Adelaide Quality Care Core Standards

Policy Manual

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Support Management Policy and Procedure

PURPOSE AND SCOPE

- To provide management and program design, individual planning, coordination and Support Management.
- To ensure staff are trained and act professionally at all times when developing plans that empower participant to achieve their needs, goals and aspirations.
- To keep participants informed on their plan whilst undertaking a holistic approach that incorporates strengths-based and person-centred plans.

POLICY

It is Adelaide Quality Care policy that all case-managed services are developed and delivered in collaboration with Participants or their advocates. All participants, family members, representatives or advocates must be included in any decision-making processes, choice of strategies or activities and approval for all aspects of their support plan. Support Management will include delivery, monitoring, review and reassessment in a timely manner.

Support Management will be utilised to:

- Empower Participants;
- Promote independence;
- Allow them to express their choices, aspirations and preferences;
- Participate in their community and engage in mainstream activities of their choosing;
- Communicate current status against goals and outcomes; and
- Enable them to make arrangements that meet their care needs.

This will ensure that a holistic approach linked to the participant's strengths, needs, goals and aspirations are incorporated within their plan. Adelaide Quality Care will utilise this policy to ensure the organisation maintains a contemporary approach to Support Management services

PROCEDURE

Adelaide Quality Care
Support Management Policy and Procedure

Support Management Principles

Support Management includes: Screening; Comprehensive assessment; Support Planning & Support Plan implementation; Monitoring; Review; and Case closure.

Adelaide Quality Care [Manager.Position] of packaged care services will:

- Match available resources and participants needs;
- Work across the service boundaries to ensure that Participants with complex care needs are able to have access to a full range of allied health, health and social support services they need;
- Provide a single point of contact for participants that require a complex range of services and/or require intensive levels of support

Screening & Comprehensive Assessment

- Ensure Participant referred to Adelaide Quality Care case managed service is screened for eligibility and suitability in accordance with applicable program guidelines and Adelaide Quality Care Policies & Procedures - Service Access and Assessment;
- Verify that consent for assessment and services was received, and is recorded in the Participant's file;
- Review the Participant's referral information and confirm eligibility and suitability for a Adelaide Quality Care service;
- Contact the Participant and arrange a suitable time for a comprehensive assessment;
- With the Participant's consent, arrange interpreters, advocates, guardians, or other service providers to attend the assessment, as appropriate;
- Determine (if possible) whether clinical assessment of the Participant's health condition is required and arrange for the appropriate staff (i.e. RNs) to attend the assessment;
- Ensure representatives identified by the Participant such as family member and carers, are contacted and if necessary, assisted to attend the assessment;
- On the day of the assessment, the assessment should be carried in accordance with organisation's Policy & Procedure and based on the participant's needs and situation.
- Within five (5) days after comprehensive assessment, contact the referrer and any existing care or support providers for further information if necessary;
- If indicated, arrange additional specialised assessments;
- Investigate potential options for sourcing care and support including availability of Adelaide Quality Care staff/resources and use of brokerage resources;

- ~~(If necessary) arrange a case conference with relevant services, and individuals to further discuss~~ the Participant's situation;
- Ensure outcomes from Support Management are documented within the support plan and advise the Participant that their services will be continually reviewed by the Coordinator for effectiveness;
- Where appropriate, and with Participant consent, provide the Support Plan to Participant's General Practitioner or Representative;
- Develop a support plan that includes a plan of action that meet the participant's needs, requirements and aspirations. The support plan will include:
    - Participant information - personal details, health details, cultural and spiritual requirements, sexual identification, Aboriginal and Torres Strait Islander
    - Goals,
    - Advocate, interpreter requirement
    - Consent forms,
    - Active engagement planning,
    - Plan to develop, sustain and strengthen independent life skills
    - Medical information including conditions, doctors, medications, use and management,
    - Risks to participant and staff - management of the risk, if required.
    - Any financial budget requirements (if application)
    - Participant involvement in any planning and decision-making process

Service Monitoring

Monitor the relevancy of the support plan through regular contact with the Participant and other representative and service providers involved in the well-being of the Participant. This should occur via:

- Home visits
- Telephone contact
- Case conferences
- Service reviews, and
- Feedback from external service providers and care staff
- Phone contact with Participant
- Collecting and reviewing Participant, Home Care Staff, representative and other service provider concerns, complaints and compliments
- Support planning meetings

- Staff meetings

Document monitoring/assessment contacts in the Participant's file. Include information source, date, information obtained, and action taken If significant changes occur: Review the service, re-assess the Participant, schedule a case conference and update the Support plan as required. Note any changes to a Support plan in the Participant's file or notes and, if necessary, assess the need to change the service agreement

Reassessment of Support Requirements

Support Management reviews are a tool to assist with Support Management, where more than one worker is involved, whether within or across organisations. This process is an essential element in the provision of focused and relevant supports, occurring at various points in the Support Management continuum, depending on the needs of the participant or family, urgency and complexity of the family's needs and changes in family circumstances. Case reviews may be held to:

- Determine if current roles and responsibilities of workers and organisations are meeting the needs of the individual;
- Review if the support workers are meeting participant's goals;
- Review the purpose, intent, and direction of an intervention;
- Review the service currently being supplied against the participant's strengths, needs, goals and aspirations;
- Review previous assessment and determine if any more are required;
- Re-assess the participant using the relevant assessment tool;
- Review using evidence gathered during work with the participant;
- Review current status of case plan;
- Make decisions relevant to the participant – ensuring that all parties are informed;
- Review goals/actions;
- Schedule a case conference with participant and/or relevant stakeholders to ensure their active involvement and to inform changes in service are discussed;
- Plan towards case transfer and/or case closure if relevant;
- Records any changes to a support plan in the participant's file or notes and, if necessary;
- Assess the need to change the service agreement.

Case Closure

When the Participant's needs begin to exceed program resources, or should the Participant change to another service provider, the [Manager.Position] will:

- Follow the guidance of Adelaide Quality Care Policy - Transition and Case Closure
- Informing the participant on any potential risk of transferring or exiting/
- Negotiate Participant handover arrangements with the new case manager or service provider.
- Inform participant of risk related to leaving the service

RELATED DOCUMENTS

- Adelaide Quality Care Suite of Assessments
- Support plan
- Care Review Form

REFERENCES

- Work Health and Safety Act 2011
- NDIS Practice Standards and Quality Indicators 2018
- NSW Disability Inclusion Act and Regulation 2014
- Privacy Act (1988)

Support Planning Policy and Procedures

PURPOSE AND SCOPE

- The purpose of this policy is to outline the legislative requirements and practice procedures for undertaking support services for NDIS participants.
- To comply with the requirements of NDIS Practice Standards. Compliance with the policy is a condition of appointment for all persons engaged to provide services on behalf of Adelaide Quality Care.

POLICY

It is the policy of the that all participants and their support networks are aided to participate in the development of a goal-oriented Support plan. The Support plan will reflect an individual's goals and aspirations and will look at strengths and functionality of the participant. It is based on the presumption of capacity and will safeguard risks and needs of the participant.

The support plan to incorporate both general supports (described as nature of a coordination, strategic or referral service or activity) and reasonable and necessary supports funded under NDIS (activities that support goals, maximise independence, allow to live independently and undertake mainstream activities).

The Plan will provide clear and written information to the participant, detailing the services and type of supports they will receive from Adelaide Quality Care. Where there is a change in the participant's needs, preferences and goals, an amended Support plan will communicate this change in supports required to the participant.

Staff must be screened, trained and qualified in the roles that they undertake.

Support Planning Principles:

- Support planning process is consultative where the participant, family, friends, carer or advocate work together to identify strengths, needs and live goals with a focus onchoice and decision-making.
- The participant's preferences, values and lifestyle choices should be supported(wherever possible).

- Support plans should promote the valued role of people with disability that is of their own choosing.
- Promotion of functional and social independence and quality of life.
- Support plans will contain goals. Service choices agreed to should reflect the participant's personal goals.
- Support plans should be creative, flexible and not developed by set patterns or methods of service delivery.
- Care must be inclusive of the participant's chosen communities and maintain connections with their community to allow for active participation.
- If a participant identifies as Aboriginal or Torres Strait Islander, then this community will be contacted to allow for engagement and support services.
- The Support plan is reviewed regularly and amended to respond to participant needs and preferences.
- Support plans should be strength based, seeking to maximise independence, and build on the participants existing networks.
- The Support plan should be provided to the participant in their first language where appropriate and/or requested.
- Participants or their advocates may request a review of the support plan at any time.
- Staff conducting support plan development will have the necessary skills and competence to undertake this function.
- Participants with a disability will also be facilitated to understand their NDIS plan including:
    - Understanding and self-directing their NDIS plan
    - Understanding the supports in their NDIS plan
    - Funded support budgets
    - Purchasing general funded supports
    - Purchasing stated funded supports)
    - Managing and paying for their supports
    - Choosing their providers
    - Making agreements with their chosen providers.

PROCEDURE

Support Plan Development

-Planning

- Explain the Support plan development process to the participant.
- Arrange a meeting time with the participant and (if applicable) their advocate.
- Develop the Support plan with as much input, choice and decision-making from the participant as the participant wishes. Document the reasons (should a participant choose to have minimal input into their Support plan).
- Prior to meeting with the participant review: Participant's assessment information; any referral documents, and other relevant notes or data available that will assist in understanding the participant as an individual.

-Providing Information to the Participant

- Emphasise the importance of the participant identifying their own personal goals and aspirations.
- Use the appropriate Support plan as a prompt to assist the participant to identify areas where Adelaide Quality Care services may help them realise their goals.
- Outline the prompts on the plan including discussion of the participant's physical, emotional, spiritual, cultural, community, social and financial needs.
- Provide the participant with a clear understanding of choices and services available so that they are able to make informed decisions about their choices and priorities.
- Provide the participant with examples or suggestions of how Adelaide Quality Careservices may be able to help them achieve their goals.

-Facilitating the Development of Participant Centred Goals

- Work with the participant and their advocate(s) to identify their personal goals.
- Ask the participant to identify the types of help or assistance that would be most important to them.
- Help the participant to recognise their strengths and capabilities
- Transform the participant's goals into SMART Specific, Measurable, Attainable, Realistic and Timely)
    - ***Example Simple Goal:*** To be able to get the mail.
    - ***Example SMART Goal:*** To be able to walk to the mailbox each day by myself to get the mail.
- Set a timeframe with each goal so that progress can be determined.
    - Example: To be able to walk to the mailbox each day by myself to get the mail. To achieve this by 30 Nov 20XX

~~• Use the participants expressed priorities, agreed actions and goals to develop their Support plan.~~

Also consider:

- The financial resource capacities and any limitations of Adelaide Quality Care services or specific programs to be utilised;
- The capacities, expertise and appropriateness of current Adelaide Quality Care care staff to provide the services;
- The availability of specialised subcontracted staff or services (if applicable);
- Other services/individuals who will provide services (as designated by the participant); and
- Any volunteer supports available.
- Determine with the participant how each goal will be measured so that progress can be recorded.
- Identify with the participant, any potential barriers to achieving their goals and work out strategies to alleviate these barriers.
- Ask the participant to prioritise their goals if many goals have been identified. For each Goal, list the actions/responsibilities / frequencies and durations, of services to be coordinated on behalf of the participant. Document in the Support plan
- Identify all stakeholders (Participants, family, community engagement links, other services or agencies) that will undertake to help the participant achieve each goal, and document this in the Support plan.

Support Plan Delivery and Review

- Negotiate the specific days for services or support and document these in the Support plan.
- (Where possible) agree upon time ranges for the services to build a level of flexibility into the service roster. (e.g.: Start time of between 1 and 1:30 pm and1hr of Domestic assistance).
- (If not yet finalised) negotiate service fees and record these in the participant Agreement and on the Support plan.
- Ask the participant to sign the Support plan to acknowledge their agreement with it.
- Agree on the criteria to evaluate the effectiveness of Adelaide Quality Careservice responses and document this in the Support plan.
- Ensure all involved stakeholders have copies of the agreed support plan

- Explain to the participant that the [Manager.Position] will monitor the progress of the Support plan, but they may also request a review of the Plan at any time.

RELATED DOCUMENTS

- Adelaide Quality Care Suite of Assessments
- Support plan

REFERENCES

- Work Health and Safety Act 2011
- NDIS Practice Standards and Quality Indicators 2018
- Privacy Act (1988)
- My first plan and Developing the Plan, NDIS, 2016