CHCDIS019

Provide person-centred services to people with disability with complex needs

Aspire
Learning Resources

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Provide person-centred services to people with disability with complex needs

Release 1

Learner Guide

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CHCDIS019 Provide person-centred services to people with disability with complex needs, Release 1

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Supporting Vocational Education and Training for 30 years
1991 to 2023

Contents

Before you begin

This Learner Guide is based on the unit of competency *CHCDIS019 Provide person-centred services to people with disability with complex needs*, Release 1.

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

How to work through this Learner Guide

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

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

Foundation skills

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

These skills are listed below:

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

Foundation skill area	Foundation skill description
Planning and organising	• Planning your workload and commitments • Implementing tasks • Completing work on time • Knowing how to deal with hazards and risks
Self-management	• Understanding and applying decision-making processes • Reviewing your behaviour and the impact of your decisions
Technology	• Efficiently using digitally based technologies and systems correctly and safely • Accessing, organising and presenting information • Using equipment correctly and safely

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

What do you already know?

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

Topic	Key outcome	Rate your confidence in each section
Topic 1 Evaluate and prioritise the support needs of a person	1A Identify and prioritise the needs and coexisting issues of the person	❑ Confident ❑ Basic understanding ❑ Not confident
	1B Identify specific problems, issues and challenges for the person	❑ Confident ❑ Basic understanding ❑ Not confident
	1C Analyse and interpret data with assistance from health professionals	❑ Confident ❑ Basic understanding ❑ Not confident
	1D Recognise the impact of complex support issues on the person's family	❑ Confident ❑ Basic understanding ❑ Not confident
	1E Establish priorities for support with the person and relevant others	❑ Confident ❑ Basic understanding ❑ Not confident

Topic	Key outcome	Rate your confidence in each section
Topic 2 Develop an individualised plan to achieve maximum quality of life	2A Use best practice guidelines to develop strategies to address complex and special needs	❑ Confident ❑ Basic understanding ❑ Not confident
	2B Liaise with relevant experts when developing individualised plans	❑ Confident ❑ Basic understanding ❑ Not confident
	2C Negotiate and establish goals	❑ Confident ❑ Basic understanding ❑ Not confident
	2D Access and negotiate resources to deliver identified services	❑ Confident ❑ Basic understanding ❑ Not confident
	2E Access community support agencies to facilitate the achievement of goals	❑ Confident ❑ Basic understanding ❑ Not confident
Topic 3 Coordinate the delivery of the individualised plan	3A Ensure services and support activities are undertaken by appropriately skilled workers	❑ Confident ❑ Basic understanding ❑ Not confident
	3B Recognise when a support worker is unable to provide required services	❑ Confident ❑ Basic understanding ❑ Not confident
	3C Support stakeholders to understand their roles and responsibilities	❑ Confident ❑ Basic understanding ❑ Not confident
Topic 4 Coordinate the monitoring, evaluation and review of the individualised plan	4A Seek feedback from all stakeholders during the evaluation of the plan and re-prioritisation of support needs	❑ Confident ❑ Basic understanding ❑ Not confident
	4B Seek advice and assistance when the person's goals are not being achieved	❑ Confident ❑ Basic understanding ❑ Not confident
	4C Revise the individualised plan in consultation with the person, their family or carer	❑ Confident ❑ Basic understanding ❑ Not confident

Topic 1: Evaluate and prioritise the support needs of a person

1A Identify and prioritise the needs and coexisting issues of the person

1B Identify specific problems, issues and challenges for the person

1C Analyse and interpret data with assistance from health professionals

1D Recognise the impact of complex support issues on the person's family

1E Establish priorities for support with the person and relevant others

1A Identify and prioritise the needs and coexisting issues of the person

A person who requires support services may have basic or complex needs.

It is important to identify and prioritise these needs and determine if there are any **coexisting issues** that may affect how support is provided. Coexisting issues may mean that the person requires support from more than one provider or service type, or that the people who work with them may require specialised training to appropriately deliver services.

Coexisting issues
Issues that arise when the person is affected by more than one type of disability; or issues that relate to environmental, societal or financial circumstances.

Basic needs

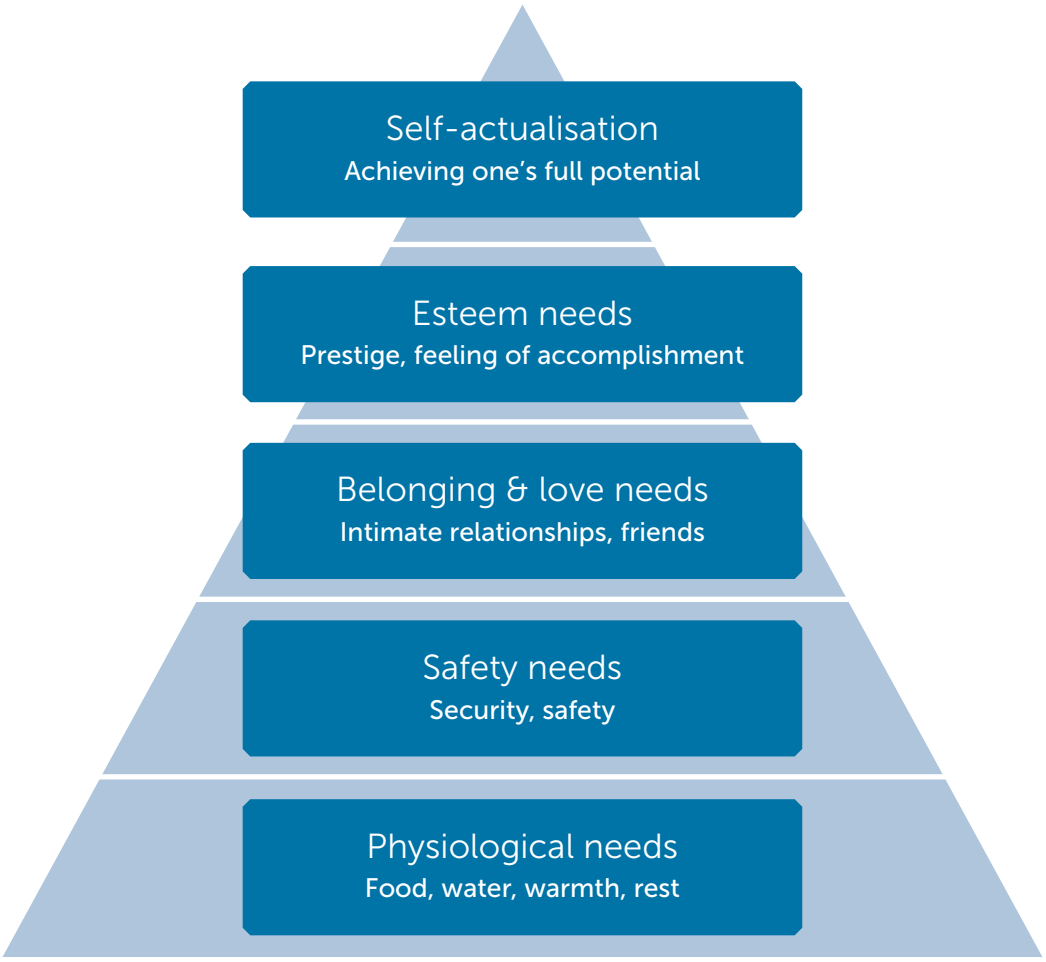
As humans we all have the same basic needs in order to survive.

These basic needs are in line with human rights and Maslow's hierarchy of needs. These include access to:

- safe, secure shelter, food and clothing
- safe, supportive social relationships (which can include family relationships, friendships and romantic relationships)
- a safe community in which to live
- education and places to work
- a community that offers a range of transport for diverse needs
- healthcare.

If a person has access to these basic human needs and can navigate through the community and society easily, then they can be said to have their basic needs met. However, clients who have more diverse needs are said to have complex needs.

Maslow's hierarchy of needs



Complex needs

People who have complex needs may have more than one type of disability or condition.

A person with complex needs may have a disability or condition that is difficult to manage, and that changes or deteriorates over time. Complex needs may arise from a disability or condition that has been present from birth (congenital) or they may arise after birth (acquired). Focusing on how the needs affect the person and their ability to function, rather than the specific type of disability or condition, is useful for identifying relevant services and supports.

Here are some areas where a person may have complex needs.

Physical functioning/mobility	Physical functioning/mobility refers to how the person moves, and any assistance they require such as a wheelchair, walker or transfers. When a person has multiple disabilities, it is called a 'comorbid disorder'. For example, a person who has autism and cerebral palsy is experiencing comorbidity.

Physical disability and mental health disorder	When someone experiences a physical disability and a mental health disorder, this is also called a comorbid disorder – for example, a person who is a quadriplegic and also has schizophrenia.
Dual diagnosis	Dual diagnosis means that a person has a mental health disorder and a dependency on drugs or alcohol.
Social/emotional/ behavioural	Social, emotional and behavioural refers to how the person interacts with others, and any relevant information about emotional or mental health or behavioural issues.
Communication	Communication refers to how the person interacts and imparts information to and with others, and any equipment or aides required (e.g. communication boards, assistive technology, signing or an interpreter).
Financial	A person may have a gambling issue, be in a lot of debt, have lost their job or Centrelink payment, or are being financially abused.
Legal	A person may be facing criminal charges, be out on bail, have lost access to their children or facing civil issues such as being sued.
Daily living/ recreation management	Daily living and recreation refer to how the person manages their activities of daily living and general leisure tasks, as well as any assistance required (e.g. making bookings, organising transport or providing supervision).
Complex situations	Complex situations refer to a range of circumstances that mean the person requires multiple and often intensive interventions to help them function and return to a normal life. For example, a person may be fleeing domestic violence, experiencing homelessness or long-term unemployment, or not be coping well with grief and loss.

Coexisting issues

Some people may have issues that coexist alongside their primary disability or condition.

This makes providing care and support more challenging; however, with careful planning and consideration, many of these issues can be easily dealt with.

Paying attention to coexisting issues and understanding how they affect a person can help prevent them from becoming a major limiting factor for activities of daily living. Use direct questioning, as well as observation, to help you understand how coexisting issues may affect a person's daily activities. You must consider coexisting issues prior to offering support services and care.

Coexisting issues to consider
• Whether the person requires a translator to interpret
• Whether drugs and alcohol are present
• Mental/physical health conditions
• Transport difficulties
• Social or geographical isolation
• Financial considerations/level of debt
• Religious or cultural requirements
• Carer or other family responsibilities

Factors that indicate complex needs

To determine whether a person has complex needs, consider their health, lifestyle, home environment, and financial and legal situation.

Professional workers – such as physiotherapists, occupational therapists, psychologists, social workers, psychiatrists or mental health nurses – may provide assessments and reports to facilitate the provision of care and support for people with complex needs or coexisting issues. Working closely with these professionals ensures that intervention and support is appropriate and delivered by workers with the right level of skill and knowledge.

Here are some factors that would lead to a person being classified as having complex needs.

Factors that indicate complex needs
• Dual or multiple disabilities
• Disability is likely to change, progress or deteriorate
• The presence of other issues (e.g. mental health, substance abuse, family violence or poverty)
• Insecure living situation (e.g. permanency, affordability, safety)
• Unstable financial situation
• Legal issues

Identify needs

Needs can be identified through an assessment process and information gathering from various sources, which allows an individual support plan to be developed.

An individual support plan contains the information required by community services workers to provide appropriate care. Individual support plans contain information such as:

- details of the client's physical or psychosocial disability and how it affects them
- what support strategies help them to function and live at home, in the community and/or at work
- what behavioural triggers they may have and how to manage them
- any medications they are currently taking
- their interests and hobbies
- their daily routines
- the professionals involved in their care
- excerpts of medical reports or medical information
- who their family, friends or carers are.

This information is collected and collated by a case manager or other key contact person who has responsibility for liaising directly with the person who requires services. They may utilise a variety of methods to obtain formal and informal assessment information about the person.

Here are some people who may contribute information about a person requiring services.

Allied health professionals	Allied health professionals include physiotherapists, occupational therapists, speech pathologists and podiatrists. They can provide information about physical care, functioning, manual handling and safety, as well as how to identify changes in physical health status or functioning.
Mental health workers	Mental health workers include psychologists, psychiatrists and mental health nurses. They are able to provide information about issues related to mental health and wellness, as well as how to identify changes in mental health status.
Family or caregivers	Family and caregivers include partners, parents, siblings, friends or others who perform voluntary care for the person. They can provide information about the needs of the person in daily activities as well as personal preferences and individual likes, dislikes and issues to be considered.

Formal and informal assessment

Formal and informal assessments are used to obtain information for inclusion in an individual support plan.

Collecting and collating information about a person requiring services occurs according to a clear timeline of events, leading to the development of an individual support plan.

Here is the order in which information should be collected and collated.

Collecting and collating information	
1	**Receive request** An initial request will be received for services for a person with complex needs via telephone, email, online application, referral or in person.
2	**Have an initial discussion** Collect informal information through an initial discussion with the person and/or others involved in their care and support.
3	**Meet with stakeholders** Meet with relevant stakeholders (family, caregivers, allied health, mental health and other professionals) to collect formal and informal information.
4	**Collect and collate** Collect and collate information from the formal and informal assessments provided by stakeholders.
5	**Identify and complete gaps** Identify any gaps in knowledge about the person and collect further information, as needed, through formal and informal assessments.

Formal assessment

Formal assessments can provide information about many aspects of daily functioning, specific needs, and health and related information.

They should only be completed by people who have the necessary skills and knowledge to use the assessment tools. Many assessment tools require specific levels of qualification or experience before they can be used – check your own workplace requirements for using formal assessment tools.

Here are a range of types of formal assessments that may be used with people who have various disabilities or needs, or who are from specific cultural backgrounds.

Mental state examination (MSE)	An MSE gives a snapshot of a person's psychological functioning at a particular point in time and can indicate if referral or risk assessment is needed.
Psychological assessment	A psychologist performs a range of psychological assessments that help to identify learning needs, cognitive strengths and weaknesses, personality disorders, anxiety and depression, cognitive issues, and a range of mental health disorders.
Australian Community Care Needs Assessment (ACCNA)	The ACCNA provides a consistent tool that is used across many service types to collect and record information about the person and their carer (if relevant).
Indigenous Risk Impact Screen (IRIS) and brief intervention	The IRIS screening tool assesses risk for alcohol, drug and mental health issues in Aboriginal and Torres Strait Islander peoples.
Psychosocial assessment	Psychosocial assessments are completed by social workers to give an overall picture of a person's social supports. An assessment may identify areas of risk and/or areas that require intervention and support.
Functional behaviour assessment	Functional behaviour assessments are performed by behavioural analysts and psychologists to identify behaviours of concern. They also offer a range of interventions and specific strategies to manage behaviours of concern.

For more information on psychosocial assessments when working with young people experiencing mental health issues, visit:
aspirelr.link/headspace-psychosocial-assessment

Informal assessment

Many workers use informal assessments every day, often without even realising it.

The observations we make about a person and the things they tell us about their needs help create a picture of how to best provide support and assistance.

Informal assessments may be created in the workplace, or they may be comprised of the notes and observations you make during an initial meeting or conversation.

Elements of an informal assessment
• Written notes about what the person tells you • Observations of their mobility and independence • Observations of the physical assistance required to perform activities of daily living • Discussion of how their needs impact their activities • Discussion of their goals and requirements • Information given to you by family members or advocates • Answers given to questions you ask about care and support needs

Prioritise needs

It is important to prioritise needs when providing care and support for a person.

Identify the person's needs that are most important – these are the needs that must be dealt with first. Care and support may be required for a short period of time, such as in response to a crisis or as part of a planned respite or short-term activity. Sometimes ongoing care is required to support daily activities or a regular schedule of tasks such as employment, recreation or personal care requirements. Establishing how urgent the needs are will determine the priority of meeting a person's needs.

Here is an example of how needs can be prioritised:

High needs	**Crisis support** Crisis support can be provided to help manage a short-term crisis such as a family illness, change to living situation, sudden change in health status or care needs, or if the person has suddenly become homeless or is fleeing domestic violence.
High, medium or low needs	**Intermittent care** Intermittent care can be provided from time to time, when required; for example, if a person's condition is exacerbated or when they are having respite care.
High, medium or low needs	**Transition care** Transition care facilitates the transition from one setting to another, such as moving from home to a residential setting.
High, medium or low needs	**Ongoing support** Ongoing support happens according to a regular planned schedule, such as weekly or daily care, to ensure the maintenance of usual life functioning and arrangements.

Language to use around prioritising and assessing needs

It is important to pay close attention to the language you use while assessing and prioritising client needs and interventions.

Here are some tips on using appropriate language:

- Do not use complicated terminology because this can cause confusion. Use simple words that your client can understand.
- Listen to the language your client uses to identify issues and circumstances, and use the same language. For example: 'I have a gambling issue not a problem; I have a learning problem not a disability'.
- Do not use pathologising language. For example: 'She is so OCD; he can't sit down for more than a few minutes, he must have ADHD; he can't look me in the eye, he must have autism'. Pathologising is the process of applying what may be considered to be normal behaviour to a mental health disorder. It results in more diagnoses being reported and goes against the social model of disability. It is also a subtle form of indirect discrimination. It is your job as a support worker to support your client by using positive language and not pathologising. Pathologising is not a person-centred practice.
- If someone is struggling to remember things you have said to them, write them down for them to take away.
- Do not give unsolicited advice. Giving advice without asking the person first is not person-centred. It disempowers clients and hinders their ability to make decisions based on the dignity of risk. It is best to use active listening to really hear what issues the client has and to offer them suggestions via questions. For example: 'You mentioned that you are struggling to get a break with being a carer. Would it help if I put you in contact with a respite service we use? They may be able to offer you some emergency respite options'

Example

Identify and prioritise needs

Peta is visiting Marcus for the first time to discuss his current living situation and to help determine what support needs and services Marcus may require. Peta has been asked to assess Marcus for eligibility for home-based care on a regular basis.

Peta initiates a conversation with Marcus to help him feel comfortable and relaxed. While they are talking, Peta observes Marcus and notices he appears pale and his hands are shaking. She asks Marcus several questions about his daily activities. Marcus appears confused and loses track of the conversation several times. He repeats himself and is upset when he cannot remember what he has had for breakfast.

Peta asks Marcus to show her where the kitchen is, so she can see if there are any health and safety issues that should be considered. Peta notices that there are dishes piled in the sink and food left uncovered on the bench. When she looks in the laundry, Peta sees clothing and soiled bedding spread on the floor. Peta determines that referral for assessment of Marcus's physical and mental health status is a high priority, and that regular ongoing household care is important but a lower priority than the assessment.

Practice Task 1

Question 1

Identify what indicates that a person has complex needs.

Question 2

When observing a person in your care, what are two indications that the person has coexisting issues and requires high priority support?

Question 3

List two examples of formal assessment approaches that may be used to assess a person requiring support.

Question 4

List two methods you could use to conduct an informal assessment.

1B Identify specific problems, issues and challenges for the person

Provide care and support in line with person-centred practices.

This requires focusing on individual support requirements and needs. Sometimes, a person may have specific issues or challenges in their life that need to be identified. These may relate to their disability or condition, or they may be a feature of their situation. Knowing what these issues and challenges are can help you plan the delivery of services according to individual requirements. When you identify issues and needs of a person in your care, make sure you consider the limitations of your own job role, follow organisational procedures and seek assistance as appropriate.

It is also worth noting that just because someone may be experiencing difficult life circumstances – such as homelessness or a drug/alcohol dependence – it does not automatically mean that they wish to have assistance for that issue. The key is to not assume what the person needs; instead, focus on what help they are interested in receiving.

Work with the person

Encourage the person to identify any specific problems, issues or challenges they are experiencing.

People with disabilities can experience daily challenges. This can be as straightforward as needing assistance to shower or prepare meals, to suffering from substance-abuse issues or homelessness. By placing the person at the heart of all decision making, you can help them evaluate how well they perform everyday tasks and then help them identify areas where they require support.

It is important to remember that people with disability have the right to receive services, performed by workers with appropriate qualifications, knowledge and expertise. The scope of a job role refers to the boundaries of the role – where a worker's responsibilities and authority begin and end. If you are unsure about a specific task or decision that you need to take, speak to your supervisor or health professional.

You may need to refer a task to another person if:
• you lack the necessary knowledge to undertake a task • you lack information about how to undertake a task • you are not physically capable of undertaking the task (e.g., you risk injuring yourself or the person if you try to undertake the task alone) • you lack the necessary resources to undertake the task.

Policy
A course of action proposed by an organisation as a basis for making decisions.

Procedure
An established or official way of doing something.

There are several key sources of information that provide information on your job role, such as your job description, **policies** and **procedures**, relevant laws, information provided by your supervisor and colleagues.

Every client you work with will have different levels of ability and needs, and different issues and challenges to manage or overcome. For this reason, you must have some understanding of the physiology and psychology associated with the person's disability, as well as an understanding of the person's individual strengths and capabilities.

Establishing an open, trusting and respectful relationship with the person will help them trust you enough to share their concerns and discuss challenges they are currently facing. When working with the person, you must respect their right to make decisions about their life as well as their right to privacy and confidentiality.

Here are a few communication tips to help you build and maintain positive relationships.

Action	Strategy
Be respectful	• Be open-minded and non-judgmental. • Show a genuine interest in the person. • Be empathetic – this is the ability to put yourself in another person's situation and to see it from their point of view.
Use active listening	• Give the speaker your undivided attention. • Wait until the person has finished speaking before responding. • Give feedback to show understanding, such as 'uhuh' and 'okay'. • Use facial expressions, gestures and body language to show you are listening (e.g. nodding, smiling). • Summarise or paraphrase what the person has said to clarify or confirm that the information received is correct.
Ask questions	• Ask open-ended questions to get the person talking in more detail, such as 'What tasks do you find challenging when home by yourself?' • Give the person time to answer; never speak for them. • Ask closed questions to clarify or confirm information, such as 'Have you had a recent fall?'

Identify specific issues and challenges for the person

The issues and challenges experienced by a person may directly relate to a specific type of disability and circumstance, or may be typical of the disability, condition or circumstance.

This could include problems such as:

- accessing buildings and facilities
- finding an accessible toilet
- being treated in an unfair or discriminatory way
- not having staff who understand how to use their communication devices
- not understanding what they need to do in order to meet the criteria for different services
- being illiterate
- not understanding English
- having very specific cultural or religious needs
- struggling to advocate for themselves and needing an advocate to help speak for them.

Discrimination and stigma

The *Disability Discrimination Act 1992* (Cth) protects people with a disability from direct and indirect **discrimination**, abuse and neglect. Complaint procedures and appeals processes are set out in state law and federal standards for disability service providers and other sector areas.

Discrimination
The act of excluding or treating a person differently based solely on an attribute such as disability, age, gender, race or sexual orientation.

Most states have a disability and equal opportunity laws that offer similar protections to the Disability Discrimination Act. For example, NDIS disability service providers must report annually to regulatory bodies all the complaints they have received and their actions in response to these complaints.

Many people discriminate because of their personal beliefs and attitudes towards disability. It is still a common belief that people with disabilities hold little or no value in society. This attitude leads to **stigma** which creates barriers for the person living with disability in their interactions in the community and in employment.

Stigma
Seeing someone in a negative way, due to a particular circumstance or quality.

Stigma is when someone sees you in a negative way because of your disability. It is a mark of disgrace that sets a person apart from others. The effects from stigma include:

- feelings of shame
- reluctance to ask for support
- fewer opportunities, e.g. employment
- bullying and harassement
- self-doubt.

Here are some examples of unfair treatment of people with disabilities based on discrimination and stigma in workplaces and society:

- a company excluding people with disabilities from gaining promotions
- favouritism of some staff or groups of people over others
- not having accessible workplaces or spaces; for example, lack of wheelchair accessible spaces or policies and procedures that make it difficult for people with disabilities to access.

Find out about the extent of disability discrimination here: aspirelr.link/aihw-disability-discrimination

To identify specific issues and challenges for a person you are caring for, it is important to understand how physiology and psychology apply to their disability.

How physiology applies to disability

It is useful to understand how the human body functions and what happens to the various organs and systems when a disability is present.

Physiological effects can range from mild to profound. Poor lifestyle conditions – such as smoking, unhealthy eating, drug/alcohol dependencies or poor living conditions – can exacerbate the signs and symptoms of a client's disability.

Physiology
The study of how the human body works, and the chemical and physical reactions that underlie every bodily function.

Here are some examples of how **physiology** applies to several types of disabilities.

Physical disability	Depending on the type and level of physical disability, a person may display signs of a compromised musculoskeletal system. This may be identified by observing the person's mobility and their ability to complete manual tasks.
Sensory disability	Depending on the type and level of sensory disability, a person may display signs of a compromised sensory system. This may be identified by the person's inability to taste, smell, see or hear.
Psychiatric disability	Depending on the type and level of psychiatric disability, a person may display changes to a variety of body systems such as musculoskeletal, digestive, respiratory or nervous systems.
Neurological disability	Depending on the type and level of neurological disability, body system changes may include nervous, sensory, musculoskeletal or respiratory systems.
Cognitive disability	Depending on the type and level of cognitive disability, there may be changes to the person's sensory or vascular/circulatory systems.
Intellectual disability	Depending on the type and level of intellectual disability, there may be changes to the person's muscular, cardiovascular, integumentary or nervous systems.

Example

Identify specific problems, issues and challenges

Shane is in residential care. He has a cognitive disability and requires moderate supervision. Jane, Shane's carer, assists him to schedule weekly tasks and organise his budget. Jane helps Shane to make lists and update his schedule when things change.

Today Shane offers Jane a coffee. As Jane watches Shane make the coffee, she notices that the milk looks a bit odd. She asks Shane if the milk is okay. He looks at it and smells it, and says it is fine. When Jane tastes her coffee, the milk is sour. Jane asks Shane to check the use-by date on the milk carton. Instead of reading it, he brings the carton to Jane so she can read it. Jane reads the date and smells the milk. She makes a face and Shane asks her what is wrong. He smells the milk and says, 'What's the problem?'

Jane identifies that Shane may have a compromised sensory system that affects his ability to see and smell. Realising that Shane's needs may have become more complex, Jane follows organisational procedures by making notes of what has occurred and reporting to her supervisor.

How psychology applies to disability

It is important to understand the psychological impacts a disability has on the person you are supporting.

Psychological impacts Changes in thinking processes and mental capabilities that affect how people behave.

When people experience a range of consistent changes to thinking and mental processes which impact their life, then a mental health disorder may be diagnosed. Psychological impacts will differ, according to the type and level of disability and mental health disorder.

Mental health disorders	
Bipolar disorder	People with bipolar disorder struggle with mania (elevated mood) and severe depression. The brain alternates between these severe states which impacts the person's ability to work and have relationships.

Mental health disorders	
Schizophrenia	People with schizophrenia experience hallucinations that can be auditory (hearing things that are not there); visual (seeing things that are not there); olfactory (smelling things that are not there); and tactile (feeling things on the skin that are not there). Schizophrenia also involves having delusions; for example, believing that the government are chasing them or they are a god.
Generalised anxiety disorder	People with GAD have very intense anxiety that affects how they access society, have relationships, and perform in activities or at work. It may also provoke panic attacks.
Post-traumatic stress disorder	People with PTSD have usually experienced a traumatic event, for example, child abuse or a natural disaster. They can experience flashbacks of the traumatic event, irritability, nightmares and sleep issues. They may also avoid reminders of the event and feel emotionally numb.
Borderline personality disorder	People with BPD experience severe emotional difficulties in managing strong emotions and reactions. They can be impulsive, which leaves them at higher risk for suicidal ideation or suicide. They may also have issues with relationships because they fear abandonment and rejection.
Depression	People with depression feel flat and unmotivated, struggle to get going, have ongoing negative thoughts and report somatic complaints.

Quality of lifestyle and available social supports also affect the severity of psychological impacts for a client. It is common for people with several physical disabilities to also have a mental health or substance abuse disorder. This is because having a physical disability is a considerable life stressor, which can contribute to depression and anxiety. This can then lead to the development of a drug dependency; for example, in order to try to cope with difficult life circumstances.

Many people with physical disabilities or mental health disorders are also at a higher risk of developing post-traumatic stress disorder (PTSD). This is because having a physical disability or mental health condition can be very stressful, and leads to more stress and anxiety being experienced. It can also lead to abuse and discrimination which can further traumatise the person with a physical disability or mental health condition. Life circumstances – such as job loss, long-term unemployment, disconnection with social supports and unstable living environment – can all be considerable stressors, which add to the risk of developing PTSD.

It is important to be able to identify specific issues and challenges when evaluating and prioritising the person's needs.

Here are some examples of how psychology applies to different types of disabilities:

Physical disability	A person with a physical disability may display signs of depression, anxiety and social isolation.
Sensory disability	A person with a sensory disability may display signs of depression, anxiety, lethargy and social isolation.
Psychiatric/ psychosocial disability	A person with a psychiatric disability may display signs of depression, anxiety and social isolation. They may also show specific signs of their psychiatric disability; for example, delusions and hallucinations in people with schizophrenia.
Neurological disability	A person with a neurological disability may display signs of depression, anxiety and social isolation.
Cognitive disability	A person with a cognitive disability may display signs of frustration, agitation, depression and anxiety.
Intellectual disability	A person with an intellectual disability may display signs of a mental health disorder; for example, schizophrenia or bipolar disorder. They may also have signs of anxiety, depression and social isolation.

Common individual issues and challenges

A person with a physical or psychosocial disability may experience many issues and challenges at the individual level.

It is important to understand and identify issues and challenges as soon as they arise. This enables you to predict difficulties and plan for issues should they occur.

A person with complex needs may have issues and challenges from several disability types. Here are some challenges and issues that may affect a person with a disability.

Physical disability	The challenges and issues experienced by a person with a physical disability may relate to: • accessing services and public transport • using devices that require motor skills • completing compound actions, such as reaching and pulling • maintaining independence across the domains of living and accommodation, financial independence and working • completing everyday tasks and functions • completing self-care activities • engaging in behaviours of concern.

Sensory disability	The challenges and issues experienced by a person with a sensory disability may relate to: • sight: reading, walking, completing household tasks • hearing: communication in the community, such as hearing public transport announcements • taste: completing household tasks, such as seasoning or tasting foods (knowing whether something is still good to eat) • smell: completing household tasks, such as cooking and safety (e.g. smelling smoke or gas) • engaging in behaviours of concern. (Note: these may also relate to people with autism, attention deficit hyperactivity disorder and sensory processing disorder.)
Psychiatric disability	The challenges and issues experienced by a person with a psychiatric disability may relate to: • thinking clearly • making decisions • understanding other people's feelings or actions • showing appropriate emotions, according to their chronological age and in response to the context of the situation; for example, they may over or under react to different situations and common life events • completing self-care activities • remembering important tasks or events • recalling information • engaging in behaviours of concern • having an increased risk of suicidal ideation (thoughts about suicide).
Neurological disability	The challenges and issues experienced by a person with a neurological disability may relate to: • loss of memory • attention deficit • incoherent speech • limited movement and body functions • accessing services and public transport • using devices that require motor skills • completing compound actions, such as reaching and pulling • maintaining independence across the domains of living and accommodation, financial independence and working • completing everyday tasks and functions • completing self-care activities.

Cognitive disability	The challenges and issues experienced by a person with a cognitive disability may be conceptual, such as task sequencing, comprehension and skill development. They may also experience difficulties with: • thinking clearly • making decisions • understanding other people's feelings or actions • showing appropriate emotions, according to their chronological age and in response to the context of the situation; for example, they may over or under react to different situations and common life events • completing self-care activities • remembering important tasks or events • recalling information • engaging in behaviours of concern.
Intellectual disability	The challenges and issues experienced by a person with an intellectual disability may relate to: • learning new things • understanding concepts • problem solving • completing self-care activities • understanding safety • using fine and gross motor skills • maintaining independence • engaging in behaviours of concern.

Systemic and structural issues faced by individuals

People with physical disabilities and mental health disorders continually face stigma and marginalisation from society in regard to their challenges and the way they live.

Because of this, people with disabilities are more likely to experience abuse, discrimination and exploitation from society. The combination of these societal issues often result in the person with a disability facing structural barriers in society which they have to navigate. Western society is mainly set up for able-bodied people to access services and systems. Many of societies' structures ignore and do not consider the diverse needs of people with physical disabilities and mental health disorders.

Structural and societal barriers can include:

- offices that do not offer many ways to access buildings; for example, lack of ramps and wheelchair-friendly spaces
- staff who do not understand the diverse needs of someone with a physical disability or mental health disorder
- not offering reasonable adjustments for diverse work needs that someone with a physical disability or mental health disorder may have; for example, adjustable desks, special access to leave, and positions with flexible times and places of work
- organisational policies and procedures that do not consider the needs of someone with a physical disability or mental health disorder
- not having access to communication devices that support communication
- assuming everyone is the same and not considering diverse or complex needs
- financial disadvantage, which often looks like socioeconomic disadvantage, where people with disabilities generally have a lower income than able-bodied workers. For example, this may be because they cannot work the same number of hours or they are surviving on Centrelink payments that are very low.

This article provides valuable information about structural and social barriers that people with disabilities commonly face: aspirelr.link/cdc-disability-barriers

Example

Identify specific problems, issues and challenges

Mateo has schizophrenia, depression and anxiety, and he lives alone. He takes heavy doses of antidepressants and antipsychotics to manage his symptoms. Mateo has a long history of being hospitalised for schizophrenia. His support worker, Jayden, comes to assist him each weekday with completing daily tasks and accessing community activities. Jayden arrives one morning to find Mateo has not slept and is not responding to his instructions. He seems agitated and begins escalating to anger. He is also saying things that do not make sense and appears to be talking to a chair.

Jayden notices that in terms of Mateo's mood and general disposition, he requires further psychological assessment to determine what has changed and what action needs to be taken. Jayden calls his supervisor immediately to seek advice as to whether he should take Mateo to the emergency department or have the Crisis and Assessment Team come to the house.

Practice Task 2

Question 1

Identify two situations where you believe that a task is beyond the scope of your role.

Question 2

List at least two common issues and challenges for a person with a physical disability.

Question 3

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

a. Stigma is the attitude that people with disability cannot contribute or have value in our society. A person with a disability being refused access into a late-night venue is individual discrimination.	Yes / No
b. Stigma occurs when inadequate services are provided to the person with disability.	Yes / No
c. A transport officer denying a vision impaired person access to the public bus because they have a seeing-eye dog is discrimination.	Yes / No
d. An employer not willing to improve the room design for an employee who has mobility issues is discrimination.	Yes / No
e. A housing department taking longer than normal to find accommodations for people with disabilities is an example of discrimination.	Yes / No

Question 4

Provide one example of how a compromised sensory system may affect a person with a disability.

Question 5

Provide one example of how psychological issues can affect a person with a cognitive disability.

Question 6

List two structural and systemic issues a person requiring mobility support may face.

Question 7

List two ways to encourage and work with the person to identify challenges in their life.

1C Analyse and interpret data with assistance from health professionals

Allied health professionals and other workers can provide formal assessment information and data, which can assist in determining the best way to provide support and care.

Data may be in the form of reports or assessments, and must be interpreted carefully and appropriately by qualified people. Depending on the person, there may be a range of people who contribute data to help evaluate their individual needs.

Here are some types of data that may need to be analysed and interpreted, as well as who may supply the information.

Informal written or verbal reports	Informal written or verbal reports provide brief information that is easy to interpret and understand. Supplied by: supervisors, other care workers and/or the family of the person receiving support
Medical reports	Medical reports contain more complex information, including specific medical language, facts, figures and numerical data. Supplied by: general practitioners, nursing staff, allied health professionals
Functional skills reports	Functional skills reports have information about how a person operates in various situations, such as walking skills assessments or transferring and mobility skills reports. Supplied by: physiotherapists, speech pathologists, occupational therapists
Risk assessments	Risk assessments provide information to staff about the relative risks of various situations and how they should respond, such as the risk of a person falling. Supplied by: care service managers, supervisors, health and safety representatives
Incidence and prevalence data	Incidence and prevalence data provides information about specific disabilities and how frequently they occur among the population as a whole, or in particular cohorts, such as children, adults or older people. Supplied by: the ABS and various regulatory bodies

Skills assessments	Skills assessments give insight into what skills a client has across a number of domains; for example, reading, writing, numeracy, daily living skills, advocacy skills, physical skills. Disability organisations may adapt their own type of skills assessments to determine skills gaps for clients. Supplied by: teachers, special education teachers, disability support workers, supervisors
Functional behaviour assessments	Functional behaviour assessments provide information about the frequency, intensity and type of a behaviour of concern that a client is engaging in. Behaviours of concern hinder clients from participating and engaging with other people in socially appropriate ways. They can also be very dangerous and put the client at serious risk of injury or even death. Functional behaviour assessments provide practical strategies to help clients stop engaging in behaviours of concern and to instead engage in appropriate behaviours. Supplied by: behavioural analysts, applied behaviour analysis (ABA) therapists, psychologists

Source: Adapted from the Australian Bureau of Statistics (2019) *Disability, Ageing and Carers, Australia*

Analyse data

If data is difficult to understand, or beyond the scope of your training and knowledge, there are some strategies that can help you to analyse it.

The following strategies can assist you in analysing data.

Data analysis strategies
• Highlight any key words or phrases you do not understand. • Seek information about words or elements you do not understand. • Look for a report summary that may explain key information more simply. • Consider the implications of the report regarding provision of care and support. • Consider any risk or safety implications in the report. • Discuss data with the person who provided it so any points can be clarified. • Ask for assistance from a team leader or mentor to help you analyse the data. • Access professional development to assist in understanding data analysis.

Interpret data

Not all data in a formal report or document will be relevant to the person's care and support.

You may need to seek assistance to help you interpret data effectively, and to work out what information is relevant to the person's care and how to apply the

information to the person. If you have difficulty interpreting the data, ask your supervisor for help. Alternatively, you may contact the person who supplied the information for clarification.

Here are some key words and phrases that may be present in documents containing data, with an example of how they may be used.

Incidence	The incidence of Type 2 diabetes was 74 per 100,000 people over 10 years old.
Prevalence	The prevalence of coeliac disease in Australia may be as high as 1 in 500 people.
Screening test	The screening test indicates there is a likelihood of a hearing impairment being present.
Percentile rank	A child's height is measured and found to be in the 5th percentile, which means there may be a developmental delay in this area.
Diagnosis	In the opinion of the qualified professional, the person had a diagnosis of bipolar disorder.

Incidence
The frequency or rate of a disease.

Prevalence
The proportion of a population who have a disease within a given time period.

Screening test
A medical test used to detect early evidence of disease by ruling out less probable diseases.

Percentile rank
The percentage of scores that are equal to or less than a given score.

Diagnosis
The identification of a disorder, disease or other problem through examination, investigation or evaluation of test results.

Example

Analyse and interpret data

Kat has a new client named Arlo to support in his home every weekday morning. Arlo has level 3 autism and is 18 years of age. Arlo's goals for the morning are to get ready for the day and to do some recreational activities before lunchtime. Arlo gets a taxi just after lunch to attend a disability service that provides recreational activities for him.

Before meeting with Arlo, Kat read his individual support plan and a functional behavior assessment that was completed by a psychologist. The functional behavior assessment found that if Arlo suddenly becomes upset from hearing loud noises, he will get onto the roof of his house to try and escape the noise. The noises that upset him include loud music, dogs barking, doors slamming and loud noises on the television. The psychologist had been teaching Arlo to soothe himself with his comfort toy and to put on his noise-cancelling headphones instead of going onto the roof.

Kat is following the plan to support Arlo by guiding him to learn this new behaviour. When the dog next door started barking, she put on his noise-cancelling headphones and gave him his comfort toy.

Practice Task 3

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

Case study

Mavis works in a community day centre where she provides and facilitates recreation and leisure activities. She has been given a report regarding a new person in her care and is unsure about analysing and interpreting the data it contains. The report is called the Alzheimer's Disease Assessment Scale (ADAS). Mavis has not seen an ADAS report before.

Mavis knows the report is about a person who is going to join the gentle exercise program on Thursday afternoon. She reads the scores, which have been written into a booklet, but realises that the report does not include a summary section or interpretation of the results.

She reads the testing booklet that includes the person's responses, but there are no written comments or interpretations from the community services professional (who conducted the assessment) about the person.

Question 1

Suggest who Mavis should contact first to help her understand the data in the report.

Question 2

Mavis is eager to have the person join her program but is unsure about what the data means. Suggest what Mavis should do next.

1D Recognise the impact of complex support issues on the person's family

Family members who support a person with complex needs may be impacted in many different ways.

Supporting a person with complex needs can affect, for example, how the family functions, and the ability of family members to operate effectively and achieve goals while maintaining their own health and wellbeing. Carers often find their own mental health and physical issues are exacerbated through caring for someone with a disability.

Support issues can affect the family environment of a person requiring support in various ways. Here are some areas where complex support issues can affect a person's family.

Relationships	Relationships and bonds between adult partners or between adults and children can be affected, with some becoming stronger and others being challenged. Carers often find they become socially isolated, which adds further stress.
Role and financial changes	The role of people or a person in a family can change as they move into a caring role and take greater responsibility for caring tasks. The person who is doing the caring may have had to adjust their work hours, which often means a change of financial position for the family. This may mean they do not have access to many resources they need to help them function. For example, they may not be able to afford to do sport or recreation activities.
Communication	The ability to communicate freely and openly about issues may be difficult to achieve and maintain.
Problem solving	Managing problems and challenges can be time consuming and demoralising. Problem solving relies on having the time and ability to think clearly and calmly.
Conflict	Conflict may arise and be difficult to manage in a family unit with added pressures.

Concepts of complex support issues

The context in which the person lives will provide you with a framework to understand their needs and care requirements.

Areas of need may span social, environmental, employment, financial, physical and mental health functioning.

There are two key concepts to help you understand complex support issues:

Breadth of need
Multiple needs that are interconnected.

Depth of need
The profoundness and intensity of needs.

- **Breadth of need**, which refers to multiple needs that are interconnected
- **Depth of need**, which refers to the profoundness and intensity of needs

Consider the following information.

Breadth of need impacts	
• Disadvantage • Disability • Health issues • High physical support needs • Mental support needs	• Poverty • Unstable living situation • Financial difficulties • Family violence • Substance abuse

Depth of need impacts
• Significant impact on the person and their family • Serious issues • Far-reaching implications • Not easy to resolve • Requires careful and experienced planning • Requires ongoing support

Impact of complex support issues

Support issues for people with complex needs vary according to their environmental and societal context:

- Parents may find it a challenge to care for their children with complex needs.
- Couples, where one person has complex needs, may find they are under extreme pressure and that their relationship becomes more conflict-ridden and unstable.
- Single parents with complex needs may need to rely on family and community support.
- Culturally and linguistically diverse (CALD) families are vulnerable to experiencing complex issues.
- Isolation and communication difficulties may manifest as depression and anxiety.
- Clients in regional areas do not have as much access to a range of services to meet their needs compared to clients in metropolitan areas. Providing support for a wide range of issues requires a multi-service and integrated approach.

Video: Family impact of disability

Watch the following video on disability and how it impacts families:
aspirelr.link/yt-family-impact-disability

Pay attention to the various ways families are impacted when receiving a diagnosis.

Example

Impact of complex support needs

Josephine has recently been diagnosed with breast cancer and is finding the treatments exhausting. She has needed to take extended leave from her job so she can complete treatment and this is having a dramatic effect on the family budget. Josephine and her husband Phil have decided to rent out their family home and move in with Phil's parents to reduce their financial burden. Phil has taken on caring duties for their two young children, as well as working full time and trying to move all their belongings into storage or the shed at Josephine's parents' house. During one late-night trip to the house, Phil falls asleep and crashes their car into a pole. He receives only minor injuries but the car is written off and there is now no way to drive the children to activities or to their preschool. The children stop attending preschool and are withdrawn from ballet and tennis classes. They spend their days at home watching television as Josephine is too unwell to entertain them, and Phil's parents are too frail to be able to meet the needs of two young children.

Practice Task 4

Question 1

Give two examples of how a complex support issue can affect family members.

Question 2

Briefly outline what 'breadth of need' refers to.

1E Establish priorities for support with the person and relevant others

When working with a person who requires complex support, their needs must be prioritised so they can be properly managed.

Prioritising needs may be done in collaboration with other people including the person themselves, family members, health professionals and other stakeholders.

Some support needs are time critical and urgent, and some family situations require immediate attention. Whatever the case, there should be a focus on trying to re-establish a safe, secure and appropriate family or living situation that is maintainable in the long term.

Early priorities include basic areas such as food, shelter and safety, while later priorities include emotional and social support. As discussed in Topic 1A, Maslow's hierarchy of needs illustrates the level of an individual's needs and can be used to systematically establish the priority of needs.

Identify priorities for support

Maslow's hierarchy of needs can be used to identify priorities for support.

When looking at Maslow's hierarchy of needs, it is evident that the needs outlined in 'physiological' should be met before the needs outlined in 'safety and security'. For example, providing a stable food source is a higher priority than providing support for finding employment. The bottom level in the hierarchy of needs must be secure before an individual can move to the next level.

Physiological needs	Access to food and water, clothing and sleep are essential for survival. This level is the first priority.
Safety and security	Safety, stable and secure shelter, protection and stability will be the high priority if the first level is already in place.
Love and belonging	Building an environment that is loving and provides care and emotional security is important, but can come later once physiological and safety needs have been met.
Esteem	Engaging in social or recreation activities builds networks and relationships, and also contributes to good health. This need can be met once the other levels have been addressed.

Collaborate with relevant people

Different groups of people, such as allied health and mental health professionals, may work together to provide support.

It is critical that these people communicate and collaborate with one another and share relevant information regarding the person's care. A case manager or social worker may be assigned to liaise directly with the person requiring support to help them understand the information and make decisions. A case manager/social worker reduces the intrusion of several different people coming into a home and can help reduce the workload for families.

Here is how the case manager/social worker fills an important role in collaborating with others in a support team.

Consult	Meet with the person directly, discuss their needs and goals, and obtain permission to contact others on their behalf.
Identify	Identify relevant personnel who can offer appropriate care and support to meet the person's goals and needs, such as a physiotherapist or mental health professional.
Contact	Contact relevant personnel to discuss their ability to provide services and the eligibility of the person to receive them. Examples include the Commonwealth Home Support Programme or the Queensland Community Support Scheme.
Meet	Meet with relevant people to develop a plan to prioritise (and help the person achieve) their goals and meet their needs. This might include the person receiving support, the person's family/carer, health professionals and other support service providers.
Report	Report back to the person and share information about what has been achieved at the meeting with other relevant people. Seek their permission to proceed with establishing support service arrangements that will meet their priorities and needs.

Example

Identify priorities for support

Sophie is a single mum who lives with her two teenage boys, Jerry and Simon. Simon has an intellectual disability and behavioural difficulties and has become very depressed and socially isolated. There is a lot of conflict at home and Jerry and Sophie are trying to help Simon re-engage with activities, return to school and seek treatment for his depression. Sophie has needed to take so much time off work recently that she has just lost her job.

With the bills mounting up, Sophie decides to borrow some money from a loan company until she can find another job. Her original intention to find work quickly is not realised and Sophie soon discovers that she is now much further in debt than she was before the loan. One morning she finds that mice have got into the pantry and eaten a large hole in the last remaining cereal box. There is no breakfast in the house.

Sophie has to send her boys to school with no breakfast. She begins to doubt that she will ever find her way out of the spiral of sadness, isolation and poverty which is now gripping her small family. Sophie needs some help to sort out the issues confronting her family and work out what to do first.

Example

Collaborate with relevant people

Cathleen makes an appointment at a carers' support service because she feels that she is struggling with her role as a carer. Cathleen cares for her husband Roy, who became a quadriplegic after a car accident. She meets with the case manager, Ari, who helps her to identify the priority of each need she has. Cathleen's top priorities are: urgent respite so she can have some time to herself to have a break; intensive home support for Roy's personal care tasks because doing these every day is aggravating a back injury she got five years ago while working; and more social interaction. Ari first determines whether Cathleen can contact services herself or if she requires assistance to do so. Cathleen confirms that she can do this herself. Ari puts Cathleen in touch with a disability respite service who can organise in-home respite care. She also puts her in contact with an in-home support service who sends out nurses to assist with high needs clients. Ari recommends that Cathleen attend their in-house carer support group which runs weekly and monthly groups. Cathleen is interested in attending both groups. Ari also explains that Cathleen can organise respite care for her husband while she attends the groups. Finally, Ari queries how Cathleen could take care of her back injury. Cathleen mentions that she could go back to her doctor to have a review.

Practice Task 5

Question 1

List three high-priority issues that need to be addressed when prioritising support needs in an individual support plan.

Question 2

Describe two ways you can prioritise support when developing an individual support plan for a person with complex needs and issues.

Summary

- People who require support services may have simple or complex needs. When a person has issues that coexist, their needs become complex and must be prioritised.
- Use active listening with clients to help identify their needs, and to prioritise their needs and services.
- Assessments can identify whether a person's needs are simple or complex. This may be a combination of formal and informal assessments.
- Analysing and interpreting data may be done with assistance and in collaboration with others.
- It is important to understand the breadth and depth of issues that can affect a person with complex needs and their family.
- Collaborate with others to help you understand the needs of the person, and to ensure the priority and level of support provided is appropriate.

Learning Checkpoint 1

Evaluate and prioritise the support needs of a person

Part A

1. List two factors that would help you evaluate if a person has complex needs.

2. Identify three types of disability and describe the physiological changes that may be experienced for each one.

3. List two informal assessment approaches you could use to assess a person who requires support.

4. Identify one high-priority area for support that should be addressed when developing an individual support plan.

5. Provide two examples of a related issue and challenge for each of the following disabilities:

- Physical
- Sensory
- Psychiatric

6. What are two strategies that could assist you in analysing data?

7. List three areas where a family can be impacted by a complex disability.

8. Identify three types of disability and describe the psychological changes that may occur for each one.

9. List one formal assessment approach you could use to assess a person in care.

10. List two structural and systemic issues a person with a psychiatric disability may face.

Part B

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

Case study

Tuk Lin lives in a housing commission flat in a large city. He is the primary caregiver for his wife, Ling Lin, who has bipolar disorder and has recently been diagnosed with multiple sclerosis. Ling requires a wheelchair for mobility and is experiencing severe muscle weakness and spasms in her legs. Tuk speaks only limited English and prefers to converse in his first language, Vietnamese. Ling had previously been the key communicator in the family, organising appointments and creating links with people in their local neighbourhood. Now that Ling requires full-time care and supervision, Tuk feels socially isolated and has become depressed.

Tuk does not want to seek more help for his wife as he feels this would bring shame on his wife and his family. He is an intensely private person and does not like to ask for help. He has difficulty completing basic tasks such as paying bills or using a credit card.

Tuk has never held a full-time job because of his limited language skills. Now that his wife cannot work, the family finances are becoming increasingly difficult to manage. They are falling behind in paying their rent, and have very little money for food.

A mental health nurse from a local community support service visits Tuk and brings an interpreter to help discuss the family's issues and needs, and to establish some priorities for providing support.

1. Identify three high-priority issues that are facing this family.

2. List at least two specific issues and challenges facing Ling.

3. Identify two health professionals who could assist with analysing and interpreting data related to reports written about Ling's disability and mental illness.

4. Suggest why health professionals should be involved in the assessment and writing of reports about Ling's needs and preferences.

5. List three impacts that Ling's complex needs have had on Tuk?

6. Briefly outline how discrimination and stigma may have led Tuk to not want to seek more help for his wife for fear of the shame it would bring to her and his family.

Topic 2: Develop an individualised plan to achieve maximum quality of life

2A Use best practice guidelines to develop strategies to address complex and special needs

2B Liaise with relevant experts when developing individualised plans

2C Negotiate and establish goals

2D Access and negotiate resources to deliver identified services

2E Access community support agencies to facilitate the achievement of goals

2A Use best practice guidelines to develop strategies to address complex and special needs

The community services sector has best practice guidelines that inform support workers about the best way to perform work tasks and carry out assessments.

These guidelines assist workers to develop strategies to address people's complex or special needs.

Best practice guidelines may be contained in community care standards or quality frameworks. It is important that strategies for addressing complex or special needs are underpinned by best practice guidelines to ensure the best and most appropriate support is provided.

Common health problems and behavioural issues

Consider common health problems and behaviours of concern when developing an individualised plan.

Different disability types have health problems and behaviours of concern associated with them. However, it is vital to consider the individual needs of the person and avoid making assumptions about specific care needs. For example, a person with a physical disability may develop health problems due to lack of mobility. They may also demonstrate behaviours of concern such as refusing to be transferred or assisted with mobility. Although this behaviour is not a direct consequence of the disability, the disability has caused an emotional response which has resulted in the person refusing assistance of any kind. Depending on the type of disability, behaviours of concern may also be present.

Behaviours of concern

Behaviour of concern
An action that can cause harm, either to the person who presents with the behaviour or to others.

Behaviours of concern put the person at risk of injury or death or into a dangerous situation.

As well as putting the person at risk, engaging in behaviours of concern can also place others at risk or cause the person's physical condition or mental health disorder to get worse.

Here are a range of behaviours of concern:

- Self-harming behaviours; for example, cutting, head-banging, picking at skin, overeating, attempting to take own life.
- Destructive behaviours; for example, destroying property, damaging equipment.
- Refusing behaviours; for example, refusing to have medications, refusing to listen to instructions which places the person at risk of injury, not taking care of themselves (e.g. not eating, showering or getting out of bed).
- Avoiding behaviours; for example, hiding to avoid something the person finds frightening, becoming frightened and running across a busy road without looking for traffic, excessively taking drugs and alcohol.
- Hurting others; for example, showing varying levels of violence to others (e.g. pushing, slapping, punching, kicking, throwing things at the person).
- Behaviours that put the person at risk of being arrested by the police; for example, destroying property, stealing, sexual assault, driving a car without a licence, graffitiing, assaulting others.

Manifestation and presentation of behaviours of concern

How a particular behaviour of concern manifests varies from person to person, even when two people have a similar condition.

You should never assume that people with the same condition or disability will have the same behavioural issues; every person is different and will display different behaviours.

Physical disability	Behaviours of concern may include social withdrawal or anger.
Sensory disability	Behaviours of concern may include withdrawal or anger.
Psychiatric disability	Behaviours of concern may include self-harm or not taking care of themselves.
Neurological disability	Behaviours of concern may include anger, social isolation or not taking care of themselves.
Cognitive disability	Behaviours of concern may include self-harm or not taking care of themselves.
Intellectual disability	Behaviours of concern may include self-harm or not taking care of themselves.

Strategies to address needs

Include strategies to address the needs of the person in their individual support plan.

The strategies used will depend on the person's health and behavioural support needs, and will describe how the person will be supported and the way it will happen. Depending on how complex the person's needs are, more than one strategy may be required to address their needs.

Strategies must be clear and specific, be linked to the person's aims and goals, and be supported by best practice guidelines. Strategies used to inform an individual care plan may be found in best practice guidelines and the policies and procedures of the community services organisation you work for.

Individual support plans can look slightly different depending on the organisation. They can also focus on slightly different areas and domains of a client's life, needs or goals.

Here is an example of an individual support plan: aspirelr.link/ms-support-plan

Legal and ethical standards
Laws and legislation that must be abided by in workplaces.

Legal and ethical standards related to the development of individual support plans

Individual support plans should not only reflect the unique situation, context, needs and goals of the person with a disability, but they must also reflect legislative, statutory, professional and ethical standards.

In terms of legal standards, all support workers must:

- abide by work health and safety laws (both state and federal) and work safely with clients; if unsure about how to safely perform any duties, they must contact their supervisor for more training or advice
- follow anti-discrimination legislation and not discriminate against clients or co-workers
- comply with their state's relevant mental health legislation, policies and procedures when working in specific mental health support roles
- follow the legislation and laws related to their duty of care with clients
- comply with the *Privacy Act 1988* (Cth), which clearly states what client information must remain confidential and when confidentiality can be broken
- ensure that an individual support plan reflects a person's human rights.

Learn more about human rights obligations concerning disability: aspirelr.link/hr-disability-rights

Professional and ethical standards refer to codes of conduct and codes of ethics that employees must abide by. These codes have guidelines that all support workers need to follow, which include:

- All workers must follow their organisation's policies and procedures to ensure they are working within the scope of their role.
- Workers have an ethical and moral obligation to report any suspicions of abuse and neglect when they are suspected. Depending on the state, it may not be a legal obligation under mandatory reporting laws; however, reporting all suspicions, disclosures or signs of abuse is imperative.
- Workers need to ensure they follow individual support plans ethically. This means that they are: not abusing, exploiting or neglecting the person; allowing the principal of the dignity of risk; upholding the person's agency and self-determination at all times; not engaging in a sexual relationship with the person or their family members; being respectful of the person's cultural and religious needs; and working with integrity, openness, honesty and transparency.

Note: it is common for legal and ethical standards to overlap each other.

The Australian Community Workers Association (ACWA) is an organisation that community services organisations can choose to be aligned with. They provide codes of conduct and codes of ethics which community services workers should ideally follow.

For more information on ethics and standards, visit: aspirelr.link/acwa-ethics-standards

Best practice guidelines: Aged Care Quality Standards

The Aged Care Quality Standards apply to a range of care providers in the community services sector.

There are eight discrete standards, including consumer outcomes, that must be met.

Standard 1: Organisational governance	Recognises the importance of a consumer's sense of self, and their ability to act independently, make their own choices and take part in their community. These are all important in fostering social inclusion, health and wellbeing.

Standard 2: Ongoing assessment and planning with consumers	Describes what organisations need to do to plan care and services with consumers. The planned care and services should meet each consumer's needs, goals and preferences, and optimise their health and wellbeing.
Standard 3: Personal care and clinical care	States that consumers and the community expect safe, effective and quality delivery of personal and clinical care. Applies to all services delivering personal and clinical care as specified in the *Quality of Care Principles 2014* (Cth).
Standard 4: Services and supports for daily living	Explains that even though consumers may experience challenges in their health and abilities, they still have goals to achieve and roles that have meaning. They want to manage their day-to-day lives and live as well as they can. Services and supports should cover a wide range of options that aim to support consumers to live as independently as possible and to enjoy life.
Standard 5: Organisation's service environment	Applies to the physical service environment that an organisation provides for residential care, respite care and day therapy centres. It aims to ensure that the service environment, furniture and equipment support a consumer's quality of life, as well as their independence, ability and enjoyment. The service environment should suit the consumer's needs, and be clean, comfortable, welcoming and well maintained. The safety and security, design, accessibility and layout of the environment can encourage a sense of belonging for consumers.
Standard 6: Feedback and complaints	Organisations must have a system to resolve complaints that is accessible, confidential, prompt and fair. It should support all consumers to make a complaint or give feedback. Resolving complaints within an organisation can help to build the relationship between the consumer and the organisation. It can also lead to better outcomes.
Standard 7: Human resources	Organisations must have and use a skilled and qualified workforce sufficient to deliver and manage safe, respectful and quality care and services.
Standard 8: Organisational governance	An organisation's governing body is responsible for the organisation and delivery of safe and quality care and services.

More information on the Aged Care Quality Standards can be accessed at:
aspirelr.link/aged-care-quality-standards

Best practice guidelines: Trauma-informed practices

Because of the prevalence of trauma symptoms and post-traumatic stress disorder (PTSD) being experienced by many disabled people, it is important to be trauma informed and to utilise trauma-informed practices.

Trauma-informed practice for the mental health and disability area is growing, and your organisation may require you to undertake additional training to become trauma informed and to be upskilled in trauma-informed practices.

To be trauma informed means to understand the following:

- Symptoms of trauma and PTSD can look different for each person who experiences them.
- Sufferers have either experienced one or many traumas.
- The term 'being triggered' is one way of explaining that someone has been triggered by a previous trauma. This can lead them to over or under react to a current situation or context. These behaviours are not chosen consciously by the brain; they are unconscious. It is inappropriate to label these behaviours as 'attention seeking' or to pathologise them.
- When a person is triggered by a past event, it is important to stay calm and support them through what they are currently feeling. If they are struggling to be calm and regain control over their feelings, they may need some additional time to calm down.

Trauma-informed practices refer to a range of strategies you can use to support the person to get back to feeling like themselves.

- Take all the time a person needs to calm down.
- Get to know a person's triggers and avoid them if possible.
- Encourage positive coping skills. These include things that calm the person down like playing a game, watching their favourite show or listening to their favourite song.
- Encourage a positive lifestyle; for example, sleeping and eating well, taking a break when tired or stressed, only doing what the person can do today and not pushing them, and addressing addictions.

The Blue Knot Foundation is one of Australia's leading organisations on trauma and trauma-informed practices: aspirelr.link/blue-knot-resources

Best practice guidelines: National Disability Insurance Scheme (NDIS) restrictive practice protocols

The National Disability Insurance Scheme Quality and Safeguards Commission (the NDIS Commission) oversees the implementation of the *National Disability Insurance Scheme Act 2013* (Cth) and the NDIS restrictive practice protocols. These educate providers on the best ways to implement the safest and most ethical restrictive practices, and also outline the policies and procedures for implementing authorised restrictive practices via behaviour support plans.

Each state and territory has its own information, legislation and guidelines about restrictive practices in the disability sector. Read your state's information about restrictive practices to ensure you are up to date.

Australian Capital Territory	aspirelr.link/com-ser-act
New South Wales	aspirelr.link/ndis-nsw
Northern Territory	aspirelr.link/nt-res-pra
Queensland	aspirelr.link/ds-dat-sip
South Australia	aspirelr.link/dhs-sa
Tasmania	aspirelr.link/com-tas
Victoria	aspirelr.link/ndis-vic
Western Australia	aspirelr.link/wa-doc

National framework principles to reduce and eliminate restrictive practices

It would be ideal if restrictive practices do not need to be used at all; however, as many clients display quite severe behaviours of concern, evidence-based practices and strategies are required.

Evidence-based practices and strategies in this context refer to those that have been researched and trialled for the best outcomes for clients. The NDIS Commission has formed the 'National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector'. These overarching principles guide the use of restrictive practices.

Person-centred focus	This involves including the perspectives and experiences of the person with a disability and their family/carers/advocates during the process of individualised behaviour support planning, and completing behaviour support plans and risk assessments. It also involves training disability staff about any restrictive practices used.
Leadership towards organisational change	Leaders in disability/community/mental health support organisations need to: • train staff in all regulated and authorised restrictive practices • be aware of their state government's policies and procedures surrounding the use of restrictive practices • provide organisational support to reduce the use of restrictive practices • be clear and have transparent mechanisms for disability representatives to inform government policymakers about practices and guidelines.
Use of data to inform practice	This refers to how and what data is collected to author, review and disseminate information about the use of restrictive practices. It includes: • use of accurate data to formulate a baseline about behaviours of concern • data collection to improve future practice and contribute to national data • risk assessments and an auditing tool developed to evaluate the use of restrictive practices • methods to collect feedback from people with disabilities and their experiences with restrictive practices • a complaint process about restrictive practices that can be used to inform an Ombudsman or Tribunal.
Workforce development	Ensuring disability support staff are well trained in positive behaviour support, trauma-informed practice, functional behaviour assessment, de-escalation techniques and restrictive practice alternatives can reduce the need for using restrictive practices with clients with complex needs.
Use of restraint and seclusion reduction tools in disability services	These approaches include: • evidence-based assessment tools • emergency management plans • changes to the environment • strategies and practices to improve the client's lifestyle and engagement in positive activities.
Debriefing and practice review	Disability service providers need to regularly review the use of restrictive practices. This can include: • undertaking case reviews and debriefing after an event where staff have used restrictive practices • asking the person and their family/carers/advocates to give feedback about the practices used.

Ethical dilemmas

Restrictive practice
Any intervention or practice that restricts rights or freedoms of movement of a person.

Using a restrictive practice on a person with a disability is an ethical dilemma.

An ethical dilemma is something that causes a conflict between:

- morals – the right thing to do
- legal practice – the legal thing to do
- ethics – the ethical thing to do
- values – the values you have about something.

Any type of restrictive practice can potentially cause harm and damage to a person with a disability. Here are some examples of how restrictive practices can impact and hinder the domains of emotions, psychology, physical and human rights of the person.

Physical	• Restrictive physical practices can cause injury to the person's body. • Long-term medications used as chemical restraints can cause harmful effects on the body.
Emotions	• Restrictive practices can cause a person's emotions to become distressed and dysregulated (out of control). • Restrictive practices can trigger emotions and responses from previous trauma.
Psychology	• Restrictive practices can cause the person to have poor or negative thoughts and feelings, which may then potentially cause more challenging behaviours or behaviours of concern. • Restrictive practices can impede the person's self-determination, dignity of risk and loss of dignity. This can make psychological processes and behaviours worse.
Human rights	• An environmental restraint restricts the person's right to freedom of movement. • The person has the right to not be subjected to torture, cruel, inhuman or degrading treatment or punishment, detention or exile. • The person has the right to education that develops their personality and strengthens their human rights.

The NDIS Commission requires five different types of regulated restrictive practices to be monitored. They include the following:

Restrictive practice	Description	Example
Seclusion	Seclusion refers to 'the sole confinement of a person with a disability in a room or a physical space at any hour of the day or night where voluntary exit is prevented, or not facilitated, or it is implied that voluntary exit is not permitted' (the NDIS Act).	• Locking a person in a room on their own where they cannot get out • Locking a person in their house where they have no way of getting out
Chemical restraint	Chemical restraint refers to 'the use of medication or chemical substance for the primary purpose of influencing a person's behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition' (the NDIS Act).	• Prescribing a medication that stops aggression or self-injury (e.g. psychotropic medications)
Mechanical restraint	Mechanical restraint refers to 'the use of a device to prevent, restrict, or subdue a person's movement for the primary purpose of influencing a person's behaviour but does not include the use of devices for therapeutic or non-behavioural purposes' (the NDIS Act).	• Using a helmet to stop someone self-harming • Using a body suit to stop masturbation • Putting up bedrails
Physical restraint	Physical restraint refers to 'the use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered as the exercise of care towards a person' (the NDIS Act).	• Holding down a part of a person's body to stop them from self-harming • Dragging someone in a particular direction

Restrictive practice	Description	Example
Environmental restraint	An environmental restraint 'restricts a person's free access to all parts of their environment, including items or activities' (the NDIS Act).	• Preventing a person's access to a different part of their environment, for example, not allowing them into the garden at their house • Restricting access to a mobile phone

Regulated restrictive practices can only be used if:

- they reduce the risk of harm to the person with a disability or to others
- it is the least restrictive restraint in response to the situation
- the type of restraint used is proportionate to the risk of harm to the person or to others
- they are short term not long term and are a last resort
- they are outlined in the person's behaviour support plan
- they are authorised by a designated behaviour support practitioner and the behaviour support plan is registered with the NDIS Commission
- the person has been/is being given the opportunity to develop new skills to avoid any type of restrictive practice – for example, they are being taught new self-soothing and comforting skills instead of banging their head on the wall.

Unregulated and unauthorised restrictive practices

Unregulated restrictive practices impede the human rights of the person, put them into unsafe environmental situations, are unethical or, in some cases, illegal.

Some examples of unregulated restrictive practices include:

- locking the person in a room where there are work health and safety hazards
- giving too much or too little of the person's prescribed medications that aim to control some behaviours of concern, potentially leading to the person being more aggressive or violent, or not alert enough to do their daily activities
- using any type of restrictive practices in order to hurt or punish the person

- not using environmental restraints correctly or consistently – for example, a person who has a behaviour of concern of running onto the road, and the environmental restraint is to lock the gate, but this is not done and the person is hit by a car.

Unauthorised restrictive practices are those practices that have not been preapproved by an appropriate behaviour support practitioner.

The consequences of using unauthorised and/or unregulated restrictive practices can include the following:

- The person doing the practices may inadvertently injure the person they are attempting to restrain. In very serious cases, this can be deemed an assault and the person doing the restraining can be charged.
- It can cause behaviours of concern to get worse.
- What were once challenging behaviours can escalate to behaviours of concern.
- It can lead to the person with a disability experiencing more abusive and discriminatory behaviours, which are all illegal, unethical and immoral.
- It can cause trauma and psychological harm.
- It can make mental health disorders worse.
- It can lead to overreliance on a type of restraint, which impedes the person's ability to regulate themselves in an appropriate way.
- It can negatively impact the relationship between the person and their support staff.

Therefore, it is imperative to work with a behaviour support practitioner when implementing behaviour support plans that contain restrictive practices.

Authorised behaviour support practitioners

There are a range of professionals who can be behaviour support practitioners.

These include:

- psychiatrists
- psychologists
- behavioural analysts (also known as applied behaviour analysis therapists)
- social workers trained in disability and positive behaviour support
- teachers/special education teachers who have been specifically trained in applied behaviour analysis
- counsellors trained in disability and positive behaviour support.

These approved behaviour support practitioners must be registered with the NDIS Commission:

- to provide specialist behaviour support
- for the class and type of support they provide.

The role of behaviour support practitioners

The NDIS Commission has outlined the role that behaviour support practitioners must undertake to provide positive behaviour supports for a person with disabilities.

The role of behaviour support practitioners includes the following:

- Complete functional behaviour assessments. An assessment provides important data about why the person is engaging in behaviours of concern. It also details how families, carers and disability support staff can begin to address these behaviours of concern, because they must never be ignored. An assessment can also be done to test how well the support strategies and replacement behaviours are going. It can be completed as often as the behaviour support practitioner decides it is needed.
- Develop short- and long-term behaviour support plans with regular reviews with the person, family, carers, support staff and any other allied health professionals involved. These plans should contain a range of behavioural strategies to support and encourage the person to engage in positive behaviours instead of behaviours of concern.
- Offer behavioural strategies that are person-centred, and that consider the person's strengths and the resources they have access to.
- If a restrictive practice is recommended, collect further data to see if it is working correctly. If it is not, then alternative restrictive practices may be recommended. If the person has learned new replacement behaviours and has begun to stop doing the behaviour of concern, then restrictive practices need to be removed to ensure the person has their dignity of risk and self-determination respected.
- Register behaviour support plans with the NDIS Commission.

Click here for the NDIS behaviour support plan template: aspirelr.link/ndis-bspt

Use positive behaviour support

As a support worker, your role is to support clients with disabilities who engage in behaviours of concern.

Your role includes the following:

Follow their individual support plan	• Use current support strategies that keep the person calm, happy and engaged. • If support strategies are not working, then use different strategies.
Participate in organisational training about restrictive practices	• Only use restrictive practices that you have been trained in.
Document behaviours of concern	• Follow organisational requirements regarding documenting behaviours of concern. For example, information can be collected using: - client and family feedback sheets - written complaints - behaviour of concern monitoring and assessment tools - risk assessment tools - restrictive practice auditing tools. • Information to include in your notes: - Whether behaviours of concern are getting worse - Restrictive practices used Documentation helps your supervisor, allied health professionals and the behaviour support practitioner to understand how the person is progressing with learning new positive behaviours and whether behaviours of concern are still present or changing.
Document incidents	• After working with a client – whether individually, in a group or in a community activity – follow your organisation's requirements to document what occurred. • This may be in the form of: - a case note - a note in the person's individual support plan - a note in the person's behaviour support plan - a skills development report - an incident report - an 'ABC sheet' (ABC refers to antecedent, behaviour, consequence). • Support workers can be trained by behaviour support practitioners to fill out an ABC sheet to collect data about behaviours.

Work ethically and legally in regard to restrictive practices	• All documentation relating to restrictive practices needs to be collected in line with the 'National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector' Principle 3 (Core Strategy 3) about collecting and using data. • It is up to your supervisor to have all this data ready for the Ombudsman or NDIS Commission to investigate.

Here is an example of ABC and scatter plot data: aspirelr.link/abc-scatter-plot-data

Positive behaviour support can be used with clients who have all kinds of behaviours, disabilities and issues.

Use the actions below to reduce the likelihood of having to use restrictive practices to manage behaviours of concern:

- Get to know the client and their family and carers well. Having a good relationship and rapport with clients and families can mean the difference between minor challenging behaviours and severe behaviours of concern.
- Seek training and advice from your co-workers and supervisors if you are struggling to manage some behaviours of concern.
- Follow the client's individual support plan, behaviour support plan and any other advice from allied health professionals or behaviour support practitioners.
- Be a good role model; demonstrate appropriate behaviours to your client.
- Use support and behavioural strategies that work.
- Do not use strategies that punish the person; these will only make behaviours of concern worse.
- Do not ignore behaviours of concern. They are happening because the person is struggling to manage their emotions or trying to communicate something. Behaviours of concern rarely happen to 'get attention' – this is a myth.
- Get to know the client's behavioural triggers, and form strategies to manage and avoid them.
- Be calm and manage your own emotions. Clients will escalate their behaviour if you react emotionally towards them.
- Take a break. If things are escalating, suggest you both do something soothing or calming.
- Create a distraction. If a client is beginning to escalate to the point just before a behaviour of concern occurs then distract them with a song, a video clip or game, or a change of scenery.

- A skills assessment can help you to understand what a client can and cannot do. Offering support to a person when they are genuinely struggling with a task can reduce the severity and number of behaviours of concern.
- Behavioural strategies recommended by behavioural support practitioners can take time to implement, especially if the client has an intellectual disability. They can take a long time to learn a replacement behaviour, so be prepared for the long haul. Having an attitude of patience and being consistent with strategies is helpful.
- If a client does not have a behaviour support plan and they are engaging in behaviours of concern, suggest that the person and their family/carers contact a behaviour support practitioner.

For more information on positive behaviour support: aspirelr.link/dem-bsp

Example

Positive behaviour support and appropriate use of restrictive practices

Frankie is 25 and has a severe intellectual disability. She attends a disability organisation every weekday that supports clients with high and complex needs. At the centre they do a range of fun recreational activities. Frankie likes trains and cars, and she also likes music and being in the centre's sensory room.

Over the last three months, Frankie has been running into traffic when out in public with her mother, Moira. She does this because she likes the cars and wants to run with them. There have been several occasions when Frankie has nearly been run over. She has also fallen quite a few times on the road and has hurt her ankles and legs.

The disability organisation has reported that Frankie has attempted to run onto the road while out doing community activities. They also noted that she has been able to get out of the centre's door easily and run out to the road.

Moira has engaged a behaviour support practitioner, psychologist Dr Aaron, to help with this behaviour of concern. Dr Aaron performed a functional behaviour assessment on Frankie. He then drew up a report of support and behavioural strategies for the disability support staff and Moira to follow.

The recommendations were:

1. Frankie requires one-on-one support while out in the community. This ratio will help her to be safe. It is not appropriate to take Frankie out into the community with any other clients.

2. When Frankie is at the disability centre, the front door and gate must be locked at all times. Staff need to check that they are both locked. People wanting to come into the centre need to ring the doorbell to be let in.

3. Frankie is more likely to want to get out when she hears the train nearby. When Frankie hears the train and wants to run out, put on YouTube clips of cars and trains for her to look at instead.

Disability support worker Alisha has been working at the centre for a while, and knows Frankie and Moira well. Alisha follows the recommendations set out by Dr Aaron. As soon as the train can be heard, Alisha takes Frankie into the sensory room to watch clips of cars and trains. After doing this over and over, Frankie has very slowly learned to go into the sensory room to look at the clips instead of running onto the road. Having the centre's front door and gate shut and locked is a reasonable environmental restraint to stop Frankie from being injured or killed.

At home, Moira has also found that having YouTube clips of cars and trains constantly on hand has helped to reduce Frankie's behaviour of concern. She still requires one-on-one support in the community because of her impulsivity to run into traffic; however, a few support workers have reported that sitting down and watching the clips on a phone have somewhat helped to stop Frankie from running away.

Example

Positive behaviour support with a behaviour support plan

Eric is 10 and has level 3 autism and an intellectual disability. He is mainly nonverbal but can speak a few words. Eric attends a special school two days per week, and his teacher has designed a communication book for him to use when he wants to communicate different needs. Eric has qualified for in-home support after his father, Darrell, got more funding from the NDIS.

Darrell needed more in-home support when he went back to work after having time off due to injury. Skylar is the new support worker who has been hired to support Eric for three days per week in his home.

Eric has had a long history of head-banging when he is angry, upset or frustrated. Specialist disability social worker Grace has completed a functional behaviour assessment for him. Her recommendations to manage the head-banging are as follows:

1. One of the functions of the head-banging is Eric being tired. Offer to give him a break and to take a nap when he needs to.

2. One of the functions of the head-banging is when he is trying to communicate anger and frustration. Offer him his communication book so he can indicate the words he is trying to use; for example, 'I am hungry', 'I want to sleep', 'I need a hug', 'I need to play a game'.

Skylar spends some time getting to know Eric and Darrell, their routine and the activities that Eric enjoys and does not enjoy. She notices that the head-banging generally begins just before meals and snacks, so she adjusts these times. She also finds that showing Eric the pictures for food around these times helps him to understand that when he uses the communication book, she will do what he wants.

Over about a month, Skylar has successfully shown Eric when to go and have a nap and to communicate when he is hungry. Both Darrell and Skylar report to Grace that the head-banging is no longer a behaviour of concern, so Grace makes the necessary adjustments to his behaviour support plan.

Organisational policies and procedures

All service providers in the community services sector will have a set of policies and procedures to follow.

It is vital that you follow organisational policies and procedures when developing and managing individual care plans, as they will ensure that all work practices meet legal and ethical obligations.

Family members, caregivers and/or relevant others play an important role in developing and managing a care plan. Policies and procedures that apply to the role of family members and/or caregivers when developing and managing a care plan may include areas such as consumer advocacy, personal care and child protection.

Example

Develop a strategy to address needs

Francis is the manager at a respite service for people who have autism spectrum disorders and/or intellectual disability, and who display some behaviours of concern. There have been several incidents where the safety of the support workers has been compromised.

Francis reads the incident reports from a one-week time period and notes the following:

- Injuries to staff: 5
- Near-miss incidents: 12
- Percentage of incidents occurring in the morning: 85%
- Percentage of incidents occurring when one staff member is working alone: 60%
- Percentage of incidents occurring when the environment is busy, loud or disorganised: 75%
- Percentage of incidents occurring when the environment is quiet, calm and peaceful: 25%

Francis realises that adjustments are required regarding service delivery and how care is provided. She consults with the support workers about how safety can be improved at the service, while still meeting the needs of the people in their care.

It is determined that:

- people using the service should arrive at staggered times in the morning, allowing workers to settle each person into the environment individually
- workers will work in pairs
- music and noise need to be regulated, particularly in the morning.

Francis monitors the incident reports for the next month and observes that the number of incidents decreases by half.

Practice Task 6

Question 1

List two behaviours of concern that a person with a psychiatric disability may present.

Question 2

List two responsibilities a behaviour support practitioner has when developing behaviour support plans that include restrictive practices.

Question 3

Explain the term 'unregulated restrictive practice'.

Question 4

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

a. Unauthorised restrictive practices are those practices that have not been pre-approved by an appropriate behaviour support practitioner.	Yes / No
b. Unauthorised restrictive practices can result in physical, psychological and emotional harm to the person.	Yes / No
c. There are no consequences to the service or workers when unauthorised restrictive practices are used.	Yes / No
d. The NDIS Quality and Safeguards Commission must be notified when a restrictive practice has been used.	Yes / No
e. If a person's support workers and/or family identify that behaviours of concern are no longer occurring, this must be documented and the support plan must be reviewed and updated by the behaviour support practitioner.	Yes / No

Question 5

List three positive proactive approaches that can help to eliminate the use of restrictive practices.

Question 6

List three ways support workers can document behaviours of concern.

Question 7

List two ways seclusion can impede a person's human rights.

Question 8

Briefly outline when it is acceptable to use restrictive practices.

Question 9

Briefly outline the responsibility of the family, carers and health professionals in supporting a person on a behavioural support plan.

Question 10

List three core principles of the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector.

Question 11

Match each type of restraint on the left to its definition/description on the right.

Physical	The use of medication or a substance to influence a person's behaviour.
Mechanical	The use of force to prevent, restrict or subdue movement to influence behaviour.
Environmental	Using devices to restrain, prevent or subdue movement to influence a person's behaviour.
Chemical	Restricting free access to parts of the person's environment, including activities and items.

2B Liaise with relevant experts when developing individualised plans

There are many health professionals who may need to be involved when developing an individualised plan of support and care.

Who is consulted will vary depending on specific needs and requirements. Professionals such as a physiotherapist, occupational therapist, continence nurse, diabetes educator, mental health nurse, psychologist, dietitian, social worker or behavioural analyst may contribute to ensure optimal care is provided. These professionals can offer guidance and advice on how to meet specific care and support needs, and any training or special skills a worker may need to learn. You may consult with relevant experts prior to writing an individualised plan or you may ask them to attend a planning meeting.

Nutritional and dietary considerations

Nutrition and dietary considerations are very important. The type of disability a person has may affect the nutritional and dietary considerations that are included in their care plan.

Nutrition and diet are fundamental to achieving maximum quality of life for the person. Ensuring they receive the **macronutrients** and **micronutrients** needed to support their health requires planning and input from a range of experts.

Some people may have food preferences that affect their nutritional and dietary intake. If some foods or food groups are rejected completely, it may be necessary to use alternative methods to maintain adequate nutrition. Some people may require food to be prepared in certain ways to encourage them to eat a balanced and nutritious diet.

Here are examples of some nutritional and dietary considerations for a range of disabilities.

Macronutrients
The protein, fat and carbohydrates required in a person's diet.

Micronutrients
The vitamins and minerals that support a person's health and wellbeing.

Physical disability	Sensory disability	Neurological disability
Depending on the type of physical disability, nutritional and dietary considerations may include texturally modified or enriched food, or food that is easy to manage.	Depending on the type of sensory disability, nutritional and dietary considerations may include texturally modified food or food that is high in flavour.	Depending on the type of neurological disability, nutritional and dietary considerations may include texturally modified food, enriched food or food that is easy to manage.

Liaise with experts and health professionals

Each health professional has expertise in different areas.

For example, dietitians, speech pathologists and occupational therapists can all help plan for the nutrition and dietetic needs of a person with a disability.

Other examples include:

- a physiotherapist supports physical needs and manual handling/lifting
- an occupational therapist assists with tasks and actions that are part of daily life
- a speech pathologist assists with oral and language skills and functioning
- a dietitian specialises in providing advice and guidance on nutrition, food, meal selection and planning.

Here is an example of how a dietitian can assist in developing an individualised plan.

- Determining food intake needs with consideration of weight loss or gain requirements and appropriate dietary balance
- Considering any food allergies or intolerances, such as peanut allergy or lactose intolerance
- Planning for appropriate timing of meals and snacks during the day and week
- Providing training in meal assistance skills, such as supporting safe swallowing or using correct positioning
- Developing a plan for emergency situations such as choking or anaphylaxis
- Considering special health requirements such as diabetes in meal planning and timing
- Considering preferences for food and meal presentation and timing of meals
- Taking cultural and religious needs into account when preparing nutritious and appropriate meals

Video: The role of a dietician

Watch the following video on the work of a dietician:
aspirelr.link/yt-dietician-role

Pay attention to how working with a dietician has significantly improved the lives of the person and his family.

Example

Liaise with experts when developing individualised plans

Sharon and Terry work in a community care centre. One of their tasks is to assist Ken at mealtimes. Ken is a 30-year-old man who has severe cerebral palsy. Sharon and Terry have expressed concerns about Ken choking on his meals as there have recently been instances where Ken has struggled to swallow his food and has begun to cough violently. Neither Sharon nor Terry has been shown how to assist him correctly. Sharon seeks specialist advice and speaks with Paula, the speech pathologist who works in the centre.

Paula speaks with Ken and asks his permission to talk to Sharon and Terry about his needs. She checks what he likes to eat most and how he likes to be assisted during mealtimes. Paula shows Sharon and Terry how to position themselves in front of Ken and cut the food into small pieces.

Paula tells Sharon and Terry to make sure they only place small amounts of food in Ken's mouth, and to check that he is ready for more food before offering more. She also explains that a quiet, peaceful, calm area will make it easier for Ken to eat and will be safer, as he is less likely to be surprised, jump or react when chewing or swallowing. Paula gives Sharon and Terry an instructional flowchart showing what to do if Ken begins to choke. This is to be displayed on the wall near where Ken eats his meals.

Paula calls in a week later to see if Sharon and Terry now feel comfortable assisting Ken with his meals. They both state that they feel more confident now they know exactly what to do and how to manage an emergency should it occur. Paula suggests that the new procedures be included in Ken's care plan. Ken also says he is much happier and more relaxed during mealtimes.

Practice Task 7

Question 1

List two reasons a health professional may need to be consulted when developing a care plan.

Question 2

Suggest two ways a dietitian can contribute to a person's care plan.

Question 3

List one dietary consideration for a person with a neurological disability.

2C Negotiate and establish goals

The goals of each person receiving support will have a different focus.

For some people goals may be easily achieved; while for others, goals may require more planning and support.

Some goals may need to be negotiated to ensure they are achievable. Goals should be negotiated and established with the person and/or their family, caregiver or relevant other person such as an advocate. Goals can change over time, but should focus on identifying what the person wishes to achieve in a given time frame and how the service can assist. It is important to recognise that the person receiving support and their family/carers are the experts in their own requirements, and goals need to reflect their needs and requests. Clear, well-designed goals are vital to an effective individualised plan.

Negotiating goals may be required when there are constraints regarding budget, equipment, expertise or staffing availability. They may need to be renegotiated if there is a change in the person's capabilities. It is vital that the person requiring support is included, respected and supported in the decision-making process. The strategies and resources required to meet the goals also need to be discussed with the person and relevant others.

You can meet with the person and relevant others to discuss and negotiate goals using an approach that is suited to the situation. Once goals have been negotiated, identify what actions should be taken and what resources are required for each goal to be achieved.

Staff members may need to be assigned specific roles in establishing and working towards achieving goals. Some goals may need to be considered in smaller parts or steps so they can be achieved over an extended time frame.

Goals need to be documented, with a clear time frame and information recorded about who is responsible for implementing actions towards achievement. Additional support, such as physical resources or specialist training, may be required on an ongoing basis while goals are being worked towards, to ensure safety and effectiveness.

Important considerations when establishing goals
Is the time frame reasonable for each goal?
How will each goal be measured?
Is the goal realistic for the person requiring support?
How will barriers or issues relating to the goal be addressed?
What specialist support is required?
When will the support plan containing the goals be reviewed?
How will information regarding goal achievement be recorded?

Example

Negotiate and establish goals

Theresa is 18 years old and has Down syndrome. She lives with her parents, Jill and Simon, but wants to move into a place of her own and work in a clothing store.

Theresa's parents support her goal, knowing how important independence is to her and how it will improve her overall wellbeing. They contact a community services organisation that provides transition support to help young people build their job skills and become independent.

Jasmine, the community services consultant, sets up a meeting with Theresa, her parents and her sister. It soon becomes evident that independence is very important to Theresa, and together they discuss the options that are open to her.

Jasmine explains that both goals are achievable, and she has sourced a retail traineeship that would suit Theresa. Jasmine discusses the traineeship time frame and the extra support Theresa may need to achieve this goal. A second goal supporting Theresa's wish to live independently is also established. Jasmine will source and negotiate independent living options for Theresa that are within her budget.

Practice Task 8

Question 1

You work with a person who has a severe communication impairment and an intellectual disability.

Identify two things you should consider when working with the person to establish goals.

Question 2

Suggest two other people you should include when discussing goal setting with the person.

Question 3

Provide one reason you may need to negotiate goals.

2D Access and negotiate resources to deliver identified services

Once service needs have been identified for a person requiring support, resources need to be accessed and negotiated.

Resources
Things that are needed to enable the appropriate delivery of services to a person requiring support.

Resources may be accessed from your organisation or other agencies. Some resources may need to be negotiated, such as funds or training, in order to deliver appropriate services.

The area of community services in which you work, and the needs of the person in care, dictate what agencies need to be accessed for support. As a community services worker, you may need to access and negotiate resources so the needs of the person can be met appropriately.

Resources may include equipment, specialist training, human resources, financial support or housing. Depending on the person's specific needs, level of needs and complexity of needs, access to more than one agency may be required. Aligning the necessary resources may require negotiation and consultation with the person requiring support, their family and/or carers and the agency providing the service.

Types of resources

Understanding and establishing the individual needs of the person in care is crucial to accessing appropriate resources to support their care.

When a person has complex needs, it may be necessary to access support from health and community services.

Here are some examples of types of resources that may be required.

Aids and equipment	Aids and equipment may be needed to enhance the person's independence. Resources may include mobility aids, home modifications, vehicle modifications or domiciliary oxygen. Communication enhancement equipment, such as speech generating devices and software, may be required.
Financial support	Concessions, carer's allowance or financial counsellors may be accessed to aid a person in need of financial support.
Housing	Depending on the circumstances of the person requiring support, they may require supported accommodation, community housing or support to live in their own home.

Human resources	Depending on the person in care, specialist community services staff may be required to provide direct care. Trainers may be required to upskill and train community services workers in specific and specialist skills that are needed to provide appropriate care.
Independence support	A person in care may need support to enhance their independence. This may include providing support in areas of need related to transport, culture and language, finance or advocacy.
Manual handling	Specialist equipment such as hoists, shower chairs, mobility aids and transferring equipment may be needed to help with tasks.
Specialist support	Specialist support may be accessed for people who require case management, therapy or behaviour support.

Access resources

When accessing support resources, there may be guidelines and requirements that need to be met before services can be supplied.

Depending on your role in the community services sector and who you are seeking support from, you may be required to provide a range of information when requesting support.

Access to resources may be influenced by criteria set by service providers, available funding and the specific requirements of the person requiring support.

Example

Access and negotiate resources

Max has an acquired brain injury resulting in left-side weakness in his limbs and cognitive challenges. He needs support to plan and organise his daily activities and to complete some personal care and household tasks. The bathroom has a narrow doorway and is difficult for Max to enter with his walking frame. The shower has a raised edge that puts him at risk of tripping as he cannot raise his left foot.

Max's case manager assists him by accessing and negotiating the following resources:

- Bathroom modifications to increase safe access
- Home support for preparing and cooking meals and completing household tasks
- Personal care support to assist with showering
- Assistance with planning and organising activities

Max is now able to maintain his current living situation safely and more easily.

Practice Task 9

Question 1

Sharon, a person in your care, would like to live more independently. She has a low level of financial literacy, and she also needs support to access shops and ongoing monitoring for a behavioural condition. Give two examples of resources you could access or negotiate that would help Sharon to live independently.

Question 2

A person in your care lives at home but is finding it increasingly difficult to manage their personal care and is often unable to get out of bed on their own. List two types of human resources you could access for them.

2E Access community support agencies to facilitate the achievement of goals

Community support agencies may be able to facilitate the achievement of goals for a person with a disability who requires support.

Depending on the person's goals and needs, a community support agency may be accessed to increase their participation and help reduce and remove barriers. Community support agencies often have eligibility criteria and service guidelines for accessing specific programs and services.

Here are some types of community support agencies and how they can facilitate the achievement of goals.

Community health services
Community health services meet a variety of needs including assessment, intervention and treatment for health conditions and disabilities, often through an allied health professional, mental health nurse, social worker or psychologist. Community health services can help facilitate goals of living independently, living with support, and maintaining physical and mental health.
Respite and carer support
Respite and carer support services provide support to voluntary primary caregivers by allowing them to take a planned break or helping them manage unexpected events. They also offer counselling and general support via telephone, online or face-to-face services. Respite and carer support can help facilitate goals regarding maintaining care relationships, strengthening carer capacity and having regular breaks from the primary carer role.
Adult day services
Adult day services support adults who have an intellectual, physical or sensory disability or other specific need. Services assist adults to achieve life, recreation and educational goals and to maintain or increase their independence. Adult day services can help facilitate goals regarding social and recreational involvement, fitness, specialised activities and mental stimulation.

Example

Access community support

Jack is 21 and lives at home with his mother and younger brother, Peter. Jack attends a day activity program but feels lost and isolated on weekends. His mother works long hours to support the family and has little energy left to organise recreation activities for Jack.

Mandy, Jack's community services worker, helps him to contact a local community centre where there are many different classes that operate on weekends. Jack decides he would like to try ballroom dancing, so Mandy helps him fill out the forms to enrol in the class. Jack discovers that he loves to dance and is soon attending the class each weekend and also going to monthly dances held on a Saturday night.

Jack's mum loves having some valuable respite time that she can spend at home relaxing and watching a movie or reading a book. Peter also enjoys having a break from Jack and being able to spend some quiet time with his mum.

Practice task 10

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

Case study

Jeremy is a full-time carer for his mother, Leah. While the care Jeremy provides is not physically demanding, he finds it mentally difficult because of the constant nature of her care. Leah wants to attend community activities to increase her social interaction with others. Jeremy is not interested in going to the community activities so Leah does not go. Sometimes this causes stress on their relationship. Jeremy would like to have time to play squash with his friends every Friday.

Question 1

Suggest one goal Jeremy should set.

Question 2

Suggest one agency Jeremy should contact so he can meet his goal.

Question 3

Suggest an agency Jeremy should contact to facilitate his mother's goal of attending community activities.

Summary

- Best practice guidelines and policies and procedures help meet a range of manifestations and presentations of various disability types.
- Engaging in best practices means you are providing the best level of legal and ethical practice.
- Positive behaviour support refers to actions taken to change or redirect behaviours of concern.
- Behaviour support strategies are usually planned and detailed in a person's individual support plan.
- Behaviour support strategies are developed to meet a person's specific needs. It is important that you know how to follow the plan and use the strategies correctly.
- All interventions to manage behaviour must comply with organisational policies and procedures and human rights.
- Document and report any observed changes in a person's behaviour or needs. Intervention strategies may need to be changed as a result.
- Liaise with relevant experts, such as allied health professionals, to help develop an individual support plan.
- Negotiate and establish goals in collaboration with the person requiring support, their family members, caregivers and relevant others.
- Resources such as equipment and staffing may need to be accessed to deliver identified services for a person.
- There are many community support agencies that can assist a person to achieve their goals.

Learning Checkpoint 2

Develop an individualised plan to achieve maximum quality of life

Part A

1. List the eight standards in the Aged Care Quality Standards that provide information and guidance on best practice in community care.

2. List three types of disability and, for each type, provide a nutritional and dietary consideration.

3. List two reasons why goals may need to be negotiated in an individual care plan.

4. Which of the following considerations do you need to think about when establishing goals and creating an individual care plan with your client? Tick all that apply.

- ❑ Is the time frame appropriate?
- ❑ How is the goal going to be measured?
- ❑ Is the goal something I am interested in supporting?
- ❑ When will the plan be reviewed?
- ❑ Is specialist support required?

5. List two factors that may influence access to resources.

6. Provide one reason why resources may need to be negotiated.

7. Explain why the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector was established.

8. List the five types of restrictive practices that the NDIS Quality and Safeguards Commission monitors. Provide an example for each.

9. You support a man with an acquired brain injury. Today, while sitting to eat in the shopping centre food court, he began screaming and wailing.

Which of the following actions would you take to respond to this situation? Tick all that apply.

- ❑ Communicate in a calm manner.
- ❑ Disapprove of the behaviour and make judgmental remarks.
- ❑ Scream back in response to draw his attention.
- ❑ Use distraction to redirect the behaviour.
- ❑ Record and report the incident to your supervisor.

10. What role do the following people play in developing a behaviour support plan?

a. Behaviour support practitioner

b. Family members and carers

c. The person

11. List three instances when it is acceptable to use restrictive practices.

12. Which of the following are possible consequences of unauthorised use of restrictive practices? Tick all that apply.

- ❑ The person doing the practices physically injures the person they are attempting to restrain.
- ❑ It can cause workers to work longer hours.
- ❑ It can cause trauma and psychological harm.
- ❑ It can make mental health disorders worse.
- ❑ It can lead to overreliance on a type of restraint, which impedes the person's ability to regulate themselves in an appropriate way.

13. List three legislative and organisational requirements in relation to documenting the use of restrictive practices.

14. If you observe that your client has continuously responded well to the positive behaviour support strategies documented in their behaviour support plan, what steps would you take to have the restrictive practices in their plan reviewed?

Part B

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

Case study

Ruby is a community support worker for Pablo, who is 18 years old and has complex needs. He has autism, a mild intellectual disability and diabetes. Pablo has finished school and lives at home with his mother, Marita, who speaks Spanish and has limited English language skills. Marita needs to work part time to support herself and Pablo. Ultimately, she would like to work full time to ease the financial stress on the family.

Pablo is often alone and finds himself getting bored. He loves football, fishing and cricket, and he would like to try some new activities and meet some new friends. When Marita is not home, Pablo forgets to eat regularly and is not capable of managing his diabetes.

Ruby meets with Marita and Pablo to discuss their goals. She discusses options with Marita and Pablo, including the community support agencies that could support their needs and help them meet their individual goals. Ruby contacts the community support agencies to see what support Marita and Pablo are eligible for.

1. List two community support agencies and the services they could provide to support this family.

2. What important organisational procedures did Ruby follow when managing the goals of Marita and Pablo?

3. List two experts or health professionals that Ruby could liaise with when developing Pablo's support plan, including support for his diabetes.

Topic 3: Coordinate the delivery of the individualised plan

3A Ensure services and support activities are undertaken by appropriately skilled workers

3B Recognise when a support worker is unable to provide required services

3C Support stakeholders to understand their roles and responsibilities

3A Ensure services and support activities are undertaken by appropriately skilled workers

Across the community services sector there are many different areas of skill that are required to perform the various work tasks.

When community support workers undertake new tasks they require training, while completing other tasks may need updated or refresher training on a regular basis. Ensuring workers have the appropriate skills and training for their roles is vital to providing quality care. The organisation, and the people who work for the organisation, must adhere to best practice obligations, relevant legislation and service standards.

Maintaining the level of skills required for a role in the community services sector is critical to delivering quality person-centred services. All community services workers should have access to training and development so that they are appropriately skilled for their roles.

Core training needs for each staff member should be identified and a plan developed to provide the required training. When working with people with complex needs, the level of care and the care requirements can change.

As a support worker, you may need to acquire new skills, update old skills and/or develop specialty skills. Skill development may be required to manage the following:

- Potential hazards, such as infection or manual handling
- Mobility equipment, such as lifts and slings
- Behaviours of concern
- Administration, reporting and documentation processes
- Basic or high-level first aid issues and medical emergencies
- Learning new and different types of support strategies
- Learning about new and emerging trends that impact community services organisations

Maintain appropriate skills

Depending on where you work, your organisation may actively provide opportunities for staff to participate in training and information sessions.

This may include a formal training plan with goals and priorities, or more informal training such as refresher courses, mentoring or workshops. The aim of any training session is to ensure appropriate skills are developed and maintained.

In some cases, a community support worker may become aware of a gap in their skills while caring for a person with changing or complex needs. The skill set initially required for care provision may have been appropriate; however, when needs become more complex and specialised, different skills are required.

The support worker should speak with their supervisor or manager if they feel they do not have the appropriate skills to complete a task within their role.

Example

Provide skills development

Archie is a team leader who organises support workers to provide care to Tom at home. Tom has motor neurone disease and his needs are changing, which affects the level of care he requires.

Recently, transfers from Tom's wheelchair to a shower chair have become more challenging. Some of the support workers are finding it increasingly difficult to manage the transfer comfortably and safely.

Archie organises a training session for the workers with Sue, a physiotherapist. Sue demonstrates the appropriate way to transfer a person from a wheelchair to a shower chair. She has the workers practice with each other, so they can gain the skills they need to assist Tom appropriately. Sue also talks to the workers about how Tom's needs and care provision may change in the coming months.

Archie records a video of the training session so the workers can refer back to it as needed. Sue also provides an illustrated flowchart of the steps for completing a transfer, which can be used for reference.

Archie is pleased to hear that the workers now feel much more confident in performing the transfers, and that they have used both the video and flowchart as reference tools.

Practice Task 11

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

Case study

Mandy is a young woman who sustained a spinal injury after she fell from a horse she was riding in an equestrian event. As a result of the injury, Mandy uses a wheelchair for mobility, needs assistance to transfer into the wheelchair and requires personal care.

Mandy's regular care worker is unwell and needs substantial time off work. A new care worker, Wendy, is filling in. Wendy transfers Mandy from her bed to the wheelchair using a sling and it hurts Mandy's back. Mandy tells Wendy that she does not feel safe the way Wendy is lifting her.

Wendy talks to her manager, Bill, about Mandy's comments. She tells him that she has not used the mobility equipment before and does not feel confident transferring Mandy on her own. Wendy also reports that Mandy appeared to be wheezing and shaky. Bill checks Mandy's care plan and notices that it does not include these issues.

Question 1

Identify two things Bill should do to ensure that Wendy has the appropriate skills to do the task required.

Question 2

Suggest two things Bill could do to ensure Mandy's changing care needs are met.

3B Recognise when a support worker is unable to provide required services

Service needs and tasks can change when the needs of the person, or the type or level of support they require, changes.

Changes to service and support may result from a range of events; for example, there may be changes to the service provider that impacts their capacity to provide a person with particular types or levels of service. They may also result from human resource constraints, variations to funding or service agreements, or provision of resources.

In the community services sector, it is vital to recognise when the services or support required in the person's care plan are not being provided.

There are five main indictors that can help you to recognise when a service or support worker is unable to provide the service that is required.

Changes to the support plan	You may be notified that there is a change to the support plan due to the person's needs changing, such as deterioration in their health or complications from their disability.
Requests from a support worker	A support worker may tell you that they are unable to provide the service required by the person, for example, due to changes to their availability or difficulties performing tasks.
Complaints made by the person	The person receiving support may make a complaint about how a service is being provided and let you know it is not satisfactory.
Feedback from the person	You may actively seek feedback from the person receiving support as to how satisfied they are with the level of service being provided. This can be done informally as the person may be more likely to express their thoughts when engaging in casual conversation.
Service provider issues	Human or physical resources may be lacking, or the service provider may no longer be receiving funding to provide a particular type or level of service, resulting in an inability to continue providing the service to the person.

Example

Indicators of support changes

Jenny has been providing support to Mark for several months. Mark has had a stroke and has increasing difficulty with communication. He becomes frustrated and angry when Jenny cannot understand what he is trying to tell her. Jenny is finding it more difficult to cope with Mark's anger and frustration. It is affecting her work, and she struggles to provide physical care for Mark when he is angry.

Jenny talks with her supervisor, Kate, who recognises that Jenny needs support and adjustments to her work arrangements. Kate organises for Jenny to have support to enable her to work more confidently with behaviours of concern. Together they decide that Jenny's shifts will be adjusted so her interaction with Mark is reduced until she feels able to work with him comfortably. Jenny begins doing some shifts with people who do not have behaviours of concern while she receives additional training.

Practice Task 12

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

Case study

Charlotte is 10 years old and has cystic fibrosis. When she was younger, Charlotte required full-time supervision and specific care to support her physical and dietary needs. Charlotte has progressed to a three-monthly care plan; however, there have been recent changes to her health.

Charlotte's health has suddenly deteriorated and she now requires daily medical care, supervision and feeding assistance. Her case manager, James, realises that Charlotte's care plan requires significant adjustment, as she now needs specialist care and a higher level of support.

Question 1

Identify two things James could do to manage the change to Charlotte's care plan to ensure she receives the appropriate level of care.

Question 2

Identify the key indicator that Charlotte's care requirements are no longer being met in her current care plan.

3C Support stakeholders to understand their roles and responsibilities

In many situations, care and support is provided via a multi-agency platform, with stakeholders tasked to give support according to their particular areas of skill and expertise.

Stakeholders in this context can refer to:

- allied health professionals, including behaviour support practitioners involved in the care of the person
- disability or mental health advocates assisting the person to access services
- case managers or social workers from various community or disability organisations
- family and friends involved in the person's care
- disability organisation supervisors, managers and support workers involved with supporting the person.

In this collaborative and multifaceted work environment it is important that all stakeholders feel well supported in their various roles while providing support and care according to the person's individual support plan. This is particularly important in situations where many agencies are working together to support a person with complex or high-level care needs.

All stakeholders need to understand the individualised care plan for each person receiving support, and their roles and responsibilities in the plan.

As a support worker, how you provide support will vary depending upon your role in your organisation, and the skills, capacities and task requirements of the stakeholders involved. Information flow between stakeholders and support workers is vital. Information must be accurate, and shared within appropriate time frames with the appropriate stakeholders.

Clarify roles and responsibilities

To ensure that stakeholders fulfil their responsibilities outlined in the care plan, there are a range of actions you can take to clarify their roles and responsibilities.

Roles and responsibilities must be clearly defined to ensure the support provided meets the requirements of the care plan. Stakeholders can be supported to fulfil their roles and responsibilities in the following ways.

Methods to support stakeholders
Use technology tools (e.g. videoconferencing, email, text messages) to share information.
Ensure input from the person receiving support is shared.
Identify roles for tasks in the plan and clarify information as needed.
Set specific timelines for the person's goals to be reached.
Negotiate which stakeholders are undertaking different types of service provision for the person. Confirm any funding or costs for service provision that the person needs to be aware of.
Discuss any changes regarding the person's needs.
Document any changes to roles and responsibilities and record new information.
Ensure all documents are understood.
Enlist specialist providers if needed to meet responsibilities.
Provide training to staff if required to meet task responsibilities.

If service workers fail to meet their **duty of care** obligations, they can be found negligent and could face discipline for not taking appropriate action.

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

For more information on duty of care, visit: aspirelr.link/mypeer-duty-of-care

Issues and risks to the person

Abuse, exploitation and neglect are real threats to people with disabilities.

People with disabilities are more vulnerable than the general population. In Australia, they are three times more likely to experience abuse and neglect than other groups.

Even more challenging is that the abuse and neglect that people with disabilities experience is often unreported and not investigated or prosecuted, resulting in the perpetrator going unpunished. For this reason, the incidence of abuse could be significantly higher as current evidence is based on reported incidents.

The following table describes different types of abuse.

Physical abuse	Physical abuse is when a support worker or caregiver intentionally causes pain or injury to the person they support, by: • hitting, kicking, punching • using unauthorised restrictive practices.
Sexual abuse	Sexual abuse is when a support worker or caregiver, without consent, forces sexual behaviour or acts onto the person they support. This can include: • unwanted touching or kissing • forcing someone to perform a sexual act • exposing a person to explicit images and videos • indecent exposure.
Psychological abuse	Psychological abuse is when a support worker or caregiver behaves in a way that takes away the person's dignity and self-worth. This can include: • insults or name-calling • removing aids, e.g. taking a wheelchair away from a person • threatening a person • isolating or ignoring a person.
Neglect	Neglect occurs when a support worker or caregiver does not meet the needs of the person they are assisting. It can include: • not giving the person enough to eat or drink • not providing appropriate supervision • not attending to the person's grooming or personal care • allowing a person to develop a medical condition • failing to have a medical condition treated.
Exploitation	Exploitation is when a support worker or caregiver takes advantage of another person for financial gain. This can include: • using their physical and financial resources without consent • misusing a person's income • stealing from a person • forging a person's signature or forcing the person to sign.

For more information on abuse and neglect, visit: aspirelr.link/adc-abuse-neglect

Indicators of abuse

Indicators of abuse
Physical and behavioural signs that might indicate a person is being subjected to abuse or neglect.

Support workers need to look out for **indicators of abuse.**

When supporting clients, it is important to observe and get to know them. As a result, you can quickly identify and follow up any new behaviours or changes in appearance or demeanour.

Depending on the person's disability, it may not be possible to obtain hard evidence that abuse is occurring; however, you only need to have a reasonable belief. If you suspect the person you support is in an abusive situation, report your suspicions to your supervisor immediately.

Indicators of abuse
• Injuries and bruising that cannot be explained • New behaviours of concern • Changes in sexual behaviour • Unusual or new fears, including fear of a person • Avoidance of certain settings or environments • Sexually transmitted diseases • Unexplained weight loss or dishevelled appearance • Difficulty gaining access to the person with care needs because the carer is making lots of excuses • Overly flirtatious behaviour between a worker/carer and the person, which could indicate an inappropriate sexual relationship • Receiving conflicting accounts of incidents from the person's carer • Witnessing hostility from the carer towards the person with care needs

Example

Support stakeholders to understand the care plan

Roger has quadriplegia after receiving a high-level injury to his cervical spine. He has undergone service-based rehabilitation for five months and is finally returning home. His parents are excited that he is able to come home but unsure about how they will meet his care needs. Several agencies are working together to support Roger's return home and his ongoing care and support. Stakeholders include district nursing staff, a physiotherapist, a discharge planner from the hospital, a case manager and representatives from two personal care agencies.

Roger's case manager, Fiona, meets with all the stakeholders who will be involved in providing care and support to Roger at home. She arranges the meeting for the week prior to his discharge from hospital so all the stakeholders will have time to finalise staffing, organise physical resources and plan administrative and managerial support for the staff who will work with Roger.

Fiona holds the meeting during a weekday morning so Roger's mother can attend. Fiona spends some time with Roger's mother prior to the meeting so they can talk in private about the arrangements, as the planning meeting will involve many people from different agencies and she does not want Roger's mother to feel overwhelmed. At his own request, Roger attends the first part of the meeting via Skype so he does not have to miss his weekly hydrotherapy session.

After the meeting, Fiona visits Roger's parents at home to make sure they are comfortable with what has been planned for Roger's discharge and to clarify any information they may not understand.

Practice Task 13

Question 1

List three ways you can support a person with a disability and other personnel to fulfil their responsibilities in the care plan.

Question 2

Identify three important aspects that must be adhered to when sharing information between stakeholders.

Question 3

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

a. Workers need hard evidence before they can report suspected abuse.	Yes / No
b. A person you support may be experiencing neglect if they appear unkempt and dirty.	Yes / No
c. It is exploitation if you use a client's money to buy yourself a gift, even if they handed you their wallet to make the purchase.	Yes / No
d. It can be difficult to identify instances of abuse when working with people with disabilities as many are unable to communicate what has occurred or understand that it is unlawful.	Yes / No

Summary

- Workers need to have the necessary skills to provide appropriate services to people requiring support.
- It is important to recognise and respond when a support worker or service is unable to provide the services required.
- All stakeholders must be aware of their roles and responsibilities as identified in the individual support plan.
- People with disabilities are faced with a range of challenges, including an increased risk of experiencing abuse, neglect and exploitation – many instances of which go unreported.
- Part of a support worker's role is to identify signs of abuse and neglect, ensure a safe environment and practise duty of care.

Learning Checkpoint 3

Coordinate the delivery of the individualised plan

Part A

1. List two things that can indicate that additional skills may need to be developed when delivering an individual support plan.

2. Provide two reasons that a service provider may no longer be able to provide the services required by a person.

3. Jackson, the manager of a community care service provider, has contacted you to say that he will be interstate and unable to attend the support plan meeting of a person in your care. Suggest how Jackson can still fulfil his role and responsibilities.

4. List one thing you could do to make sure the individual support plan is well coordinated between all stakeholders.

5. Explain why abuse, neglect and exploitation are faced by people with disabilities on a greater scale.

6. As part of their duty of care, suggest what responsibilities support workers have in relation to identifying and reporting abuse, neglect and exploitation of a person with a disability.

Part B

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

Case study

Simon is the case manager for Terri, a person with complex support needs. Terri has multiple sclerosis (MS) and has recently been diagnosed with type 2 diabetes. She needs support with understanding and managing her diabetes and, as the MS progresses, she will require more care.

It is Simon's role to coordinate the delivery of services according to Terri's individual support plan. Lisa is Terri's current support worker, but she does not have the skills to manage diabetes. She requires training in recording data, using insulin, managing blood sugar levels and managing any difficulties or issues.

Lisa does have the skills required to care for the current stage of Terri's MS; however, as the MS advances and Terri's condition deteriorates and changes, Simon knows Lisa will require more training.

Simon creates a training plan for Lisa and arranges for her to attend a workshop for disability support workers caring for people with diabetes. Simon also makes a note to access training for Lisa to enable her to provide care for Terri as her needs change.

1. Lisa needs new skills and development of the skills she already holds. Suggest two things Simon can do to make sure Lisa has the skills she needs for her role.

2. Should Terri be asked about the level of support she is currently receiving? Briefly explain your response.

Topic 4: Coordinate the monitoring, evaluation and review of the individualised plan

4A Seek feedback from all stakeholders during the evaluation of the plan and re-prioritisation of support needs

4B Seek advice and assistance when the person's goals are not being achieved

4C Revise the individualised plan in consultation with the person, their family or carer

4A Seek feedback from all stakeholders during the evaluation of the plan and re-prioritisation of support needs

You may need to seek feedback from a variety of people when evaluating the effectiveness of the care plan.

Contact may be made with case managers, mental health nurses, general practitioners, outreach workers, psychologists, allied health professionals or direct service providers. It is also important to get feedback from the person with a disability about the support and care they have received from all involved stakeholders. Feedback is used to evaluate the effectiveness of the plan that is currently in place for a person requiring support.

Here are some examples of feedback that may be offered by stakeholders to help evaluate a plan.

Feedback to help evaluate a plan	
Allied health professionals	Physiotherapists, occupational therapists and speech pathologists, etc. can evaluate physical functioning, skills and safety and help re-prioritise goals.
Case managers	Case managers can evaluate how all the supports for a person work together and advise on general life goals and skill areas.
Direct service providers	Direct service providers can evaluate direct care support, such as personal care and social supports, and help evaluate if staff skills are still suited to the needs of the person.
Mental health professionals	Psychologists, mental health nurses and general practitioners can advise on mental health issues, set new goals and identify potential issues that may require a change in the plan.
Person receiving support	The person receiving support is best able to identify problem areas in their existing plan and advise on what needs to change in the future.

Example

Seek feedback to evaluate the plan

Rhonda is planning a support group meeting to discuss the progress of the support plan for Eleanor, an older woman who has an acquired brain injury. Eleanor's needs have changed recently and she now requires higher level care and a greater amount of supervision during community-based activities.

Several agencies provide care and support to Eleanor, and Rhonda wants to make sure she seeks feedback from each one. She knows it is important to have input from everyone involved in Eleanor's care and support, and the current multi-agency arrangement has been working well to date.

Rhonda emails all the key stakeholders to let them know the details of the meeting. She attaches a copy of the current support plan and a template document for each person to write any comments or suggestions for re-prioritising Eleanor's needs and their service provision. Rhonda is pleased to see that most of the agencies respond to her email prior to the meeting and are positive about sharing their ideas and suggestions. By the time the meeting comes around, everyone is prepared to discuss and finalise changes to the support plan to reflect the new priorities for Eleanor.

Seek feedback from the person receiving support

When evaluating the support plan, encourage the person receiving support to provide feedback and identify any needs that are not being met.

When meeting with other stakeholders to discuss a person's support plan, it is vital to consult with the person and/or their carer or other relevant people identified by the person, such as advocates. The person's feedback is important in informing you what is working well from their perspective and what changes may be required. Their feedback is valuable as they know exactly how the existing plan is working for them. They should be recognised as the expert in their own requirements, along with their family and/or carers.

As with feedback from key stakeholders, feedback from the person receiving support and their carer or significant others is used as part of a continuous improvement process. A person may need more or less care and support, or may require support to be offered in a different way, at different times or for different reasons. Be mindful that if a person is unable to speak for themselves, a carer, advocate or interpreter should be present to assist.

Here are some tips for seeking feedback on a person's support plan:

- Use good communication and interpersonal skills with the person and their family, carers and allied health professionals/stakeholders. This will build trust, safety and security and solidify a good working relationship.
- Ask direct questions about what is working well for them.
- Ask direct questions about what is not working well for them.
- Negotiate new strategies for support for areas that are not working well.
- Suggest referral to other services if there is a service provision gap in the current services they are receiving.
- If the person is struggling to voice their opinions, needs, preferences and goals for the support plan, suggest they engage with a professional advocacy service.
- Accept that, occasionally, clients and their family/carers may not want help for specific areas of their lives. For example, you may observe that a client who is a very heavy smoker is being financially disadvantaged by the cost of smoking, but they may not wish to address this area despite the cost to them. In situations like these, it is important to respect the person's desires and wishes.

Example

Seek feedback

Ken is a case manager for an early intervention program. He is working with a mother, Prisha, to update the support plan for her child. Prisha does not speak or read in English and so Ken has organised for all the documents to be translated into her preferred language of Hindi. He also arranges a Hindi interpreter to be present and makes sure the interpreter arrives after he and Prisha do, to avoid any suggestion that he and the interpreter are working together. Ken greets Prisha warmly and encourages her to be open and frank when talking about what is working well for them in the support plan and what is not.

Together, they plan the support services that are needed for the next 12 months and discuss how the plan will be implemented. Ken writes down their feedback about how the child's needs have changed as he has grown and developed new skills. Most of the feedback is positive and useful as it shows that the support provided to date has been effective. The only changes needed reflect the growing skills and confidence of the child.

Practice Task 14

Question 1

Provide one reason you would seek feedback from a key stakeholder about a person's individual support plan.

Question 2

You are working with a person who has a mental health disorder. List three stakeholders who may be involved in providing feedback for their support plan.

Question 3

Suggest why it is so important to seek feedback from the person receiving support in relation to their care plan.

Question 4

If the person in care is unable to provide feedback themselves, what is one way that feedback can be provided?

4B Seek advice and assistance when the person's goals are not being achieved

There may be occasions in your work when you notice that a person receiving your support is not achieving the goals outlined in their care plan.

You may need to seek advice and assistance from your supervisor to determine the reason the person's goals are not being achieved. There may be a variety of reasons for this; for example, the goals may have been unrealistic, the person's abilities may have changed, resources may no longer be available or the person's level of care may have changed.

However, it is advisable to first consult the person receiving support, as they are best positioned to give you information on why they think their goals have not been achieved.

It may be that the person's interests and preferences have changed or that their disability or health condition has deteriorated or improved. Ensure you also consult the person's family and carers.

If you discover that the level of support you are providing is not meeting the person's needs and their goals are not being achieved, it is worth checking with your supervisor to ensure you are doing all you can. Your supervisor may give you the following advice in order to meet the person's needs and goals:

- Adjust the support strategies to see if they help to meet the person's needs and goals.
- Speak to the person and their family/carers about what other support strategies currently work well to help meet their needs and goals.
- If there are needs and goals that are beyond the scope of your role, suggest they see another professional who can meet those needs. They could also contact your supervisor to discuss these needs and goals further.

Depending on the complexity of needs of the person receiving support, here are some people who can provide assistance and advice when the person's goals are not being achieved.

Person receiving support	The person receiving support can offer direct input into meeting and adjusting existing goals.
Family and carers	Family members and carers may be able to explain why goals are not being achieved from the perspective of the person and their family and living situation. They can also provide input into adjusting the care plan.

Allied health professionals	Allied health professionals can provide advice on strategies for managing mental health issues and recognising and responding to changes in mental state or emergency/crisis situations.
Nursing staff	Nursing staff can provide guidance and instruction regarding medical and personal care tasks such as tube feeding, continence issues, diabetes care and other specialised areas of support.
Physiotherapist	A physiotherapist can provide advice and training on positioning, movement and completion of physical tasks and activities.

Example

Seek advice and assistance

Ben lives in a community care centre. He has communication challenges, so he uses assistive technology (AT) to communicate with his carers and family. One of Ben's goals is to be able to go to the local shops and communicate with the shopkeepers without his carer speaking for him. Being able to communicate on his own is very important to Ben.

Phillipa, Ben's case manager, is reviewing his care plan to check his progress. She notices that the agreed goal of being able to visit the local shops independently has not been met by the target date. Phillipa consults with Ben, his carer and his family to find out the reason the target date has not been met.

Ben says that sometimes the AT batteries are flat on the weekend and, even when recharged batteries are inserted, the AT needs to be reset. After discussion with Ben's carer, Phillipa realises that during the week the community support workers are trained in programming the AT and recharging the batteries. However, on the weekend, the community care centre is staffed by casual support workers who are not trained in using and maintaining the AT Ben uses. Thus, when the batteries need to be recharged and the AT reset during a weekend this is not done, and Ben is unable to use the AT when he needs to.

Phillipa organises a training session with an AT expert who shows all the carers how to maintain the AT so it is usable at all times. Phillipa notes this in the review plan and monitors the plan to make sure Ben is making progress to meet his goal.

Example

Seek advice and assistance

Sebastian is 34 and has borderline personality disorder and bipolar disorder. He lives by himself and has recently received funding from the National Disability Insurance Scheme (NDIS) to have a support worker come to his home to support him to access community activities three mornings a week.

Sebastian has had a behaviour support plan and a risk assessment completed by his psychiatrist, Neil. Sebastian sees Neil every three weeks to review how he is going. Neil has formulated a safety plan with Sebastian, for times when he becomes manic or suicidal. Sebastian has also been connected with a local social worker, Helena, who is assisting him to access various community programs. Sebastian has given consent for Helena and his new support worker, Theo, to communicate with each other about his situation.

Theo has been working with Sebastian for around a month. However, Theo noticed that Sebastian was struggling with hallucinations the last morning that he saw him. With Sebastian's consent, Theo contacts Neil for further advice. Neil arranges an emergency appointment for that afternoon. Neil also comes up with a new support and treatment strategy for Sebastian while he is experiencing intense hallucinations. Neil informs both Theo and Helena of the changes and encourages them to contact him if Sebastian's symptoms worsen.

Practice Task 15

Question 1

List three people you can consult with if health goals are not being met.

Question 2

Lisa is a person with complex needs. Recently, her mobility has diminished and she is unable to meet her goal of maintaining her own personal care. List two professionals you could seek advice from.

4C Revise the individualised plan in consultation with the person, their family or carer

Like all work in community services, it is important to follow the correct procedures when making revisions to an individual support plan.

You must have a clear understanding of your own job role, level of responsibility and accountability. When making any revisions, follow the care plan guidelines and the policies and procedures of the community services organisation in which you work.

Make revisions to the person's plan

When making revisions to a care plan, you must follow organisational policy and procedures.

For example, the organisational policy may be that any changes need to be signed off by two people before they are implemented.

Here are some things you should check before you make revisions to a care plan.

Your relationship to the person named in the plan
Your role and level of responsibility for revising support plans
Who can provide support and advice at your organisation before revising a plan
What the procedure is at your organisation for revising a plan
Who needs to be consulted about the revisions, prior to making them
What documentation or reporting is required by your organisation once a plan is changed
What service or program guidelines apply to the person and their support
What input the person, their family, carers and others want regarding revisions

Outcomes to achieve

A plan review is an opportunity for all stakeholders to discuss what supports are working for the person and if they are helping the person work towards their goals.

At the end of the review process, the following should have been achieved:

- The person has been able to reflect on how things are working.
- The person (or their family/carer or advocate) has identified any changes in circumstances, including any changes to their informal support network.
- All stakeholders have agreed to any changes needed at that point in time.
- The person is supported to identify new (or continued) outcomes and goals for the coming period.
- The person is informed about their progress in relation to how well they are doing in achieving the original outcomes included in their care plan.
- New or improved ways of increasing the person's independence and control over the way support is arranged are identified.
- There is a record of strategies or supports that have and have not worked for the person, and strategies or supports they want to change for the future.

Time scales

Revisions need to be conducted within specific time periods, influenced by organisational policy, regulatory requirements or the person's circumstances.

Revisions may be held annually or more frequently if circumstances require it. The person receiving support has the right to request that their plan be reviewed ahead of the review date if they feel it is necessary.

When deciding how often a plan should be reviewed, consider the person's mental capacity to request a review themselves. The frequency should also be proportionate to the person's need and previous reviews. For example, if the person's circumstances have not changed and the supports are still meeting their needs, reviews may be scheduled every 12 months. However, if the person's needs are increasing or have changed, their care plan may need to be reviewed much more frequently.

Essentially, the time between reviews should be enough to allow the person to reflect on how things have gone so far and to consider how they wish to proceed in the next planning period.

For more information and a video on NDIS plan reviews to provide insight into an example of how a plan review is conducted, visit: aspirelr.link/ndis-plan-and-goals

Example

Make revisions to a plan

Tammy has only been working in her role as a case manager for a few weeks when she is asked to make some revisions to a person's support plan in response to their changing needs. She consults with the person and the changes seem very straightforward. Tammy is keen to make sure she does everything correctly, though, as she does not want to get it wrong the first time she revises a support plan.

She reads the organisation's procedures for revising support plans on the intranet and downloads the existing support plan document from the computer. She follows the procedure carefully and then takes a draft of the revised plan to her manager and asks her to check it. Tammy also shows the draft to the person requiring support, and seeks their feedback before finalising the new plan.

After a few minor editing suggestions from her manager, the new plan is finalised. Tammy dates the new plan and includes a new date by which it should be revised in the future. She saves the document to the organisation's system and emails the final version to the appropriate people so they have a copy for their own reference.

Practice Task 16

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

Case study

Tuyet is a recreation worker who has just spent an afternoon with Carmen, a person receiving support. Tuyet's position description says her primary role is to work directly with clients to support them in their chosen recreation activities, as listed in their support plans.

Tuyet reports to Jenny, a team leader who is responsible for developing the program, administering and managing services, and liaising and consulting with the people who use the program. Jenny works three days a week and is not in the office today. She has written a program guidelines document that outlines the procedures for carrying out all the administrative and managerial tasks. The guidelines state that Jenny, as manager, is responsible for revising support plans.

Tuyet believes that Carmen's plan does not reflect her current needs, abilities and service provisions. She thinks Carmen is more capable than her plan suggests and that she does not need the level of support she is currently receiving.

As Jenny is not in the office today, Tuyet downloads Carmen's current support plan herself. She reads it and highlights some sections she thinks are no longer current. She then drafts some new content and carefully edits it to make sure it is grammatically correct. She types up a new edition of the plan and photocopies it, leaving a copy of the old and new plans stapled together in Carmen's file in the filing cabinet. She attaches a post-it note to the front to remind herself she has made the changes and so that she remembers to tell Carmen what she has changed when she sees her next. The changes she has made include reducing Carmen's support hours and reallocating them to another person on the program who she thinks has higher support needs.

Question 1

Identify one thing Tuyet has done well.

Question 2

Identify three things Tuyet has done incorrectly.

Question 3

Suggest what Tuyet should have done differently.

Summary

- Stakeholder input is important and should be sought when evaluating and re-prioritising a support plan.
- Seek feedback from the person receiving support and their family, carers and any relevant others about the effectiveness of the person's support plan.
- Many different people can provide advice and assistance when a person is not achieving their goals; for example, case managers, mental health nurses, general practitioners, outreach workers, psychologists, allied health professionals and direct service providers.
- It is important to follow program and organisational guidelines, policies and procedures when revising support plans, and to always work within your job role.

Learning Checkpoint 4

Coordinate the monitoring, evaluation and review of the individualised plan

Part A

1. List one reason why it is important to seek feedback from the person and others when evaluating the effectiveness of a care plan.

2. List two examples of feedback that a family member may provide about the effectiveness of the current care plan for their family member.

3. List three people you could consult with when the person in care is not achieving their goals.

4. Which of the following actions should you take when contributing to the revision of your client's care plan? Tick all that apply.

   - ❑ Help your client to reflect on how things are working.
   - ❑ Ensure all stakeholders have agreed to any changes needed.
   - ❑ Inform your client about how well they are doing in achieving the original outcomes of their care plan.
   - ❑ Only make changes based on the recommendations and information delivered by the health practitioners involved in your client's care.
   - ❑ Record the strategies or supports that have worked for the person and those that have not.

Part B

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

Case study

Kerri is the case manager for a number of people who use the services of her organisation. She is responsible for revising each support plan and lodging an updated copy on the organisation's server. Kerri has not been through the process of revising support plans before as she is new to the organisation, and she is quite nervous. She has also been asked to send an email to the external stakeholders regarding the revision process of the support plans.

1. Suggest two things that Kerri should check within her organisation before making changes or revisions to any support plans.

2. Provide three examples of external stakeholders who should receive the email.

Glossary

Behaviour of concern

An action that can cause harm, either to the person who presents with the behaviour or to others.

Breadth of need

Multiple needs that are interconnected.

Coexisting issues

Issues that arise when the person is affected by more than one type of disability; or issues that relate to environmental, societal or financial circumstances.

Diagnosis

The identification of a disorder, disease or other problem through examination, investigation or evaluation of test results.

Discrimination

The act of excluding or treating a person differently based solely on an attribute such as disability, age, gender, race or sexual orientation.

Depth of need

The profoundness and intensity of needs.

Duty of care

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

Incidence

The frequency or rate of a disease.

Indicators of abuse

Physical and behavioural signs that might indicate a person is being subjected to abuse or neglect.

Legal and ethical standards

Laws and legislation that must be abided by in workplaces.

Macronutrients

The protein, fat and carbohydrates required in a person's diet.

Micronutrients

The vitamins and minerals that support a person's health and wellbeing.

Percentile rank

The percentage of scores that are equal to or less than a given score.

Physiology

The study of how the human body works, and the chemical and physical reactions that underlie every bodily function.

Policy

A course of action proposed by an organisation as a basis for making decisions.

Prevalence

The proportion of a population who have a disease within a given time period.

Procedure

An established or official way of doing something.

Psychological impacts

Changes in thinking processes and mental capabilities that affect how people behave.

Resources

Things that are needed to enable the appropriate delivery of services to a person requiring support.

Restrictive practice

Any intervention or practice that restricts rights or freedoms of movement of a person.

Screening test

A medical test used to detect early evidence of disease by ruling out less-probable diseases.

Stigma

Seeing someone in a negative way, due to a particular circumstance or quality.