- To help the client connect with other men for regular social interaction

Strategy

- Client to attend Men's Shed every Wednesday.

Responsibility and time frame

- Social support officer from All-In Community Services to transport the client each Wednesday: once a week.

Grief and depression following loss of wife

Goal

- To address the client's depression and grief

Strategy

- Client to attend fortnightly sessions with psychologist.

Responsibilities and time frame

- Appointment with psychologist from the community health centre: twice a month
- Appointment with the client's GP: twice a month.
- Transport to appointments provided by Red Cross volunteers: once a week.

Reduced capacity to attend to personal care needs and domestic tasks

Goal

- To help the client retain optimal degree of independence in relation to self-care, home care and domestic tasks.

Strategy

- Home care staff to attend the client three times a week to assist with personal care and domestic tasks, such as cleaning.

Responsibility and time frame

- Visits from homecare staff: once a month.

If a client is experiencing any issues or difficulties, these will be identified by evidence indicators and monitoring mechanisms. There is no single right way for a case coordinator to choose the evidence indicators and monitoring mechanisms that will be used to monitor client progress.

The following outlines how to monitor client progress in relation to the goals in the previous example.

Example

Evidence indicators and monitoring mechanisms

Goal: Maintain blood glucose levels

Evidence indicators

- BGL readings
- Client's feedback – Is he managing the injections and the BGL monitoring? Is he struggling? Is he remembering?

Monitoring mechanisms

- Client to record his BGL readings daily
- Dietitian to monitor
- GP to monitor
- 'Plate waste' – Is the client eating the Meals-on-Wheels food?
- Client's feedback – Is he enjoying the meals?
- Review meeting in one month

Goal: Optimise mobility

Evidence indicators

Client's levels of function regarding his:

- mobility
- use of manual wheelchair.

Monitoring mechanisms

- Client's feedback
- Submission has been lodged by the case coordinator
- Plan review meeting in one month

Goal: Improve upper body strength by 10%

Evidence indicators

- Improved strength/functional capacity demonstrated through measured exercises
- Can the client use his manual wheelchair with more ease, or for longer distances/ time periods?
- Client's level of functioning at home may improve, e.g. can he complete tasks that he could not previously?

Monitoring mechanisms

- Physiotherapist: data collection of client's progress at the sessions
- Plan review meeting in one month
- Client's feedback

Goal: Reduce social isolation

Evidence indicators

- Attendance at Men's Shed
- There may be a flow-on from Men's Shed; for example, the client may have exchanged numbers with one of the men for the formation of a friendship.

Monitoring mechanisms

- Client's feedback
- Attendance patterns
- Plan review meeting in one month

Goal: Reduce depression and grief

Evidence indicators

- Client may report feeling less depressed.
- Client's levels of activities may increase.
- Client's sleep patterns may change (if they had been affected by his depression).
- Client's may go out more frequently.

Monitoring mechanisms

- Client's feedback
- Plan review meeting in one month
- Psychologist's data collection at session with the client

Goal: Improve independence in relation to self-care and domestic tasks

Evidence indicators

- Client's functional levels, such as self-care and domestic tasks he can partially or fully complete
- Areas in which he is struggling

Monitoring mechanisms

- Client's feedback
- Attendance of staff
- Home care staff including data collection, such as notes from home visits
- Plan review meeting in one month

Practice task 9

Click icon to open online version

Check your understanding of case plan requirements.

Question 1

Which of the following are components of an effective case management plan? Tick all that apply.

☐ Setting SMART goals

☐ Defining strategies

☐ Specifying roles and resources

☐ Setting time frames and review dates

Question 2

Which of the following should a plan do to help clients work toward their goals? Tick all that apply.

☐ Identify all tasks

☐ Encourage the client to defer decisions to an allocated decision-maker

☐ State who is responsible for each task

☐ Ensure the client is actively participating

Question 3

Which of the following are outlined by time frames in the case plan? Tick all that apply.

☐ When meetings will be held

☐ How often meetings will be held

☐ Milestones or key points

☐ Measurement of goals

☐ Length of time for each service

3B Arranging services

Coordinating multi-disciplinary services requires negotiation and collaboration with services, bodies, health professionals and stakeholders.

This process must be as collaborative as possible, so that a good professional rapport is built between all parties.

Arranging services includes:

- negotiating working arrangements
- managing service duplication
- identifying barriers to service
- determining funding eligibility
- organising referrals.

Negotiate collaborative working arrangements

It is important to understand what each stakeholder can provide or contribute to the plan, so that when the formal client plan is devised, the care strategies are realistic.

It is vital to be clear about the expectations for all stakeholders in the planning, implementation, monitoring and review of the client's case coordination. Establishing role requirements and boundaries should begin when negotiating and planning services. Some negotiations on working arrangements will occur in meetings, via phone or email, or through the referral process. This should be formalised in planning meetings to ensure clarity from the beginning.

Arrangements that may need to be negotiated include details of the service agreement, such as:

- roles and expectations of all parties involved
- services to be provided
- time frame of service provision
- financial arrangements.

Here are examples of working arrangements that may need to be negotiated and agreed on when coordinating services for a client.

Mia is a health professional.

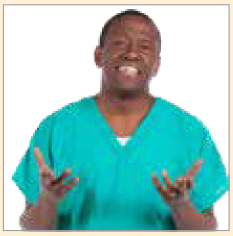
Discussion with health professionals may involve negotiating how many appointments per week the health professional can commit to. If a particular practitioner has an existing case load they are struggling with, they may not be able to adequately provide service for the client.

Jasmine is a family member.

Collaboration and negotiations with family members need to occur if the client depends on them for care or services, such as driving the client to appointments. Discussions may indicate that transport will need to be provided as a formal service.

Bill works for a home care provider.

Discussions with home care providers may involve negotiating specific services such as assisting a client with showering three times a week or providing a female care worker to shower a client who requires this for cultural/religious reasons.



Robert works for a health service.

If the client requires care from a health service, arrangements may need to be negotiated. For example, if a client needs to be admitted to a drug detoxification or rehabilitation unit, there may be a waiting list, which means other services may need to be put in place until there is a vacancy.

Barbra works for a funding body.

Discussions may relate to what services or equipment the client's funding package (or other source) cover, and under what conditions.

Aspects to consider when coordinating services

When coordinating services it is vital that the roles and boundaries are clearly defined and that all parties agree with their service responsibilities.

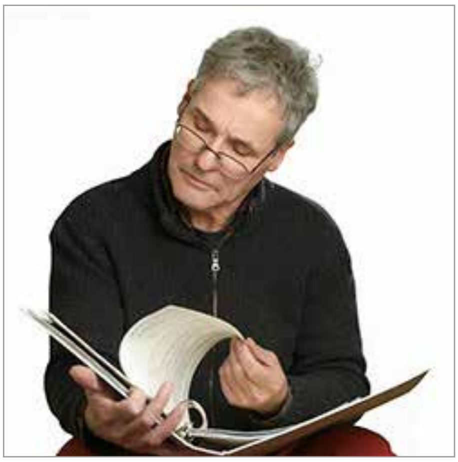
Clear and well-documented communication is critical to ensure that the client's service delivery occurs seamlessly, and that all stakeholders are working within legal and service parameters.

Roles in a client's case coordination should be based on the following four factors.

Factor 1: Availability
Stakeholders should only agree to undertake services they can manage.
Factor 2: Suitability and expertise
If there are requirements in the support activities that require specific roles such as a registered nurse, psychologist or health professional, are they available or do they need to be engaged?
Factor 3: Funding limits
How can the funding be most economically used? Are there options to use voluntary services or the client's natural supports rather than using funding to pay for services?
Factor 4: Logistics
The administrative load of case coordination must not be overlooked. Responsibilities to book meeting rooms and interpreters, and dispatch pre-meeting information must be allocated and defined.

Manage service duplication

Service duplication occurs when the same activity is unintentionally undertaken by more than one service provider.



Service duplication can occur due to poor service planning, coordination or monitoring. It may also be the result of a change of roles or responsibilities in the case coordination process. This all results in wasted funding – if one organisation is being funded to provide a service, and another is duplicating the service, two allocations of funding are effectively being channelled into providing the same service. This could mean that funding does not reach all clients because it has been used up.

Federal, state and local government funding is allocated to organisations and clients to address specific needs that have been determined through formal assessment processes, and each funding body expects that the funding they allocate will be used to provide the optimal benefit for the client receiving the services.

Here are six effects that service duplication can have on client care.

1 **Compromised future funding**
Funding bodies require reports from service providers outlining how funding has been used and whether client goals have been met. If significant service duplication has occurred and goals have not been met, funding bodies may withhold future funding because existing funding has not been appropriately managed.

2 **Increased client confusion**
Clients accessing multiple services may struggle to understand or keep track of when a particular service is being provided, and by which service provider. Service duplication can increase this confusion when the client does not understand which services they have been allocated.

3 **Increased legal risk**
Staff may not be covered by workers' compensation if they have not been authorised to undertake the duties they are carrying out.

4 **Scope of practice boundaries are breached**
There are legal risks for the organisation and safety risks for clients if staff undertake duties they are not qualified or authorised to carry out.

5 **Outcomes not achieved**
If one service is being duplicated, it is possible that another service is not being provided. Therefore, the outcomes that are intended to be achieved may not eventuate. A client's condition could worsen if they are not receiving a particular service due to duplication.

6 **Client loses faith in the service**
If the services are not producing the desired outcomes or duplication is causing confusion and stress for the client and their family, the client may lose faith in staff and cease to access the services. This may have significant adverse effects on the client's health and wellbeing.

Identify and manage service duplication

Unless an effective monitoring system is implemented, service duplication may not be revealed for some time. Many staff work in clients' homes, and in other locations in which they are not directly supervised by their line managers. Sometimes staff act outside of established rules or client plans.

Staff may misunderstand or forget to consult the client plan. They need to be monitored to make sure everything is running smoothly, and that staff are sticking to the roles and actions in the client plan.

Watch this video about service duplication.

Sharon's story

Sharon is 82 years old and living in her own home. She receives a range of support through a Home Care Package, which is provided by multiple services.

Sharon has severe osteoarthritis in her knees and back, which significantly limits her mobility and capacity to undertake self-care. Sharon struggles to prepare meals, and has been assessed as having a high falls risk. Sharon also has diabetes and requires weekly blood glucose level (BGL) monitoring. Her declining vision means that she can no longer drive, so she needs assistance to go shopping and pay the bills. Sharon experiences depression, which is exacerbated by her social isolation, and has chronic obstructive pulmonary disease.

Sharon's suite of services, including her Home Care Package, is coordinated by Carmen, her case manager. Some services are provided by direct support staff from Carmen's organisation; others are contracted out to other providers through a brokerage arrangement. Carmen makes sure that all of the services cover Sharon's needs, and that none of them are duplicating or doubling up on the same tasks or services.

The services include:

- Weekly home care and domestic support: Home Care Package, staff member: Susan
- Twice weekly personal care (showering): Home Care Package, staff member: Tina
- Lunches delivered twice a week: Contracted provider
- Weekly home visit from a registered nurse to monitor BGL: Contracted nursing service
- Fortnightly social support to go out for lunch or do a social activity with a staff member: Contracted social support service
- Fortnightly transport services for shopping and paying bills: Home Care Package, staff member: Alison

Prevent service duplication

It is critical that the roles and boundaries of all service providers are determined and formally recorded in the context of client plans, so that all parties are clear about the services they will be delivering.

As a case coordinator, you can take steps to reduce the likelihood of service duplication occurring.

Practices to prevent service duplication

- Seek regular client feedback.
- Monitor service delivery through documentation.
- Establish written and verbal reporting mechanisms for staff who work in clients' homes to provide regular reports of the duties they are undertaking.
- Participate in staff training and instruction.
- Manage unsatisfactory staff performance by following organisational procedures for counselling, retraining and monitoring employees who do not follow care plans.
- Conduct regular review meetings.
- Liaise regularly with all organisations involved in the client's service delivery.

Identify barriers to service

The issues that have brought clients into your service can present barriers to those clients attaining outcomes through the service.

The needs identification and assessment processes will ideally identify at least some of the factors that may become barriers. Case coordinators should work collaboratively with the client and other service providers to address the presenting barriers. It is important to facilitate an environment of emotional safety in which the client or their family can openly discuss their difficulties so that a solution can be found. Any changes to client plans or service strategies must be made through the appropriate processes.

Barriers

- English as a second language (ESL)
- Language, literacy and numeracy (LLN) issues

Ways to address barriers

- Provide service information in multiple languages.
- Use interpreters (formal and informal) as appropriate.
- Determine client needs and use their preferred method of communication.
- Provide simplified or plain English service information.
- Use verbal communication.
- Employ multi-lingual staff.

Barrier

- Alcohol and other drug (AOD) issues

Ways to address barrier

- Apply organisational policies for clients attending appointments or services while intoxicated.
- Encourage clients to access services and support that will help them reduce substance use.
- Help clients to find medical support, such as a GP they feel comfortable with.

Barrier

- Mental health issues

Ways to address barrier

- Develop an understanding of the client's mental health issues and the impact their condition has on daily life.
- Ensure that all expectations are realistic.
- Work with the client's mental health services to optimise support for mental health needs.
- Optimise funding opportunities for mental health support.
- Engage with the client's representatives, advocates or decision-makers.

Barrier

- Cognitive disability that leads to reduced insight, judgment and decision-making ability

Ways to address barrier

- Determine needs through appropriate assessment.
- Work with the client's capabilities.
- Provide simplified or plain English service information.
- Engage with the client's representatives, advocates or decision-makers.

Barrier

- Cultural differences or values that conflict with service provision

Ways to address barrier

- Identify areas of cultural need.
- Consult the service's cultural liaison officer if you have one.
- Involve cultural representatives and community members to help you understand the client's needs (with the client's consent).
- Employ multi-lingual staff.
- Provide cultural training for staff who attend the client.

Barrier

- Ongoing non-compliance with strategies or service provision

Ways to address barrier

- Find out the reasons for non-compliance.
- Work with the client to plan services in a way that optimises their interest and buy-in.
- Use a strengths-based, person-centred approach.
- Minimise obligations and focus on the client's most pressing areas of need.
- Find out what motivates your client, and build these motivators into support strategies.

Barrier

- Lack of natural support (family or friends) makes it hard to attend appointments

Ways to address barrier

- Explore funding opportunities.
- Source the most effective services to meet the client's needs.
- Access services provided by volunteers, such as transportation to appointments or social support.

Barrier

- Financial pressures make it difficult to get to appointments or purchase essentials

Ways to address barrier

- Help the client to access Centrelink welfare services.
- Access services provided by volunteers, such as transportation to appointments or social support.
- Arrange community assistance with food, clothing and furniture.
- Support the client with budgeting.
- Refer the client to a financial counsellor (free service).
- Explore the possibility of waiving fees, if appropriate.

Barrier

- Negative experience with a staff member

Ways to address barrier

- Acknowledge that something went wrong and apologise on behalf of the service.
- Find out what the problem was and seek a solution in collaboration with the client.
- Take corrective action in the organisation to prevent future occurrence, if applicable.
- Follow up with performance management of staff concerned, if applicable.

Barrier

- Poor service quality from one or more service providers

Ways to address barrier

- Acknowledge the problem and apologise on behalf of the service.
- Find out what the problem was and seek a solution in collaboration with the client.
- Audit all processes to find out what was causing quality issues.
- Take corrective action in the organisation/s to prevent future occurrence.
- Follow up with performance management of staff concerned, if applicable.

Barrier
- Loss of trust in the system

Ways to address barrier
- Acknowledge past experiences.
- Work with the client to plan and select services in a way that optimises their interest and buy-in.
- Ensure professional and compassionate conduct at all times.
- If mistakes are made, acknowledge the error and apologise.
- Identify areas of loss of faith in services.
- Honour commitments to client.

Barrier
- Unrealistic expectations of case coordinator or service

Ways to address barrier
- Make sure the client understands the roles, responsibilities, boundaries, processes and funding limits that apply to their client plan.
- Be clear about what you can help them with and the scope of the service.
- Provide information in the most appropriate format for the client.

Practice task 10

Click icon to open online version

Check your understanding of managing service provision.

Question 1

Which of the following are matters to negotiate in relation to effective collaborative service provision? Tick all that apply.

- [ ] Roles and expectations of all parties
- [ ] Services to be provided
- [ ] Time frame of service provision
- [ ] Financial arrangements

Question 2

Which of the following are possible effects of service duplication? Tick all that apply.

- ☐ Compromised future funding
- ☐ Increased client confusion
- ☐ Decreased legal implications
- ☐ Compliance with scope of practice boundaries

Question 3

Which of the following are ways to manage service duplication? Tick all that apply.

- ☐ Conduct regular review meetings
- ☐ Carry out annual monitoring
- ☐ Regularly liaise with everyone involved in the client's service delivery
- ☐ Seek client feedback

Question 4

Which of the following are challenges that could present a barrier to the client receiving services? Tick all that apply.

- ☐ English as a second language (ESL)
- ☐ Mental health issues
- ☐ Cultural issues
- ☐ Financial pressure
- ☐ Adequate family support

Determine funding eligibility

All funding mechanisms and streams have eligibility requirements, which are the criteria that must be met to obtain the funding.

Funding criteria, eligibility requirements and the range of funding available will vary depending on the industry sector and the funding body. All organisations must ensure that their client intake and assessment processes reflect the relevant funding requirements. Organisations may be required to report to funding bodies to justify that funds have been used within the required parameters.

Funding criteria and requirements may relate to:

- age
- disability
- a specific condition or diagnosis
- family situation
- migration status (e.g. refugee)
- Aboriginal and Torres Strait Islander origin
- living situation (e.g. homelessness)
- AOD factors.

Options for funding

There are different funding options available depending on the client's needs and eligibility.

Consumer-directed care (CDC) and portable funding

CDC represents a social policy for the client or consumer of services to have the main say over the services they use. Under CDC, the government funding is directly allocated to the client, not the organisation that delivers services. The CDC model gives the client greater capacity to choose the service providers they prefer and greater purchasing power. Clients can take their funding to another service provider if they are not happy with a service – the funding is 'portable'.

Home Care Packages Program

The aim of the Home Care Packages Program is to keep older people living in their own home for as long as possible. Many older people have complex needs in connection with their ageing, and other personal factors and circumstances. Funding that supports clients to access multiple services to address these needs is better for the person.

Disability services

The disability sector has been largely state- or territory-funded, although this will change with the full roll-out of the NDIS. Many clients currently receive individual funding packages, the levels and amounts of which are calculated on the basis of their support needs.

National Disability Insurance Scheme (NDIS)

The NDIS represents full application of the CDC model. Clients are determined to be eligible for NDIS through a centralised NDIS assessment process. The levels of funding they receive is determined by their assessed support needs. Many people with disability have complex and multiple needs, so flexible packages of funding facilitate the ability to access a range of chosen services to address the various areas of need and preference.

Organise referrals

A referral is a formal document used to introduce a client to an organisation or practitioner to access services.

To access specialist and publicly funded services, a formal referral may be required. Clients may enter your service on the basis of a referral from another organisation or practitioner. As a case manager or service coordinator, you will also need to prepare referrals to other services for your clients.

Information required in a referral may include:

- The client's name, address, phone number, email address, date of birth and next of kin
- Details of a representative, advocate or substitute decision-maker (if applicable)
- The reason for the referral
- Brief history outlining why the client requires services from the organisation
- Medications the client takes (if the referral is for medical or allied health services)
- Level of urgency with which the client requires the service
- The referring party's details and relationship to the client
- Important cultural, religious or personal requirements, such as being looked after by a female staff member
- Dietary requirements
- Allergies
- Communication needs, such as an interpreter
- Behavioural issues
- Details of pending legal matters, such as court orders
- Power of attorney arrangements (medical/financial)

Consent to share information in a referral

Clients must be made aware of organisational policies and procedures regarding privacy and confidentiality.

All staff must adhere to these rules when discussing, reporting, documenting and sharing client information. Breaching these is not only illegal; it will potentially destroy a client's trust in the professional relationship, and may even result in a client leaving a service, to their own detriment.

Clients (or their representatives) must give written consent for a case coordinator to share their personal information with another organisation. No organisation may send a referral containing any of the above information without the client (or their substitute decision-maker or representative) providing informed consent in writing.

It is vital that referrals are made by authorised personnel with the required scope of practice in an organisation to ensure the appropriateness of the referral and the process through which the referral is made. If this does not occur, funding or service opportunities may be compromised and other legal requirements may be breached.

Practice task 11

Click icon to open online version

Check your understanding of referrals and funding arrangements.

Read the following statements and select true or false for each one.

Question 1

Client referrals must be made by authorised personnel.

☐ True

☐ False

Question 2

Client consent is not required when sharing information between similar services.

☐ True

☐ False

Question 3

Funding criteria and requirements may relate to age, disability and migration status.

☐ True

☐ False

Example

Arranging services

Bill lives in a residential aged care facility. He has mild dementia. In the facility, Bill receives services related to leisure and health activities, which are run by the facility's lifestyle department. Bill partakes in a range of activities in the facility, and also goes on fortnightly outings.

Bill's daughter applied to a local Commonwealth Home Support Programme (CHSP) provider to see whether Bill could attend the Planned Activity Group (PAG) three days per week. This group offers social and recreational activities for older people living in the community in need of social and recreational support.

Bill's daughter was informed that Bill was not eligible to attend the PAG because he is living in a residential aged care facility, and is therefore not eligible for CHSP-funded services.

Bill is already receiving funded leisure and social support, and if he were also able to access CHSP-funded social support, service duplication would occur. There would be one less place in the PAG program that could be taken up by another older person living in the community.

These eligibility guidelines are designed to prevent service duplication, and ensure that funding is directed to provide equitable services across the community.

3C Role responsibilities

Your role as a case coordinator may include various duties in accordance with the responsibilities set out in the job description created by your service.

You may be required to:

- provide information to clients
- facilitate meetings and case conferences
- implement client plans
- monitor client progress
- review and evaluate client plans
- complete client plan documentation.

Provide information

Clients have the right to be fully informed about the service options available to them.

As a case coordinator, you need to explain service options thoroughly to make sure your clients have all the details and can give informed consent for all aspects of care. It is important that clients know what the coordinator is responsible for and what their role covers. Providing this information is important so that clients understand the process, confusion is minimised, and client expectations of service providers are realistic and reasonable.

Clients need to know about:

- the case coordination role, including the limits and boundaries of the role
- the appeals process of the organisation
- the complaints process in the service
- the complaints process to an external body (if a complaint is not resolved internally)
- their rights and responsibilities when using the service
- the case coordination process
- the purpose and process of case meetings
- the roles of meeting participants and why they are attending
- the intended outcome of the meeting.

Practice task 12

Click icon to open online version

Check your understanding of information that must be provided to a client.

Match the beginning of each sentence to the correct ending.

- All service provision information must be provided in a format the client can understand so that
- Information about case meetings must be explained clearly so that
- Information about appeals processes must be provided so that

- the client understands the process if they disagree with any decisions made.
- the client can give informed consent.
- the client understands the purpose and roles of the participants.

Facilitate meetings and case conferences

During the case coordination process, meetings may be held for many reasons.

Examples include meeting with a client and their family to follow up on a complaint, or to see how a client is progressing after a setback. To facilitate high quality service provision, client plans are developed in a case planning meeting, or series of meetings, that involve the client, their significant others, their advocates or representatives, and key stakeholders who will provide services to the client.

You can facilitate a meeting by:

- enabling participants to contribute via phone or video link
- acknowledging participants when they make contributions to the discussion
- encouraging participation by making sure everyone has a chance to contribute
- identifying the priorities of the meeting
- explaining the topics that are to be discussed in the meeting
- keeping the participants focused on the issue at hand
- giving the participants enough time to discuss issues
- summarising the end of a discussion to clarify and confirm what has been said.

Case conferences

Case conferences can be used for planning, monitoring or reviewing services.

Conferences should be scheduled at a convenient time for the client and other stakeholders in order to facilitate optimal attendance and participation. Client communication needs must be taken into account; for example, by having substitute decision-makers present, making sure clients have their communication aids or devices with them, or booking an interpreter.

Practice task 13

Click icon to open online version

Check your understanding of facilitating case conferences and meetings.

Which of the following describe how a case coordinator can facilitate a meeting? Tick all that apply.

- ☐ Discourage participants from contributing via phone link or Skype, and insist on face-to-face participation.
- ☐ Acknowledge participants when they make contributions to the discussion.
- ☐ Encourage participation by making sure everyone has a chance to contribute.
- ☐ Summarise the end of each discussion to clarify and confirm what has been said.

Formal meeting processes

It is important that case conferences follow a formal meeting process.

The outcomes of some meetings may be recorded in the client's case notes as 'records of contact'. Case coordinators must ensure they understand and follow the processes required by their organisations. Minutes taken in the meeting safeguard against attendees forgetting what needs to be actioned. In a formal meeting process, the minutes of a meeting will be accepted at the following meeting if all agree that they accurately reflect the meeting contents. This gives them credibility as a legal record of the events.

Agenda

The agenda:

- is sent to all invitees prior to the meeting so they can add the points they wish to discuss at the meeting
- lists items in the order they will be discussed
- states who is responsible for each item
- includes the date, time and duration of the meeting.

Chairperson

The chairperson:

- opens the meeting and welcomes the participants
- runs the meeting according to organisational standards
- keeps discussions on track
- keeps the meeting to the set time frame
- closes the meeting and thanks the participants.

Minute taker

The minute taker:

- takes notes in the meeting
- types up the minutes (a record of the meeting) using the appropriate workplace template
- sends out copies of minutes to attendees
- stores the minutes document in the allocated place.

Meeting environment

The formality of the meeting should not lead to the environment feeling intimidating, overwhelming or inaccessible to the client or their family members.

You must create an environment in which clients and their family members feel emotionally safe and respected.

As the case coordinator you should:

- ensure furniture is comfortable
- offer beverages
- create an environment that is inviting for the client
- make sure client needs are accommodated, such as easy access for a wheelchair
- use a round table to promote inclusion and equality
- use language that is easily understood by the client, avoiding jargon or technical terms
- use active and reflective listening skills to ensure that all participants understand what is being discussed.

Practice task 14

Click icon to open online version

Check your understanding of formal meeting processes.

Match the beginning of each sentence to the correct ending.

* A chairperson	* should list items in the order they will be discussed.
* A minute taker	* is responsible for running the meeting.
* An agenda	* is responsible for taking notes in the meeting.

Implement a client plan

Implement the client plan by delivering services – putting the plan into action.

As a case coordinator, you are responsible for monitoring the overall client plan. The client and other stakeholders will contribute significantly to this process, and individual practitioners will monitor their own service area. You need to monitor the progress, difficulties and funding, and any aspect that has implications for the ongoing success of the plan.

Monitoring activities ensure that when issues or difficulties arise, they are identified before they escalate into major issues. If changes need to be made to the plan, such as the priority of the client's needs, this must be done according to organisational or inter-organisational processes. One stakeholder cannot change the plan unilaterally.

Monitor client progress

Monitoring is ongoing and involves checking on the progress of the plan and the effectiveness of the support strategies in meeting client goals.

Monitoring facilitates review and evaluation of services, and this informs ongoing service delivery. Monitoring is done through a range of mechanisms, including observation, reporting and documentation, and client and stakeholder feedback. It may also involve testing in some situations, such as drug tests to monitor clients' use of illicit drugs.

Monitoring involves acknowledging and celebrating milestones reached, and identifying issues or barriers to progress. The client should always be encouraged to monitor their own progress and difficulties. They may use a diary or journal to keep track of improvements they have made and problems or worries that have arisen.

The role of case coordinators

Effective monitoring means that issues can be identified and rectified early.

It also means that if a client has reached a goal before the predicted time, new goals can be formulated so that the momentum of progress can continue, and funding will be used where it is most needed.

You must be aware of the changing needs of the client and reprioritise the needs according to urgency. This must be done in collaboration with the client and coordinated with all parties that are affected by the change in service needs.

As a case coordinator you must:

- oversee and monitor client plans
- ensure all services are fulfilling requirements and agreements, such as time frames and budgets
- oversee and monitor the plans that other organisations have with the client
- draw together all of the monitoring activities of the individual services that are providing client services
- monitor progress through documentation
- collect client and service provider feedback
- monitor the client's funding to ensure that it is not used up too quickly.

Obtain feedback

Avenues for the client to provide feedback must be clear and open, and feedback must be encouraged.

You should actively seek clients' feedback about the services they are receiving. This is a key element of effective service monitoring. Client feedback will reveal the progress the client is making, and the issues or barriers they are facing.

All feedback and other evidence gathered through monitoring activities will be used to review the plan and to evaluate the effectiveness of the services the client is receiving.

You can encourage clients to provide feedback by:

- making sure the client understands their feedback is valued, and will be acted on
- facilitating an open and transparent culture where clients feel emotionally and culturally safe to share their feedback
- supporting clients and their families/representatives to provide feedback in ways they are comfortable and confident with.

Practice task 15

Click icon to open online version

Check your understanding of why it is important that a case coordinator gathers client feedback.

Which of the following are reasons for a case coordinator to actively seek client feedback about the services they receive? Tick all that apply.

- [ ] Feedback will reveal any progress the client is making.
- [ ] Feedback will reveal any issues or barriers the client is facing.
- [ ] Feedback will inform the case coordinator of how the client is experiencing the service.
- [ ] Feedback can be used to review the plan.
- [ ] Feedback can be used to evaluate the effectiveness of the services the client is receiving.

Review and evaluate the case plan

This process involves measuring achievements against the plan.

When reviewing plans, the data and information collected through monitoring is analysed to determine what has and has not worked. Review meetings are case conferences, and they should be held as formal meetings. The client and other stakeholders present are encouraged to openly share their thoughts and feelings.

As with the initial case conferences, it is unlikely that all stakeholders will be present, but they should all be invited to contribute their own service reviews via an appropriate method.

Time frames for review

Reviews of client plans must occur within a scheduled time frame.

Depending on the organisation, and the type of supports that are being reviewed, reviews may be two-monthly, three-monthly, six-monthly or yearly. Review dates should be set at the formal planning meetings.

An additional review should be held if there is a significant change in the client's circumstances. You will need to check that the client's funding is ongoing. Changes may have occurred to funding systems, and if this happens, you may need to explore the new requirements to seek optimal funding opportunities for the client.

Depending on the changes, the review may be a full or a partial plan review. Sometimes only a specific area of a client plan will need to be reviewed before the scheduled review date, as there has only been a small change.

Changes to plans must be made through the appropriate process, regardless of whether the changes are small or large, or part of a scheduled review. This way, changes to services and funding can be managed effectively, and the focus of the plan is retained.

Here are examples of plan reviews.

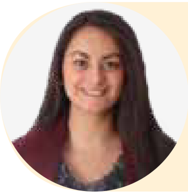
Full plan review
The client has experienced a significant medical event in the form of a stroke, and his support needs have significantly changed. The client is no longer receiving services in his home or the community because he has been in hospital, and then in a rehabilitation unit. He has lost significant functional ability and the current supports need to be revised immediately.
Partial plan review
A client's daughter has been taking her to her physiotherapy appointments, but can no longer do so. The client now requires transport to be added to her suite of support services, so the case coordinator will determine if funding can be acquired for this, then source this service and add it to the client's plan.

Purpose of review

The purpose of the review is to examine the plan's effectiveness and appropriateness, and to identify changes that need to be made.

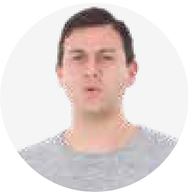
Lily is planning to review Jason's client plan. She wants to make sure she covers everything, so she asks her colleague Dave for advice.

Lily

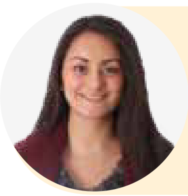


Dave, I'm planning to review Jason's client plan. I'm going to make a checklist of things I need to look for when I'm conducting the review. What should I be looking for in the review of the plan?

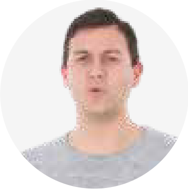
Dave



Grab a pen and I'll tell you a few questions that I ask myself when I'm doing a client plan review.



Got it. I'm ready.

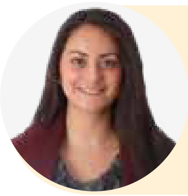


Okay, these are some of the things you can ask Jason:

- How is he feeling about his suite of services?
- Have his goals been reached – if not, why not?
- If his goals have been reached, what is his next step?
- Have there been improvements in his functioning, his life, his mood, etc.?
- Are the strategies effective – if not, why not?
- Are the resources adequate – if not, why not?

You can also ask more general questions, such as:

- Are the staff supporting Jason appropriately?
- Has something changed in Jason's health, needs or preferences?
- Was there an issue with the appropriateness of the goals – should the goals be revised?
- Have organisations/staff been providing high-quality services?
- Has any service duplication occurred?
- Have funding requirements been met?



Thanks, Dave. I'm going to put these in a checklist so I can make sure I have asked everything I need to.

Move forward with services

Plan reviews inform the next course of action in terms of the services the client will receive.

Depending on the outcome of the review, there may be new goals or strategies.

Applying the cycle of assessment, planning, monitoring and review ensures that changes to aspects of services will occur as required, in response to the client's changing needs and preferences.

Effectively, after a review a new client plan commences.

There may be changes to:

- goals
- strategies
- support staff, service providers
- resources
- support or appointment times
- venues/locations
- frequency of services.

Exit from a service

Clients may exit services because of a change in circumstances or funding arrangements.

Some clients may transition to other services. In these instances, you will need to facilitate the transition with introductions, referrals and other appropriate strategies to make the transition easy for the client.

If a person passes away, refer to the service policies to complete the correct documentation and assist the family as much as possible.

A client may exit a service because they:

- no longer require services that addressed a temporary need
- have met their goals
- are no longer eligible to continue receiving services
- find the service is no longer able to meet their needs
- have reached a certain age
- need to access different funding sources
- have moved away from the area in which they were receiving services
- have moved out of their own home into residential care
- have found another service that better suits their needs
- are not happy with the service.

Complete documentation

As a case coordinator you need to complete a wide range of documentation relating to your role.

Documentation is essentially a written record of all aspects of services delivered to clients, and the client's responses to the services. Documentation may be in paper or electronic form, depending on organisational protocols.

Examples of documentation you may need to complete:

- case notes, progress notes and file notes
- assessment tools
- incident reports
- referral forms
- client plans
- funding applications
- hazard identification and risk assessment forms
- inter-organisational correspondence
- analytical charts.

Principles of documentation

All documentation must be completed in line with the principles that govern professional reporting.

Implementing the following six principles will lead to best practice in documentation.

Six principles of documentation

1. Objective

Documentation must be:

- free from the influence of personal feelings, interpretations or prejudice
- free of judgment and bias.

2. Factual

Documentation must:

- relate to the facts
- not contain speculation
- not make diagnoses
- record only what you directly witnessed.

3. Clear

Documentation must be:

- easy to understand
- logical
- legible
- free from unauthorised abbreviations or jargon.

4. Timely

Documentation must be completed:

- according to organisational or legal time requirements (e.g. within 24 hours of an incident)
- as soon after the events as possible, to ensure accurate recall.

5. Legally compliant

Documentation must comply with:

- privacy legislation
- any other relevant legal provisions such as anti-discrimination or health and safety legislation.

6. Organisationally compliant

Documentation must be:

- in an approved format or template
- signed off with your name, signature, designation, date and time.

Legal implications of documentation

Organisational documentation may be used in a court of law if legal action is undertaken.

A party in a court proceeding may issue a subpoena, which is an order that compels a person or organisation to provide documents to the court.

In general, an organisation needs documentation to prove that it has complied with financial, ethical and other obligations relating to government departments, anti-discrimination and privacy, and legislation and regulations that govern community services.

Documentation is legally required to:

- form a record of care
- inform the next steps to be taken in client support
- facilitate continuity of care/support
- substantiate/prove duty of care
- record client refusal of services
- access and substantiate funding
- substantiate the need for additional or adjusted services
- substantiate eligibility for services
- determine appropriate services
- monitor and review services for ongoing effectiveness.

Example

Role responsibilities

Bob is 52 years old and has been in a psychiatric ward for almost five months. Before this, Bob had a managerial position with a major bank and lived at home with his partner and their two children. Since then, Bob has been made redundant from his position.

Bob's case coordinator, Hazel, has the role and responsibility of monitoring Bob's progress by facilitating regular reviews of his progress and goals. As Bob progresses, the case plan is re-evaluated and adjusted to reflect Bob's progress and changing goals. Hazel works with Bob to meet his overall goal of gaining employment in the financial sector by focusing on his strengths and preparing Bob to transition out of the care service.

Practice task 16

Click icon to open online version

Read each statement about monitoring, reviewing and documenting a client's progress, and select true or false.

Question 1

Monitoring and reviewing a client's progress ensures that changes to aspects of services will occur as required in response to the client's changing needs and preferences.

☐ True

☐ False

Question 2

Reviews do not need to occur in addition to those that have been scheduled, even if there has been a significant change in the client's circumstances.

☐ True

☐ False

Question 3

All organisational and inter-organisational documentation must comply with privacy legislation.

☐ True

☐ False

Summary

- Assessment outcomes and information gathered during the assessment phase are used to develop client plans.
- When collecting and analysing evidence in the assessment process, it is important to collect both quantitative and qualitative evidence.
- An effective plan includes SMART goals, strategies, specification of roles and resources, time frames and review dates.
- Negotiations on working arrangements will occur in meetings, via phone or email, or through the referral process; arrangements should be formalised in planning meetings to ensure clarity.
- Unless an effective and organised system of monitoring is implemented, service duplication may not be revealed until it has caused problems.
- Case conferences can be used for planning, monitoring or reviewing of services and should be scheduled at convenient times for the client and other stakeholders to facilitate optimal attendance and participation.
- Monitoring involves acknowledging and celebrating milestones reached, and identifying issues or barriers to progress.
- Plan reviews inform the next course of action in terms of the services the client will receive.
- Depending on the outcome of the review, there may be new goals or strategies to implement in the client plan.

Learning checkpoint 3

Click icon to download this in Word format

This learning checkpoint allows you to review your skills and knowledge in coordinating care for a client.

1. Briefly describe the input that is used when developing a client plan.

2. List **two** aspects that must be considered when coordinating services.

3. Briefly describe one of your role responsibilities when working with or providing information to a client.

4. How can a case coordinator facilitate a meeting?

5. Briefly describe one role or component of a formal meeting process.

6. How can service duplication be minimised and managed?

7. How can a case coordinator encourage clients to provide feedback?

8. Briefly describe why a client may need a range of support services.

9. Briefly describe **two** principles of documentation.

10. How can you identify and respond to a client's changing needs?

11. What information must be included in a referral?