



CHCAGE003

# **Coordinate services for older people**

Release 1

**Learner guide**

Aspire version 1.3



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## Version control and modification history

Version	Release date	Modification
Release 1, version 1.1	April 2017	First release
Release 1, version 1.2	December 2018	Minor corrections as part of our continuous improvement program
Release 1, version 1.3	July 2019	Updated to reflect changes to voluntary assisted dying laws in Victoria.

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### CHCAGE003 Coordinate services for older people, Release 1

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Level 1, 464 St Kilda Road  
MELBOURNE VIC 3004 AUSTRALIA  
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Port Melbourne VIC 3207

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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: .....



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## Before you begin

This learner guide is based on the unit of competency *CHCAGE003 Coordinate services for older people*, 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](http://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.

<b>Feature of the learner guide</b>	<b>How you can use each feature</b>
<b>Learning content</b>	<ul style="list-style-type: none"> <li>▶ 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.</li> </ul>
<b>Examples and case studies</b>	<ul style="list-style-type: none"> <li>▶ Examples of completed documents that may be used in a workplace are included in this learner guide. You can use these examples as models to help you complete practice tasks and learning checkpoints.</li> <li>▶ Case studies highlight learning points and provide realistic examples of workplace situations.</li> </ul>
<b>Practice tasks</b>	<ul style="list-style-type: none"> <li>▶ Practice tasks give you the opportunity to put your skills and knowledge into action. Your trainer will tell you which practice tasks to complete.</li> </ul>
<b>Video clips</b>	<ul style="list-style-type: none"> <li>▶ Where QR codes appear, learners can use smartphones and other devices 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: <a href="http://www.aspirelr.com.au/help">www.aspirelr.com.au/help</a></li> </ul> <div data-bbox="1161 1328 1353 1619" style="text-align: right;">   <p style="font-size: small;">V1234</p> </div>
<b>Summary</b>	<ul style="list-style-type: none"> <li>▶ Key learning points are provided at the end of each topic.</li> </ul>
<b>Learning checkpoints</b>	<ul style="list-style-type: none"> <li>▶ 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.</li> </ul>

## 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	<ul style="list-style-type: none"> <li>▶ Understanding your job role, organisational procedures and legal responsibilities</li> <li>▶ Managing your work and seeing how well you are going and making goals for yourself at work</li> <li>▶ Seeking professional development opportunities for continuous improvement</li> </ul>
Reading	<ul style="list-style-type: none"> <li>▶ Understanding how documents are presented and being able to navigate through documents</li> <li>▶ Understanding industry- and job-specific terminology</li> <li>▶ Interpreting key information in relevant documents</li> <li>▶ Understanding routine workplace checklists and documentation</li> </ul>
Writing	<ul style="list-style-type: none"> <li>▶ Planning, drafting and writing reports and documents</li> <li>▶ Communicating through written letters, email and online</li> <li>▶ Recording progress; reporting incidents</li> </ul>
Oral communication	<ul style="list-style-type: none"> <li>▶ Clarifying instructions</li> <li>▶ Providing information</li> <li>▶ Supporting others through encouragement, negotiation and conflict resolution</li> <li>▶ Using body language to model desired behaviour and responding to others' body language</li> </ul>
Numeracy	<ul style="list-style-type: none"> <li>▶ Calculating costs, weights, measurements of height and distance</li> <li>▶ Interpreting measurements</li> </ul>
Teamwork	<ul style="list-style-type: none"> <li>▶ Working well with other people by cooperating, collaborating, encouraging and building rapport</li> </ul>
Planning and organising	<ul style="list-style-type: none"> <li>▶ Planning your workload and commitments</li> <li>▶ Implementing tasks</li> <li>▶ Completing work on time</li> <li>▶ Knowing how to deal with hazards and risks</li> </ul>
Making decisions	<ul style="list-style-type: none"> <li>▶ Understanding and applying decision-making processes</li> <li>▶ Reviewing the impact of your decisions</li> </ul>
Problem-solving	<ul style="list-style-type: none"> <li>▶ Identifying problems</li> <li>▶ Working out how to fix a problem using problem-solving processes and reviewing the outcome</li> </ul>
Innovation and creation	<ul style="list-style-type: none"> <li>▶ Recognising opportunities to develop and apply new ideas</li> <li>▶ Generating ideas by thinking of new ways to do something</li> <li>▶ Making suggestions to improve work</li> </ul>

Foundation skill area	Foundation skill description
Technology and digital literacy	<ul style="list-style-type: none"> <li>▶ Efficiently using digitally based technologies and systems correctly and safely</li> <li>▶ Accessing, organising and presenting information</li> <li>▶ Using equipment correctly and safely</li> </ul>

## 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 Coordinate the delivery of the individualised plan	1A Identify and prioritise needs, goals and preferences	<input type="checkbox"/> Confident <input type="checkbox"/> Basic understanding <input type="checkbox"/> Not confident
	1B Consult person and colleagues and co-ordinate services and support	<input type="checkbox"/> Confident <input type="checkbox"/> Basic understanding <input type="checkbox"/> Not confident
	1C Outline and clarify service providers' roles and responsibilities	<input type="checkbox"/> Confident <input type="checkbox"/> Basic understanding <input type="checkbox"/> Not confident
	1D Recognise signs of abuse or neglect and respond in line with organisational guidelines	<input type="checkbox"/> Confident <input type="checkbox"/> Basic understanding <input type="checkbox"/> Not confident
Topic 2 Liaise and negotiate with appropriate personnel and service providers	2A Support the older person to access and negotiate resources	<input type="checkbox"/> Confident <input type="checkbox"/> Basic understanding <input type="checkbox"/> Not confident
	2B Support the older person to access community support agencies to achieve established goals	<input type="checkbox"/> Confident <input type="checkbox"/> Basic understanding <input type="checkbox"/> Not confident
	2C Recognise when the level of service required is no longer provided and take action	<input type="checkbox"/> Confident <input type="checkbox"/> Basic understanding <input type="checkbox"/> Not confident
Topic 3 Support family and carers	3A Recognise the impact of support issues on the carer/s and families and refer appropriately	<input type="checkbox"/> Confident <input type="checkbox"/> Basic understanding <input type="checkbox"/> Not confident
	3B Provide support and respite for carer/s	<input type="checkbox"/> Confident <input type="checkbox"/> Basic understanding <input type="checkbox"/> Not confident

Topic	Key outcomes	Rate your confidence in each section
Topic 4 Coordinate feedback	4A Explain mechanism/s for providing feedback on the individualised plan	<input type="checkbox"/> Confident <input type="checkbox"/> Basic understanding <input type="checkbox"/> Not confident
	4B Obtain feedback on the individualised plan and report to supervising health professional	<input type="checkbox"/> Confident <input type="checkbox"/> Basic understanding <input type="checkbox"/> Not confident
	4C Seek feedback from the older person and/or their advocate and report to supervising health professional	<input type="checkbox"/> Confident <input type="checkbox"/> Basic understanding <input type="checkbox"/> Not confident
	4D Support the older person to seek assistance when their goals are not being reached	<input type="checkbox"/> Confident <input type="checkbox"/> Basic understanding <input type="checkbox"/> Not confident



## Topic 1

In this topic you will learn how to:

- 1A Identify and prioritise needs, goals and preferences**

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- 1B Consult person and colleagues and co-ordinate services and support**

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- 1C Outline and clarify service providers' roles and responsibilities**

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- 1D Recognise signs of abuse or neglect and respond in line with organisational guidelines**

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## Coordinate the delivery of the individualised plan

In the role of a coordinator, you may need to evaluate the needs of older people with more than one condition, who require a range of support programs. The aim is to ensure older people's complex needs are identified and addressed individually. To do this, you must address, support and prioritise their needs using a range of tools and in consultation with a range of health professionals.

# 1A Identify and prioritise needs, goals and preferences

The individualised plan is used to support individuals receiving care and is developed in collaboration with the person receiving care and their support team. The plan should be up-to-date and specific.

The plan will be centred on the person's needs. Needs are physical, emotional, mental, spiritual and social. Goals are agreed upon with the person. Goals address the person's needs, and should be specific and achievable. A person's preferences should be outlined in the care plan. These include food preferences and preferences for activities.

Learn to identify and prioritise these needs, goals and preferences according to the individualised plan.



## The social model of disability

The social model of disability proposes that if a person has a disability, it is society that dictates how they are treated; in other words, society can create the disability by excluding the person. This way of seeing things puts the focus on the person themselves, and suggests that it is their social or physical environment that may cause them to be segregated, unable to access buildings or move around, and be isolated. Social devaluation may create loneliness, resentment and severe restriction on opportunities for learning, working, being part of a family, travel and so on.

## Competency and evidence-based intervention

The principle of competency emerged from the social model of disability. Competency focuses on what the individual can do; in your work as a support worker you should focus on the person's strengths. This is known as providing strengths-based support.

The social model of disability is linked with the current practice of using evidencebased behavioural intervention. Evidence-based means that enough research has been carried out that suggests the findings are firm evidence from which to proceed. Research in all fields follows this principle. Behavioural intervention is simply intervening to modify behaviour – but it should always be planned and based on evidence.

Applying a person-centred approach is important when delivering community services. Taking a person-centred approach means ensuring the individual is at the centre of decisions which relate to their life.

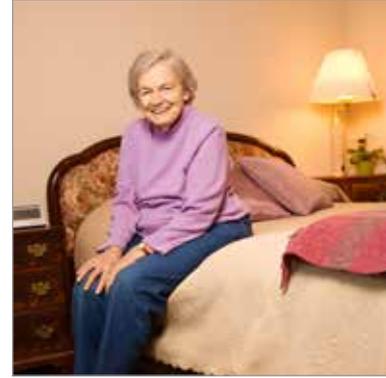
The social model of disability and a person-centred approach should underpin your work when supporting older people.



## Identify needs

Complex needs occur when the person's disabilities or conditions affect multiple areas of their lives. In these instances, the delivery of appropriate care and support requires careful planning and coordination.

You might be working with a person with complex needs in any of a number of different settings. For example, they may live in an aged care home, in a supported residential service, in the community or in their own home. The setting impacts the care and support programs provided to the person.



You might also need to assess a person's needs for a number of reasons. For example, the person may be inquiring about receiving support from your service. The assessment you perform is intended to establish whether your service is able to provide support to meet their needs.

The person may be new to the service. The assessment you perform is to establish and prioritise their care needs and the support required to meet these needs.

## Assessment and the service

Assessments are carried out for many different reasons and are necessary when identifying a person's needs. The assessments you perform depend on the type of service that employs you.

Examples of services are below.

Types of services	
▶	A day program
▶	Personal care
▶	A home care service
▶	An overnight respite service
▶	A residential accommodation service or independent living accommodation

## Identify and prioritise needs

The purpose of an assessment is to identify a person's needs. The health team assesses the impact of the person's conditions and then prioritises their needs to identify which ones should be addressed urgently. This can be difficult when the person has a dual or multiple diagnoses. You need to understand the types of conditions older people have and how they can impact on identifying their needs. Sometimes it is not possible to meet all of the person's needs, perhaps because there are just too many needs for funded services to meet. Therefore you need to prioritise certain needs.

Here are considerations to make when prioritising needs.

### Risk

Does the issue or need put the person at risk? For example, does the need:

- ▶ put them at risk of injury or harm
- ▶ prevent them from receiving nutrition or hydration
- ▶ put them at risk of illness or disease?

What is the immediate risk? For example, might the situation change immediately or next month? Issues or needs that put the person at risk are a higher priority.

### Independence

Does the issue or need prevent the person from being independent? The following issues may affect the priority you give to dealing with a particular need. For example, is it likely that they will:

- ▶ need to move out of their own home into residential care
- ▶ need a higher level of care if they are in residential care
- ▶ put excessive demands for support on their family members, friends and carers?

### Participation

Does the issue or need prevent the person from interacting or participating in their community or social network? The following issues may receive a lower priority initially, but are still important needs for the person. For example, are they unable to:

- ▶ visit friends
- ▶ participate in their interests and hobbies
- ▶ get out in their community?

## Complex care needs

Some older people you interact with will have a dual diagnosis or multiple diagnoses and hence they will have complex care needs. These terms have different meanings in different health care settings. In home support and general aged care environments, dual diagnosis means a person has been diagnosed with two distinct conditions and multiple diagnoses means they have been diagnosed with more than two distinct conditions. For example, an older person could have Parkinson's disease, chronic back pain and skin cancer.



In other fields, the definition may have a slightly different meaning. For example, in the mental health field, dual diagnosis or complex needs refers to a person with a mental illness and an addiction to drugs and alcohol. In the disability field, dual diagnosis refers to a person with an intellectual disability and a mental illness.

## Conditions associated with ageing

The people you provide services to may be living in residential aged care settings or living in their own homes; they may be veterans and war widows entitled to a range of supports; or they may be older people who are prospective service consumers.

People working in aged care should be familiar with the following health problems which may be associated with ageing.

### Mental health conditions or mental illness

Mental health problems are conditions that affect mood and thinking such as depression. Depression may present as confusion or a general cognitive decline and persistent low mood. These conditions may mean older people put themselves at risk because they are unable to reliably perform daily living and self-care activities or they behave irrationally. People with a mental illness may have periods of time when they appear well with no symptoms of the illness.

Be aware how the mental illness affects the person's lifestyle. Make accommodations as required. Consult the person and health professionals about how to provide the best support you can.

### Memory loss

Several conditions affect cognition; that is, thinking and memory. Some examples include Alzheimer's disease, vascular dementia and frontal-lobe dementia. Some older people with forms of dementia need support for their activities of daily living (ADLs). People may have problems with their short term memory, remembering appointments and planning and preparing meals. The memory problems may mean it is not safe for the person to go out into the community as they may get lost or lose their money. They may also be unsafe at home as they may forget how to use appliances safely or lock doors. People with severe forms of dementia may display behaviours of concern such as being aggressive or violent in certain situations.

Be alert to changing conditions, and report changes. Ensure the person's environment is safe and appropriate for their needs.

### Terminal illness

Terminal illnesses have no cure and are sometimes called life-limiting illnesses. People with terminal illnesses are expected to die of their condition. The medical care provided is often referred to as palliative care. There are many types of terminal illnesses. Examples include some cancers, Huntington's disease and Alzheimer's disease. People with terminal illnesses may have increasing needs as their condition worsens: they may need a lot of medical support, they may be unable to spend much time out of bed or they may need assistance with eating and drinking.

People with terminal illnesses often have serious emotional and mental struggles as they approach death. Ensure that the person and their family have the emotional support they require to move through this period. In Victoria, voluntary assisted dying is available to people with terminal illnesses who want to choose the timing and manner of their death.

## Chronic pain

Some older people suffer from frequent and constant pain, which may be managed with medication or therapy, but cannot be completely cured. Chronic pain can be caused by many different conditions. Some examples include arthritis, rheumatism, previous injuries, Parkinson's disease and liver disease. Chronic pain can be exhausting to the person. It can affect their mood and behaviour. Pain medication may make older people drowsy and forgetful.

A person may get used to the pain they are in, but this does not mean you should ignore their pain. Be alert to any changes in their condition. Validate the pain they are in, and provide emotional support where you can.

## Acquired disability

Acquired disabilities can be physical or intellectual. The disability may occur later in life due to an accident or illness. A disability is considered to be a permanent condition that affects one or more of the core functions of mobility, communication and self-care. Disabilities may be moderate, severe or profound.

Don't exclude a person from activities because of a disability. Consult with the person and others about how their disability can be accommodated.

## Dysphagia

People with dysphagia have difficulty swallowing or may experience pain while swallowing. Some people may be unable to swallow or may have trouble swallowing liquids, foods or saliva. Eating becomes a challenge. Dysphagia can make it difficult for someone to take in enough calories and fluids to nourish their body.

When preparing foods for people with dysphagia, ensure it is liquid and the person can ingest it safely. Drinks can be thickened to make them easier to swallow.

## Incontinence

Over 50 per cent of people in aged care homes are estimated to have this problem. A person's bladder may become weakened so that they urinate more frequently and involuntarily. They may urinate when they cough or stand up, wet their clothes and may be reluctant to discuss the problem. They may smell of urine.

Responses to this include organising medical investigation of the cause, bladder retraining, incontinence aids and diet.

## Loneliness and grief

Grief is a common experience for aged people. As people reach the end of their lives, they may have lost partners, spouses, friends and others who are close to them. People experience grief for homes, activities and aspects of their life they can no longer partake in. Grief may present as depression, and may be ongoing and complicated if the person's emotional needs are not recognised and met.

Loneliness is also common for older people who live alone. People may feel cut off from community, as they can no longer participate in certain activities.

Recognise people's emotional needs, and provide support where you can. For example, help the person identify outings that are more suitable to meet their social needs.

## Appropriate actions in response to needs

Follow the person's individualised care plan to determine the appropriate actions. The care plan will detail specific actions, such as medication administration, how to support a person with activities of daily living, and how to support a person to meet their health and wellbeing needs.

If the person has complex needs, you may need to seek support in order to meet needs. You may require medication administration training, for instance. You may need to speak to the person's health provider to understand the specific exercises or actions you need to take to meet that person's needs.

Here are considerations to keep in mind when responding to needs.

### Responding to needs

Ensure the action you take is in line with the person's individualised care plan.

Ensure the action you take is within organisational requirements, and follows policies and procedures.

Ensure the action you take dignifies the person, and respects their rights, such as their right to freedom, and privacy.

Ensure you are qualified to respond to the needs, and act within the limitations of your role.

Ensure that you practise safely, and provide duty of care at all times.

## Identify and prioritise goals

Goals are developed in collaboration with the person you support. They address specific needs. For example, if a person fears social interactions, the goal may be to encourage the person gently to participate in social activities they feel comfortable with. The goal should be SMART: specific, measurable, achievable, realistic and have a specific time frame.

Identify the person's goals outlined in the support plan. Some of these goals may be more meaningful to the person than others, and therefore will be given priority. For example, if the person has an urgent health need, the priority goal will address this need.

Monitor a person's ability to reach their goals. If a person is not achieving their goals, there may be a good reason. For instance, the goal may be unachievable.

The goal in the care plan should then be reviewed for suitability.



## Identify and prioritise preferences

It is important that the person is always central to all decision-making and care provided. Support provided should always take a person's preferences into consideration.

Preferences are closely related and often overlap with a person's goals and needs. Preferences may be physical, mental, emotional, spiritual or social. Preferences may relate to a person's cultural or ethnic background or their religious preferences.

Talk with the person about preferences detailed in the individualised care plan. If a person appears distressed or dissatisfied, it is possible their needs or preferences aren't being met. It is also possible that their needs and preferences need to be reviewed, or reprioritised because they have changed.

Here are some examples of needs and preferences.

### Examples of needs and preferences

- ▶ A person is vegetarian. They only eat food that does not contain meat.
- ▶ A person is Islamic. They only eat food that is Halal, which means it has been prepared according to Halal specifications.
- ▶ A person is Islamic. They pray at five specific times of the day.
- ▶ A person prefers outdoor activities to indoor activities.
- ▶ A person has requested that they have the opportunity to go out dancing.
- ▶ A person likes to see their family every Sunday in a quiet, private location.

## Duty of care, negligence and dignity of risk

When identifying and prioritising needs, preferences and goals, you have the responsibility to provide a duty of care to ensure the safety and wellbeing of the person. Legislative and regulatory obligations underpin an organisation's policies, which determine the procedures to guide service delivery that promotes and enhances the safety and wellbeing of people.

Here is more information about duty of care, negligence and dignity of risk.

### Duty of care

- ▶ Duty of care is the obligation a person has to act in a way that would not cause harm. You have a moral and legal obligation to ensure you do all that is possible to ensure the person's safety.

### Negligence

- ▶ Negligence occurs when duty of care has been breached and harm to either 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, also require that duty of care or safety is not used as a reason to limit a person’s freedom or personal choice. A support worker’s adherence to duty of care and safety must be coupled with the concept of dignity of risk, which means that a person has the right to make their own choices and to take risks. Respecting a person’s dignity is likely to reduce the incidence of behaviours of concern, as a person feel more empowered and involved.

**Example**

**Identify priorities**

**Mrs Hargreaves**

Mrs Hargreaves is 75 years old and lives in her own home. She has a form of dementia that is moderate and so often forgets to perform her activities of daily living. A stroke three years ago and consequent weakness in her right hand, arm and leg also makes it difficult for her to perform her activities of daily living. Arthritis in her hands impedes her ability to lift and hold anything small or heavy or that needs fine motor control.

An assessment would identify Mrs Hargreaves’s need for support with her daily living activities as a high-priority issue. It is not necessarily important which diagnosis (dementia or arthritis) contributes more to the need for daily living support.

**Mr Stabler**

Mr Stabler is 80 years old. He recently lost a significant amount of weight due to an illness and this has left him with a lack of energy. The recommended support is to prepare frequent meals with high calorie and carbohydrate content. Mr Stabler has Type 2 diabetes and has difficulty monitoring his blood sugar levels. The recommended support for this is to ensure he eats low calorie, low carbohydrate and high GI (glycemic index) meals.

Assessment would indicate that managing Mr Stabler’s diabetes is a higher priority than assisting him to have more energy. In this case, the diagnosis is important in prioritising issues.

**Practice task 1**

1. What term is used to describe a diagnosis of two conditions in a person in an aged care environment?

.....

.....

2. What is the main reason assessments are carried out when a person accesses aged care services?

.....

.....

3. When a person has multiple diagnoses, why does a health team need to assess before prioritising their needs?

.....  
.....

4. Why is the social model of disability important when meeting people's needs?

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.....  
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5. What types of individual preferences should you consider when providing care?

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6. Identify three common health problems associated with ageing, and outline the appropriate response.

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**Click to complete Practice task 1**

# 1B Consult person and colleagues and co-ordinate services and support

Providing services to older people should be done in collaboration with the person, and with others providing support. The person should be integral to all decisions made.

Consultation may be done in person, through letters or email or over the phone. Consultation should be open, clear and specific. Adjust your communication style to meet the person's needs. For instance, if the person has language needs, you may need to speak slower and more clearly. You could also engage visual material.



## Interview to gather information

When gathering information about the issues affecting an older person, sit and talk with them and, where possible, their close family members or carers. If a face-to-face discussion is not possible, a telephone interview is a useful solution.

Some people find assessment stressful. Be courteous, speak clearly and use appropriate interpersonal skills, such as empathy, body language and active listening, to show interest in the person and establish a positive atmosphere. A carer, advocate or family member may need to be present if the person has communication difficulties. Here are points to note about interviewing.

### Conducting interviews

- ▶ Interviewing is different to just having a conversation as it involves asking a person a series of questions to obtain specific information.
- ▶ When interviewing a person, they will feel more comfortable if the tone is conversational.
- ▶ When conducting the interview, you need to know the type of information required from the person and their family members.
- ▶ Most services have a form to complete for gathering information about the person and their needs.
- ▶ The interview will flow more naturally if you can become familiar with what you want to learn about the person.
- ▶ Try not to look at the form too much while talking but take notes as you talk so you record all the required details.
- ▶ Ask questions in a way that steers the conversation or gathers extra information without making the interview feel formal and rigid.
- ▶ The information collected is likely to be more detailed and comprehensive if the person and their family members or carers are relaxed.

## Observe the person

You can gather a lot of information from observing a person in their own environment. Observing a person may tell you about their skills and abilities, their difficulties, their behaviour and memory, their environment and their relationships. It is often very useful to conduct assessment interviews in the person's home, especially if this is where services are to be delivered.



Observations may be informal; such as making observations while you provide support. They may also be formal; such as conducting a formal assessment to identify how a person's needs have changed.

## Consult with older people, advocates, carers and significant others

There are many people you may need to consult with in relation to the needs of an older person. It may be useful to speak with family members, their advocate, carers or significant others. Some older people have an informal carer or carers, perhaps a close family member or friend who sees them on a regular basis and can give an accurate account of their behaviour and preferences. Other older people may have an advocate, a friend or someone assigned to them by an advocate agency, who makes sure the person's best interests and preferences are taken into consideration. Any or all of these people can be included in the assessment process and can offer information that may not be easily obtained from the person.

## Review previous health records

Another useful source of information about an older person's issues and needs is the records of health and support services they have received. Past records may provide information about previously diagnosed conditions, indicating whether the person's condition has changed or if there are any new or recurring issues. These records tell the story of a person's health and support needs and how they have developed and changed over time.



If transcribing health records, make sure you are careful, and accurate. Data such as numerical data about the amount of medication administered must be transcribed accurately. Errors can result in serious problems, such as medical issues or unwanted side effects.

## Requirement for high-level assessment

If the person has multiple diagnoses a full assessment will be required to determine care goals and requirements. A full assessment of complex needs usually requires input from, and assessment by, a number of different professionals including doctors, nurses, physiotherapists, occupational therapists, psychiatrists, psychologists and geriatricians. In some instances you may require the input of many of these health professionals to find out whether a high-level assessment is needed or if you can carry out a routine assessment yourself using relevant tools you are authorised to use.

## When to seek assessments

There are situations that require expertise that you do not have. The person's situation will determine the number and types of professionals that need to be involved with assessing and prioritising support needs.

You may need to seek assessment when:

- ▶ a person has multiple conditions that you believe requires a high-level assessment
- ▶ you may need to know more about a person's needs
- ▶ you may need to find out which needs are higher-priority
- ▶ a person's condition may have worsened and their original diagnosis and assessment are no longer current
- ▶ a person's family may insist that further high-level assessments are carried out.

## Collaborate with others

Here are some ways you can collaborate with others, including your supervisor, your colleagues and health professionals.

### **Liaise**

You may meet with all the professionals and workers involved in the assessment in a single meeting, known as a case meeting or case conference. Alternatively, you may need to meet or talk to each of the professionals individually. Be prepared with appropriate documentation about the person and any questions you need to ask.

### **Ask, clarify, seek feedback**

You may need to ask a specific question about the older person's well-being to clarify your understanding. Together, you and the professional will be able to decide whether a high-level assessment is required.

Always seek feedback if you are unsure whether a person needs further assessment. It is better to be rigorous in your job than be uncertain about a course of action that may have serious consequences.

### **Document issues**

Make sure you document the issues raised, the people who have contributed the information and the action to be taken. List the different assessments that the professionals and supervisors decide need to be carried out.

### **Negotiation**

You may need to negotiate with a health professional to ensure that a high-level assessment is carried out. If you provide them with sufficient background information, they may agree that further assessment is needed.

You may need to negotiate with your supervisors and colleagues to ensure that the person's needs are being met fully.

### **Provide information and reports**

Make sure you collect any initial assessments, progress reports or other documents that may help others decide whether more support is required.

## Identify and explore perceptions and expectations

It may be the case that the person's family want additional assessments to occur. Perhaps you feel that the person's condition has worsened and you believe it would be worthwhile to do further assessments.

## Use relevant tools to assess specific problems

The assessments you perform for a person with specific needs may be carried out in different settings and for different reasons, depending on the type of service you are employed in.

When assessing older people, it is important to use different methods, tools and sources to get a detailed picture of their needs. In addition to the information you receive from health professionals, you may need to use your organisation's purpose-designed assessment tools to assess the older people your service supports. You need to know the tools you can use, in terms of your level of expertise, and the tools that must be used by someone with different or higher qualifications.



## Use assessment tools

Different tools and methods are used to gather information for a comprehensive assessment of a person's needs related to physical, mental or cognitive abilities or states. These tools include specially designed forms for identifying and recording specific information. You may need to conduct interviews, observe a person's behaviour, analyse previous health records or consult with family members, friends or advocates. Some of the main tools are explained below.

### Personal information

Individual services have forms to record essential personal details such as name, address, date of birth and phone number. Other information recorded may include the person's country of birth, preferred language and communication method, emergency contacts and information such as their health care, Department of Veterans' Affairs or private health insurance details. This information forms part of a person's care plan.

### Functional ability assessment form

During the assessment process, ask the person about their current abilities, including their ability to perform domestic and personal hygiene activities, their mobility and/or access to transport, how they manage their finances and their medication. Questions about memory and behaviour are usually not asked directly to the person, but may be asked of a family member, carer or health professional, or assessed by observation. Examples include the Barthel Index and Katz Index of activities of daily living, and your organisation may have specific forms for certain conditions.

## Health assessment questionnaire

Most information about an older person's diagnosed conditions comes from a doctor or other health professional; however, it is often necessary to ask the person questions to assess how these conditions are affecting them. For example, a diagnosis of arthritis tells you their condition, but does not tell you how the condition affects them, whether they are in pain or if they take medication. These forms are written in plain language making it easier for lay people (non-health professionals) to understand the questions.

## Psychosocial needs

You may require information about the formal and informal support people the person has access to. For example, you may need to ask people if they have someone to help them when they feel nervous, are sad, are sick and need to stay in bed, or are lonely. You need to determine if they need help with their daily chores, taking care of themselves or help to maintain their home. You may need to ask other questions to gather information about the older person's personal and social support, level of social isolation and/or family and personal relationships.

## Mental health

A person's mental health and wellbeing are generally assessed by health professionals such as a general practitioner, psychologist or psychiatrist. However, it may be your role to gather information to identify whether a person needs to be referred for a mental health assessment by a health professional. An example is the Kessler psychological distress scale (K10), a ten-item questionnaire that may determine if a referral for a mental health assessment is required.

## Mental status

Health professionals usually conduct mental status examinations. However, many services use a simplified version as a general assessment of a person's cognitive and memory abilities. An example is when an assessor asks the person to remember three items such as a knife, a gate and a balloon. The assessor may then ask the person to perform a cognitive task such as counting backwards from 100 by sevens. Once this task has been completed, the person is asked to recall the three items. These types of tests are then scored to indicate whether or not the person has cognitive or memory problems.

## Seek advice when analysing and interpreting data

Once all of the assessment information has been collated, the next step is to analyse and interpret it. This means looking at the information, identifying themes or issues and interpreting what they mean in terms of the person's support or care. This information is then translated into a plan to deliver the support and services needed to address the issues identified. This is called a service delivery plan or care plan.

If you require clarification on any form of the assessment, such as the numerical data, consult with the person who conducted the assessment, such as the health professional.

## Consult health and other professionals

When interpreting the information you have gathered, you should seek advice from health professionals, who can interpret information in ways that you are not able to; for example, by identifying patterns or themes in information according to their area of expertise.

A carer can provide assistance to interpret information about the person's skills and abilities in doing daily tasks. However, when assessing older people with dual or multiple diagnoses, you may need to consult with a variety of specialists beyond the person's professional carer. Who you consult with depends on the information you have gathered and the issues you have identified, as outlined here.

### Occupational and diversional therapists

Diversional therapists specialise in designing activities to stimulate and occupy people. They can provide advice or interpret information about social isolation or about hobbies and interests that engage people socially.

An occupational therapist can interpret data about maintaining independence in activities of daily living.

### Geriatricians and neuropsychologists

A geriatrician can provide specialist advice in relation to interpreting medical information about the ageing process.

Neuropsychologists and behaviour consultants are helpful in interpreting data about acquired brain injury, brain disease and dementia and the behaviours of concern that can result from these conditions.

### Pain and palliative care specialists

A pain specialist is a doctor or nurse who specialises in assisting people to manage chronic (ongoing) pain related to a condition. They advise on chronic pain treatment, medication and related behaviour.

A palliative care specialist can advise on providing care for those with terminal illnesses.

### Speech pathologists and physiotherapists

A speech pathologist is a health professional that assists with problems to do with speech and swallowing difficulties.

A physiotherapist can assist in making decisions about or interpreting data related to mobility or flexibility.

### Psychiatrists and psychologists

Psychiatrists assist in the diagnosis and treatment of mental illness. They interpret information related to mental health issues.

Psychologists specialise in providing advice and treatment of emotional and mental health issues.

### **Dietitians and respiratory technicians**

A dietitian is a health professional who applies knowledge of diet and nutrition to manage, treat or prevent illness.

A respiratory technician is a health professional who specialises in assisting those with illnesses or diseases that affect breathing. They interpret data related to these conditions or advise on equipment to assist with breathing.

### **Aboriginal and Torres Strait Islander health workers**

These workers have specialised knowledge about the needs and culture of people of Aboriginal and Torres Strait Islander background and can advise on social, health and welfare and cultural issues.

### **Drug and alcohol workers**

Drug and alcohol workers specialise in issues dealing with the use and misuse of alcohol and drugs as well as related behaviours.

## **Consult colleagues**

Your colleagues such as your supervisor and other staff providing support should be consulted when preparing and delivering support. Your colleagues may have additional information about the person receiving support. For instance, they may have observed the person tripping in their home. This information is important to the person's overall care.

Situations when you may consult colleagues are outlined here.

### **Team meetings**

- ▶ Regular team meetings will be arranged by your supervisor to ensure that policies and procedures are being carried out, and all staff and client needs are being met. Meetings are a good opportunity to share, and listen to information about the people you support. If you have made a recent observation about a person you support, be sure to raise it at the meeting, if not before for clarification.
- ▶ Team meetings should be collaborative; that is, participants should work together to meet the needs of the individuals.

### **One-on-one meetings**

- ▶ One-on-one meetings with your supervisor or colleagues are useful opportunities for exploring issues in depth. If the issue contains sensitive information, it may be more appropriate to consult your colleague in a private setting.

### **Informal briefings**

- ▶ Discussing the well-being with your colleagues while you work may be an opportunity to share information and knowledge. You must always be respectful of a person, however, and only share information you are entitled to share.

## Communication book

- ▶ Complete an entry in the communication book if you observe any changes, or make an observation about a person you support. Consult the communication book for advice from others.

## Consult the person

The older person you support should be central to all decisions and conversations about their care. Consult with the person informally as you provide care. For instance, ask a person about their day, or about how they are feeling. Record their responses.

Consult the person formally in an interview. This may be necessary for assessment purposes.

Ensure that the person's communication needs are met. If communication barriers exist, provide supports as required.



## Methods to seek advice or make referrals

Sometimes, information in the person's care plan or assessment will exceed your knowledge and skills. The person you support may also require care which goes beyond your abilities and limits of your role. You may need to make a referral to another agency or a health professional.

When making referrals and seeking advice, ensure that confidentiality is maintained. A person's information, such as their address or health records, should only be shared with a third-party if permission is given.

There are a number of different methods you might use to approach or make a referral when seeking the advice or assistance of a specialist. These are outlined here.

### Face-to-face contact

People you consult may be on-site or external to your organisation. You may need to meet the relevant person off-site for a discussion. Consultations may be on a one-on-one basis, or you may invite all of the relevant people to a single case meeting where the information you have gathered is presented and each person can provide their interpretations of the data.

### Phone contact

If a person is not available to meet face-to-face, the discussion can occur over the phone, either individually or as a conference call. To be successful, this method requires that all people involved in the call have a summary or a detailed brief before they can advise or interpret the data.

### Written correspondence

In some instances a specialist may provide interpretation and advice as a written report. For the report to be accurate and relevant, they require a clear explanation of the reason for the assessment and the types of services and support your workplace can provide or arrange.

## Seek advice from appropriate personnel to determine service issues

You may need to consult with others to determine how the service is delivered and whether there are any issues that need to be resolved. If so, you need to identify with the relevant people what needs to be done before the service can be delivered. It may be that your service cannot provide the specific support that is required for the person because of their multiple conditions and you have to refer the person elsewhere.

Consider whether the person will need:

- ▶ a number of support workers rostered throughout the day
- ▶ transport
- ▶ personal care help
- ▶ help to maintain their home
- ▶ mobility aids
- ▶ social activities that meet their cultural needs as well as their diagnosis.

## Ongoing consultation

Ongoing consultation with the person and their significant others is required to ensure they are kept informed about the progress of assessment, evaluation and prioritising. You need to make sure the care plan continues to meet their needs and expectations and continually check the currency and accuracy of the information. The consultation process allows you to take the person's support needs into account when interpreting information and identifying and prioritising complex care needs.



## Care plans

Care plans contain information about the person's health, mobility, eating preferences, religion, traditions, and likes and dislikes. They may also contain information about medication, managing the client's pain and any behavioural and safety issues you need to be aware of.

You should report any changes that you notice in your client's mental or physical state that differ from the information in the care plan.



**Example**

**Consult others**

Ari is a 67-year-old man with multiple sclerosis. He lives alone in his own home. Ari was diagnosed with the condition 25 years ago and has remained fairly independent, needing only minimal supports. Over the last five years, however, his multiple sclerosis has progressed, leaving him reliant on a wheelchair for mobility and requiring significantly more supports to stay at home. Ari has recently been diagnosed with depression related to his increasing dependence and social isolation. Recommended supports for his depression include social day outings. However, Ari's lack of mobility and requirement for a wheelchair make providing this support very difficult.



The coordinator, Sally, is not sure how to resolve Ari's expressed need for social integration with his lack of mobility and reliance on a wheelchair, and so she asks help from the health professionals who assisted with the initial assessment – a diversional therapist and psychologist. Sally calls a meeting, and invites Ari, Ari's primary carer, and the health team. Ari and the team provide information about how the delivery plan can address Ari's need for social integration.

## Practice task 2

1. Identify two different health professionals you could contact to seek advice about a service delivery plan.

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2. Discuss how you could arrange a consultation with one of these health professionals.

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3. Describe a situation that may involve the need to refer to another person for advice.

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4. Describe a situation that would involve the need to interpret numerical data when consulting others.

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**Click to complete Practice task 2**

# 1C Outline and clarify service providers' roles and responsibilities

Once an individualised service plan has been produced, the focus shifts to implementing the plan. A significant part of coordinating the delivery of services described in the service delivery plan is making very sure that everybody involved in the service delivery is clear about their role and their responsibilities. The commencement and continuation of service delivery to the person must be co-ordinated as the delivery of services might involve a number of different service providers. Each service provider must know how to contact the co-ordinator if they do not understand the plan, cannot fulfil their responsibilities or notice a change that must be reported.

You need to communicate regularly with those providing the services, making sure they have all the information and resources they require to meet the goals set out in the plan. It is especially important to provide support to workers, the older person and their carer, both in the initial stages and as an ongoing feature of service delivery.



## Delegate services and care activities to relevant workers

As the coordinator, you need to delegate different parts of the service delivery plan to the appropriate workers; that is, those with the right skills to deliver the service. To delegate effectively, you need to identify the type of skills or activities required, and then identify the appropriate type of worker or service provider. In some cases, this may be a worker or health specialist within your service. At other times, you may need to refer the delivery or service to another provider or purchase the service from another provider. The way you delegate depends on the service you work for. Here are some examples of services that may be required and the relevant service provider you may need to coordinate.

### Meal preparation

- ▶ To develop a person's knowledge of cooking and preparation of meals for diabetics, you may need to arrange for Meals on Wheels or a home support worker.

### Behaviours of concern

- ▶ If you need to address behaviours of concern, a diversional therapist may be engaged to develop and implement appropriate diversional activities for those exhibiting behaviours of concern.

### Daily personal care

- ▶ For an older person who requires daily personal care assistance, you will need to coordinate the services to ensure they are provided by a suitably qualified aged care worker.

## Inform service providers of their roles and responsibilities

How you inform service providers of their roles and responsibilities with respect to the service delivery plan may depend on your workplace procedures, whether the provider/worker is from your workplace or from outside, and what type of role they have.

You might arrange a meeting to discuss the plan face-to-face and arrange times for them to provide the service, or these arrangements can be made by an alternative method, such as email, following an agreed process.

Some providers need to know everyone's role, responsibilities and level of authority while others need only know what they are expected to do. Everyone involved is obliged to provide a reasonable standard of care and respect the rights of people with care or support needs.

Some providers may need a copy of the whole service delivery plan, so they can see how their role fits with other roles. For others, it may only be necessary to provide them with information about their part in the plan.



### Example

#### Co-ordinate service providers

Joel McCallum has high blood pressure, diabetes, arthritis and some memory problems. He also has a hearing impairment. The service delivery plan for Joel involves a number of service providers. The coordinator provides the following information to each of the service providers.

Service provider	Information provided
Personal care worker	Full copy of service delivery plan provided as personal care worker needs to be aware of Mr McCallum's conditions and when other providers are expected.
Home support worker	Information about what cleaning is to be done and when. Also informed about Mr McCallum's memory and hearing problems for communication purposes.
Gardener	Information about what mowing and gardening is to be done and when. Also informed about Mr McCallum's memory and hearing problems for communication purposes.
Volunteer visitor	Provided with information about when to visit and about memory and hearing problems. Needs to know about diabetes in case they have a meal or snack together. Also provided with information about Mr McCallum's interests and social history.
District nurse	Full copy of service delivery plan provided as nurse needs to be aware of all conditions and when other providers are expected.
Podiatrist	Provided with information about when to attend and information about Mr McCallum's health conditions.

## Practice task 3

1. When co-ordinating delivery of services to an older person, what do you need to ensure you have done?

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2. When should a service provider contact the person responsible for co-ordinating service delivery?

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**Click to complete Practice task 3**

# 1D Recognise signs of abuse or neglect and respond in line with organisational guidelines

Abuse is a complex issue. It can be financial, physical, emotional, sexual or failure to provide adequate care for a person's basic physical, social and emotional needs. A person experiencing abuse may show signs of physical or mental anguish or may demonstrate more subtle signs of abuse such as withdrawal and anxiety.

You have a duty of care to the people you are supporting to keep them safe and free from harm. Your duty of care is increased in instances where people are more vulnerable to harm from others due to age or impairment. It is useful to know the factors that may contribute to a person being at risk of abuse or neglect.



## Risk factors

Certain risk factors make a person more vulnerable to abuse or neglect.

People at risk are those who:

- ▶ have a cognitive impairment; for example, dementia
- ▶ live alone
- ▶ have a history of family abuse
- ▶ misuse alcohol and other drugs
- ▶ are stressed or are emotionally unstable
- ▶ have financial issues
- ▶ are relatively powerless; for example, children and older people.

## Causes of abuse

Abuse can be intentional or unintentional. Intentional abuse is when a person deliberately causes harm to the other person by depriving and/or hurting the other person. Unintentional abuse can occur when another person doesn't realise, through ignorance or other reasons, that their behaviour towards the person with care needs is abusive. An example would be when a primary carer hasn't had a break and is caring for someone with very high needs. If there is no one else the carer can call on, they can become very tired and resentful; not realising the impact their behaviour is having. This is still abuse and needs to be reported.

Here are some other causes of abuse.

### Causes of abuse

The primary carer may be stressed at home or at work.

A person may be in debt and may steal from the person.

There is conflict, arguments and fights within the family.

The person is isolated and alone and the abuser thinks no-one will find out if they treat them badly.

A carer may be using drugs or drinking too much alcohol and cannot care for the person properly.

## Neglect

This is when the person with care needs is neglected either through intentional or unintentional acts that result in the person not being provided with basic necessities.

Here is further information about neglect.

### Neglect

- ▶ Not providing enough food or drinks.
- ▶ Not spending time with the person - leaving them alone for prolonged periods.
- ▶ Inadequate provision of clothing or personal items.
- ▶ Unwillingness to allow for adequate medical, dental or personal care.
- ▶ Inappropriate use of medication, for example overdosing a person so they sleep for longer periods of the day.
- ▶ Leaving the person in the same continence aid for the whole day.

### Indicators of neglect

- ▶ Weight loss, dehydration, poor skin quality.
- ▶ Person appears unkempt – same clothing worn every day of the week, loose or baggy clothing, clothing in poor state, hair unwashed, untrimmed nails, poor hygiene.
- ▶ No dentures, hearing aids, mobility aids or glasses.
- ▶ Skin burns from urine being in contact with the skin for prolonged hours.

## Identify abuse and neglect

You and your team will only detect abuse if everyone is aware about abuse and understand how to respond to situations of abuse. This is particularly important when the older person is unable to make decisions regarding their own wellbeing; for example, if they have a form of dementia. Sometimes abuse is obvious and easy to detect, while at other times it may be quite subtle and difficult to prove. Sometimes it occurs when a worker has a momentary lapse of judgment; for example, fails to respect an individual's privacy and dignity or isolates them socially and emotionally.



## Signs of abuse and neglect

Make sure you and your team members are familiar with the signs of abuse and neglect. Changes in behaviour can be a result of other things as well as being an indicator of abuse, so it is important to check your assumptions before coming to the conclusion that the person is in fact being abused.

Here are some indicators of abuse.

### Behaviour changes of person with care needs

- ▶ A person may become withdrawn, depressed, and anxious or display signs of being scared. They become quite ambivalent or non-responsive.
- ▶ You might find the person is becoming disorientated or making contradictory statements. (This of course can be a sign of a range of illnesses, so should be thoroughly assessed before making an assumption that the person is being abused.)

### Behavioural signs from the carer

- ▶ You might encounter situations where the carer makes lots of excuses so you cannot gain access to the person with care needs.
- ▶ The carer might be overly affectionate and flirtatious with the person which might indicate an inappropriate sexual relationship.
- ▶ You might find the carer is giving conflicting accounts of incidents or is hostile towards the person with care needs.

### General indicators

- ▶ Changes in the person's health such as unexplained weight loss, bed sores, poor colouration, sunken eyes and cheeks.
- ▶ Unexplained injuries or continual injuries.
- ▶ Person's personal care needs not being met which can be indicated by dirty hair, dirty clothing, soiled bedding and unclean living conditions.
- ▶ Inappropriate use of medication, such as drugging the person so they sleep for longer periods of the day and night.

## Types of abuse

If identified, the following types of abuse and neglect need to be reported in accordance with organisational guidelines.

### Physical abuse

Physical abuse is when harm is done to the person's body. Examples include:

- ▶ hitting, pushing, and shoving
- ▶ leaving the person in pain
- ▶ leaving a person unattended when they have been incontinent
- ▶ inappropriate restraint; for example, using a seatbelt to stop a person moving, or using drugs to sedate a person
- ▶ not providing enough food or drink
- ▶ sexual abuse, which is unwanted sexual contact.

Signs include:

- ▶ unexplained bruises, marks or swelling, bleeding, broken bone/fractures
- ▶ weight change, especially weight loss
- ▶ malnutrition or dehydration
- ▶ constant infections
- ▶ broken possessions.

Sexual abuse signs include:

- ▶ increasing withdrawal or depression
- ▶ difficulty walking or sitting
- ▶ vaginal/penile bruising, bleeding or discharge
- ▶ pulling away when receiving physical care.

### Financial abuse

Financial abuse is when a person's money is taken from them or used in a way that is not helpful to them. It can include situations where a person with impaired cognitive abilities has given consent without truly understanding what their consent means. This abuse needs to be reported. Examples include:

- ▶ controlling or removing a person's goods or possessions
- ▶ denying a person access to their money
- ▶ forcing a person to change their will (a legal document)
- ▶ enduring power of attorney refuses to provide enough money.

Signs include:

- ▶ inability to pay bills; having insufficient funds to meet everyday expenses
- ▶ unexplained bank withdrawals; unusual signatures on banking documents
- ▶ money spent in ways that are not supportive or beneficial to them
- ▶ becoming increasingly withdrawn and fearful.

## Emotional abuse

This form of abuse is an ongoing intimidating behaviour that is designed to disempower a person. Psychological and emotional abuse can be both verbal and non-verbal. It can include belittling, threats and withdrawal of affection.

Emotional abuse affects a person's feelings and can make them feel afraid or worried about being isolated or hurt. Examples include:

- ▶ bullying, threatening and harassing
- ▶ belittling the older person
- ▶ isolating the person
- ▶ not respecting the person's customs or cultures
- ▶ not listening to or respecting a person's choices.

Signs include:

- ▶ distress, lethargy, confusion and mood swings
- ▶ lack of grooming
- ▶ increasing withdrawal
- ▶ unexplained weight loss or gain, increase in alcohol intake
- ▶ fearfulness, helplessness, withdrawal, reluctance to make decisions.

## Environmental abuse

Environmental abuse is when a person's environment is neglected. This may be their house, unit or accommodation within a family member's home.

Examples include:

- ▶ the person's home is not looked after
- ▶ the person's place of care is neglected
- ▶ the person's environment is isolated.

Signs include:

- ▶ the accommodation is dirty and messy
- ▶ clothes and linen are not cleaned
- ▶ inadequate heating or sanitation
- ▶ poor repair of housing
- ▶ electrical appliances that need repair
- ▶ isolation from physical or social contact.

## Social abuse

This occurs when another person behaves in ways to reduce or restrict a person's social contact with others. It can include stopping a person from being involved in activities with others and/or preventing contact with friends and family, resulting in social isolation.

Signs include:

- ▶ withdrawal and sadness
- ▶ grieving for loss of family and friends
- ▶ low self-esteem and passive behaviour.

## Emotional impacts of abuse

The impact of abuse can be far-reaching and long-lasting. At the time, abuse can cause a person distress. A person may become withdrawn, depressed, and anxious or display signs of being scared. Emotional impacts can remain long after abuse has happened. Some people experience post-traumatic stress, which may result in feelings of anxiety or depression.

Monitor a person's emotional impact to the abuse, and ensure they have the support they require.

## Identify and report abuse

Abuse affects people differently and each person responds to their situation with different behaviours. If anything about an older person makes you question whether they may have been harmed, you must discuss it with your manager as soon as possible. Reporting signs of abuse can prevent further abuse from occurring and/or the abuse escalating.

Abuse is illegal and mandatory reporting of abuse and neglect is a legal requirement. For example, all government-funded residential aged care services must report all incidents or allegations of sexual or serious physical assault. Guidance on identifying and reporting abuse is provided here.

### Identify the abuser

Often the abuser, or person causing the harm, is a worker, relative or close friend. This can cause the victim to have feelings of shame and guilt and that they are to blame. It also means the victim is reluctant to complain or report experiences of abuse as they are dependent on the care or company of the abuser.

If you believe a co-worker is breaking the law or breaching policies and procedures, you have a responsibility to speak to the person and inform your manager.

### Report abuse or neglect

It is crucial that any signs of suspected abuse, distress or other issues of concern regarding a person's treatment and safety are reported immediately. The person may be in danger, need protection by police or need medical treatment.

If a team member reports a situation to you, make sure you collect as much detail as possible. It may be your responsibility to take action or to report the matter to your manager. Your manager may ask you to follow the situation up by reporting to an external agency such as the police or state protection authority.

### The Aged Care Act 1997 (Cth)

Under the *Aged Care Act 1997 (Cth)* workers in aged care are required to report sexual abuse of residents. Remember also that abuse is illegal and therefore the person can be encouraged to report issues of sexual and physical abuse directly to the police.

The *Aged Care Act 1997 (Cth)* states that:

"... if the approved provider receives an allegation of, or starts to suspect on reasonable grounds; a reportable assault, the approved provider is responsible for reporting the allegation or suspicion as soon as reasonably practicable, and in any case within 24 hours to ..." (Section 63-1AA).

### Immediate reporting required

Situations that require immediate reporting in accordance with an organisation's guidelines:

- ▶ You observe someone behaving towards a person in a way that makes you feel uncomfortable.
- ▶ A person shows a sustained change in behaviour or mood.
- ▶ A person tells you they are being abused or harmed by another person.
- ▶ A person, staff member or visitor tells you they have observed abusive acts.
- ▶ You observe an action or inaction that may be considered abusive.
- ▶ Someone is not responding to the financial or medical needs of a person.
- ▶ You have clear evidence an abusive situation is occurring.

## Report processes

To report abuse you must follow your organisation's procedures, and all staff need to be aware of the compulsory reporting requirements for allegations or suspicions about abuse. Report and respond only to those signs for which you have witnesses or evidence. Look for signs that show that this is what has really occurred. Remember that this can be difficult when the person has memory problems or is confused, but do not disregard this information or assume concerns are just a result of their condition.

Here is what service providers must do to report instances of abuse. It may be your role to carry out some of these tasks.

### Make reports

- ▶ Report abuse to the relevant people, such as your supervisor or senior manager who may be required to report the matter to the relevant agency in your state or territory.
- ▶ Report the situation, when advised by your manager, to the Commonwealth Aged Care Advocacy Service, the Aged Care Complaints Investigation Scheme, the State Guardianship and Administration Board, or the ombudsman.

### Document details

- ▶ You may speak to your manager or supervisor verbally, but you must also document the report. Provide details in progress notes or case notes and fill out an incident report form with what you saw (the signs), when you saw it, what you did, the older person's response and follow-up action taken.

### Discuss with the older person

- ▶ Provide people you are supporting with an opportunity to talk about what is happening with them and inform them about services to assist them. You may be the only person available for some people to speak to; you may need to prompt discussion by gently raising your concerns with them.

### Keep records and maintain confidentiality

- ▶ Keep records of all incidents involving allegations or suspicions of reportable abuse.
- ▶ Ensure these staff members are protected from victimisation by keeping their identity confidential.

## Follow policies and procedures when reporting

Organisational policies and procedures relating to reporting abuse are aimed at protecting the older person from any further abuse. They comply with the *Aged Care Act 1997* (Cth), that requires that abuse, or suspicions of abuse that are well grounded and take place in a residential aged care setting, be reported as soon as practicable within 24 hours to the police and Department of Social Services.

Verbally report abuse to your supervisor and then document your report.

The information you need to provide may be recorded in case, continuation or file notes and in an incident report form. Here is an example of what to include in a report.

### Objective report

- ▶ What you saw (for example, the size, location and type of bruising)
- ▶ When you saw it (date, time, day)
- ▶ What you did (for example, removed the person from the situation)
- ▶ What you said (for example, explained to the person that you had to report the incident)
- ▶ The person's response (what they said or did)
- ▶ Follow-up action to be taken

### Example

#### Recognise and respond to signs of abuse

Bee is providing care to Michael, who lives at home. Michael is 70, and has Parkinson's disease. His condition has worsened in recent months.

Several days later when Bee visits again, she passes Michael's son, Rex, who is leaving Michael's house. Bee has heard of Rex, but has never met him. Rex seems very agitated. Bee finds Michael shaking more than usual. He seems very distressed. Bee asks if his distress is related to Rex's visit, but Michael doesn't say anything.

Several days later, Bee gets a call from police. She says that Michael's house was broken into at night, and all her valuables were stolen. They suspected that the crime was committed by someone Michael knows, as there was little destruction and the thief obviously knew where things were kept. Bee talks to Michael about how he is feeling. Michael is understandably very shaken. He says that it was Rex and his friends, and that he can't do anything to stop him ruining his life.

Bee talks to her supervisor about how to support Michael. She also makes a report to the police about her conversation with Michael. She writes a report about the incident for the organisation's records.



# Practice task 4

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

## Case study

Ron lives in residential care. He is 89. Ron has dementia and an ABI, so his short-term memory is poor. Ron struggles to remember details about the previous day or weeks. His long-term memory is stronger.

When Jackie, one of the carers, visits Ron one morning, she notices a deep scratch on his arm and a bruise on his cheek. When she asks Ron, he can't recall the details. There is no evidence in his room that he has fallen. Jackie makes a note about the incident, and decides to keep an eye on Ron.

The next day, Ron appears particularly distressed and confused. Again, he can't remember any details, but he said he thinks 'someone' was in his room at night.

Jackie asks around, but none of the night staff heard anything unusual.

The next day, Ron has a second bruise on his cheek. His room appears dishevelled.

1. What are the indications of abuse?

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2. What type of abuse might be indicated?

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3. What are some of the emotional impacts of the abuse?

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4. How should Jackie manage issues around the abuse according to organisational standards and policies?

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**Click to complete Practice task 4**

## Summary

1. Learn to recognise an older person's needs, goals and preferences. These will correspond with their individualised care plan. Know how to prioritise needs, goals and preferences, particularly if there are complex needs.
2. The social model of disability should underpin the care you provide. This is also a person-centred approach.
3. Assessment can be used to identify needs. Assessment often requires the input and advice of a health professional. In some cases, a high-level assessment is required.
4. In addition to the advice of health professionals, different assessment methods, tools and sources can be used to provide a picture of the older person's needs. Be aware of the limitations of your role and expertise.
5. Consult health professionals, your colleagues and the person being supported to obtain an integrated perspective on the person's needs and the support that needs to be provided.
6. Coordinate the service delivery by ensuring that all staff members are aware of their roles and responsibilities.
7. Be aware of the different types of abuse (physical, emotional, financial, neglect) and the signs to watch for. Follow workplace procedures to report any signs of abuse immediately to prevent further abuse from occurring and/or the abuse escalating.

# Learning checkpoint 1

## Coordinate the delivery of the individualised plan

This learning checkpoint allows you to review your skills and knowledge in coordinating the delivery of the individualised plan.

### Part A

1. How can you identify and prioritise a person's needs, goals and preferences according to the social model of disability?

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2. Identify two common health problems associated with ageing, and discuss how you could identify the needs, goals and preferences, and make priorities.

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3. Focus on one need associated with ageing, and identify the appropriate action in response to this action.

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- 4. Identify one health need associated with ageing, and discuss the relevant health professional you could consult and refer to. Discuss how you could consult and collaborate with this person.

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- 5. Identify how you could clarify the roles and responsibilities of one service provider who is meeting the needs of an older person.

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- 6. Discuss why accuracy is important when consulting others, particularly in relation to numerical data.

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## Part B

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

### Case study

Tori is a support worker, who visits older people in their homes. Tori has been assigned a new case. She visits Kelly Rose in her home. Kelly is 78. She has dementia. She lives with her son, Paul, who is a musician. Paul has been responsible for Kelly's care needs since she was diagnosed with dementia three years ago. Kelly has no other living family.

When Tori arrives, she notices Kelly's house is very untidy. Dirty dishes line the sink. The toilet and bathroom are very grimy. Kelly appears disorientated when Tori arrives. She doesn't understand who Tori is, and has forgotten about the assessment that took place two weeks ago.

Kelly has a strong body odour. Her hair is greasy. Tori guesses she has not had a shower in a while.

Tori asks Kelly where her son is. Kelly says he's just gone to the shops for milk. Tori decides to wait until Paul gets back so she can have a chat to him about Kelly's daily living activities and how to improve Kelly's life so she can live independently.

Paul doesn't come back. An hour passes. Tori tries to call the number Kelly gives her, but it is disconnected. She asks a neighbour if they have seen Paul, and they said they haven't seen him in weeks. Tori is concerned that Paul is not actually living with his mother at the moment, and that Kelly has been left alone.

1. Identify the indication of elder abuse or neglect.

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2. What are the possible impacts of this abuse or neglect?

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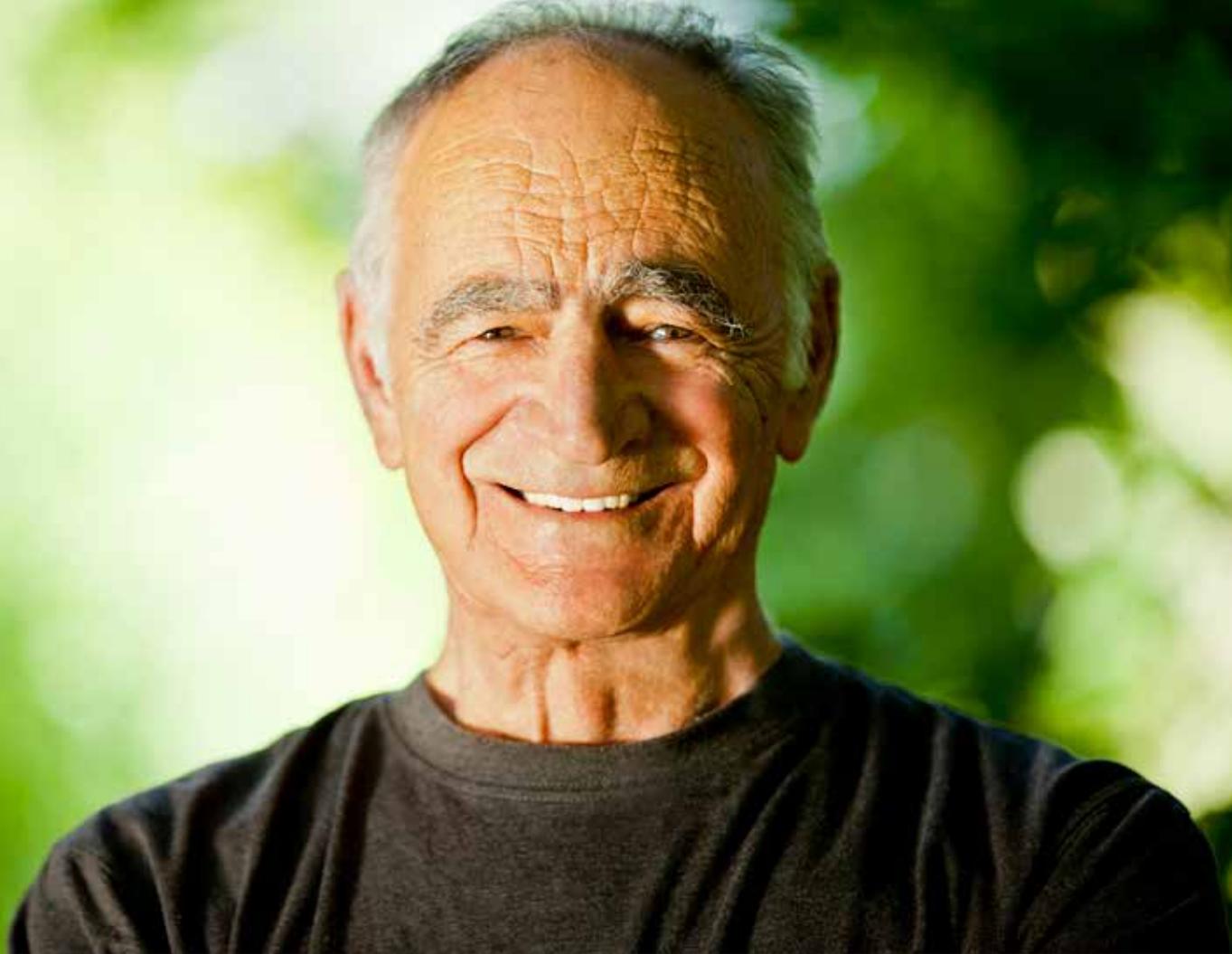
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3. What is the appropriate management of this abuse or neglect according to organisational policies and procedures?

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## Topic 2

In this topic you will learn how to:

- 2A Support the older person to access and negotiate resources**

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- 2B Support the older person to access community support agencies to achieve established goals**

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- 2C Recognise when the level of service required is no longer provided and take action**

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## Liaise and negotiate with appropriate personnel and service providers

Consultation and negotiation is critical when delivering care to older people. Services provided should be integrated, and meet the range of needs. Your service alone may not be equipped to provide the care the person requires, and so other services should be engaged.

Open and clear communication between all parties will ensure that appropriate support is provided, and errors are minimised.

The older person should be central to all negotiations and decisions.

## 2A Support the older person to access and negotiate resources

Your organisation will meet some of the older person's needs, but not all. Additional resources may be required. Resources may be human, physical or information. Human resources include advice from health professionals, the caseworker or drug and alcohol counsellors. Physical resources include aids, such as mobility equipment. Information resources may relate to a person's health and wellbeing.

Where possible, the person should be supported to access resources themselves. This is empowering, and person-centred.



### Identify resources

Identify the resources required to achieve the person's goals set out in their individualised plan. Investigate all the options available to deliver the services and think creatively if services are not directly available to meet a need. Consider the older person's preferences, cultural needs and financial position when identifying the required resources.

The types of resources you may look at when planning service delivery include financial resources, aids and equipment and qualified care specialists, which are discussed below.

#### Financial resources

Many of the support services provided for older people are funded by the Australian or state and territory governments. Often these services charge an additional service fee, which is usually small and can be adjusted to the older person's financial status. Non-government-funded services must be paid for in full by the older person or their family. In these instances, service costs must be fully explained before planning to deliver a particular service and the older person's ability to pay for the service considered.

#### Aids and equipment

When considering the resources required to provide support to an older person, it is important to consider whether there is an aid or a piece of equipment that may help the older person to be more independent, rather than providing a service that performs the task for the older person. The service coordinator must ensure the older person is provided with the correct aids and equipment to support them. There are a number of programs that provide financial assistance for the purchase or hire of equipment.

### Health specialists

Sometimes a health specialist is needed to provide a service that meets a goal. For example, you may need to consult with a dietitian to assist in developing a diet suitable for managing a person's diabetes and an occupational therapist to help with their activities of daily living. Where the goal is to consult with a health specialist for treatment, equipment or planning for the future, the plan should identify who the specialist is, their contact details and the expected outcome of the consultation. This facilitates approval for accessing the specialist.

### Advocacy and legal support

If the person you support requires legal advice or representation, or needs someone to represent their rights, or act on their behalf, you may need to support the person to access advocacy or legal support. Ensure the agent you engage is appropriate for the older person. Consider language needs, intellectual needs and cultural needs. For instance, some people may prefer to be represented by someone from their culture and gender. The support you engage should be fully qualified and accredited.

### Translating and interpreting services

People with communication needs, such as language needs, may require translating or interpreting services. These services can help a person read and understand documents, complete forms and communicate in meetings.

Services you engage should be appropriate for the person. For example, some people are more comfortable with a translator who is the same gender. The service should also be accredited and professional. Access the Translating and Interpreting National Service for accredited professionals at: <http://aspirelr.link/tis-national>

## Support the older person to access resources

Once the need for resources, and the appropriate resources have been identified, provide the person with support to access those resources.

For internal resources within your organisation, such as information about your organisation's complaint procedures, provide the older person with the required information.

For external resources, you may need to provide the person with a phone number, email or website address. Depending on the older person's capabilities, you may be able to phone the external organisation or agency on their behalf.

If resources are written, make sure communication barriers, such as language barriers, are addressed. Text may need to be translated, or presented in large font. If resources are verbal, you may need to assist with communication aids, such as accessing a translation service.

Consider the following when supporting a person to access resources.

### Considerations when accessing resources

What is the cost of the resource, and can the person afford this cost?

Are there any specific communication needs, such as translation, and how will you meet these needs?

Where is this resource located? Can the older person access this location?

How will this resource impact the person?

Will this resource meet the older person's needs?

## Support the older person to negotiate resources

Support the older person to access and negotiate resources. Negotiation may be required if, for example, there is a cost issue. The person may not have the funding to access the resource, and so needs to negotiate how to pay. This may require you accessing further resources; in this case, financial aid or advice.

Due to communication barriers, the older person may not be able to negotiate the resource themselves. The provider or the resource may take advantage of the older person. Support the older person to negotiate their rights, and ensure they have the means to communicate.



### Example

#### Access and negotiate resources

The financial circumstances and goals of a person need to be considered when supporting them to access and negotiate resources.

#### Mrs Mahoney

Mrs Mahoney is on an aged pension. She owns her unit but has no other income or assets. She has been assessed and one goal of her service delivery plan is to move into residential care. Mrs Mahoney's financial situation must be considered when deciding which type of residential facility is suitable. She needs to avoid paying a large regular fee. She is more likely to be able to manage the cost of a facility that requires a large up-front payment (which she could pay from the sale of her unit) and then charges only a percentage of the pension as a regular fee.

#### Harry

Juan has assessed Harry and identified that he is unable to shower independently, as he is quite shaky and often feels off-balance. A goal of Harry's service delivery plan is to make sure he is showered three times a week. Juan looks at the option of having a worker attend the house three times a week to help Harry. Juan also considers providing Harry with a shower chair and having grab rails put in the shower and bathroom, which means Harry could sit during his shower and have rails to hold when getting in and out. The second option provides Harry with more independence and is less costly.

## Practice task 5

1. Why might a person require additional resources?

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2. Identify two different resources a person may require.

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3. How can you support older people to access resources?

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4. Why may you need to support the person to negotiate resources?

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[Click to complete Practice task 5](#)

## 2B Support the older person to access community support agencies to achieve established goals

To reach their goals, an older person may require support from a community services agency. Community service agencies are government or community funded organisations, which support different areas of a person's life. Agencies such as those provided by the Salvation Army, or the state government, generally take a person-centred approach to meet a person's needs and goals.



If the person is not already being supported by a community support agency, identify an appropriate service, and support the older person to make access.

### Access community support agencies

Many agencies and organisations receive funding from governments to provide support to older people and their carers living in the community. The range of agencies providing assistance is listed here.

#### Agencies providing assistance

- ▶ Day programs; for example, activities conducted in specific day care centres.
- ▶ Personal care, such as community aged care packages that provide assistance with bathing, dressing, grooming, toileting, mobility and eating.
- ▶ Home care, including local home and community care services offering assistance with domestic cleaning, shopping and laundry.
- ▶ Delivered meals and centre-based meals that offer a nutritious, appetising and culturally appropriate main meal.
- ▶ Home maintenance; for example, providing assistance with minor repairs to the person's home or garden to ensure safety.
- ▶ Respite services that give carers a break from their responsibilities during the day or overnight.
- ▶ Professional nursing, including district nursing services that provide clinical care, assessment, education and information.
- ▶ Allied health, which can include additional services such as podiatry, physiotherapy, occupational therapy, dietetics and counselling.
- ▶ Case management, which provides a professional to assist with planning, sourcing and coordinating the services and supports.
- ▶ Transport; for example, providing taxis, courtesy buses or volunteers to take people to activity centres, shopping or appointments.

## Service eligibility criteria

Each agency has particular target groups that identify the types of people they support, such as people over 65 years of age, people with memory support needs, or the carers of older people. They will have expertise in providing support in this area. Agencies also have other eligibility criteria; for example, the person may need to live in a certain region or area or they may have high-care needs.



Access to community services is usually through direct referral. Many services have referral forms that must be completed and, in some jurisdictions, all community services must agree to use the same referral form. In other cases, forms are to be completed electronically on a secure network. For some services, especially those related to a government-funded community aged care package, it is necessary to have an assessment of eligibility from a service such as the aged care assessment team.

## Access a service

Accessing a service can take time and effort. You may need to complete forms, contact a number of agencies and arrange meetings. You may also need to support the person to access the service by ensuring communication needs are met.

Be prepared with a list of agencies and their contact details and know who you need to contact. It is useful to develop a network of people to help and advise you.

To suggest and obtain the best service, you need to:

- ▶ be familiar with the range of community support agencies
- ▶ understand the criteria they have for accepting people
- ▶ know how to refer an older person to the service
- ▶ know what the service will cost the older person.

## Home support program

Many Australians receive home support. These services allow people to be independent and continue to live in their own homes. From November 2015, the Commonwealth Government implemented a new service delivery model. The Commonwealth Home Support Programme aims to provide a source of support to a large number of frail, older people to enable them to live independently for longer. Older people needing more assistance can apply for support through the home care package program or subsidised residential aged care.

The Commonwealth Home Support Programme provides a streamlined source of support that includes access to the following programs:

- ▶ Commonwealth Home and Community Care Program (HACC)
- ▶ National Respite for carers program (NRCP)
- ▶ Day Therapy Centres (DTC) Program
- ▶ Assistance with Care and Housing for the Aged (ACHA) program

## Sub programs of home support

The Commonwealth Home Support Programme has four sub programs. Here is more information about the programs.

<b>Community and home support</b>	<b>Care relationships and carers support</b>
Aims to provide entry level support to frail, older people to remain living at home.	Aims to maintain the carer relationship through provision of respite to give the primary carer a break.
<b>Assistance with care and housing</b>	<b>Service system development</b>
Aims to support vulnerable people to remain living in the community through accessing accommodation and support services.	Aims to support and develop the aged care service system to keep people living in the community for as long as possible.

### Community and home support

This program targets frail older people aged 65 years and over (or 50 years and over for Aboriginal and Torres Strait Islander peoples) who need assistance with daily living to remain living independently.

Types of services offered under this program include:

- ▶ meals
- ▶ other food services
- ▶ transport
- ▶ domestic assistance
- ▶ personal care
- ▶ home maintenance
- ▶ home modifications
- ▶ social support – individually focused
- ▶ social support – group based
- ▶ nursing
- ▶ allied health and therapy services
- ▶ goods, equipment and assistive technologies.

### Care relationships and carer support

The target group for this program is primary carers. The aim is to maintain the care relationship between the primary carer and the person with care needs. By providing this support, people are empowered to remain living in the community rather than prematurely moving into an aged care accommodation setting.

Here are the types of services offered.



#### Flexible respite

Includes in-home day respite; in-home overnight respite, individual community access; host family day respite; mobile respite and other planned respite.



### Centre-based respite

Day respite; residential day respite and community access group respite.



### Cottage respite

Overnight community-based respite.

## Assistance with care and housing

The target group for this program are people aged 50 years and over who are on low income and either homeless or at risk of homelessness. The program assists people through:

- ▶ providing streamlined access to support services
- ▶ standardised assessment processes
- ▶ focus on restorative approach
- ▶ promoting equity and sustainability
- ▶ reducing red tape for service providers.



You can read more about the Commonwealth Home Support Programme and assistance with care and housing at the following site:

- ▶ <http://aspirelr.link/chsp-assistance>

### Example

#### Support access to community support services

Susan has developed a service delivery plan to address the needs of Mrs Jenny O'Neill who wishes to remain in her current living situation. Mrs O'Neill is cared for by her daughter, Philippa, in Philippa's family home.

As part of the plan, Philippa's need to have regular respite is to be addressed by referral to the local planned activity group, which is part of a home and community care program run through a regional provider.

An additional respite goal is for Mrs O'Neill to stay in an aged care home for two weeks, three to four times a year so Philippa can have a longer break.

In order to access residential respite in a funded aged care home, Mrs O'Neill must be assessed as eligible by the aged care assessment team. Susan calls the local Aged Care Assessment Team (ACAT) to make a referral for Mrs O'Neill to be assessed.



## Practice task 6

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

### Case study

Manik supports Alice, who lives independently in the community. Alice is 90. She has macular degeneration, which affects her vision. This means she can no longer drive. The village shops are a 30 minute walk away from Alice. In her condition, a walk of this distance is too far.

1. Research relevant community support services in your area that Alice could access. Provide the name and contact details.

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2. How can Manik support Alice to access this agency?

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[Click to complete Practice task 6](#)

## 2C Recognise when the level of service required is no longer provided and take action

In the early stages of implementing the service plan, service delivery and the performance of workers should be carefully monitored. Monitoring service delivery closely means you can identify situations where a worker or service provider is unable to provide the required service. For example, it is possible the initial assessment may not have identified the level of assistance required for some tasks.

Once a worker commences delivering a service, they may find the older person requires more assistance than indicated in the service delivery plan or the assistance may need to be provided by a worker with higher level skills or qualifications. The other reason services may no longer provide the support required is if the older person's needs change. Changes may be due to physical, mental, emotional, or social changes, or may be related to the person's environment.



### Monitor service plan delivery

Identify situations where services need to be amended or changed. Changes should be made quickly so services can be adjusted to meet the older person's needs. These situations can also occur at later stages in the delivery of services. The person's needs or environment may change. The worker, or the worker's abilities may change. Assessment information and service delivery plans should be reviewed regularly throughout the life of the plan to keep abreast of changes.

There are a number of signs you can watch for that may indicate inadequacy of the service. Investigate the signs to work out how to address the change.

Signs that may indicate a service is not adequate include:

- ▶ complaints from the older person, their carer or their advocate
- ▶ feedback from the worker providing the service
- ▶ the older person looking unkempt or unwell
- ▶ the older person's home being poorly maintained
- ▶ indications in the communication book, progress or care notes.

### Take action to minimise disruption to service delivery

Address changes as quickly as possible to minimise disruption to the service. The action you take will depend on the scenario, but in general, report changes or indications that the service is not providing adequate support. Reports should be made to your supervisor. If necessary, consult others who can help address the service delivery. You may consider calling a team meeting, involving the older person, their carer or advocate and any relevant health professionals. All consultation should take the older person's needs into consideration, and all decisions should involve the older person.

Below is a list of possible actions you could take if you observe that the service is not providing adequate support.

- Actions to take if a service does not provide adequate support**
- ▶ Consult with your supervisor, person’s family, carer or advocate and relevant professionals, such as the doctor, psychiatrist or physiotherapist.
  - ▶ Consult the older person about changes that have occurred, and changes that need to be made.
  - ▶ Clarify the issue and cause of issue.
  - ▶ Identify options for making changes.
  - ▶ Discuss how changes can be made with minimal disruption to service.
  - ▶ Review the individualised goals in the support plan.
  - ▶ Review the individualised support plan.
  - ▶ Consult the older person and team about making the changes.

**Example** **Identify inadequacies in the service and take action**

Assessment information about Mrs Hemmerling was gathered at an interview with her and her son before she moved into an aged care home. At assessment, Mrs Hemmerling indicated that as long as there was a shower chair available, she could shower independently. The resulting service delivery plan indicated that the shower chair was required.

Since moving into the care home, Mrs Hemmerling has slipped in the shower twice and pressed her emergency call bell frequently because she has felt nervous and unstable.

The coordinator, Anja, re-assesses Mrs Hemmerling’s needs and finds that a shower chair is not enough to meet her needs. The service delivery plan is amended to indicate the need for a worker to assist Mrs Hemmerling with showering each morning.



## Practice task 7

1. Think of three reasons why the service delivery plan may not be providing the right level of service.

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2. Explain four things you can do to address the issue with minimal disruption to the service.

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**Click to complete Practice task 7**

## Summary

1. Older people may need to access internal or external resources, such as financial support, legal support or advocacy. Support older people to access resources.
2. Support the older person to negotiate cost and access to resources. Empower the older person to direct their own access.
3. Community support agencies provide additional support, such as advocacy, legal representation, transport and activities. Support the older person to access agencies which help them achieve their goals.
4. Changes in service delivery, changes in a person's needs or inadequacy of service may mean a person is not receiving appropriate support.
5. Recognise inadequacies, and take action to minimise disruption to the service.
6. Consult with the older person, their carer, advocate, family and professionals to address the inadequacies in the service delivery plan, and make changes.

## Learning checkpoint 2

# Liaise and negotiate with appropriate personnel and service providers

This learning checkpoint allows you to review your skills and knowledge in liaising and negotiating with appropriate personnel and service providers.

### Part A

1. Give one example of how you can support a person to access resources.

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2. Why might you need to support a person to negotiate resources?

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3. Identify three different relevant community support services that could be accessed in your local area by older people.

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4. How can accessing community support resources help a person reach their goals?

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5. What indications might suggest that a service is no longer providing the support that is required?

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## Part B

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

### Case study

Danny lives in the community. He has a serious back injury and is in chronic pain. In recent months, Danny's mood has been increasingly irritable. He spends most of the time alone. Danny can't drive, which is very isolating.

Danny is quite a spiritual person, but has not been to church for many years, as his back causes him too much pain, sitting in the pews during the service. He also feels like he is a burden on his church community.

1. What community support services could you suggest for Danny?

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2. How could you help Danny access these services?

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3. What could you do if these services no longer meet Danny's needs?

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## Topic 3

In this topic you will learn how to:

**3A Recognise the impact of support issues on the carer/s and families and refer appropriately**

**3B Provide support and respite for carer/s**

## Support family and carers

The role of carers in Australian society will become more important as our population ages and the number of older people requiring care and support increases; government funding can only meet a small proportion of this need.

A primary carer is usually a family member, friend or neighbour who provides informal assistance to the older person, without payment. Often, this assistance allows the older person to remain living in the community.

While many carers choose to care for a loved one, others may provide care out of a sense of duty. Some carers may have no choice as they have nowhere else for the older person to go and no one else to help with the care.

You need to understand the role of the carer and the effects of caring on them. Providing carers with support and regular respite is critical to assisting them to continue in the role.

# 3A Recognise the impact of support issues on the carer/s and families and refer appropriately

Providing unpaid care or support can be taxing. Full-time carers are often exhausted, and have little time for their own needs and commitments. Part-time carers may struggle to find the balance between providing support and their own commitments.

Resources like time and energy become scarce. If carers are unable to work, financial stress may also be present.

Be alert for indications that suggest a carer or family member is struggling. If they are struggling, their own needs can be compromised along with the needs of the older person. You may need to provide additional support by referring the carer or family member to a professional.



## The impact of complex care issues on carers

A person's care needs may impact the primary carers and the people who support them.

While being a carer can be very worthwhile, it can also be very stressful. It can have an impact on every area of the carer's life, including their own family life, social activities, health and finances. It can be exhausting and is often a 24 hour, 7 day a week job.

Being a carer can affect:

- ▶ the relationships that a carer has with their own spouse or partner, children, other family members and their employment
- ▶ the time and energy they have to devote to their own personal lives
- ▶ their health, particularly if a carer loses sleep or worries about the older person
- ▶ their physical health; for example, if the role involves heavy physical tasks such as lifting or moving the client or doing home maintenance
- ▶ social contact and activities; for example, if the nature of the older person's condition makes it difficult for a carer to have visitors at home
- ▶ their financial situation; sometimes carers have to cut their working hours to provide care or they need to pay for treatments.

## Meet the needs of primary carers

If the burden on a carer becomes too great, they may become too unwell to maintain their caring role or they may decide to cease their caring role. The result is that the older person needs more funding to stay at home, or they may need to move into residential care.

When assessing the older person, identify and prioritise the carer's needs. Wherever possible, plan services and supports to meet the needs of both the older person and their carer. For example, you could arrange for transport for a person you are supporting to attend an appointment, which would also give the carer some time to themselves.



## Recognise the need for additional support

There are a number of indications that the carer or family member may be struggling to provide adequate care, or struggling to meet their own needs.

Be aware of the following indications.

### Indications that a carer is struggling

- ▶ The carer appears tired and exhausted.
- ▶ The carer tells you they are struggling.
- ▶ The carer is making errors or forgets things.
- ▶ The carer is short-tempered with the person they support.
- ▶ The carer appears unhappy or depressed.
- ▶ The carer has little time for their own needs.
- ▶ The carer's personal relationships or work are suffering.

## Make a referral

If you recognise that a carer or family member is struggling, provide appropriate support. This may be offering to help with the support role, or reviewing the individualised care plan with the carer's own needs in mind.

You may need to make a referral for the carer or family member. You may also need to refer the older person for additional support, to relieve pressure on the carer.

Referrals may be made by phone or in writing. Ideally, put the person in touch with the service, so they can access the support themselves.

When making a referral, maintain the carer and the older person's confidentiality. Only share information you have permission to share. Ensure the carer and the older person have access to the services you are referring to. For instance, ensure they can meet the financial cost.

Here are some places and people you may refer to.

### Refer carer

You may refer the carer to:

- ▶ a GP for physical, mental or emotional support
- ▶ a counsellor for emotional support
- ▶ financial counsellor for financial support
- ▶ employment agency for advice about how employment can work around care
- ▶ respite agencies
- ▶ housework agencies
- ▶ food delivery services.

### Refer person you are supporting

To provide additional support to the carer, the person being supported may require additional support. You may make a referral to:

- ▶ a GP for medical advice
- ▶ a counsellor for emotional support
- ▶ community support agencies.

### Example

#### Recognise the impact of support issues on the carer/s and families and refer appropriately

Linda is the primary carer for her mother Holly. Holly is 91, and has Alzheimer's. Linda is married with three children and works part time. She used to work full time, but when her mother's needs increased, Linda cut back to look after her mother.

Linda visits her mother daily. She helps dress her, and prepare her meals for the day. She helps Holly with her daily schedule, and reminds her of any appointments or activities she has planned. If Holly has a doctor's appointment, Linda accompanies her to the clinic.

Holly hasn't got many friends anymore. She is often lonely and relies heavily on Linda both physically and emotionally. After several years of caring for her mother, Linda starts to experience exhaustion and signs of depression. She has little time for her own family, or interests. She sometimes feels resentful towards her mother, but does not complain, as she regards it as her duty to provide support.

Tamara, Holly's case worker, notices that Linda is struggling. She calls Linda in for a chat, and suggests that she might need some time out to look after her own needs. Tamara suggests putting Linda in touch with a respite service that may be able to address Holly's needs some of the time, so Linda can have a break.



# Practice task 8

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

## Case study

Dave has three children. He works as a contract builder. In 1996, Dave’s father Jack had a serious fall at work, which left him with a chronic back injury. Jack was unable to work, and cannot leave the house without assistance. He cannot drive, has difficulty walking, and is in constant pain. His pension isn’t enough to cover full-time support.

Dave has been caring for Jack since his accident. He visits Jack most days, bringing him what he needs. On weekends, he takes Jack out to the football. He also takes Jack to most of his appointments.

Last year, Dave’s marriage broke down. Dave thinks a lot of his relationship problems related to the lack of time and energy he had for his own family. Dave’s ex-wife Sandra was resentful towards Jack and the way he treated Dave. She thought Jack took advantage of Dave’s kindness, and was unappreciative.

Dave is less patient with his dad since the marriage breakdown. He is irritable and depressed and has been drinking more in the evenings, and sleeping poorly. He has forgotten a couple of Jack’s appointments, and his work life is also suffering.

1. How has caring for Jack impacted Dave’s life?

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2. What indications suggest Dave is struggling?

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3. What referral could be made for Dave, and how?

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**Click to complete Practice task 8**

# 3B Provide support and respite for carer/s

Respite is a means of giving carers a short-term break from their caring role. What constitutes respite for one carer may be different for other carers. For some people, being able to have a day or a few days away from home and their caring role may be a good break. For others, being able to stay at home while the person in their care goes away for a few days may be the ideal respite. For most carers, having a respite plan that ensures they get a variety of respite and support including regular planned breaks is the best way to support them.

There are many different types of respite. Respite is generally divided into two categories: direct and indirect, explained here.

## Direct respite

Direct respite means providing a service that allows the carer a break from the caring role. A service provider takes over the caring role temporarily. Some examples of direct respite care include the following:

- ▶ In-home: An aged care worker attends the home of the older person and provides care, support and companionship for a time.
- ▶ Community or outing-based: The older person takes part in community activities either with a worker, or as part of a group.
- ▶ Day centre: While day centres are run to provide stimulating activities and socialisation for older people, they also provide respite for carers.
- ▶ Holiday: Some service providers arrange to take small groups of older people away for a short holiday break, giving carers relief from the role.
- ▶ Residential respite: Some older people have regular stays in an aged care home for one or more weeks to give the carer a longer break.

## Indirect respite

Indirect respite means providing support to the primary carer by assisting with tasks they do as part of the caring role. The carer maintains their caring role but receives some support to make the role a little easier. Some examples of indirect respite include the following:

- ▶ Education, information and training about issues to do with caring that make a carer's role easier. For example, assisting a carer to understand more about the condition the older person has and lessons in caring techniques.
- ▶ Equipment that makes a particular part of the caring role easier can be a type of indirect respite. Examples include hoists for lifting, Hi-Lo beds, incontinence aids and shower and toilet chairs.
- ▶ Assisting with household tasks can make the caring role easier and less stressful.

**Example**

**Provide support and respite for carer/s**

Kate is a consultant who works with respite service providers to assist them to improve and grow the services they offer to primary carers. She often trains workers in carer-friendly practices to highlight the burden of caring, the needs of carers and the impact carers have in the community and on the economy. Kate says:

‘Many carers have difficulty identifying with the term ‘carer’. They feel that as a husband, wife, son or daughter or even friend, caring for their loved one is just what you do. It can help to explain that the term carer is one that is recognised in politics and in the area of community-care funding. Often carers don’t think to ask for help for themselves.



Many carers never expected that there would be services specifically designed to support them. It is sometimes really valuable to get carers together as a group. Often a carer will hear or understand information much better if it comes from another carer. I guess a carer can put the information in context for them and show them the benefits.’

## Practice task 9

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

### Case study

Tony is 69 years old and cares for his wife, Lena, who was diagnosed with Alzheimer’s disease seven years ago. Tony gave up his full time job as he could no longer leave Lena alone in the house for even half a day.

Lena has developed behaviours of concern such as breaking household items and yelling. She thinks she can still do things like drive the car, go for a walk or boil the kettle. She must be supervised at all times. She doesn’t sleep through the night and wakes Tony in the early hours of the morning.

Without regular respite, Tony knows he would not be able to care for Lena at home. Lena has been assessed for services by the local home and community care agency and the carer respite service. She goes to a day centre group for women with forms of dementia two days a week. Lena has three stays per year in a secure aged care home. Each stay is two to three weeks long and Tony likes to plan to go away himself for one or two weeks each time.

Tony has help from the home and community care service with cleaning and a worker comes to the house for three hours a week so he can do his shopping. He also knows that if something unexpected occurs, such as getting sick himself or having a special event to attend, he can call on the carer respite centre for additional in-home respite. With all this support, Tony knows Lena can stay at home for a few more years.

1. Identify direct respite care services that Tony receives.

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2. What indirect respite care services does Tony receive?

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[Click to complete Practice task 9](#)

## Summary

1. Assessment of an older person's needs must also take into consideration the needs of their carer and the impact the caring role can have on them.
2. Caring can have an impact on a carer's and family member's physical status, their emotional status, their relationships and their work life.
3. Recognising and accessing support for the carers as soon as possible is in the best interest of the person being cared for.
4. When referring carers or family members for support, ensure you maintain their confidentiality. Support carers and family members to access support themselves.
5. Carers need support in their role and periods of direct or indirect respite to allow them to maintain their own health and wellbeing and continue in their role.

# Learning checkpoint 3

## Support family and carers

This learning checkpoint allows you to review your skills and knowledge in supporting family and carers.

### Part A

1. Why is it important to recognise the impact of support issues on carers and the person's family?

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2. Describe two possible impacts caring for an older person can have on the carer.

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3. What is respite and how can it help a carer?

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4. How can you provide support to a carer?

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## Part B

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

### Case study

Azeen has taken on the care of two older people from her Islamic community. The care is unpaid. Azeen sees it as her spiritual duty to care for and respect older people in the community. Her role initially involved visiting the people in their homes a few times a week, bringing meals she had made and spending time with them for company. As the older people's care needs increased, Azeen started spending more and more time preparing meals, obtaining medication from the pharmacy, accompanying the older people to appointments and helping them maintain their homes. Azeen has two children of her own, and works two days a week as an accountant. Her employer gives her a warning. He says her work is suffering, and if she doesn't improve her performance, she will be asked to resign. Azeen has put on a lot of weight in recent months, as she has little time for self-care and exercise. Her husband is also irritated that she has so little time to spend with the family between her care responsibilities, which are unpaid.

1. What are some indications that Azeen may be struggling to provide care?

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2. How might providing care be impacting Azeen?

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3. How could you support Azeen?

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## Topic 4

In this topic you will learn how to:

- 4A Explain mechanism/s for providing feedback on the individualised plan**
- 4B Obtain feedback on the individualised plan and report to supervising health professional**
- 4C Seek feedback from the older person and/or their advocate and report to supervising health professional**
- 4D Support the older person to seek assistance when their goals are not being reached**

## Coordinate feedback

Once an individualised plan is in place, you must regularly check that it continues to meet the older person's needs. Collect information from everyone involved, including service providers who deliver the care, the older person, their carer or advocate and health professionals. You can then review and revise the service delivery plan to reflect any changes in the older person's needs. The information and feedback you receive will offer prompts for reassessment or reprioritising the support needs of the older person or their carer. A coordinator should respond appropriately to feedback and the older person's changing needs.

# 4A Explain mechanism/s for providing feedback on the individualised plan

An individualised service delivery plan must be regularly monitored, evaluated and reviewed. This ensures the plan continues to meet the complex care needs of the older person. You need to identify whether the service is being delivered correctly and make adjustments where necessary. You can use case notes, observation and feedback to monitor and evaluate the service delivery plan. These are all feedback mechanisms.



Although each service delivery plan should be formally evaluated and reviewed at least once a year, an immediate re-evaluation and review of the plan should be conducted where feedback is received indicating the service is not meeting the person's needs. It could be that a need does not have such a high priority anymore, that the person's condition has worsened or that other conditions have developed.

## Provide feedback

Coordinators must actively seek feedback about the progress of the service delivery plan. Any changes or issues noticed should be documented and a response made to ensure the services delivered will meet the older person's care needs, and the older person's health and safety is not at risk. An inappropriate level of care may mean the older person's quality of life decreases.

Feedback from service providers is valuable as they see the older person frequently and, if they are specialists, they can provide feedback on specific health issues. When the service delivery plan is prepared, all service providers should know how to provide feedback about the progress of the services they provide.

Service providers need to know:

- ▶ who should receive the feedback; for example, the coordinator of the program
- ▶ when they need to provide feedback; whether weekly, monthly, six-monthly, immediately as an issue arises or when care needs change
- ▶ the type of feedback required, which may comprise observations of changes in behaviour, condition, effectiveness of service and so on
- ▶ how the feedback is to be delivered; for example, by telephone, in person, at case conferences, or through written progress, case notes or incident reports.

## Inform service providers about how to provide feedback

There are a number of ways service providers can be informed about how to provide feedback: through a service agreement or contract, the service delivery plan or verbal instructions. Below are examples of how coordinators may request feedback.

### Service agreements

- ▶ External providers might sign a service agreement with the organisation purchasing their services. Part of this agreement may be a requirement for workers to provide regular progress reports. This may be through a clause such as:  
 ‘The service provider must, where requested by the coordinator or manager, provide periodic reports relating to the provision of services delivered to individual people, including all matters specified in the service delivery plan and delegated to the specific provider’.

### Formal feedback tools

- ▶ Service providers may receive instructions and tools, such as forms, for providing feedback when they receive a copy of the service delivery plan. The coordinator may outline the type and frequency of feedback when initially discussing the service delivery plan with the service provider. For service providers to give useful feedback that can be effectively acted on, they must be given clear instructions about how to provide feedback and to whom.

### Example

#### Explain mechanisms for providing feedback on the service delivery plan

Janice is a support worker in an aged care home. She helps support more than twenty older people. Janice’s coordinator, Yvonne, has given Janice a form to complete for each of the older people she supports. It is a feedback form, intended to obtain feedback about how well the service delivery plan meets older people’s needs. Yvonne explains how to complete the form, and where to lodge the form when it is complete. She also tells Janice that the purpose of the form is to help identify issues with the service delivery plan, and made changes.



Questions on the form include:

- ▶ How would you rate the overall quality of service? (Poor, Average, Good, Excellent)
- ▶ How often was expected service delivered? (Never, Sometimes, Mostly, Always)
- ▶ What are the reasons for unmet needs?
- ▶ How satisfied was the person being supported? (Not very, Partly, Mostly, Very)
- ▶ How often did you understand your rights and responsibilities? (Never, Sometimes, Mostly, Always)
- ▶ How supported did you feel? (Not very, Partly, Mostly, Very)
- ▶ Did the person being supported make a complaint? (Yes/No)
- ▶ How would you describe the nature of the complaint?
- ▶ How do you think this service can be improved?

## Practice task 10

1. Describe two of the mechanisms for obtaining feedback, which are used in a care organisation you are familiar with.

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2. Why do you think it is important to obtain feedback about the service delivery plan?

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[Click to complete Practice task 10](#)

# 4B Obtain feedback on the individualised plan and report to supervising health professional

Seeking feedback from relevant service providers is a fundamental part of monitoring, evaluating and reviewing service delivery plans. As a coordinator, you must actively seek feedback and not just assume all is well if you have not heard otherwise.

Taking a case management approach enables a person's goals to be met through a collaborative and orderly process.



## Principles of case management

Case management is a coordinated and collaborative approach to care focused on meeting the needs of people. A case manager facilitates the process of case management by using their expertise to coordinate and facilitate activities that help the people they support to achieve their goals.

The strengths model of case management is based on the premise of positive regard for people with support needs. Within this model, the case manager and other health care professionals view the person as an equal who plays an important role in the case management process. Relationship-building, both with health workers and with members of the wider community, is a key focus of this model. This can be effective because it promotes a person's sense of control and self-efficacy, which in turn promotes active participation in dealing with issues.

Here is a list of key principles of case management. It has been adapted from a Commonwealth Department of Health published document that can be found.

You can read the original document at the following site:

- ▶ <http://aspirelr.link/principles-effective-case-management>

### Principles of case management

- ▶ Service providers are partners in care
- ▶ Individual and team case management can both be effective
- ▶ The case manager has responsibility for the person's services
- ▶ Case load should allow a high frequency of contact
- ▶ Case management service should be time un-limited if required
- ▶ Case managers should deliver as much of the support as possible
- ▶ Case management should be person-centred and strengths-based

## Process of case management

Here are the main steps involved in case management.

### Case management process

Identify a person's needs

Set goals

Develop and implement an action plan for the person

Identify specific services or businesses that will provide forms of support

Review progress and identify any further needs

## Provide written feedback

Service providers can and should, as an essential part of their role and responsibilities, provide feedback as progress/case notes, in communication books, in a written report or in an incident report form, as outlined here.

### Progress/case notes

Service providers working in residential care are required to document all the care and support they provide in the older person's file. As a coordinator, you can use these notes to assess the progress of the service delivery plan.

### Communication books

Service providers working with older people in the community, such as in their family home or at a day centre, may write feedback in a communication book to highlight an issue or change they have noticed.

### Incident reports

Service providers in all settings need to complete incident forms if an incident has occurred that has caused harm or injury (or if there has been a near miss) to the older person, the worker or a third party. This information can highlight a significant change to the person's needs.

## Characteristics of feedback

In order for the feedback to be valuable, it must be clear, specific and documented.

Feedback needs to:

- ▶ describe any changes or issues noticed
- ▶ indicate whether the changes or issues have been noticed once or more often
- ▶ describe what other factors may have impacted the change.

## Technology and digital literacy

Most care and support staff that are providing support and care services now need to be computer literate to write and save records required for monitoring the care and support of a person on the computer system of a facility or organisation.

There is an inbuilt mechanism for supporting the use of objective language in aged care reporting, where programs offer a drop down menu of phrases that can be used to describe changes in a person's state and care needs. The use of digital technology allows all records needed to provide an accurate picture of a person's condition and needs to be located together.



## Appropriate and inappropriate feedback

If you read the following in a person's progress notes, you would be unable to form a clear understanding of changes in Mrs Bradshaw's health and care needs:

'Provided assistance to Mrs Bradshaw today with showering and dressing. She seemed a bit wobbly today. She sometimes seems like this.'

A co-ordinator would find it hard to assess what actions may be required.

The following report is written in objective language and includes appropriate details.

### Progress notes for Mrs Bradshaw

Provided assistance to Mrs Bradshaw today. When she was in the shower, she complained of feeling dizzy. I assisted her out of the shower and with drying and dressing. While doing this I asked her for more information. She said she had felt dizzy a couple of times over the past few weeks. She said her doctor had discovered two days ago that her blood pressure is quite low. She says her doctor has prescribed medication and advised her not to stand up for long periods.

### Analysis of notes

The nature and frequency of, and possible reasons for the issue are explained. The coordinator reading this report knows that possible appropriate actions could be to contact the doctor for further information and to arrange for a shower chair.

## Provide verbal feedback

Encourage service providers to provide feedback verbally via the following methods.

### Over the telephone or face to face

- ▶ A service provider may phone to provide feedback if it is important that the feedback is received quickly. Where the service provider is a staff member at your own agency or if they are with the older person when you are there, feedback can be provided face to face.

### Asking and clarifying

- ▶ You may contact and speak to a service provider specifically to ask about the progress of the plan, a particular issue or to clarify information you have received through feedback from another provider, the older person or their carer.

### Case conferences

- ▶ You might request all service providers for a particular person, including health specialists, attend a case conference to provide feedback about the progress of a service delivery plan. An agenda will ensure efficient use of time.

## Report to supervising health professional

Once you have obtained feedback about the service delivery, collate feedback. It may be useful to complete a report about each person's service delivery plan at regular periods; for example, a monthly report.

Report to the appropriate supervising health professional. This may be a registered nurse, a GP or another specialist. The feedback report is intended to give the health professional an overview of how effective the care plan is for meeting a person's needs.

The report may be written or verbal. Written reports may comply with a template, and must comply with organisational policies and principles. Verbal report can be made face-to-face, over the phone or at a case conference.

Ensure that the written feedback report:

- ▶ is accurate
- ▶ is specific
- ▶ is detailed
- ▶ contains evidence
- ▶ is signed and dated.

### Example

#### Obtain feedback on the plan

Tony is the coordinator at a residential aged care home. Four months ago, he assessed the complex care needs of Mr Reid Sullivan and developed a service delivery plan. He has been monitoring the plan's progress and in the last week has had feedback from two personal care workers that Mr Sullivan memory and ability to self-care appear to be declining compared to when he was first assessed.

Tony calls a case conference to ask for feedback and to discuss this change. He arranges a time when the doctor and the physiotherapist will be at the aged care home and can attend the conference. He also requests that the two personal care workers, the diversional therapist and the nurse who monitors his blood sugar levels, also attend the conference. He prepares a brief agenda.

At the case conference, Tony asks the personal care workers to describe the changes they have noticed in Mr Sullivan's abilities or care needs. He then asks the specialists to provide advice and suggestions about how this impacts the appropriateness of the services being provided. He takes notes and asks for their recommendations for future actions.

Tony uses this information to review the service delivery plan to meet Mr Sullivan's changed needs.



# Practice task 11

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

## Case study

Val is the manager of an aged care home that has a secure memory support unit and caters to those with high behavioural and medical support needs. Val says:

'I always let the staff and visiting specialists know when a service delivery plan is being reviewed. As often as possible, I try to get as many of them together to discuss the service being provided to the older person, the issues arising for them and to get suggestions about how we can provide a better service.'

'I am constantly surprised at the observations that staff and specialists bring to the meeting, and the insight and innovation that we can create as a team. I know that if I just perform the assessment without asking others, services are rarely as successful in meeting the specific needs of the resident.'

'It is also important to talk to the residents themselves and to their family members or regular visitors about how they feel their care is progressing. Sometimes they want more than we can give, but they are mostly grateful and have really constructive suggestions about how we can support and care for them in the best way.'

1. Which of Val's actions are consistent with case management principles?

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2. What advantage does Val identify in asking others for feedback?

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3. The aged care home must keep specified written records which report on the service delivery plan. What is another way that Val has organised for health professionals to receive and give feedback?

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**Click to complete Practice task 11**

# 4C Seek feedback from the older person and/or their advocate and report to supervising health professional

While feedback from service providers is essential, it is also crucial to obtain feedback from the older person, their advocate or carers. The older person is the only person who is present for every aspect and moment of the service delivery. They are often excellent judges of how well the plan meets their needs. Most are able to offer constructive suggestions about how you can support and care for them in the best way. Where the older person is unable to comment reliably on the delivery and progress of services because of their condition, it is necessary to seek feedback from their advocate.

Feedback received from the older person or their advocate may be about:

- ▶ the way services are being delivered
- ▶ the level of services
- ▶ the timing of services
- ▶ the workers delivering the services
- ▶ whether or not they are enjoying the services.

## Communication

In your role you will encounter colleagues and older people with care and support needs of different ages, races, religions and levels of expertise or ability, among many other things. You will communicate with people in many different situations. When seeking feedback from an older person, their advocate or reporting to a supervising health professional, you can work more effectively and efficiently if you pay attention to communication and make efforts to improve communication skills.



Speak clearly and use appropriate vocabulary and an effective pitch and intonation. Intonation and pitch are how you use your voice to show extra information such as whether you are asking a question, what your attitude is; for example you can demonstrate respect using vocal intonation.

You will need to listen actively and may need to ask clarifying questions or read back a summary of the details you have noted to clarify that all details are correct. An example of a clarifying question is: 'Have I got it right?'

## Tips for communication

Here are tips for communicating with people who have diverse abilities.

### Tips for communication

- ▶ Limit background noise and other distractions.
- ▶ Face towards the person, but still show respect for their personal space.
- ▶ Use the communication method they prefer to use.
- ▶ Maintain eye contact and normal conversational habits of your own as you would in any other conversation.
- ▶ Use nods, smiles and nonverbal indicators to show you understand.
- ▶ Don't finish a sentence for the person; wait for them to finish speaking themselves before you interrupt or speak yourself.
- ▶ Don't pretend you understand if you don't.

## Deal with issues

Sometimes the feedback received from the older person or their advocate may be about issues that cannot be fixed by you or your workplace. When received, this feedback must be documented. As a coordinator, you must be clear with the older person and their advocate in response. Inform them that it is unlikely the service delivery will change to meet their request, but the request has been recorded and will be re-addressed if the situation changes.



## Seek and respond to feedback

Seeking and responding to feedback from the older person or their advocate can be done in a number of ways using the methods described here.

### Seek feedback from a resident

- ▶ In an aged care home, you may see the older person each day and be involved in delivering services. You may also see their advocate on a regular basis. These are all opportunities to ask for feedback on the service delivery. They are opportunities to observe whether the service delivery is meeting the older person's needs.

### Seek feedback from someone receiving support at home

- ▶ Coordinating a community program may not offer many opportunities to see the older person. You must keep in touch with the older person or their advocate either by phone or in person. It is important to ask them for feedback about the progress of the service delivery plan. Make sure they know exactly how to contact you if they have feedback to provide.

## Responding to feedback

- ▶ When you receive feedback from the older person or their advocate, you need to follow up. Investigate any concerns by asking service providers to clarify any changed care needs, reassess needs or request health professionals to provide an assessment of a particular area of need. It is important to tell the person or their advocate what will happen with the feedback provided. Make sure they are clear about what to expect and when.

## Report to supervising health professional

You need to relay information you obtain from the older person or their advocate to the supervising health professional. This may be a registered nurse, a doctor or another medical professional.

The health professional needs to be briefed about any changes in the person's status, so that adjustments can be made to their service delivery plan as quickly as possible.

Reports can be made verbally, over the phone or face-to-face, such as in a case meeting. Written reports, such as letters, must comply with organisational policies.

Always be accurate, object and succinct. Relay the older person's feedback exactly as they presented it. Remain as impartial as possible.



### Example

#### Seek feedback from the older person and report to supervising health professional

Mrs Steiner phones Larry, the coordinator of the local home support service. This service provides Mrs Steiner with personal care services three days a week and cleaning once a fortnight. Larry did the original assessment and service delivery plan development for Mrs Steiner. Mrs Steiner tells Larry she would like a few changes to her service delivery plan.

Mrs Steiner explains that she has just given up her driver's licence and can no longer drive to the shops. She would like help to do a full supermarket shop once a fortnight.

She has also noticed the very high windows in her sunroom are dirty and wonders if the home support worker could clean them.

After considering the feedback:

- ▶ Larry tells her he will arrange for the home support worker to stay an extra one and a half hours each fortnight to drive Mrs Steiner to do her supermarket shopping.
- ▶ Larry provides her with phone numbers of private contractors who clean windows as the home support worker is not permitted to climb a ladder to clean high windows.
- ▶ Larry makes a note of all Mrs Steiner's changes.
- ▶ Larry files a report to the registered nurse, who supervises the support service. The RN reviews the changes, and is satisfied that no adjustments need to be made to Mrs Steiner's health plan.

# Practice task 12

1. Why should you obtain feedback from the older person or their advocate about the service delivery, rather than just relying on the feedback from carers?

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2. Think of three different health professionals you might report this information to.

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**Click to complete Practice task 12**

# 4D Support the older person to seek assistance when their goals are not being reached

The older person should be central to their service delivery. This means they should be involved in decision-making, and reporting changes.

Encourage the older person's independence by supporting them to seek assistance when their goals are not being reached. Goals may be health goals, personal growth goals or skill goals, for instance.

If a person feels empowered to seek assistance themselves, they are more independent. They can also obtain support from the relevant person faster if they can access it themselves.



## Provide support to older people to seek advice from supervising health professionals

Different levels of support to communicate with health professionals will be appropriate according to the person's abilities and needs. The person can obtain relief more quickly than if they wait for others to address their unmet goals. You can assist the person to contact the supervising health professional in the following ways.

### Seeking advice and assistance

- ▶ Know how to contact health professionals in the way they prefer, including out of usual hours, and share this information with the older person.
- ▶ Provide the older person with relevant contact details.
- ▶ Ensure the older person has easy access to mode of communication, such as a telephone.
- ▶ Maintain continual communication with older people about the service they are receiving, so they are aware of updates and changes.
- ▶ Communicate with older people about their goals to help them clarify goals.
- ▶ You may need to call a case conference, especially if there are a number of different health professionals involved in the service plan. Involve the older person.

**Example**

**Support the older person to seek assistance**

Romi, a personal care assistant notices that Jack’s toenails are very long and the nail beds seem red and inflamed. He has a couple of sore-looking lumps and bumps on both feet. Romi speaks with Jack about this and he agrees that he would like a podiatrist to look at his feet as soon as possible. Romi provides this feedback to the coordinator.

The coordinator, Safi, suggests that Jack should be supported to seek assistance himself. She locates the number of Jack’s podiatrist, and asks Romi to give Jack the number. Jack phones the podiatrist, and arranges an appointment.

The podiatrist suggests that Jack needs weekly treatment for about six weeks to manage a fungal infection and corns, and monthly visits to maintain his feet after that. He also talks to Safi about Jack’s needs, and advises that managing his foot care should be considered a high priority, as Jack is in danger of developing a more serious infection. Safi, Jack, Romi and the podiatrist discuss how the service delivery plan can be adjusted to accommodate this need.

Jack is told to ring the podiatrist, or contact Romi if his feet are at all sore, so immediate action can be taken.



## Practice task 13

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

### Case study

Daisy is an older person. She has been having frequent dizzy spells in the shower. She is worried that this means she will not be able to live independently.

1. How could you support Daisy to seek assistance from a supervising health professional?

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2. Who could Daisy contact?

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3. How can assisting Daisy to seek assistance support Daisy to reach her goals?

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**Click to complete Practice task 13**

## Summary

1. Mechanisms for obtaining feedback include verbal or written reports from older people, or support staff and observations made by support staff.
2. Feedback ensures that the individualised service delivery plan is effective, and needs are being met.
3. While feedback may be provided verbally or in writing, all instances should be documented by the coordinator or the service provider. Written feedback may be required to support applications for increased funding or services.
4. It is essential to gather feedback from the older person, their advocate or carers as these people are well placed to comment on the success of the service delivery plan in meeting the older person's needs.
5. Relevant health professionals should be consulted as part of the monitoring and review process, or to address the changing needs of the older person.
6. Support older people to seek assistance from the supervising health professional so they feel empowered, and assistance can be delivered faster.

# Learning checkpoint 4

## Coordinate feedback

This learning checkpoint allows you to review your skills and knowledge in co-ordinating feedback.

### Part A

1. What three mechanisms could service providers use for providing feedback on the effectiveness of the individualised plan?

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2. What do service providers need to know in order to provide feedback about the progress of the services they provide?

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3. Why do you need to obtain feedback from service providers on the effectiveness of the individualised plan?

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4. Identify three communication strategies you should use when obtaining feedback from the older person about the individualised plan.

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5. When providing feedback on the individualised plan to the reporting supervisor, what standards should you adhere to in your writing? Describe three characteristics.

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6. What are four core principles and practices of case management?

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7. Why is technology and digital literacy important when obtaining feedback and reporting to the supervising health professional?

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## Part B

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

### Case study

Eden lives in a residential care community. Eden is very social, and enjoys the social activities provided for residents. She loves physical activities, like aqua aerobics, and tries to do an activity most days.

When Eden's funding arrangement changes, she cannot afford to do activities outside of the residential community. This means she can no longer attend aqua aerobics. Eden becomes irritable and depressed with lack of physical activity. She also finds her hip is starting to cause her problems.

1. How have Eden's goals changed?

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2. Which health professionals could assist Eden with the changes?

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3. How can Eden be supported to seek advice and assistance to meet her goals?

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