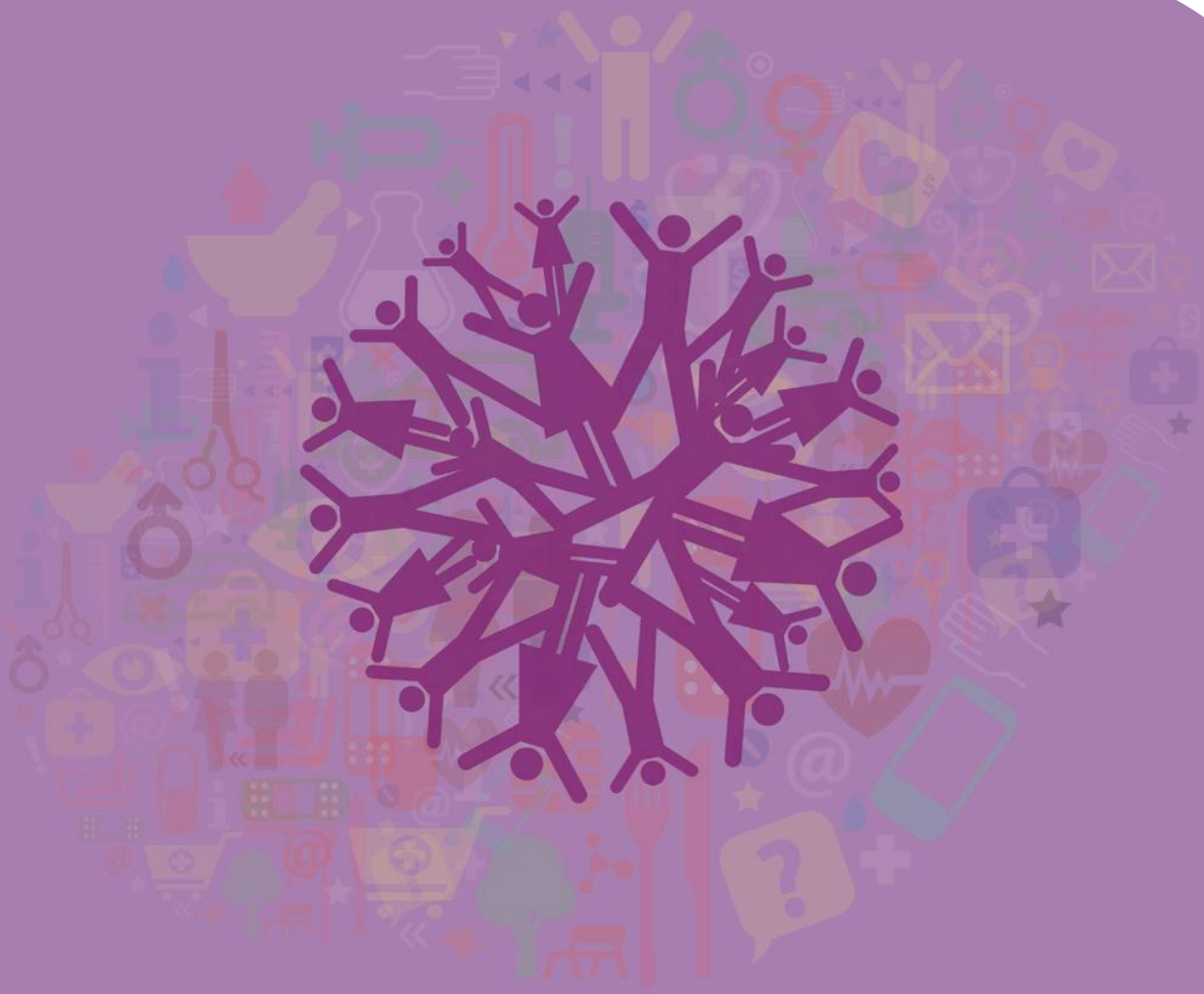
CHCDIS010
Provide person-centred services to people with disability with complex needs

Release 1



Learner guide

Aspire learning resources

CHCDIS010

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Release 1

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Aspire version 1.3

Aspire learning resources

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Version control and modification history

Version	Release date	Modification
Release 1, version 1.1	April 2017	First release
Release 1, version 1.2	November 2018	Minor corrections as part of our continuous improvement program
Release 1, version 1.3	July 2019	Updated to reflect the new Aged Care Quality Standards

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CHCDIS010 Provide person-centred services to people with disability with complex needs Release 1

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Contents

Before you begin

This learner guide is based on the unit of competency *CHCDIS010 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. You can access the unit of competency and assessment requirements at: www.training.gov.au.

How to work through this learner guide

This learner guide contains a number of features that will assist you in your learning. Your trainer will advise which parts of the learner guide you need to read, and which practice tasks and learning checkpoints you need to complete. The features of this learner guide are detailed in the following table.

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 and case studies	▶ Examples of completed documents that may be used in a workplace are included in this learner guide. You can use these examples as models to help you complete practice tasks and learning checkpoints. ▶ Case studies 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.
Video clips	▶ Where QR codes appear, learners can use smartphones and other devices to access video clips relating to the content. For information about how to download a QR reader app or accessing video on your device, please visit our website: www.aspirelr.com.au/help 
Summary	▶ Key learning points are provided at the end of each topic.
Learning checkpoints	▶ There is a learning checkpoint at the end of each topic. Your trainer will tell you which learning checkpoints to complete. These checkpoints give you an opportunity to check your progress and apply the skills and knowledge you have learnt.

Foundation skills

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

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

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

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

What do you already know?

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

Topic	Key outcomes	Rate your confidence in each section
Topic 1 Evaluate and prioritise the needs of a person with complex support issues	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 outcomes	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/or 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 service and/or support worker is unable to provide the level of service required	☐ Confident ☐ Basic understanding ☐ Not confident
	3C Support stakeholders providing a service to understand their roles and responsibilities within the plan	☐ Confident ☐ Basic understanding ☐ Not confident

Topic	Key outcomes	Rate your confidence in each section
Topic 4 Coordinate the monitoring, evaluation and review of the individualised plan	4A Seek feedback from all stakeholders when evaluating the effectiveness of the plan and re-prioritising support needs	☐ Confident ☐ Basic understanding ☐ Not confident
	4B Seek feedback from the person and others when evaluating the effectiveness of the plan	☐ Confident ☐ Basic understanding ☐ Not confident
	4C Seek advice and assistance when the person's goals are not being achieved	☐ Confident ☐ Basic understanding ☐ Not confident
	4D Revise the plan in line with your role, organisation and/or program guidelines and in consultation with others	☐ Confident ☐ Basic understanding ☐ Not confident

Topic 1

In this topic you will learn how to:

- **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**

Evaluate and prioritise the needs of a person with complex support issues

A person with complex support issues typically has a number of areas of need and various issues that need to be carefully identified and prioritised. The process of prioritising means that the most important and time critical issues are assessed first, often using data that is provided by allied health professionals or medical professionals. This process may demand support and assistance from other professionals as well as from family members or caregivers and from the person.

Prioritising issues and areas of need allows for the development of an appropriate plan that takes into account individual requirements and available resources and support services. It is important, during the process of evaluating and prioritising the needs of a person with complex support issues, to recognise the impact these issues may have upon family members.

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

Factors that indicate complex needs

Professional workers such as physiotherapists, occupational therapists, psychologists 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 is delivered by workers who have the appropriate 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
▶ If disability is likely to change, progress or deteriorate
▶ Presence of other issues (mental health, substance abuse, family violence or poverty)
▶ Insecurity of the living situation (permanency, affordability, safety)
▶ Unstable financial situation

Identify needs

Needs are identified through an assessment process and through 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.

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.

People who may contribute information

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 time line 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 phone, email, online application, referral or in person.

2. **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 informal and formal 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 assessment.

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 assessments.

Here are three types of formal assessments that may be used with people who have various types of 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.

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.

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 within 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 may include:

- 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 upon 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.

Complex needs

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

Areas where there may be complex needs

Physical functioning/mobility

Physical functioning and mobility refers to how the person moves, and any assistance they require such as wheelchair, walker or transfers.

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 (communication boards, assistive technology, signing or an interpreter).

Daily living/recreation

Daily living and recreation refers to how the person manages their activities of daily living and general leisure tasks, and any assistance required (making bookings, organising transport or providing supervision).

Coexisting issues

Some people may have issues that coexist alongside their primary disability or condition. This makes providing care and support more challenging; although 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 avoid them becoming a major limiting factor for activities of daily living. You can use direct questioning, as well as observation, to help you understand how coexisting issues may affect a person's daily activities. Coexisting issues must be considered prior to offering support services and care.

Some coexisting issues that must be considered are:

- presence of mental/physical health conditions
- transport difficulties
- social or geographical isolation
- financial considerations/level of debt
- religious or cultural requirements
- carer or other family responsibilities.

Prioritising needs

It is important to prioritise needs when providing care and support for a person. Identify the 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 determine the priority of meeting a person's needs. Here is an example of how needs can be prioritised.

Crisis support

Crisis support can be provided to help manage a short-term crisis such as a family illness, change to living situation or a sudden change in health status or care needs.

Intermittent care

Intermittent care can be provided from time to time, when required; for example, if a person's condition exacerbates or when they are having respite care.

Transition care

Transition care facilitates the transition from one setting to another, such as moving from home to a residential setting.

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.

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 him 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

1. What indicates that a person has complex needs?

2. When observing a person in your care, what are two indications that the person requires high priority support?

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

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

Click to complete Practice task 1

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

Care and support must be provided 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 particular 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.

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 or they may be typical of the disability or condition. This could include problems such as:

- accessing buildings and facilities
- finding an accessible toilet
- being treated in an unfair or discriminatory way.

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

How physiology applies to disability

Many disabilities affect the physiological functioning of the body; that is, the way the body works at a system level (for example, respiratory, cardiovascular, endocrine systems) and organ level (for example, the heart, lungs, skin or pancreas). 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.

Here are some examples of how physiology applies to a range of disabilities.

Disability type
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 with a psychiatric disability may display changes to a variety of body systems such as musculoskeletal, digestive, respiratory or nervous system.
Neurological disability Depending on the type and level of the neurological disability, body system changes may include nervous, sensory, musculoskeletal or respiratory systems.
Cognitive disability Depending on the type and level of the cognitive disability, there may be changes to the sensory system or vascular/circulatory system.
Intellectual disability Depending on the type and level of the intellectual disability there may be changes to the muscular system, cardiovascular system, integumentary system or nervous system.

How psychology applies to disability

As a support worker, it is important to understand the psychological impacts a disability has on the person you are supporting. The impacts will differ, according to the type and level of disability.

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 a range of disabilities.

Disability type
Physical disability A person with a physical disability may display signs of depression and generalised anxiety disorder.
Sensory disability A person with a sensory disability may display signs of depression, anxiety, lethargy and social dissatisfaction.
Psychiatric disability A person with a psychiatric disability may display signs of depression, generalised anxiety, panic or paranoia.
Neurological disability A person with a neurological disability may display signs of depression and social isolation.
Cognitive disability A person with a cognitive disability may display signs of frustration, agitation, depression or anxiety.
Intellectual disability A person with an intellectual disability may display signs of psychiatric disorder or borderline personality disorders.

Common issues and challenges

A person with a disability may experience many issues and challenges. 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.

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

Disability type
Physical disability The challenges and issues experienced by a person with a physical disability may relate to: ▶ accessing services and public transport, etc. ▶ using devises that require motor skills ▶ completing compound actions, such as reaching and pulling ▶ maintaining independence.
Sensory disability The challenges and issues experienced by a person with a sensory disability may relate to: ▶ sight: reading, walking, completing household tasks ▶ hearing: communicating within the community such as hearing public transport announcements ▶ taste: completing household tasks such as seasoning foods, tasting foods (whether it is still good to eat) ▶ smell: completing household tasks such as cooking; safety, such as smelling smoke or gas
Psychiatric disability The challenges and issues experienced by a person with a psychiatric disability include the ability to : ▶ think clearly ▶ make decisions ▶ understand other people's feelings or actions ▶ show emotions ▶ complete self-care activities.
Neurological disability The challenges and issues experienced by a person with a neurological disability may be: ▶ loss of memory ▶ attention deficits ▶ incoherent speech.

Cognitive disability

The challenges and issues experienced by a person with a cognitive disability may be conceptual difficulties such as sequencing tasks, comprehension and skill development.

Intellectual disability

The challenges and issues experienced by a person with an intellectual disability relate to:

- learning new things
- understanding concepts
- problem-solving
- completing self-care activities
- understanding safety
- using fine and gross motor skills
- maintaining independence.

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 is the milk is OK. 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 Shanes needs may have become more complex, Jane follows organisational procedures by makes notes of what has occurred and reporting to her supervisor.

Practice task 2

1. What are two common issues and challenges for a person with a physical disability?

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

3. Provide one example of how psychology applies to a person with a cognitive disability.

Click to complete Practice task 2

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.

Types of data

There are many types of data that may be gathered, and depending on the type of data, it may be analysed and interpreted differently. Depending on the person, there may be a range of people who contribute data to help evaluate the person's individual needs.

Here are some types of data that may need to be analysed and interpreted, and who the information may be supplied by.

Types of data to analyse and interpret
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 have 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 pathologist, 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 manager, supervisor, health and safety representative
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 within particular cohorts such as children, adults or older people. Adapted from the Australian Bureau of Statistics: Disability, Aging and Carers, Australia: summary of Findings; http://aspirelr.link/abs

Analysing data

It is important to carefully analyse data contained in formal and informal reports. 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. Consider the following information.

Strategies to assist in analysing data are to:

- 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.

Key words and phrases

Incidence

- The incidence of Type 2 diabetes was 74 per 100,000 people in over 10 year olds.

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 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.

Example

Analyse and interpret data

You work with children who have been identified as coming from 'at risk' living situations. Your supervisor has asked you to research a screening tool that can be used to identify any children who may have an as yet undiagnosed developmental delay or disability. You consult with the local community health centre and the early childhood intervention team in your area and seek their advice.

They both recommend the PEDS tool (Parents' Evaluation of Developmental Status) because it is simple, easy to administer and the data can be scored and interpreted in around five minutes. You trial the PEDS for several weeks and then ask for feedback from parents, carers, staff members and your management team. The feedback is generally positive, so you write a recommendation that the PEDS tool be adopted as a regular aspect of service provision in your service.

You also recommend that all staff be fully trained in administering, scoring, analysing and interpreting the results, and in knowing when and how to refer any concerns on for further evaluation.

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 about the person.

1. To help Mavis understand the data in the report, who should Mavis contact first?

2. Mavis is eager to have the person join her program but is unsure about what the data means. What should Mavis do?

Click to complete Practice task 3

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

The family members who support a person with complex needs may be impacted in many different ways. For example, how the family functions may be impacted, as can the ability of family members to operate effectively and succeed in achieving goals, while maintaining their own health and wellbeing.

Complex support issues

Support issues can impact in various ways on the family environment of a person requiring support. Here are some areas where complex support issues impact upon 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.

Role change

The role of people or a person within a family can change as they move into a caring role and take greater responsibility for caring tasks.

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

Consider the contextual aspects of the person's situation. 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', 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-wide range of areas

Breadth-wide range of areas include the following:

- Disadvantage
- Disability
- Health issues
- High physical support needs
- Mental support needs
- Poverty
- Unstable living situation
- Financial difficulties
- Family violence
- Substance abuse

Depth-complex impacts

Depth-complex impacts include the following:

- Significant impact on the person and their family
- Serious issues
- Far-reaching implications
- Not easy to resolve
- Require careful and experienced planning
- Require ongoing support

Impact of complex support issues

Support issues for people with complex needs vary according to their environmental and societal context. For example, 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. Providing support for a wide range of issues requires a multi-service and integrated approach.

Example

The impact of complex 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 TV 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

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

2. What does the concept 'breadth of need' refer to?

Click to complete Practice task 4

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

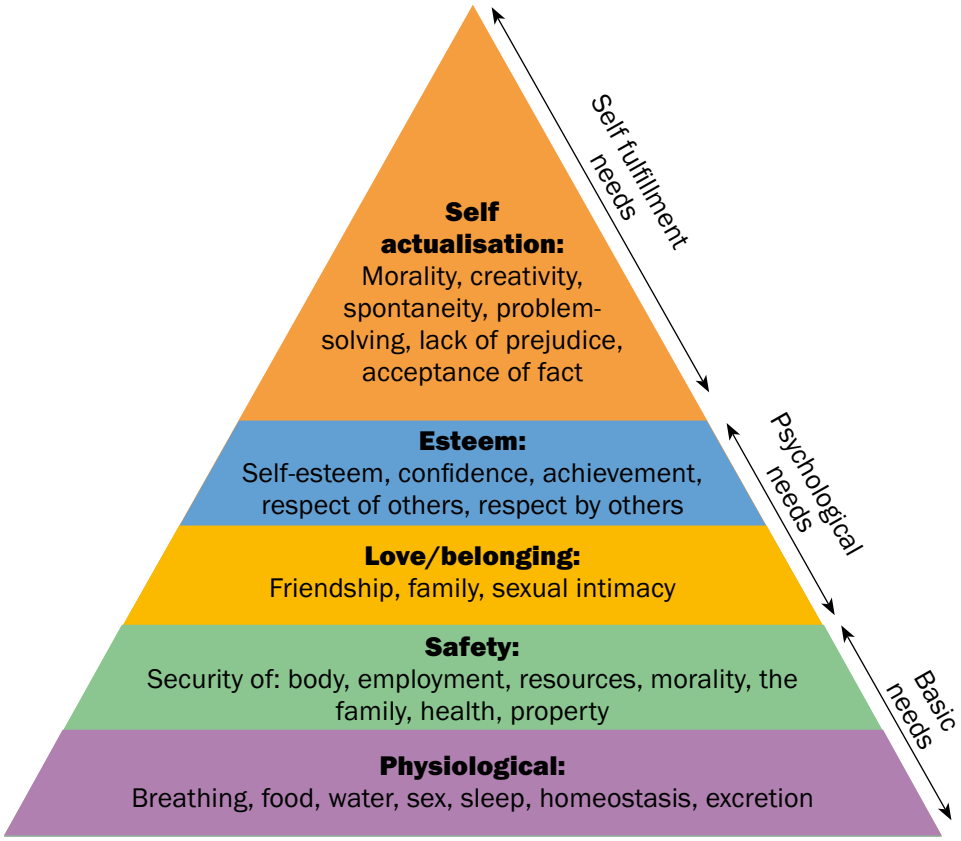
When working with a person who requires complex support, their needs must be prioritised so they are properly managed.

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

Establish priorities

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. 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 priority of support

When looking at Maslow's hierarchy of needs, it is evident that the needs outlined as 'Physiological' should be met before the needs outlined as 'Safety'. For example, providing a stable food source is 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.

Some issues are a higher priority than others.

Consider Maslow's hierarchy of needs in working out what to prioritise
Physiological needs Access to food and water is essential for survival. This level is the first priority.
Safety and security Shelter, protection safety and stability may 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 safety and physiological 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.

Collaborating 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 may be assigned to liaise directly with the person requiring support to help them understand the information and make decisions. A case manager reduces the intrusion of different people coming into a home and can help reduce the workload for families.

Here is how the case manager fills an important role in helping collaborate with others within 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 other relevant people to discuss their ability to provide services and the eligibility of the person to receive them. Examples may include the Commonwealth Home Support Programme or Queensland Community Care Services.

Meet

Meet with other relevant people to develop a plan to prioritise (and help the person achieve) their goals and meet their needs. This may include the person receiving support, the person's family, 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 and seek their permission to proceed with establishing support service arrangements that will meet priorities and needs.

Example

Establish 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 try 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 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.

Practice task 5

1. List three high-priority issues that need to be addressed when prioritising support needs in the individualised support plan.

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

Click to complete Practice task 5

Summary

1. People who require support services may have simple or complex needs. When a person has issues that coexist, their needs become complex and the needs must be prioritised.
2. An assessment takes place to identify whether a person's needs are simple or complex. This may be a combination of formal and informal assessments.
3. Analysing and interpreting data may be done with assistance and in collaboration with others.
4. It is important to understand the breadth and depth of issues that can affect a person with complex needs and their family.
5. Collaborating with others will help you to understand the needs of the person requiring support and ensure the priority of support and level of support provided is appropriate.

Learning checkpoint 1
Evaluate and prioritise the needs of a person with complex support issues

This learning checkpoint allows you to review your skills and knowledge in evaluating and prioritising the needs of a person with complex support issues.

Part A

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

2. Provide three examples of a type of disability and explain how physiology applies to 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 individualised support plan.

5. Provide two examples of a disability and a relating issue and challenge.

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

7. List three areas for how a complex disability has an impact on a family.

8. Provide three examples of a type of disability and explain how psychology applies to each one.

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

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 limited language skills. Now that his wife cannot work, the family finances are becoming increasing 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 comes to visit Tuk and brings an interpreter to help discuss the family's issues and needs, and to establish some priorities for providing some support.

1. What three high-priority issues are facing this family?

2. What are three 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. List three impacts that Ling's complex needs have had on Tuk?

Topic 2

In this topic you will learn how to:

2A **Use best practice guidelines to develop strategies to address complex and/or 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**

Develop an individualised plan to achieve maximum quality of life

Best practice in community services settings includes supporting people to meet their goals and achieve the best possible quality of life. An individualised support plan assists in bringing all the necessary information together from experts and community support agencies and ensuring that needs are appropriately met and goals achieved.

2A Use best practice guidelines to develop strategies to address complex and/or 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 within 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

Common health problems and behaviours of concern must be considered when developing an individualised plan. Different disability types have health problems and behaviours of concern associated with them. However, this is not always the case, so 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. Depending on the type of disability, behaviours of concern may also present.

Manifestation and presentation of health issues

How a particular health problem or 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.

Here are different types of disabilities and the health problems and behaviours of concern that may present.

Physical disability

A person with a physical disability may present with muscular skeletal issues. Depending on the disability and the level of impairment, health issues may include respiratory distress, cardiovascular issues or blood pressure concerns. Mental health issues such as depression and anxiety may present.

Behaviours of concern may include social withdrawal or anger.

Sensory disability

A person with a sensory disability may present with compromised sense of sight, hearing, taste or smell.

Depending on the disability and the level of impairment, overall physical health may be affected. Mental health issues such as feelings of isolation, lack of self-esteem and depression may present.

Behaviours of concern may include withdrawal or anger.

Psychiatric disability

A person with a psychiatric disability may present with a range of health issues.

Depending on the type of disability and the level of impairment, health issues may include weight loss or gain, respiratory distress or cardiovascular disease. Mental health issues such as feelings of isolation, lack of self-esteem and depression may present.

Behaviours of concern may include anger, anxiety or self-harm.

Neurological disability

A person with a neurological disability may present with muscular skeletal, respiratory and/or sensory issues.

Health issues may include issues with muscle weakness, incontinence, swallowing, weight loss or gain or respiratory distress. Mental health issues such as depression or withdrawal may present.

Behaviours of concern may include anger or anxiety.

Cognitive disability

A person with a cognitive disability may present with a range of health issues. Depending on the disability and the level of impairment, health issues may include malnutrition, or vascular/circulatory problems. Mental health issues such as depression may present.

Behaviours of concern may include anger or anxiety.

Intellectual disability

A person with an intellectual disability may present with range of health issues. Depending on the disability and the level of impairment, health issues could include issues with the cardiovascular, muscular, integumentary or nervous systems. Mental health issues such as withdrawal, isolation, depression or lethargy may present.

Behaviours of concern may include anger, anxiety, frustration or depression.

Strategies to address needs

Strategies to address the needs of the person should be included in the individualised 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 needs of the person 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 individualised care plan may be found in best practice guidelines and the policies and procedures of the community services organisation you work for.

Best practice guidelines

The Aged Care Quality Standards apply to a range of care providers within community services.

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

Standard 1: Organisational governance

- Reflects concepts that recognise the importance of a consumer's sense of self. It highlights the importance of the consumer being able 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

- Describes that consumers and the community expect the safe, effective and quality delivery of personal and clinical care. The Standard applies to all services delivering personal and clinical care specified in the Quality of Care Principles 2014.

Standard 4: Services and supports for daily living

- Explains that a consumer might have some challenges in their health and abilities, but they still have goals they want to achieve. They also have roles that have meaning, and they want to manage their day-to-day life and live as well as they can. Services and supports cover a wide range of options that aim to support consumers to live as independently as possible and enjoy life.

Standard 5: Organisation's service environment

- This applies to the physical service environment that the organisation provides for residential care, respite care and day therapy centres. It aims to make sure that the service environment, furniture and equipment support a consumer's quality of life, as well as their independence, ability and enjoyment. This means that the service environment suits the consumer's needs, and is clean, comfortable, welcoming and well maintained. It includes how the safety and security, design, accessibility and layout of the service environment encourage a sense of belonging for consumers.

Standard 6: Feedback and complaints

- The organisation must have a system to resolve complaints. The system must be accessible, confidential, prompt and fair. It should also support all consumers to make a complaint or give feedback. Resolving complaints within the organisation can help to build the relationship between the consumer and the organisation. It can also lead to better outcomes.

Standard 7: Human resources

- Requires an organisation to have and use a skilled and qualified workforce sufficient to deliver and manage safe, respectful and quality care and services.

Standard 8: Organisational governance

- The intention is to hold the governing body of the organisation responsible for the organisation and the delivery of safe, quality care and services.

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

Organisational policies and procedures

All service providers within 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 the policies and procedures ensure all work practice meets legal and ethical obligations.

Family members, care givers 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. The respite service is for people who have autism spectrum disorders and /or intellectual disability, and 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 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

1. When providing support to people who have a physical disability, what is one health issue that may present?

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

3. How many standards are there in the Aged Care Quality Standards?

Click to complete Practice task 6

2B Liaise with relevant experts when developing individualised plans

There are many health professionals who may be 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 or dietitian 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 that a worker needs to learn. You may consult with relevant experts prior to writing an individualised plan or you may ask them to attend a planning meeting.

Liaise with experts and health professionals

Dietitians, speech pathologists and occupational therapists can help plan for nutrition and dietetic needs for a person with a disability. Each health professional has expertise in different areas – a physiotherapist supports physical needs and manual handling /lifting; an occupational therapist assists with tasks and actions that are a part of daily life; and 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.

A dietitian can assist by:

- determining the food intake needs with consideration of weight loss or gain requirements and appropriate dietary balance
- considering any allergies or food intolerances such as peanut allergy or lactose intolerance
- planning for appropriate timing of meals and snacks during the day and week
- providing training for 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
- thinking about preferences for food and meal presentation and timing of meals
- taking cultural and religious needs into account when preparing nutritious and appropriate meals.

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

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 ensure adequate nutrition is maintained. 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.

Physical

Physical 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.

Sensory

Sensory disability – Depending on the type of sensory disability, nutritional and dietary considerations may include texturally modified food or food that is high in flavour.

Neurological

Neurological disability – Depending on the type of psychiatric disability, nutritional and dietary considerations may include texturally modified food, enriched food or food that is easy to manage.

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 within 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 Ken is ready for more food before he is offered more. She also explains that a quiet, peaceful and calm area will make it easier for Ken to eat, and be safer as he is less likely to be surprised, jump or react when he is 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 are included in Ken's care plan. Ken also says he is much happier and relaxed during mealtimes.

Practice task 7

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

2. What are two ways a dietitian can contribute to a person's care plan?

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

Click to complete Practice task 7

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 in achieving their goals. It is important to recognise that the person receiving support and their family or carers are considered the experts in their own requirements, and that the goals established reflect the needs and requests of the person and their family. Clear, well designed goals are vital to an effective individualised plan.

Negotiate goals

Goals may be need to be negotiated with the person, their family, carer and/or relevant other people such as an advocate.

Negotiating a goal may be required when there are constraints regarding budget, equipment, expertise, staffing availability; or renegotiated if there is a change in the person's capabilities.

The strategies and resources required to meet the goal need to be discussed with the person and relevant others. It is vital when negotiating goals, that the person requiring support is included, respected and supported in the decision-making process.

You can meet with the person and the relevant others to discuss and negotiate goals using an approach that is suited to the situation.

Establish goals

Once goals have been negotiated with the person and others, you need to identify what actions should be taken and what resources are required for the goal to be achieved.

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

The goals need to be documented and established with a clear time frame and information recorded about who is responsible for implementing actions towards goals. 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.

Some important considerations when establishing goals are:

- 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 achievement of goals be recorded?

Example

Negotiate and establish goals

Theresa is 18 years old and has Down syndrome. Theresa 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 Theresa. Jasmine explains that both goals are achievable, and has sourced a retail traineeship that would suit Theresa. Jasmine discusses the traineeship time frame and what extra support Theresa may need to achieve this goal.

A second goal supporting Theresa's wish to live independently is established and Jasmine will source and negotiate independent living options for Theresa within her budget.

Practice task 8

1. You work with a person who has a severe communication impairment and an intellectual disability. What are two things you should you consider when working with them to establish goals?

2. What is one reason you may need to negotiate goals?

Click to complete Practice task 8

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 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 are met appropriately.

Resources

Resources are the things that are needed to enable the appropriate delivery of services to a person requiring support. Resources may include equipment, specialist training, human resources, financial support or housing. Depending on the specific needs, the level of needs and the complexity of needs of the person, access to more than one agency may be required. Aligning the resources required 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 up-skill 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 relate to transport, culture and language, financed 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 within community services 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 provider, available funding and 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. Max needs support to plan and organise his daily activities as well as to complete some personal care and household tasks. The bathroom has a narrow doorway and is difficult for him enter with his walking frame. The shower has a raised edge that puts Max at risk of tripping due to him not being able to 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

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

2. A person in your care lives at home, but finds 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.

Click to complete Practice task 9

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

Community support agencies may be able to facilitate a person requiring support reaching their goals. Depending on the goal and the needs of the person, a community support agency may be accessed to increase the participation of a person and help reduce and remove barriers to a person with a disability. Community support agencies often have eligibility criteria and service guidelines for accessing specific programs and services.

Community support agencies

There is a wide range of community support agencies that provide support including health services, educational services, sport and recreation, day services and advocacy 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 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 to help them manage unexpected events. They also offer counselling and general support via phone, online or face-to-face services.
- Respite and carer support can help facilitate goals regarding maintaining care relationships, strengthening the capacity of the carer 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 Jack 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 regular 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

Case study

Jeremy is a full-time carer for his mother, Leah. While the care he 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 be able to play squash with his friends every Friday.

1. What goal should Jeremy set?

2. What agency should Jeremy contact so he can meet his goal?

3. What agency should Jeremy contact to facilitate his mother's goal of attending community activities?

Click to complete Practice task 10

Summary

1. Best practice guidelines and policies and procedures help meet a range of manifestations and presentations of various disability types.
2. Liaising with relevant experts, such as allied health professionals, can help develop an individualised support plan.
3. Negotiate and establish goals in collaboration with the person requiring support, their family members, caregivers and relevant others.
4. Resources such as equipment and staffing may be needed to be accessed to deliver identified services for a person.
5. 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

This learning checkpoint allows you to review your skills and knowledge in developing 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 within 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 individualised care plan.

4. When creating an individualised care plan, what are two important considerations you need to think about when establishing goals.

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

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

7. List two types of disability and for each type, explain what health issue/s may present.

Part B

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 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 procedure did Ruby follow when managing the goals of Marita and Pablo?

Topic 3

In this topic you will learn how to:

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

3B **Recognise when a service and/or worker is unable to provide the level of service required**

3C **Support stakeholders providing a service to understand their roles and responsibilities within the plan**

Coordinate the delivery of the individualised plan

Coordinating the delivery of an individualised plan for a person in care is an important job that involves careful planning, supervision, support, good communication and a commitment to ongoing evaluation to ensure the plan is meeting the person's goals and needs. Community services workers must have the skills and knowledge to undertake specific tasks and activities. It is critical to identify when a service cannot meet its service commitments or when a community services worker cannot meet the requirements of their role. Wherever possible, workers should support others effectively so they can fulfil their role in coordinating the delivery the individualised plan.

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

Across the community services sector there are many different areas of skill where work is performed. It is important that community support workers have the appropriate skills to match the tasks that are required of their job role.

The need to complete new tasks will require training, while completing other tasks may require updated or refresher training on a regular basis. Ensuring community services 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.

Support skills development

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

Core training needs for each staff member should be identified and a plan should be 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, new skills may be needed, old skills may need to be refreshed and/or specialty skills may need to be developed. 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

Maintain appropriate skills

Depending on where you work, the organisation may actively provide opportunities for staff to participate in training and information sessions. This may include a formal training plan that includes goals and priorities, or it may be involve 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 needs. The skill set initially required for care provision may have been appropriate, but when the 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 who provide support to Tom at home. Tom has motor neurone disease, and his needs are changing, which affects the level of care required.

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 the shower chair. Sue has the workers practise 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 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 feel much more confident in performing the transfers and that they have used both the video and flowchart as a reference tool.

Practice task 11

Case study

Mandy is a young woman who has sustained 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 a substantial time off of 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 she doesn't feel safe the way she lifts her.

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

1. What are two things Bill should do to ensure that Wendy has the appropriate skills to do the task required?

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

Click to complete Practice task 11

3B Recognise when a service and/or support worker is unable to provide the level of service required

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 be a result of 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. It is vital within the community services sector to recognise when the services or support required in the person's care plan are not being provided.

Indicators of service changes

As a community support worker, you need to be aware of changes in service provision. Changes to service and support may be a result of human resource constraints, variations to funding or service agreements or provision of resources.

There are four 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

- The support worker may tell you they are unable to provide the service required by the person for reasons such as 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.

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. Mark becomes frustrated and angry when Jenny can't understand what he is trying to tell her. Jenny is finding it more and 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. When speaking with Jenny, Kate 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 shifts will be adjusted so her interaction with Mark will be reduced until Jenny feels she is able to work with Mark comfortably. Jenny begins doing some shifts with people who do not have behaviours of concern while she receives additional training.

Practice task 12

Case study

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

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

2. What is the key indicator that Charlotte's care requirements are no longer being met in her current care plan?

Click to complete Practice task 12

3C Support stakeholders providing a service to understand their roles and responsibilities within the plan

In many situations, care and support is provided via a multi-agency platform with stakeholders tasked to provide support according to their particular areas of skill and expertise. In this collaborative and multi-faceted 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 when many agencies are working together and supporting a person who has complex or high level care needs.

Understand the individualised plan

All stakeholders need to understand the individualised care plan or each person receiving support, and their roles and responsibilities within the plan. Stakeholders include community support workers, service providers, specialists, carers, family members and advocates. How you provide support will vary depending upon your role within your organisation and the skills, capacities and task requirements of the stakeholders. Information flow between stakeholders and the support worker is vital – information must be accurate, shared in the appropriate time frame and with the appropriate stakeholders.

Clarify roles and responsibilities

To ensure that stakeholders fulfil their responsibilities outlined in the care plan, there is 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.

To support stakeholders you may:

- use technology tools (videoconferencing, email, text messages) to share information
- ensure input from the person receiving support is shared
- identify roles for tasks within the plan and clarify information as needed
- document any changes to roles and responsibilities and record new information
- ensure all documents are understood
- enlist specialist providers if needed to fill specialist roles in meeting responsibilities
- provide training to staff if required to meet task responsibilities.

Example

Support stakeholders to understand the care plan

Roger has a 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 are able to have time to finalise staffing, organise physical resources and plan administrative and managerial support for the staff who will work with Roger.

She 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 doesn't want Roger`s mother to feel overwhelmed. At his own request, Roger attends the first part of the meeting via Skype so he doesn't have to miss his weekly hydrotherapy session.

After the meeting, the case manager 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 do not understood.

Practice task 13

1. List two ways you can support stakeholders to fulfil their responsibilities in the care plan.

2. What are three important aspects that must be adhered to when sharing information between stakeholders?

Click to complete Practice task 13

Summary

1. Workers need to have the necessary skills to provide appropriate services to the people requiring support.
2. It is important to recognise and respond when a support worker or service is unable to provide the services required.
3. All stakeholders must be aware of their roles and responsibilities as identified in the individual support plan.

Learning checkpoint 3
Coordinate the delivery of the individualised plan

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

Part A

1. What two things can indicate that additional skills may need to be developed when delivering an individualised support plan?

2. What are 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 he will be interstate and unable to attend the support plan meeting of a person in your care. How could Jackson still fulfil his role and responsibilities?

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

Part B

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

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. Terri 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 individualised 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, insulin use, 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 needs development of the skills she holds. What are two things Simon can do to make sure Lisa has the skills she needs for her role?

Topic 4

In this topic you will learn how to:

4A **Seek feedback from all stakeholders when evaluating the effectiveness of the plan and re-prioritising support needs**

4B **Seek feedback from the person and others when evaluating the effectiveness of the plan**

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

4D **Revise the plan in line with your role, organisation and/or program guidelines and in consultation with others**

Coordinate the monitoring, evaluation and review of the individualised plan

Just as an organisation has continuous improvement processes in place regarding the running of the organisation, there are also processes in place to monitor, evaluate and review a person's individualised support plan.

Feedback and revisions are useful in making sure the individualised support plan is being effective and delivering outcomes that are in line with the goals of the plan. Feedback should be sought from a number of different sources and the plan updated and revised as required.

4A Seek feedback from all stakeholders when evaluating the effectiveness of the plan and re-prioritising 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. Feedback is used to evaluate the effectiveness of the plan that is currently in place for a person requiring support.

Seek feedback from all stakeholders

There may be a range of stakeholders who can supply feedback to help evaluate the effectiveness of the care plan of a person with complex needs. The feedback is also used to prioritise the person's needs.

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 be involved in evaluating how all the supports for a person work together and can 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 and 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 you 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.

Practice task 14

1. What is one reason you would seek feedback from a key stakeholder about a person's individualised support plan?

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

Click to complete Practice task 14

4B Seek feedback from the person and others when evaluating the effectiveness of the plan

During the process of seeking feedback when evaluating the support plan, it is vital to consult with the person and /or their carer or relevant other people, such as advocates. Their feedback is important in informing you what is working well from their perspective and what changes may be required. Feedback from the person receiving support is most valuable as they know exactly how the existing plan is working for them. They should be recognised as being the experts in their own requirements, along with their family and/or carers.

Feedback from the person receiving support

As with feedback from key stakeholders, the feedback from the person receiving support, their carer or significant others is used as part of a continuous improvement process. The person receiving support has first-hand experiential knowledge of how the plan is working and if adjustments need to be made. 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.

Example

Seek feedback

Ken is a case manager for an early intervention program. He is working with a mother to update the support plan for her child. The mother 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 the mother do, to avoid any suggestion that he and the interpreter are working together. He greets the mother 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 and the only changes that are needed are a reflection of the growing skills and confidence in the child.

Practice task 15

1. Why is it so important to seek feedback from the person receiving support in relation to their care plan?

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

Click to complete Practice task 15

4C 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 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.

Seek advice and assistance

It is best 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 with the person's family members and carers.

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 a direct input into meeting existing goals and adjusting goals.

Family/carer

- Family members and carers can explain why goals are not being achieved from the perspective of the person and their family and living situation and provide input into adjusting the care plan.

Mental health nurse

- Mental health nurses 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. He has communication challenges, so he uses assistive technology (AT) for communicating with his carers and his 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 and notices that the agreed goal of being able to visit the local shops independently has not met the target date. Phillipa consults with Ben, his carer and his family to find out the reason that the target date has not been met.

Ben says that sometimes the AT batteries are flat on the weekend. This means that even when recharged batteries are inserted the AT needs to be reset. After a discussion with Ben's carer, Phillipa realises that during the week, the community care workers are trained in programming the AT and recharging the batteries. However, on the weekend, the community care centre is staffed by casual care workers who are not trained in using and maintaining the AT Ben uses. Sometimes the batteries need to be recharged or the AT reset, but the casual care workers are not trained how to do this, which means 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.

Practice task 16

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

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.

Click to complete Practice task 16

4D Revise the plan in line with your role, organisation and/or program guidelines and in consultation with others

Like all work in community services, it is important to follow the correct procedures when making revisions to an individualised support plan. You must have a clear understanding of your own job role, level of responsibility and accountability. Follow the care plan guidelines and the policies and procedures of the community services sector in which you work, when making any revisions.

Make revisions to the person's plan

When making revisions to a care plan, you must ensure that organisational policy and procedures are followed. For example, the 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.

Make sure you have checked:

- 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.

Example

Make revisions to 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 doesn't 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 17

Case study

Tuyet is a recreation worker who has just spent an afternoon with a Carmen, a person receiving support, during a recreation program. Tuyet's position description says her primary role is to work directly with clients supporting 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. Jenny 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 Jenni is not in the office today, Tuyet goes back to the office and downloads Carmen's current support plan herself. She reads through it and highlights some sections she thinks are no longer current. She then drafts some new content and spends time editing it carefully 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 that she has made the changes and so she remembers to tell the 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.

1. What is one thing Tuyet has done well?

2. What are three things Tuyet has done incorrectly?

3. What should Tuyet have done differently?

Click to complete Practice task 17

Summary

1. Stakeholder input is important and should be sought when evaluating and re-prioritising a support plan.
2. You should seek feedback from the person receiving support, their family members, carer and any relevant others about the effectiveness of the person's plan.
3. There are many different people who 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 or direct service providers.
4. 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

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

Part A

1. List one reason why it is important to seek feedback from stakeholders 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 two people you could consult with when the person in care is not achieving their goals.

4. What are two things you should check within your organisation before making changes or revisions to a support plan?

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 is quite nervous. She is also asked to send an email to the external stakeholders regarding the revision process of the support plans.

1. What is the first thing Kerri should do before she begins the process of revising the support plans?

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