CHCCCS015

Provide individualised support

Learner Guide

the **learning** collaborative

CHCCCS015 - Provide individualised support

Student's Workbook

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CHCCCS015

Provide individualised support

Contents

Modification History

Release	Comments
Release 1	This version was released in CHC Community Services Training Package release 2.0 and meets the requirements of the 2012 Standards for Training Packages. Merged CHCICS302B/HLTCSD304D. Significant change to the elements and performance criteria. New evidence requirements for assessment including volume and frequency requirements. Significant changes to knowledge evidence.

Your Learning Guide

Welcome to your self-paced learning guide. This learning guide has been designed to lead you through a range of experiences to enable you to become an independent learner.

Independent learning means that you will choose the level and pace of your own education and training.

A learning guide is a guide to help you learn. A learning guide is *not* a text book.

Your learning guide will:

- describe the skills you need to demonstrate to achieve competency for this unit
- provide information and knowledge to help you develop your skills
- provide a wide range of structured learning activities to help you absorb knowledge and information and practice your skills
- direct you to other sources of additional knowledge and information about topics for this unit

To use your learning guide effectively, work through each of the sections in the order provided.

Throughout each section in your learner guide, there are exercises and activities that will help your understanding of the competencies required for the completion of this Unit.

What are competencies?

The broad concept of competency relates to the ability to perform particular tasks and duties to the standard of performance expected in the workplace. Competency requires the application of specified skills, knowledge and attitudes relevant to effective participation in an industry, industry sector or enterprise. The intended learning outcomes address the competencies required for the successful completion of this unit. Your learning guide has been developed in alignment with the National Training Package, **Community Services Training Package** (Release 3.0)

How does this resource relate to the National Training Package, CHC - Community Services Training Package (Release 3.0)**?**

This learning guide has been written to address the National Training Package unit **CHCCCS015 – Provide Individualised Support.** Each section relates to the elements, performance criteria and the skills and knowledge required for this unit of competence.

Progress Checklist

Use the progress checklist to chart your progress through this learner guide. Indicate that you have completed each Learning Assessment Activity or Knowledge Evidence Checkpoint, as you progress through your learning guide.

Portfolio Guidelines

Throughout your learning guide you will be asked to complete Learning Activities which require you to include information in a portfolio.

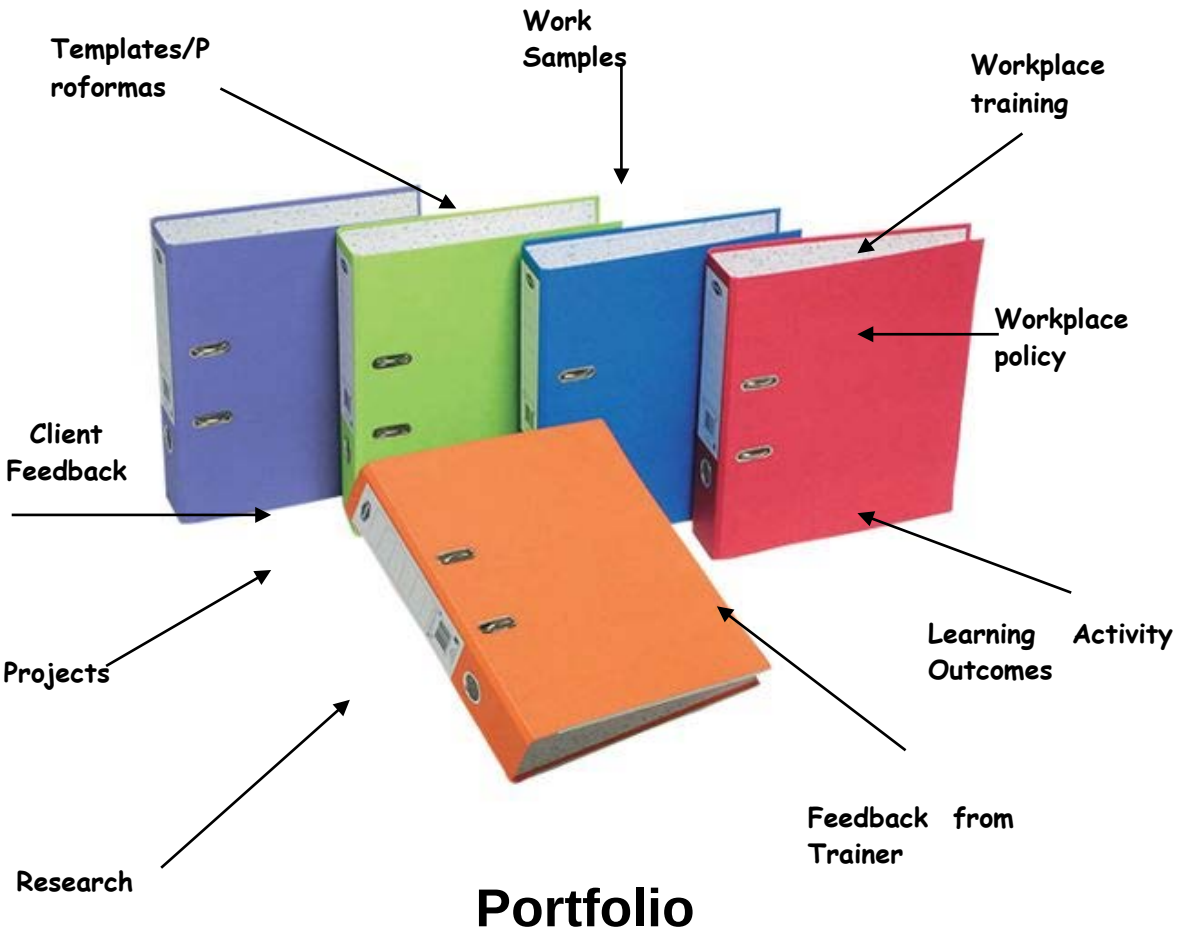
What is a Portfolio?

The term 'portfolio' describes a means of keeping a record of development to analyse and evaluate learning and practice. Your portfolio will include a range of evidence.

Compiling your Portfolio

The first step is to either buy a portfolio or make your own with an A4 ring binder file. Or you may choose to develop an e-portfolio.

As you work though the activities in the teaching materials, clear guidance is given about the mandatory portfolio content. It is for you to decide what additional evidence you want to include. The diagram below contains some suggestions about other possible sources of evidence.



Organising your Portfolio Structure

There is no right or wrong way to complete your portfolio, as it should be designed to suit you. However, the contents must be organised in such a way that you can find all of the information easily. It might be a good idea to use the Progress Checklist (at the front of this learning guide) as a Table of Contents and place all of the evidence you collect in the order shown on this checklist.

The information gathered from each Activity should be placed in the portfolio immediately so that you do not misplace it. Do not wait until you have finished a Section to add it to the portfolio or you will waste time trying to sort it all out. Start today and move forwards.

You might wish to use dividers to separate the contents, if required, grouping evidence into areas of learning.

Finally

Everything you do during this unit is evidence of your competence, so don't destroy anything – place it in your portfolio!

CHCCCS015

Provide individualised support

Application:

This unit describes the skills and knowledge required to organise, provide and monitor support services within the limits established by an individualised plan. The individualised plan refers to the support or service provision plan developed for the individual accessing the service and may have many different names in different organisations.

This unit applies to workers who provide support under direct or indirect supervision in any community services or health context.

The skills in this unit must be applied in accordance with Commonwealth and State/Territory legislation, Australian/New Zealand standards and industry codes of practice.

Introduction

As a worker, a trainee or a future worker you want to enjoy your work and become known as a valuable team member. This unit of competency will help you acquire the knowledge and skills to work effectively as an individual and in groups. It will give you the basis to contribute to the goals of the organisation which employs you.

It is essential that you begin your training by becoming familiar with the industry standards to which organisations must conform.

This unit of competency introduces you to some of the key issues and responsibilities of workers and organisations in this area. The unit also provides you with opportunities to develop the competencies necessary for employees to operate as team members.

This Learning Guide covers:

- Determining support needs
- Providing support services
- Monitoring support activities
- Completing reporting and documentation

Learning Program

As you progress through this unit you will develop skills in locating and understanding an organisations policies and procedures. You will build up a sound knowledge of the industry standards within which organisations must operate. You should also become more aware of the effect that your own skills in dealing with people has on your success, or otherwise, in the workplace.

Knowledge of your skills and capabilities will help you make informed choices about your further study and career options.

Additional Learning Support

To obtain additional support you may:

- Search for other resources in the Learning Resource Centres of your learning institution. You may find books, journals, videos and other materials which provide extra information for topics in this unit.
- Search in your local library. Most libraries keep information about government departments and other organisations, services and programs.
- Contact information services such as the Equal Opportunity Commission, and Commissioner of Workplace Agreements. Union organisations, and public relations and information services provided by various government departments. Many of these services are listed in the telephone directory.
- Contact your local shire or council office. Many councils have a community development or welfare officer as well as an information and referral service.
- Contact the relevant facilitator by telephone, mail or facsimile.

Facilitation

Your training organisation will provide you with a flexible learning facilitator.

Your facilitator will play an active role in supporting your learning, will make regular contact with you and if you have face to face access, should arrange to see you at least once. After you have enrolled your facilitator will contact you by telephone or letter as soon as possible to let you know:

- How and when to make contact;
- What you need to do to complete this unit of study;
- What support will be provided;
- Here are some of the things your facilitator can do to make your study easier;
- Give you a clear visual timetable of events for the semester or term in which you are enrolled, including any deadlines for assessments;
- Check that you know how to access library facilities and services;
- Conduct small 'interest groups' for some of the topics;
- Use 'action sheets' and website updates to remind you about tasks you need to complete;
- Set up a 'chat line". If you have access to telephone conferencing or video conferencing, your facilitator can use these for specific topics or discussion sessions;
- Circulate a newsletter to keep you informed of events, topics and resources of interest to you;
- Keep in touch with you by telephone or email during your studies.

Flexible Learning

Studying to become a competent worker and learning about current issues in this area, is an interesting and exciting thing to do. You will establish relationships with other students, fellow workers and clients. You will also learn about your own ideas, attitudes and values. You will also have fun – most of the time.

At other times, study can seem overwhelming and impossibly demanding, particularly when you have an assignment to do and you aren't sure how to tackle it…..and your family and friends want you to spend time with them……and a movie you want to watch is on television….and…. Sometimes being a student can be hard.

Here are some ideas to help you through the hard times. To study effectively, you need space, resources and time.

Space

Try to set up a place at home or at work where:

- You can keep your study materials;
- You can be reasonably quiet and free from interruptions, and;
- You can be reasonably comfortable, with good lighting, seating and a flat surface for writing;
- If it is impossible for you to set up a study space, perhaps you could use your local library. You will not be able to store your study materials there, but you will have quiet, a desk and chair, and easy access to the other facilities.

Study Resources

The most basic resources you will need are:

- a chair;
- a desk or table;
- a reading lamp or good light;
- a folder or file to keep your notes and study materials together;
- materials to record information (pen and paper or notebooks, or a computer and printer);
- reference materials, including a dictionary

Do not forget that other people can be valuable study resources. Your fellow workers, work supervisor, other students, your flexible learning facilitator, your local librarian, and workers in this area can also help you.

Time

It is important to plan your study time. Work out a time that suits you and plan around it. Most people find that studying in short, concentrated blocks of time (an hour or two) at regular intervals (daily, every second day, once a week) is more effective than trying to cram a lot of learning into a whole day.

You need time to “digest” the information in one section before you move on to the next, and everyone needs regular breaks from study to avoid overload. Be realistic in allocating time for study. Look at what is required for the unit and look at your other commitments.

Make up a study timetable and stick to it. Build in “deadlines” and set yourself goals for completing study tasks. Allow time for reading and completing activities. Remember that it is the quality of the time you spend studying rather than the quantity that is important.

Study Strategies

Different people have different learning 'styles'. Some people learn best by listening or repeating things out loud. Some learn best by 'doing', some by reading and making notes. Assess your own learning style, and try to identify any barriers to learning which might affect you. Are you easily distracted? Are you afraid you will fail? Are you taking study too seriously? Not seriously enough? Do you have supportive friends and family? Here are some ideas for effective study strategies:

Make notes. This often helps you to remember new or unfamiliar information. Do not worry about spelling or neatness, as long as you can read your own notes. Keep your notes with the rest of your study materials and add to them as you go. Use pictures and diagrams if this helps.

Underline key words when you are reading the materials in this learning guide. (Do not underline things in other people's books.) This also helps you to remember important points.

Talk to other people (fellow workers, fellow students, friends, family, your facilitator) about what you are learning. As well as helping you to clarify and understand new

ideas, talking also gives you a chance to find out extra information and to get fresh ideas and different points of view

Using this learning guide:

A learning guide is just that, a guide to help you learn. A learning guide is not a text book. This learning guide will

- describe the skills you need to demonstrate to achieve competency for this unit;
- provide information and knowledge to help you develop your skills;
- provide you with structured learning activities to help you absorb the knowledge and information and practice your skills;
- direct you to other sources of additional knowledge and information about topics for this unit.

The Icon Key

Key Points

Explains the actions taken by a competent person.

Example

Illustrates the concept or competency by providing examples.

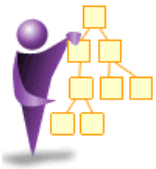
Learning Assessment

Provides learning assessment activities to reinforce understanding of the action. This is called formative assessment

Formative assessment

The goal of formative assessment is to monitor your learning to provide ongoing feedback that can be used by your trainer to improve their teaching and so you can improve your learning. More specifically, formative assessments:

- help you identify your strengths and weaknesses and target areas that need work
- help your trainer recognise where you are struggling and address problems immediately



Chart

Provides images that represent data symbolically. They are used to present complex information and numerical data in a simple, compact format.

Intended Outcomes or Objectives

Statements of intended outcomes or objectives are descriptions of the work that will be done. These are also known as your Performance Criteria

Assessment

Strategies with which information will be collected in order to validate each intended outcome or objective. This is called summative assessment.

Summative assessment

The goal of summative assessment is to *evaluate your learning* at the end of an instructional (learning) unit by comparing it against some standard or benchmark.

Case Studies

Documented study of a specific real-life situation or imagined scenario

Knowledge Evidence Checkpoint

Specifies what the individual must know in order to safely and effectively perform the work task described in the unit of competency;

The type and depth of knowledge required to meet the demands of the unit of competency

Performance Evidence Checkpoint

Specifies the skills to be demonstrated relevant to the product and process

The frequency or volume of the product or process

How to get the most out of your learning guide

1. Read through the information in the learning guide carefully. Make sure you understand the material.

Some sections are quite long and cover complex ideas and information. If you come across anything you do not understand:

- talk to your facilitator
- research the area using the books and materials listed under Resources
- discuss the issue with other people (your workplace supervisor, fellow workers, fellow students)
- try to relate the information presented in this learning guide to your own experience and to what you already know.

Ask yourself questions as you go: For example "Have I seen this happening anywhere?" "Could this apply to me?" "What if….?" This will help you to make sense of new material and to build on your existing knowledge.

2. Talk to people about your study.

Talking is a great way to reinforce what you are learning.

3. Make notes.

4. Work through the activities.

Even if you are tempted to skip some activities, do them anyway. They are there for a reason, and even if you already have the knowledge or skills relating to a particular activity, doing them will help to reinforce what you already know. If you do not understand an activity, think carefully about the way the questions or instructions are phrased. Read the section again to see if you can make sense of it. If you are still confused, contact your facilitator or discuss the activity with other students, fellow workers or with your workplace supervisor.

Additional research, reading and note taking

If you are using the additional references and resources suggested in the learning guide to take your knowledge a step further, there are a few simple things to keep in mind to make this kind of research easier.

Always make a note of the author's name, the title of the book or article, the edition, when it was published, where it was published, and the name of the publisher. If you are taking notes about specific ideas or information, you will need to put the page number as well. This is called the reference information. You will need this for some assessment tasks and it will help you to find the book again if needed.

Keep your notes short and to the point. Relate your notes to the material in your learning guide. Put things into your own words. This will give you a better understanding of the material.

Start off with a question you want answered when you are exploring additional resource materials. This will structure your reading and save you time.

Performance Evidence

The student must show evidence of the ability to complete tasks outlined in elements and performance criteria of this unit, manage tasks and manage contingencies in the context of the job role. There must be evidence that the student has:

- used individualised plans as the basis for the support of 3 individuals

Assessment Conditions

Skills must have been demonstrated in the workplace or in a simulated environment that reflects workplace conditions. The following conditions must be met for this unit:

- use of suitable facilities, equipment and resources, including:
  - individualised plans and equipment outlined in the plan
  - infection control policies and procedures
- modelling of standard industry operating conditions and contingencies, including involvement of real people when using relevant equipment

Assessors must satisfy the Standards for Registered Training Organisations (RTOs) 2015/AQTF mandatory competency requirements for assessors.

Foundation Skills

The Foundation Skills describe those required skills (such as language, literacy, numeracy and employment skills) that are essential to performance.

Foundation skills essential to performance are explicit in the performance criteria of this unit of competency.

Elements and Performance Criteria

CHCCCS015 - Provide individualised support		
Element		
1.	**Determine support needs**	
	1.1	Interpret and clarify own role in implementing individualised plan and seek appropriate support for aspects outside scope of own knowledge, skills or job role
	1.2	Confirm individualised plan details with the person and with family and individual support workers when appropriate
	1.3	Ensure the person is aware of their rights and complaints procedures
	1.4	Work with the person to identify actions and activities that support the individualised plan and promote the person's independence and rights to make informed decision-making
	1.5	Prepare for support activities according to the person's individualised plan, preferences and organisation policies, protocols and procedures
2.	**Provide support services**	
	2.1	Conduct exchanges with the person in a manner that develops and maintains trust
	2.2	Provide support according to the individualised plan, the person's preferences and strengths, and organisation policies, protocols and procedures
	2.3	Assemble equipment as and when required according to established procedures and the individualised plan
	2.4	Respect and include the family and/or individual support worker as part of the support team
	2.5	Provide support according to duty of care and dignity of risk requirements
	2.6	Provide assistance to maintain a safe and healthy environment
	2.7	Provide assistance to maintain a clean and comfortable environment
	2.8	Respect individual differences to ensure maximum dignity and privacy when providing support
	2.9	Seek assistance when it is not possible to provide appropriate support
3.	**Monitor support activities**	
	3.1	Monitor own work to ensure the required standard of support is maintained
	3.2	Involve the person in discussions about how support services are meeting their needs and any requirement for change
	3.3	Identify aspects of the individualised plan that might need review and discuss with supervisor
	3.4	Participate in discussion with the person and supervisor in a manner that supports the person's self determination
4.	**Complete reporting and documentation**	
	4.1	Maintain confidentiality and privacy of the person in all dealings within organisation policy and protocols
	4.2	Comply with the organisation's informal and formal reporting requirements, including reporting observations to supervisor
	4.3	Identify and respond to situations of potential or actual risk within scope of own role and report to supervisor as required
	4.4	Identify and report signs of additional or unmet needs of the person and refer in accordance with organisation and confidentiality requirements
	4.5	Complete and maintain documentation according to organisation policy and protocols
	4.6	Store information according to organisation policy and protocols

Knowledge Evidence

The student must be able to demonstrate essential knowledge required to effectively complete tasks outlined in elements and performance criteria of this unit, manage tasks and manage contingencies in the context of the work role. This includes knowledge of:

- rationale and processes underpinning individualised support planning and delivery:
  - basic principles of person-centred practice, strengths-based practice and active support
  - documentation and reporting requirements
- roles and responsibilities of different people and the communication between them:
  - individual support workers and family
  - person being supported
  - health professionals
  - individual workers
  - supervisors
- service delivery models in the relevant sector
- legal and ethical requirements and how these are applied in an organisation and individual practice, including:
  - privacy, confidentiality and disclosure
  - duty of care
  - dignity of risk
  - human rights
  - discrimination
  - mandatory reporting
  - work role boundaries – responsibilities and limitations
- factors that affect people requiring support
- practices that support skill maintenance and development
- indicators of unmet needs and ways of responding
- risk management considerations and ways to respond to identified risks

1. Determine support needs

1.1	Interpret and clarify own role in implementing individualised plan and seek appropriate support for aspects outside scope of own knowledge, skills or job role
1.2	Confirm individualised plan details with the person and with family and individual support workers when appropriate
1.3	Ensure the person is aware of their rights and complaints procedures
1.4	Work with the person to identify actions and activities that support the individualised plan and promote the person's independence and rights to make informed decision-making
1.5	Prepare for support activities according to the person's individualised plan, preferences and organisation policies, protocols and procedures

1.1 Interpret and clarify own role in implementing individualised plan and seek appropriate support for aspects outside scope of own knowledge, skills or job role

As a support worker you may well begin working with your clients at any stage of their life, for example you may begin direct care with your client from the day they engage your organisations services, or they may be a long term client when you commence work with the organisation.

Either way you will come into contact with the health professionals working with the same client. It is an important part of a client's individual plan that support workers and health professionals work together, to help the client achieve their own independence goals.

This can be by way of further reading or procedure manuals, obtaining assistance from another staff colleague or by advising your supervisor and having a more experienced person assist or take over the care of the client.

What is an Individual Care Plan?

Care Plans are a vital part of a Clients/residents ongoing record.

Residents, clients or their representatives are entitled to view their individual Care Plan as needed. Whether it is a paper document or stored on a computer your Care Plan should be readily accessible to you or their representative, care staff, medical staff, doctor and other health care practitioners (e.g. physiotherapist, podiatrist, dentist).

Care Plans need to be reviewed regularly, Facilities with schedule these reviews and involve you in the process.

You can also request changes to the Care plan based on alterations in care needs.

Personalisation (Person-Centred Approach)

Personalisation means thinking about care and support services in an entirely different way. It means starting with the person as an individual with strengths, preferences and aspirations and putting them at the centre of the process of identifying their needs and making choices about what, who, how and when they are supported to live their lives. It requires a significant transformation of adult social care so that all systems, processes, staff and services are geared up to put people first.

Personalisation for individual support workers means:

- tailoring support to people's individual needs and being part of the discussion about support for yourself and support for the person you are looking after
- not having to take on all the responsibility and all the managing of care and support – the relevant people and organisations should ensure that you are sufficiently supported
- recognising and supporting individual support workers in their role, while enabling them to maintain a life beyond their caring responsibilities
- ensuring that people have access to information and advice to make good decisions about their care and support
- ensuring all clients have access to universal community services and resources such as health, transport and leisure
- making services more flexible so you can agree outcomes and find solutions that are right for your situation
- if needs change over time, personalisation should enable you and the person you are looking after to change the way you are supported.

The traditional service-led approach has often meant that people have not received the right help at the right time and have been unable to shape the kind of support they need. Personalisation is about giving people much more choice and control over their lives and goes well beyond simply giving personal budgets to people eligible for funding.

Personalisation means addressing the needs and aspirations of whole communities to ensure everyone has access to the right information, advice and advocacy to make good decisions about the support they need. It means ensuring that people have wider choice in how their needs are met and are able to access universal services such as transport, leisure and education, housing, health and opportunities for employment regardless of age or disability.

What are the implications for individual support workers?

There are two main elements to personalisation for individual support workers. Firstly, personalisation should impact on the support provided to the person you are looking after, which may help both them and you. Secondly, personalisation should affect the support provided for you as a individual support worker.

Personalisation in relation to the support provided to the person you are looking after

Everyone is entitled to an assessment of their needs. Following such an assessment, the person you are looking after will access support either through the relevant person, organisation or authority, and/or by paying for support themselves independently.

Personalisation is not just about what social services can provide, it is also about what and how other public services can help – for example, through providing health, housing, transport, leisure services. What personalisation is supposed to do is find the solution that is right for your client and meets the individual support worker's and family's needs.

Making sure personalisation is working for your situation

Decide what outcomes you both want. What other outcomes do you want as a individual support worker? To work? Does the person you care for need to socialise a bit more? Are they really keen to get involved in the local community, but need support to do so? Or do you need basic help getting the person out of bed, dressed and washed?

Example: Deciding on outcomes

If you want to make sure that your father is safe, you will need to find out what support there might be that you could call upon. Would a day respite centre work for both of you? If your father does not want to attend a respite centre then would an alarm system help to provide a safer environment and reassure you as his individual support worker? Or do you think that a direct payment should be made that would enable you to employ someone to sit with him while you are out of the house? What solution will make life better for you both? Personalisation should be flexible enough to allow you to find a solution.

Learning Activity 1:

As part of your learning journey how would you manage your fathers care and what would you put in place to maintain his safety and meet his need?

Once you have answered this question please have your assessor or facilitator check your answer to see if you are on the right track.

1.2 Confirm individualised plan details with the person and with family and individual support workers when appropriate

In formulating a care plan for your client/resident, the registered nurse (RN) will again synthesise knowledge, experience, critical thinking, attitudes and standards. Critical thinking ensures that your client's/residents plan of care integrates all that the care team knows about your client. Professional standards are especially important to consider when a care plan is developed taking into account personal preferences of your client/resident. An individualised care plan is developed for each diagnosis or risk assessment. As an individual support worker you and your client/resident need to set realistic expectations for care. Goals need to be individualised and realistic with measurable outcomes. In establishing goals, your client should be consulted to ensure the goals are realistic and achievable.

Consultation with significant others including family, mental health workers, Allied health services – Physiotherapists, Occupational Therapists, Speech Therapists, Podiatrists and community resources can result in a more comprehensive and workable plan.

In Australia as in many other Western countries, the ageing population continues to increase primarily due to the advancement of medical techniques and treatment and support services and with a greater emphasis on living a healthier lifestyle. Many ageing people are able to remain in their own homes longer whilst others require nursing home care, hostel accommodation or self-care accommodation within aged care facilities.

There is a minimum requirement of data which is required to be known about your client in order to produce an informative individualised plan.

These include but are not limited to:

- Clients background, ethnicity and culture.
- Cognitive, communication, language, hearing and vision requirements.
- Mood, behaviour, leisure and activities interests.
- Psychological and psychosocial conditions.
- Bladder and bowel functioning's.
- Cardiac conditions.
- Skin integrity.
- Physical abilities and prosthesis.
- Nutritional requirements and desires and oral hygiene.
- Medication requirements and administration.
- Disease conditions and associated problems.

The Individual Client Agreement from the Department of Community Services can be found at the following website:

http://www.community.QLD.gov.au/docswr/_assets/main/documents/oohc_header_indiv.pdf

Learning Activity 2:

What are some of the details to ensure an Individual Care plan is accurate?

List 4 details

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

Once you have answered this question please have your assessor or facilitator check your answer to see if you are on the right track

Foundations of individual care planning process:

An individual support plan strengthens individual authority and provides meaningful options for individuals/carers/families to express preferences, to make informed choices, and to achieve hopes, goals and dreams.

- Individual care planning discovers and understands what is important to the individual/family and what is important for the individual/family; and balances these viewpoints.
- Individual care planning begins with strengths, gifts, skills and contributions of each individual/family.
- Individual care planning is used as a framework for providing supports designed to meet the unique needs of each individual/family, while honouring goals and dreams.
- Individual care planning is a process that enhances community connections and natural supports and encourages the involvement of the individual/family in the community.
- Individual care planning recognizes that connections with other people who love and care about the individual are central to their well-being.
- Individual care planning recognizes that everyone can have relationships with people who are not paid to be there.
- Individual care planning supports mutually respectful partnerships between individuals/families and providers/professionals.
- The individual care planning process respects culture, ethnicity, religion and gender.
- Individual scare planning involves listening, action, being honest and realistic; and discussing concerns about staying healthy and safe.

Some Things to Remember When Writing a Care Plan

- Show how what is requested is the most effective way to help the person express their gifts and talents while also helping them meet their disability related needs and personal goals
- List informal community supports and resources that will help the person meet their goals [e.g. the role of family and friends, public transportation, sports clubs, hobby groups, etc.]
- Ensure that requested supports and services that are funded by the relevant authorities are the most cost effective without compromising quality
- Identify any short term goals [6 months or less] and the time frames and supports needed to reach these goals
- Be guided by the values and principles of community living, relevant health and safety standards and identify appropriate safeguards for the individual.
- Show that the plan has a reasonable balance between formal, paid supports and services funded by the relevant authorities and informal community supports and resources

You will need to describe how the person has met their disability-related needs in the past.

Give an overview of the different types and amount of supports and services the person has used to meet their disability related needs in the past. As well, provide a brief analysis of how effective these supports and services have been, or any problems that have been encountered.

A description of the individual's current situation including where they live, whom they live with, daytime activities, the type and amount of support they currently receive, and whether there is a Representation Agreement or legal Committee acting for the individual.

In addition to a general description of the person's current situation, provide enough detail to help the person understand why the person needs support, or is requesting a change in how/where they are supported.

The benefits the person expects from the supports and services requested need to be described

The following needs to provide a brief summary of the needs that are important to the person and how they will be effectively addressed by the relevant authorities funded supports and services that are requested in the support plan.

Some things to consider are:

- What different supports and services were considered?
- What are the specific benefits of the funded supports and services requested from the relevant authorities?
- How will the relevant authorities funded supports and services work with informal community supports and resources?
- Is short term funding [6 months or less] required to put informal community supports or resources in place, ore enable them to respond more effectively to the person?

You need to describe how the person and, if appropriate, family members and significant others, have been included in the development of the plan.

Depending upon the person's circumstances, identification of any family members and any other important people who provided input and what their relationship is to the person should be detailed.

Type and cost of supports and services needed to achieve personal goals.

In addition to any specific requests for funding or specific supports and services from the relevant authorities, this section must include any relevant information on;

- The role of informal [i.e. unpaid] community supports and resources
- Support or contributions that may be provided by family members and friends
- Any other sources of funding that have been considered, or that the person has access to that will be used in implementing the support plan.

Use of Generic Supports

You need to be able to describe the role that informal community supports and resources will play in assisting the person to achieve personal goals including participating in community life.

For example;

- Are local transportation services or community clubs and groups, recreation centres or special interest or hobby clubs used now?
- Are they, or other supports and resources, being considered? If not, why?
- If the individual has not been able to use community supports and resources in the past, describe why, using specific examples.

Example

A person is interested in jazz. Instead of requesting paid money therapy, the plan identifies how the person will join a jazz club that meets on Friday nights. Jazz club members have said they are willing to pick your client up, provide support during the evening, and then drop your client back home.

In some circumstances, community supports and resources may, with some improvements, be helped to include the person and respond more effectively to the person's disability-related needs

Examples of this are an orientation provided to a local dentist or support for an assistant to attend aerobics with an individual until the aerobics instructor, or other class participants, know how to support the person in the class.

Example

Using a similar example to the one above, another person who enjoys jazz may need 3 hours each week of short term (6 weeks) paid staff support to be successfully included in the group, until fellow club members can provide support.

If short term support is needed, outline the type and length of the support that is required and how this is linked to the person's goals. The template below can be used to present this information and summarise any known costs.

Support or Contribution Being Provided by Family and Friends

You need to identify the role family members and friends will play to assist the person to achieve their personal goals. It is understood that parents and other family members are not required to make a financial contribution, unless required to do by a legal obligation [e.g. through a Trust].

Cultural issues may also influence a family's involvement and/or contribution.

Other Sources of Funding

A brother or sister may provide transportation to a hobby group, or the parents may contribute to the cost of an annual holiday.

The individual or family needs to list any sources of government funding they might now receive for community living supports and if they have a discretionary or financial trust account.

This information will ensure that the relevant authorities decisions about what is requested in the plan are based on a complete picture of the individual's disability-related needs and current supports.

Personal goals

Clear statements are required about what the person wants to achieve through the use of the supports and service they are requesting. For example:

- I will increase the number of friends and social contacts I have by spending more time in community settings like social clubs and interest groups. I will do this by receiving staff support up to 8 hours each week for the next 3 months. I expect this use of staff time to end after 3 months as I develop supportive unpaid relationships in these settings.
- I want to work and earn money but I need help preparing my resume and learning how to ask employers for a job. The local job club has agreed to help me with this. I need someone to go with me when I look for work because I don't know the bus routes. I need 6 hours of support each week for a month to look for work.
- Once I get a job, I will need some help to learn the bus route. This should take about 20 hour of support as I learn the routes pretty quickly.
- I am a hard worker but at my new job I will need some help from a job coach to learn what I should do. The local job club has agreed to help me and will provide

up to 12 hours each week for the first two months. After that I will only need help when the job changes or I don't understand what I am supposed to do.

Requested Supports and Services

A care plan needs to explain what supports and/or services are needed to assist the individual to achieve his or her personal goals and disability related needs.

- Where applicable, use the 8 areas in the person's life listed below to describe how needs will be addressed.
- Please include an explanation of why the particular type of support or service is being requested

The examples provided below are not meant to limit what may be included under any particular heading.

1. Home Living

Locating a place to live and support for activities such as preparing food, eating, housekeeping, personal hygiene, dressing, respite

2. Transition Supports

Participating in volunteer or training settings, learning self-management strategies, learning life skills, completing work tasks, part-time jobs, connections with school, moving from home

3. Community Inclusion

Learning how to use public transportation, shopping, using recreational facilities, assistance to access and join social clubs and groups, church or volunteer activities

4. Education and Employment

Participating in training or educational settings, learning self-management strategies, learning skills like reading signs and counting money, completing work tasks, and job support including interacting with co-workers

5. Professional Support

Examples include counselling, augmentative communication, service provider training, and psychological assessment

6. Behavioural Support

Prevention of self-injury, assistance to learn more appropriate ways to interact with others in the environment, behavioural intervention

7. Health Care Planning & Medical Support

Equipment, seizure management, manual handling, transferring, respiratory care, nursing support, medication management, health care protocols, and other specific areas that need to be considered for the person

8. Anticipated Need for Crisis Support

It may be possible to anticipate a crisis, particularly if there has been a pattern of crisis activity in the past. In such situations, a description of the anticipated or potential crisis is required, as well as how it will be addressed and the potential cost of crisis support

When describing supports and services in the 8 areas listed above, please include the following information:

- How often support is required [e.g., always, daily, weekly, monthly, none]
- How much time is required [e.g., specify hours or minutes required in a day]
- How long you think this support will be required [weeks, months, ongoing]
- What kind of support is provided [e.g., none, verbal encouragement / reminders, partial physical assistance, or total assistance]
- How the support will be provided [e.g. by a live in roommate, living with a family, in own apartment with drop in support]
- Who will provide needed supports/services [e.g. agency staff, an independent contractor, live in caregiver, and whether resources will be shared with others]

A description of how this information can be organized is presented below:

Table 1

Description of Required Support or Service	Name and Type of Provider	Hours or Days of Support	Duration Support is needed
1. Home Living			
2. Transition Supports			
3. Community Inclusion			
4. Education and Employment			
5. Professional Support			
6. Behavioural Support			
7. Health Care Planning & Medical Support			
8. Anticipated Need for Crisis Support			
9. Enhancements for Generic Support			

Safeguards

You will have to look at what safeguards are now in place to support the person as well as a plan to secure additional safeguards that may be required.

Below is an example of an informal safeguard that could be implemented as part of a person's support plan

Example:

A woman with a developmental disability eats too much food at lunch following church, with a risk of becoming very sick. One approach to address this issue would be for the family, who does not attend church, to seek funding to hire a support worker to go to church with the woman to provide full time supervision. While this would "protect" her, it would also stigmatise her in this public setting because she wants only to be with her friends. The family chose instead to work with members of the congregation to let them know about the issue and to identify appropriate ways in which the woman could be supported to know an acceptable amount of food to eat. The family talks with key church members each week by phone after the service and luncheon to see how things went.

"Intentional safeguards can be thought of as conscious design or practice features that can variably be added on, built in or strengthened in order to preserve or enhance something of value in a situation and thereby better manage the vulnerabilities of people and situations." - Michael Kendrick

Learning Activity 3:

As part of your learning journey you have been discussing and learning the support required for a resident/client. List 4 of the foundations of the care planning process.

1. _____

_____

2. _____

_____

3. _____

_____

4. _____

_____

Are individual support workers allowed to write care plans?

Yes **or** **No**

If No., who is able to determine and write the care needs in the care plan of your resident/client?_____

_____

_____

Do Individual care support workers contribute to care planning? How?

_____

_____

_____

_____

_____

_____

_____

Once you have answered this question please have your assessor or facilitator check your answer to see if you are on the right track

1.3 Ensure the person is aware of their rights and complaints procedures

Advocacy - Traditional meaning

Advocacy means different things to different people. Its plain English meaning is that advocacy is supporting another person's cause. This idea of people representing others has gathered strength in the last 20 years, particularly in disability areas. It has been thought that sometimes people benefit from having others speak out on their behalf.

Consumers of health services and individual support workers associated with health services have strong cause to participate in decisions about the services and to ensure that their views about a range of related issues are expressed and heard. Sometimes, perhaps when a consumer or individual support worker is particularly vulnerable, it is useful to have someone to speak on behalf of the person.

Advocacy in an aged care context means that the worker acts for and on behalf of the client. To act as an advocate for a client the worker must ensure that the client is provided with adequate and accurate information relating to their care, and must support the client in any informed decisions they make about their care. In this way the worker meets the ethnical requirements of honouring a client's right to self-determination.

Ethnics in aged care involve respecting a client's right to:

- be informed
- Make decisions and choices
- Confidentially
- Privacy and dignity
- Hold their own cultural and religious beliefs

All the workers in the aged care sector have a responsibility to ensure that, in relation to aged care practices, the client is assured of safe and competent care and that their rights will be protected.

It is worth noting that advocacy isn't confined to the relationship between aged care workers and their clients. You will find advocacy being applied in a myriad of different workplaces and environments and therefore it takes on many different forms.

Within the scope of this unit of competency advocacy means 'supporting clients to voice their opinions or need and to ensure their rights are upheld', and may include:

- Assisting clients to identify their own needs and rights
- Meeting client's needs in the context of organisational requirements
- Supporting clients to ensure their rights are upheld
- Awareness of potential conflicts between client's needs and organisational requirements.
- Providing accurate information

There are many ways of undertaking advocacy. Consumers and individual support workers can influence how services are provided to them on a day-to-day basis and can look for ways to have their views heard by health professionals. They may participate in the training of health professionals. Some people will be involved in influencing the structure or policies of their local service and so may gain a place on a planning committee or a committee of management or participate in service evaluation. Others will see benefit in trying to influence State/Territory or national structures and gain membership on committees or working parties at this level.

How is advocacy undertaken?

Advocacy, in the first instance, is something that individuals undertake according to their own requirements and expectations. Each person will have a different personal purpose for engaging in advocacy and his or her actions will reflect this. Some will want to act at a local personal level, others at a higher level of influence on matters of national importance.

No matter how small or personal, every advocacy action is valid and important.

Increasingly, consumers and some individual support workers are finding opportunities to be employed as paid consultants and to more consistently participate in service design and organisation. Some consumer and individual support worker organisations have moved into direct service provision as a way of ensuring that particular needs are adequately met. Some people see community issues as being a particular problem and choose to engage in community education and community development and radical action.

All people feel particularly vulnerable at times and unable to adequately express their needs and requirements. Some may want another person to advocate on their behalf. This form of advocacy is a very legitimate form of advocacy, provided the authority of the vulnerable person is accorded the utmost respect at all times.

There is no one way or right way to undertake advocacy. It is something that happens every time a consumer or individual support worker speaks out in support of his or her own cause or that of the peer group. Sometimes the activity is effective and things change for the best, sometimes nothing happens as a result and sometimes it feels like things might have got worse.

Access and equity

All areas of ageing and aged care understand the importance of and deliver culturally and linguistically responsive care:

- All ageing and disability services have the responsibility to provide culturally, linguistically and spiritually appropriate and flexible aged care (across generalist, multicultural and ethno-specific service types) to facilitate maximum choice for CALD aged care recipients.
- Ageing and disability specific information is delivered through communication strategies that are clear, easily accessible and relevant to older people from CALD backgrounds, their families and carers.
- Care should be provided using a consumer directed approach. It is important to have an appropriate understanding of each individual's background, culture, beliefs and needs.
- All healthy ageing policy initiatives consider and address the needs of older people from CALD backgrounds, their families and carers.
- Language and support services are available and utilised to enable older people from CALD backgrounds, their families and carers to access all components of the aged care system.
- Ensure the diverse sub groups within CALD communities (including regional, rural, remote, small communities, emerging CALD ageing communities, care leavers and seniors with low levels of health literacy) are considered in the design of aged care services so as to meet their needs.
- All aged care complaints and feedback mechanisms are culturally and linguistically appropriate.

Making Complaints

Various laws exist that provide an infrastructure to formal understanding of justice. From a consumer and individual support worker perspective, some laws appear to advantage those with power and disadvantage those without. Legislation is constantly under review. It can be both responsive to social changes and reactive to social unrest.

Laws may be State/Territory specific or have national application. The differences between States/Territories represent a challenge for activity in pursuit of change at a national level.

Some legislation is particularly relevant to mental health interests. The various States/Territories maintain their own mental health acts that continue to go through amendments towards a more consistent national outcome.

Some legislation has been represented as enabling for people with disabilities or proactive in ensuring no disadvantage in a general sense. The Disability Discrimination Act is an example of the former and equal opportunity legislation an example of the latter.

Addressing legislation through advocacy is particularly complex. It is a political process requiring negotiation of substantial hoops and hurdles to bring about change. It is also a conservative process. Existing laws need to be demonstrated to be inappropriate before change is

Advocacy may be directed to legislative change through organised political activity. Alternatively, it may be directed towards issues of rights infringement, inequity and injustice that current legislation may be seen to perpetuate.

References

Hutchinson M and Ausland T User Participation in the Mental Health System, Mind, London, pp13-20

Mental Health Consumer Outcomes Task Force (1991) Mental Health Statement of Rights and Responsibilities, Australian Government Publishing Service, Canberra

Disability Services Act 1992 (Commonwealth)

NACAP

The National Aged Care Advocacy Program (NACAP) is a national program funded by the Australian Government under the Aged Care Act 1997. The NACAP aims to promote the rights of people receiving Australian Government funded aged care services.

Under the NACAP, the Department of Health and Ageing funds aged care advocacy services in each State and Territory. These services are community-based organisations which are there to give your client's advice about their rights, and help them to exercise their rights. Aged care advocacy services also work with the aged care industry to encourage policies and practices which protect consumers.

If your client lives in an Australian Government aged care home or receive Australian Government funded aged care services in their own home, and would like to speak to someone about their rights, your client or your client's representative can contact one of the advocacy services. These services are free and confidential.

Aged Care Complaints Investigation Scheme

The Aged Care Complaints Investigation Scheme is available to anyone who has a complaint or concern about an Australian Government-subsidised aged care service (residential or community care).

Working together to fix the problem

The Complaints Investigation Scheme (CIS) is available to anyone who wishes to provide information or raise a complaint or concern about an Australian Government-subsidised aged care service, including:

- residents of aged care homes;
- people receiving community aged care packages or flexible care; or
- relatives, guardians or legal representatives of those receiving care.

What is the Complaints Investigation Scheme (CIS)?

The CIS:

- is a free service which investigates concerns raised about the health, safety and/or well-being of people receiving aged care;
- has the power to investigate these concerns and require the service provider, where appropriate, to take action; and
- is able to refer issues that may be more appropriately dealt with by others (e.g. police, nursing and medical registration boards).

You may download these documents in PDF and HTML format from their website:

- Aged Care Complaints Investigation Scheme
- The Aged Care Complaints Investigation Scheme - Plain English Brochure
- The Aged Care Complaints Investigation Scheme - Information for Residential Aged Care Workers

What concerns can you raise?

The Aged Care Act 1997 (the Act) sets out the responsibilities of approved providers who receive Australian Government funding to provide care and services to care recipients. The CIS can investigate information or complaints about cases where an approved provider may not be meeting their responsibilities under the Act.

The information, complaint or concern may be about anything regarding the care and services provided to aged care recipients.

For example:

- quality of care
- choice of activities
- personal care
- meals
- communication between you and staff
- physical environment.

Who can contact the CIS?

Anyone can contact the CIS with a complaint or a concern - care recipient, family member, care provider, staff member, GP etc. Complaints can be made openly, anonymously or your name can be kept confidential.

Your client may want to talk to your aged care manager first - some issues can be resolved easily. If your client is uncomfortable doing this, or isn't happy with what has happened with their complaint, they can contact the Aged Care Complaints Investigation Scheme directly.

If required, the CIS can provide access to:

- an interpreter service;
- a TTY (deaflink) phone service; or
- a free and confidential advocacy service.

Representatives of advocacy services may:

- inform you of your rights and entitlements;
- tell your client about the help they can provide; and
- assist you to voice your concerns with the CIS.

How can you or your client provide information, raise a concern or make a complaint?

You can you provide information or make a complaint either on free-call 1800 550 552 or in writing to:

Aged Care Complaints Investigation Scheme

C/- Department of Health and Ageing

GPO Box 9848

In your Capital City

When you contact the CIS they will:

- listen to and clarify your client's concerns;
- explain how the CIS works; and
- inform your client of their right to have the assistance of an advocacy service if they wish.

The CIS will, where appropriate:

- take detailed notes and record information in the CIS database;
- decide if the information provided relates to an approved provider's responsibilities;
- refer the matter to another agency if that is more appropriate;
- investigate the information they receive to determine whether or not a service provider is providing appropriate care and services;
- tell providers who have not met their responsibilities what they have to do to address an issue and specify the timeframe in which this must be done;
- provide feedback on the outcome of the contact.

There are however, some matters the CIS cannot deal with. For example, they cannot say who should make financial, legal or health decisions on behalf of a care recipient. They cannot comment on industrial matters such as wages or employment conditions or provide legal advice on any problems.

Who manages the CIS?

The CIS is managed by the Office of Aged Care Quality and Compliance within the Department of Health and Ageing. If your client has any concerns about the way the CIS has handled their complaint or concerns, your client can raise them with the CIS Manager in their State or Territory. Alternatively, your client can contact the Aged Care Commissioner.

Aged Care Commissioner

The Office of the Aged Care Commissioner has been established to independently review the way in which the CIS handles complaints. The Aged Care Commissioner can look at decisions made by the CIS in relation to the investigation of complaints and also has the power to examine, as a result of a complaint or on their own initiative, the CIS's administrative processes for investigating complaints.

The Office of the Aged Care Commissioner can be contacted during business hours on free call 1800 500 294.

Further information can be found on the Office of the Aged Care Commissioner's website at http://www.agedcarecommissioner.net.au

CIS Privacy Statement

You may download this document in PDF format from the website

Australian Government agencies must comply with the Information Privacy Principles (IPPs) set out in the Privacy Act 1988 (Cth). The IPPS cover the collection, storage, quality, use and disclosure of personal information about individuals.

The Aged Care Complaints Investigation Scheme (the Scheme) is administered by the Office of Aged Care Quality and Compliance in the Australian Government Department of Health and Ageing. The Scheme complies with the IPPs contained in the Privacy Act 1988.

Why might the Scheme collect personal information?

The Scheme might collect and use personal information for the purpose of performing its functions as set out in the Investigation Principles 2007 made under the Aged Care Act 1997.

Personal information may be collected by the Scheme in response to a particular concern or complaint.

When a concern is raised with the Scheme, its officers may collect personal information which relates to the complaint from any of the following parties;

- The person raising the concern
- The affected care recipient and/or their relatives or representatives
- The relevant approved provider and/or their staff.

This personal information may be used by the Scheme to assess whether the approved provider has met its responsibilities under the Aged Care Act 1997.

Does the Scheme disclose the personal information that it collects?

The Scheme has procedures to ensure that personal information is protected against misuse and is not unlawfully disclosed.

The Scheme must ensure that any request for confidentiality is complied with unless doing so would harm the investigation, or pose a risk to the informant or the affected care recipient. The Scheme must take all reasonable steps to notify the informant before deciding not to comply with a request for confidentiality.

Under section 16A.10 of the Investigation Principles 2007 personal information collected by the Scheme may be referred to another organisation. Referrals to another organisation are made where a concern raises issues that require, or may require, action by the other organisation.

Personal information collected by the Scheme may be disclosed to, and used by, relevant officers of the Department of Health and Ageing for the purpose of taking compliance action against an approved provider under the Aged Care Act 1997.

Personal information collected by the Scheme may also be used or disclosed in accordance with part 6.2 of the Aged Care Act 1997 or where otherwise permitted or required by law.

Learning Activity 4:

1. As we look at the client's rights and responsibilities we see that their needs to be a process for compliments and complaints. How would we disseminate (distribute) this information and how would it be explained to clients?

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2. Use the following statement from the Department of Health and Ageing and from your knowledge describe how the process for client complaints would help in this example.

There is a 'power differential', which does not exist with other customers. Many aged care facilities do not understand how easy it needs to be so that people will complain. Unlike other customers, residents are a captive market. They can't easily withdraw themselves or their capital. They might feel it ungrateful to complain if they're happy with the other 95% of the service they're getting from an aged care home

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_____

Once you have answered this question please have your assessor or facilitator check your answer to see if you are on the right track

Learning Activity 5:

As part of your learning journey you have been learning about client/residents rights.

1. How does your workplace demonstrate a commitment to access and equity for clients?

_____

_____

_____

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_____

_____

2. How does this commitment to access and equity impact on your position and your work?

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_____

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_____

3. You are to present a case study of a diverse older client and explain your role in supporting their rights and interests,

_____

_____

_____

_____

_____

_____

Once you have answered this question please have your assessor or facilitator check your answer to see if you are on the right track

1.4 Work with the person to identify actions and activities that support the individualised plan and promote the person's independence and rights to make informed decision-making

The Australian aged care system provides a range of services that support older people—and a small number of younger people with disability—in both a residential and community setting.

The *Living Longer Living Better* aged care reform package was passed into law on 28 June 2013. The reform package gives priority to providing more support and care in the home, better access to residential aged care, more support for those with dementia and strengthening the aged care workforce. People aged 70 and over (or 50 and over if Indigenous) are used as a 'planning population' for the allocation of aged care places; however, note that services for older people are provided on the basis of frailty or functional disability, rather than on specific age criteria. Some younger people are currently using aged care services, where no other appropriate care is available.

If it is determined an elderly person or someone living with a disability need help at home or are considering moving into an aged care home, they may first need a free assessment by an Aged Care Assessment (ACAT). The ACAT team helps them, and their families/carers, determine what kind of care will best meet their needs.

This may be residential care in an aged care home or a Home Care Package provided to them in their own home.

The ACAT may include a doctor, nurse, social worker, or other health professional.

One member of the local ACAT will visit the individual at home or in hospital to assess their needs. They will be asked a series of questions to determine the best care option for your situation.

These questions are designed to work out how much and what sort of help they require with daily and personal activities.

With the approval, the ACAT will also contact their local doctor to gain more information on their medication history to assist with the assessment process.

The ACAT will discuss the options that would be most suitable and what is available in your area. Carers, relatives or close friends are encouraged to be involved in the discussion.

The ACAT will discuss the result of its assessment, and arrange referrals to either home or community care services or a place in residential care. There is no charge for the assessment as the ACAT/ACAS is Government funded.

Consent by the individual or their EPOA (enduring power of attorney), if diminished cognitive ability (dementia) will be sought. Informed consent is not simply about getting a client or representatives signature on the consent form. It is about the entire interactive communication process for ensuring a client/representative fully understands the proposed healthcare and has, where appropriate, supportive information to make an informed decision whether to agree or not.

For more information re consent:

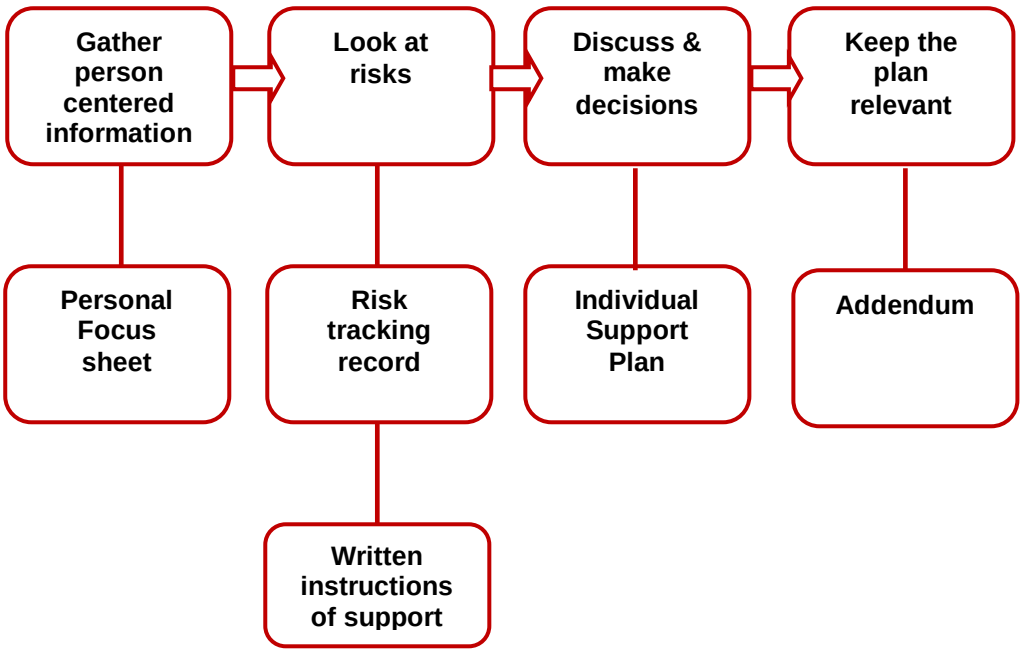
https://www.health.qld.gov.au/consent/documents/ic-guide.pdf

Whatever the care need is, residential care in an aged care home or a Home Care Package provided to them in their own home. A care plan will be written.

The purpose of a care plan is to provide a summary or the client/residents needs and goals.

Care planning is a collaborative process, health professionals e.g. physiotherapists and occupational therapists, doctors, support workers, family and the individual are all included to determine the needs of the client/resident. Assessment tools are used to get the 'big picture'. Tools such as pain management, mobility/manual handling etc.

Figure 1: Individual Support Plan System



The care provider promotes the rights and responsibilities of people using its services by:

- giving clients information about the services provided to them
- assisting clients to take part in making decisions that are relevant to them
- providing opportunities for clients to participate in service planning, development, delivery and evaluation
- promoting, encouraging and empowering clients to express their views, and valuing and using their perspectives to improve services at all levels.

When communicating with patients, each individual support worker has to find the ways that are the most effective for the people and circumstances concerned. If the individual support worker tries to express care and concern for the patient and can communicate well verbally and nonverbally, the individual support worker-patient relationship will thrive.

In conversation and working with your client, and associated personnel **you** will gain an insight into their life and what they did in the past and what they would like to do in the future. This is diagnosing, planning and goal setting, and can then be set as a critical pathway setting out your client's needs and priorities and devising appropriate interventions and activities to make the plan both individualised and workable.

Whilst your client may have specific goals, it is your position to advise if those goals are suitable and obtainable, without increasing complications. As you gain experience in deliberating this you become more efficient based on experience.

In the process of preparing your clients plan you would analyse and disseminate your information from multiple sources, thus ensuring that your client's plan of care integrates all the individual support worker knows about their client.

There are a number of 'tools' that can be used for working with a client to identify actions and activities that support the individualised plan development. One of these that gained a renewed interest is the Seven Phase Sequence especially when it comes to meaningful employment.

The Seven Phase Sequence

The degree to which support is given, approximated or accommodated within a setting must be considered in many areas of client's environment. When focusing on job training, an immediate problem arises—the multitude of approaches and perspectives utilised to provide instruction on supported job sites.

Regardless of the particular approach endorsed by a service provider, every approach to training should be evaluated as to the degree to which both natural validity and instructional power are effective and held in balance. However, a general model for achieving a balance between natural validity and instructional power, into which any approach to training could be placed, should prove to be a useful tool.

In 1980, Marc Gold suggested a linear model for writing and revising task analyses which he called the Seven Phase Sequence (Gold, 1980). This strategy had been developed during the 1970s as a guide for facilitators in planning instruction and developing task analyses.

The Seven Phase Sequence

Phase 1. Decide on a method

Phase 2. Write a Content Task Analysis

Phase 3. Write a Process Task Analysis

A.Write format

B.Write informing plan

C.Write motivating plan when necessary

Phase 4. Begin Training

When this plan needs revision (additional power) do the following, one at a time, in order:

Phase 5. Redo Phase 3

(Are there additional or alternative ways of informing or motivating that might work?) (Is there a different format that might work?) .

Phase 6. Redo Phase 2

(Are there parts of the task which are not being learned which could be divided into smaller, more teachable steps?)

Phase 7. Redo Phase 1

(Is there an altogether different way of doing the task?)

As the services and opportunities offered to persons with severe disabilities began to evolve from laboratory demonstrations of competence to ecologically-based, functional perspectives during the early 1980s, the Seven Phase Sequence lost much of its relevance for persons providing instruction (Callahan, 1986). Even though the model continued to provide a useful structure for thinking about training, its emphasis on formalized writing and decisions made by the facilitator caused the approach to become rapidly dated.

However, direct service persons who were influenced by Gold's approach to training continued to utilize the sequence in facilitating employment for persons with severe disabilities (Garner, Zider, & Rhoads, 1985). It began to become clear that the Seven Phase Sequence, with some modification to reflect current directions, could become a valuable tool to help balance natural validity and instructional power on supported employment job sites.

The revised Seven Phase Sequence shown in Figure 5 provides supported employment facilitators with a paradigm that views training as primarily driven by natural factors but also backed up with powerful instructional components. It is circular in design, rather than linear, and the only acceptable way to exit the sequence is for learning to occur by the individual support worker.

This Seven Phase Sequence is a model for managing the components found in most approaches to instruction. It represents a decision making loop that keeps the individual support worker in the system until successful acquisition of the tasks is achieved.

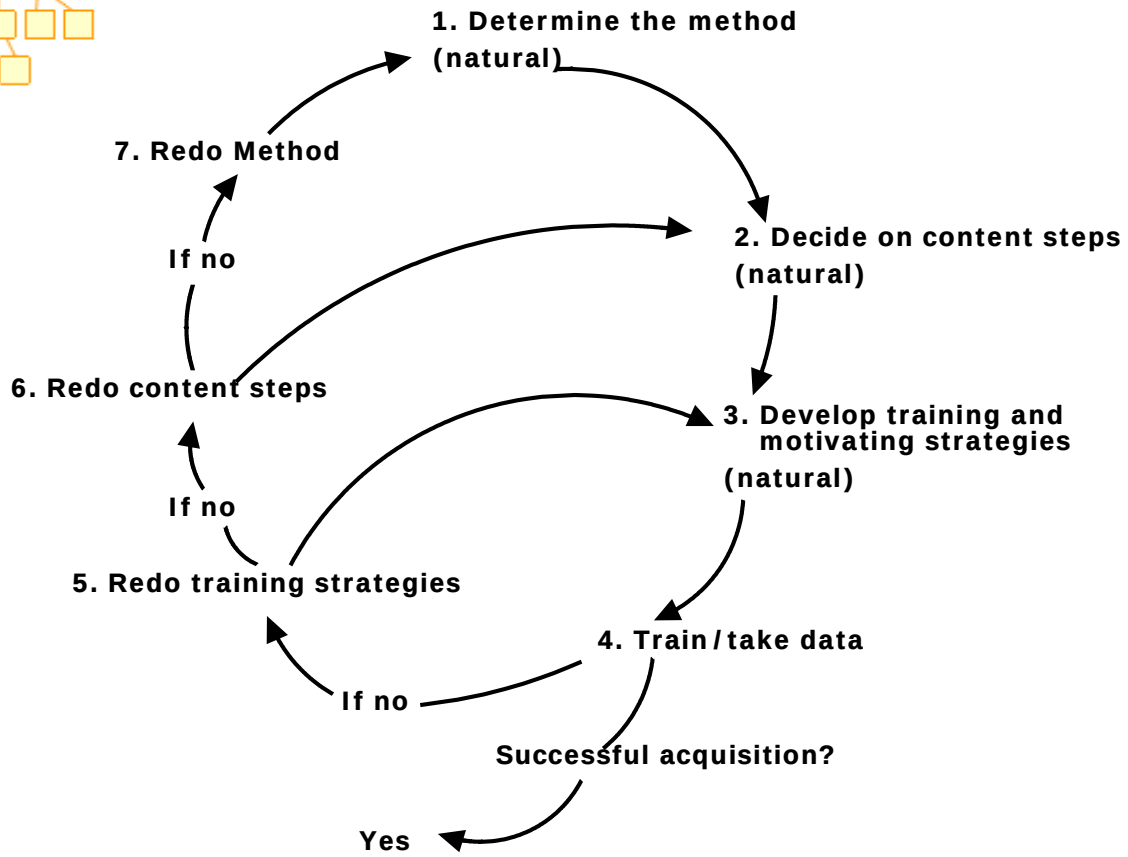
This Seven Phase Sequence is designed with a bias toward the use of natural approaches in the initial phases of training. This helps ensure natural validity. The back-up system, Phases 5, 6, and 7, provides the facilitator with all the instructional power necessary for training.

Steps 1-4 are designed based on a logical flow of activities for training. Steps 5-7 are designed for efficiency. Taken in order, Phase 5 requires less work than phases 6 or 7, and so forth.

This revised Seven Phase Sequence represents a decision-making loop that is helpful in planning for the components of training at community-based job sites and other

integrated settings. Once again, note that the only way out of the loop is for the individual support worker to experience successful acquisition of the skills being taught.

Figure 2: The Seven Phase Method (Revised)



Taken from: The Seven Phase Sequence (revised). (Marc Gold & Associates. [1990]. Systematic instruction training materials. Gautier, MS: Author, p.3.

Phase 1, Determine the Method

The phases of the sequence comprise common sense strategies for planning almost any type of job-related instruction. Possibly the most crucial phase of the revised sequence is Phase 1, Determine the Method. The facilitator receives information on how job tasks are to be performed from the natural setting rather than from personal creativity.

The method in the new approach is the way in which a task/routine is typically performed in a given natural setting. It also serves as the facilitator's conceptual standard for correctness. Methods are determined by careful observation of the techniques, styles, and general culture of the work setting by the supported employment facilitator.

For those tasks that the facilitator feels will require more assistance than is available in the setting for support and teaching, the sequence is continued.

For tasks that others natural to the setting should be able to teach, the facilitator helps the supervisor and/or coworkers identify teaching methods and strategies and offers to assist if needed. Except in cases in which natural methods clearly do not make sense for an individual support worker, they are always considered before facilitator-developed methods.

However, if supervisors and coworkers suggest modifications to the method, they should be encouraged. This type of natural enhancement by the employer can lead to increased ownership of training and support for the supported individual support worker and can ultimately build a commitment for successful employment.

Phase 2, Decide on Content Steps

Phase 2, the development of content, is also driven by natural considerations. Content task analysis has long been a strategy for structuring instruction for persons with disabilities and for training in general (Gold, 1972).

However, content steps were traditionally viewed in relation to the expected needs of a learner, rather than the needs of a natural work setting. Content in Phase 2 refers to the steps into which various jobs would be divided for the purpose of teaching a typical individual support worker in that setting. In this case, content is a naturally referenced concept that provides a starting point for instruction.

There are numerous examples of content written for a particular broad audience. For example, recipes, instruction sheets, and operating manuals are all written for general groups rather than certain individuals. The rationale for this perspective is that if an individual support worker is able to learn from procedures that would approximate those necessary to teach anyone in the setting, the opportunities for natural supports to be successful are enhanced.

Additionally, if this information is shared with the employer, it should indicate that the individual support worker is much like anyone else in the setting. It is suggested that formalized content task analyses be developed only in instances when the information is requested by the employer for use in the company.

Phase 3, Training and Motivating Strategies

Training and motivating decisions made for Phase 3 are influenced by the teaching, support, reinforcement, and interactional approaches identified in the natural work setting. During the job analysis activity performed by virtually all job facilitators before a supported employment job begins, the facilitator observes and considers the effectiveness of the support capacity, of the work place.

An effective way to obtain accurate information is to request that the employer provide you with instruction, regardless of the complexity of the job. This information can then be used to remind the supervisors and coworkers if they vary from techniques typically used. Suggestions can be offered on teaching and feedback techniques if initial

interactions between a company trainer and the new individual support worker are problematic.

The facilitator can then provide initial instruction that is as close as possible to the typical strategies utilised at the work site, while minimising difficulties for company trainers. For instance, if it is observed that a coworker demonstrates the job several times without talking very much, the facilitator might choose, to introduce training of various job tasks using this approach.

In addition to referencing the instructional procedures used at a given job site, the facilitator must also observe and plan to use naturally occurring strategies for motivating and reinforcing individual support workers. It is vitally important that these natural procedures be included in the initial facilitation and training of the individual support worker. When natural reinforcers are referenced early in training, it is entirely possible that artificial reinforcement will not be needed, and, therefore, will not have to be faded.

Phase 4, Training and Data Collection

The instructional interactions between the facilitator and the individual support worker are a result of the decisions made during the first three phases of the sequence. Since training of actual skills, in the setting where they will be used, is undoubtedly the most accurate evaluation of skills and needs, Phase 4 provides the facilitator the opportunity to assess whether natural procedures are working or whether more instructional power is required.

Sufficient data to make these decisions must be kept by the facilitator. Experience has shown that data collection should be unobtrusive and as painless for the facilitator and individual support worker as possible. Data collection strategies that utilise data probes and other efficient approaches are preferred over intrusive, complex procedures. The company should be fully informed about why data are being collected.

Phases 5, 6, and 7, The Power Phases

If successful acquisition of job skills results from the use of Phases 1-4, a good foundation for transferring instructional responsibility to natural supports has been" established. It is possible, however, that individual support workers with severe disabilities will require procedures that are tailored to their individual needs.

The Seven Phase Sequence recognises this possibility and, therefore, offers the Power Phases. Phase 5, Redo Training and Motivating Strategies, is the first point of individualised decision making. In this phase the facilitator considers ways to provide information that can be better understood by the individual support worker.

For instance, the facilitator might de-emphasise the observation of other individual support workers by the learner in favor of a hands-on training approach of direct instruction if the supported individual support worker was becoming extremely distracted while watching others work.

Additionally, the facilitator might suggest other, more artificial, approaches to motivation and reinforcement if the individual support worker's attitude, behavior, or enthusiasm became problematic. As previously discussed, the employer should be involved in this process as much as possible, and it should be emphasised that these techniques are very similar to those that can be utilised with any other individual support worker.

Phase 6 involves breaking problem steps into smaller, more teachable steps. The value of waiting until Phase 6 to do this is significant. If the task were divided into smaller steps in Phase 2, the entire task would need to be considered. By waiting until Phase 6, the facilitators need to break down only the problem steps. This reduces work for the facilitator and, more important, for persons in the natural setting who may be using this strategy for learning to function in that setting.

Phase 7 asks the facilitator and employer to consider a different way of performing the task than is typical in the setting. Facilitators should try to change tasks as little as possible from natural methods, and they should always have the approval of the employer before changing methods and encourage those persons who know the most about the job, supervisors and coworkers, to take an active role in any modifications.

By following this step by step approach through the Seven Phase Sequence, facilitators can help ensure that natural procedures always drive training efforts. This should allow for others in the work setting to become part of the training in numerous instances. In fact, in many cases, the entire responsibility for teaching certain tasks can be assumed by natural supporters.

Additionally, this Seven Phase Sequence provides the back-up that is necessary to ensure that job tasks are performed to an acceptable standard. Finally, by adhering to the sequence, facilitators follow a path of least effort. Rather than changing the method as soon as a problem occurs (which would entail new content and training/motivating strategies), the sequence provides for decisions that do not require additional effort by the facilitator until it is needed.

A Case Example

The following case example of a young man in Sydney provides insight into how the Seven Phase Sequence can be utilized at an actual supported employment job site to increase the likelihood of obtaining natural supports:

Jason attended a high school special education class in Sydney. He was 18 years old and was labeled as having cerebral palsy and moderate mental retardation. He was contacted by a local supported employment provider and was asked if he was interested in working half time during his last year of school. Jason said that he would be very interested in working with computers. A 20-hour-per week job was found at a grocery in his area. The job that was negotiated required Jason to enter incoming grocery inventory into the market's computer program. Jason did not have previous experience with computers, and his teacher and parents were doubtful if he could successfully perform the job.

In her preparation for supporting Jason, Laura, the employment specialist, performed a detailed job analysis of the grocery. During this time she was able to observe all the required job components, come to know the supervisors and coworkers, and get a feel for the culture of the market. She also received training and performed Jason's job duties. Laura concentrated from the beginning on clarifying the procedures and methods used by the employer. She carefully considered the training strategies used by the store manager and by the coworkers she asked for assistance. As she planned for the first day of Jason's employment, Laura decided which tasks the company would probably be able to teach and which tasks would require more intensive teaching. She based this decision on her knowledge of Jason, gained during the Vocational Profile (Marc Gold & Associates, 1990), and on her experience in the market.

Laura then met with the store manager to clarify responsibilities and to explain her role as a facilitator/consultant rather than as the primary provider of training for Jason. Of course, this was also done during job development, but she wanted to make sure everyone understood. She then wrote step by step procedures for two of the most potentially challenging job tasks. These procedures were written from the perspective of the general training procedures of the market, not from the perspective of Jason's needs. Laura then showed the store manager the procedures to make sure that the methods described were consistent with those typically used in the market.

The manager was impressed with how useful the procedures might be with other new individual support workers, and he showed them to a few of the senior individual support workers. Starting with Jason's first day of work, and continuing throughout the period she was offering support, Laura continually evaluated whether she or someone

in the market should teach each job skill. If she decided that someone in the market could teach a skill, she planned time to ask the person in advance if she or he felt confident teaching Jason and if she or he would like her to suggest strategies that might be successful.

If Laura felt that a problem required a strategy that was more complex than those typically used in the market, she would always ask the manager or another office individual support worker to watch, at least for a short time, as she used the strategy to teach the task.

By the end of the first month of employment, it was clear that Jason was having a great deal of difficulty accurately inputting data into the computer. The problem seemed to be the long inventory sheets that the market received from suppliers, which listed the goods shipped according to various orders. Using the Seven Phase Sequence, Laura began to solve the problem by changing the instructional cues from conversational verbal, which was most natural to the setting, to gestural cues with limited verbal cues. She was concerned that all her talking was confusing to Jason. This strategy resulted in some improvement, but his inconsistency remained.

Laura's next decision came in two parts. First, she checked with the manager to determine if the market had experienced this type of problem and to discover their response, if any. The manager indicated that indeed other individual support workers had encountered difficulty, but they usually got "straightened out" in a week or so. Jason was still experiencing difficulty after 5 weeks. She then looked at the most difficult parts of the task and considered breaking them down into smaller, more teachable parts of the natural method. It was quickly clear to her that even though this strategy helped her focus more closely on the problem areas, it did not seem to help Jason perform the task any better.

Finally, Laura considered an altogether different method or an adaptation of the natural method. Since she wanted the method to remain as natural as possible, and since the inventory sheets were not produced at the market, but rather by suppliers, she did not try to change the sheets. Instead, she determined the number of suppliers for the input for which Jason was responsible, and she developed a Plexiglass overlay for each of the six forms. She asked the manager to help her design the devices and she arranged for a rehabilitation technologist to produce them.

The overlays each had color coded positions that corresponded to the columns of the inventory sheets. Jason was taught to determine the correct overlay, to slide the inventory sheet into the device, and to align the first row of figures. The color coded overlays provided Jason with quick visual feedback for his place on the sheet. His consistency immediately began to improve. The supervisor was so impressed with Jason's productivity increase that he suggested that the other part-time data entry clerk use the overlays.

This effort was so successful, and naturally referenced, that the employer began to think of ways to make Jason's job easier. He was also much more comfortable with teaching Jason new tasks. The role of the employment specialist smoothly evolved into facilitator/consultant due to the teaching strategies that referenced natural approaches from the beginning.

Discussion

It could be argued, perhaps, that this is not about the role of natural supports in delivering job training but, rather, about naturally referenced job training strategies that can be utilized by job facilitators who are not natural to job settings. Both perspectives are likely to be necessary to ensure the fullest success and participation of supported individual support workers.

Gold warned supported employment facilitators that one-directional supports, whether initiated by human services personnel or by coworkers and supervisors, can lock persons with severe disabilities into a 'benevolence trap' in which they are always receiving the good works of others but are not in a position to offer assistance in return. He viewed this as a consequence of the lack of teaching effective enough to result in competencies that were wanted and needed by others.

Competencies at job sites are fairly easy to determine. The degree to which one's job is effectively done, the amount of time a worker requires of others to do the job effectively, the degree to which an individual support worker functions smoothly all contribute to feelings on the part of others as to an individual support worker's relative competency.

Even if coworkers are willing to assist an individual support worker who needs ongoing support in order to perform a job successfully, what can be the cost of such support in terms of dignity, self-esteem, and the perceptions of others? When natural approaches are not likely to provide necessary support, then naturally referenced strategies, provided by a supported employment facilitator, should be considered. Finally, if these approaches are not successful, more intensive instructional procedures should be implemented in a manner that is as natural and naturally referenced as possible.

Supported individual support workers should be assisted to do the best work they can, and natural supports must be utilised to the greatest degree possible. It is altogether possible that we might neglect the real needs of persons with disabilities in our haste and desire to connect people with natural support systems. Effective systematic instruction has rarely been available to supported individual support workers. The use of an approach such as the Seven Phase Sequence is a step in the right direction.

Some Definitions

Active Ageing

The process of optimizing the opportunities for physical, mental and social well-being throughout the life course, in order to extend healthy lie expectancy, productivity and quality of life in older age.

Successful Ageing

This concept emphasises the roles of healthy life styles and daily routines, degree of social support, amount of exercise, and sense of autonomy and control in enabling older people to maintain their health and independence for as long as possible.

Health

The ever-changing process of achieving individual potential in the physical, social, emotional, mental and spiritual and environmental dimensions.

Healthy Ageing

The ability to continue to function mentally, physically, socially and economically as the body slows down its processes.

Re-ablement

Re-ablement refers to intensive and time limited interventions for people with poor physical and/or mental health to help them accommodate their illness by learning or re-learning the skills necessary to manage their illness and to maximally participate in everyday activities.

Self-Management of Chronic Disease

The individual's ability to manage the symptoms, treatment, physical and psychosocial consequences and life style changes inherent in living with a chronic condition.

Social Rehabilitation

Social rehabilitation focuses on restoring confidence and skills lost through illness, injury, bereavement or other trauma or loss, by learning or re-learning the skills necessary for social interaction and activities.

Wellness

Wellness refers to a state of optimal physical and mental health, especially when maintained by proper diet, exercise, and other habits. It can also be considered from an ecological viewpoint as something that is dependent on the dynamic relationship between people and quality of their physical and social environment.

As the elderly are often frail as well as having failing health, their ability to participate in their community and home environment may be significantly disruptive. They may need supervision and / or assistance for domestic tasks such as dressing and cooking (ADL – Assisted Daily Living) or community activities which include shopping, cinemas, dining out and even in catching public transport (buses, trains and airplanes)

The elderly often need assistance to maintain and even increase their independence and participation in daily tasks which in-turn enhances their individual self-esteem. It would also impact in a positive way on their sense of choice and self-worth and they would then have some control in their life.

You can employ many strategies to assist clients to increase their participation and independence within daily tasks. Remembering that when increasing your client's independence, you must consider the associated risks and perform a risk assessment in line with developing the plan.

Why is it necessary and important to promote independence in your clients? You might consider that to teach or promote independence is time consuming and difficult to accomplish. You might consider it quicker to DO the task yourself rather than assist your client to attend to the task.

An example may be in assisting your client to shower and dress, where it is easier and quicker for you to do the activity for your client rather than getting / encouraging them to do it themselves or with assistance. Independence is important for improving one's self esteem and self-worth, for having a choice and control within their lives, and to make it easier for family and individual support workers who are supporting your client

Decision making, Choice & Independence (Self-esteem)

Service Standards can be interpreted in many ways.

Quality Standard 3 from DSQ (Disability Services Queensland) - Participation as fully as possible in decision making, choice of activities and events in daily life in relation to the service received.

"The freedom to choose to do whatever we wish at any time and in any place is something we rarely experience. Even from childhood we are bound and guided by the wishes of our parents, peers and the community in general. As we mature we recognise the need to make decisions and choices within the boundaries of acceptable behaviour and while balancing the needs and rights of those around us. Our world is a web of interconnecting projections of the choices we all make individually and collectively".

An individual support worker must be careful to ensure that Standard 3 is not interpreted outside the context of these 'real world' expectations. Doing so can create a false environment where service users are accorded, and even come to expect, rights that are out of balance with their responsibilities as clients and the rights of others.

In the context of a 'real world' workplace or educational campus, we may not be able to choose to do whatever we want at any time, however this does not mean we lack choice or freedom in decision making. As a individual support worker, we can ensure that clients and families understand that they can choose whether to join or even remain in a specific service and that they will in no way be penalised for the choices they make.

They can participate in the decision making around the array of possibilities for activities throughout the year. They can also participate in the decision making around the choice of activities scheduled for that quarter and even for specific days or units.

Clients can of course also choose not to participate in activities in which they feel unsafe. Importantly we can all choose how we act in relation to any aspect of life. How often do we see two people affected by the same event act in totally different ways?

All of the above decision making must then be framed, for the client, in the light of an impaired capacity attributable to an intellectual disability, for example. The very reason these clients require support from services is due to an acknowledgement of their impaired capacity. Without this support, they are unable to safely and meaningfully access their community and engage in the opportunities that participation presents.

Perhaps there is a basic problem with the way we qualify the nature of the relationships involved when we receive or provide support. As a support service, your primary goal is assist your clients to build their capacity to their maximum potential or to access and use other appropriate support mechanisms. Sometimes clients struggle to understand that support role and to perceive the benefits and opportunities in the situation or activity.

This may be due to either diminished cognitive / intellectual capacity and/or lack of behavioural discipline. The support role may then be one of explaining and interpreting the situation / activity and assisting the client to understand the benefits of participation and to help them make choices that allow them to move forward. This does not infringe the clients' rights around choice and decision making. In effect, failing to perform that role could be construed as not supporting that person.

Isn't it true that we all, at various stages in our lives, require the support of others to do exactly that at some level? We might engage the services of a professional to support us in a legal or health matter for example. Alternatively we might informally seek the support of family and friends to understand or deal with difficult personal issues or the support of your colleagues around a work-related matter. We could be said to have a 'diminished capacity' in relation to those issues at that time.

To recognise that we will both require and provide a blend of personal and professional support and guidance throughout your lives is to recognise your common humanity. The absence of co-dependence or dependence does not necessarily indicate

independence. On a larger scale and with more insight we might find it reflects the innate underlying reality of interdependence.

We may be independent in tying your shoes yet, in having shoes, some place we can go in them and friends to go there with, we are supported in an intricate web of interdependence. Interdependence is based in mutuality – a deep respect for each other and the connection we all share an acceptance of the paradox of being entirely, uniquely individual while being simultaneously totally and utterly part of 'one'.

An individual support worker needs to be careful not to cross the fine line where we are unwittingly devaluing those we support through what effectively constitutes over support.

This can happen in a myriad of ways including through nurturing and mirroring the misconception that in the real world we can do what we wish when we wish.

Another important role for the individual support worker can be to advocate for their client in the community. The dark undertone of being perceived in the community as disadvantaged or disabled is also to be consciously or unconsciously devalued and so not to be included as a 'serious' partner. That implicit devaluation skews the perception of the general community towards the conviction that young people with an intellectual disability cannot contribute.

It is more accurately the community that needs to re-evaluate what constitutes a 'contribution'. In the modern world we can place too much weighting on 'economic' contribution and too little on contribution of the heart and spirit.

Research

"A growing body of research literature has demonstrated it is often possible to rehabilitate or re-enable occupational and social functions in frail older adults with chronic illness (e.g., McWilliam et al., 2000). A variety of the specific elements of an wellness approach, such as exercise and balance programs, health promotion and programs involving the provision of aides and equipment, have been trialed, with largely positive outcomes. The majority of studies have been trialed as separate programs—as single components outside of existing HACC type services (i.e., typically not undertaken by HACC staff)—and are not directly compared to "standard" services. Almost all the research and evaluation undertaken within HACC services has specifically investigated the effects of intensive, time limited programs.

In Australia, while there is little peer reviewed published evidence about the efficacy of multi-component programs, a growing body of grey literature, including service evaluations and government reports, outlines the success of pilot programs that have been developed, including work undertaken within the Silver Chain service in Western Australia (Lewin et al., 2006), the Supported Independent Living Collaborative in Queensland (Matthews, 2004) and the recent implementation of four pilot programs within Victoria (e.g., Saxon, 2007)."

Three Key Examples of Programs Utilising a Wellness and Restorative Approach

"Among all of the relevant literature, the three programs that have received the most thorough attention as well as the most robust evaluations include the Silver Chain 'Home Independence Program' in Western Australia (Lewin et al., 2006), the 'Leicestershire Home Assessment and Re-enablement Team' in the UK (Kent et al., 2000) and the 'Restorative Home Care Agency' based in Connecticut, US (Tinetti et al., 2002). Each program involves the input of a multi-disciplinary team delivering multi-component interventions that are time limited in duration, and based within home and community care services.

Both the WA and the UK programs have targeted relatively low dependency clients, who are referred at the point of entry to home care services. Following the completion of the program, clients, are then referred for ongoing "standard" HACC services if required. The US program was slightly different in that it targeted clients who were referred for a time-limited burst of Medicare covered home care post discharge from hospital, who may well have been at a higher level of dependency than those included in the other two programs."

Outcomes from implementation of the new approach

Clinical

i) Functional status "An older adult's capacity to undertake activities of daily living impacts directly on their overall quality of life and capacity to remain integrated into normal community life. Either improvement or maintenance of functional status is clearly a fundamental objective of a wellness approach. There is now a relatively robust body of evidence that indicates it is possible to either prevent deterioration or directly improve the functional status of frail older adults, including those with significant chronic illness (e.g., stroke; Trialists, 2003).

A range of physical, occupational and health-based interventions that constitute components of an ASM have been associated with such improvements. Those that have been specifically demonstrated to have a positive impact on functional status in randomized controlled trials include the provision of aids and equipment and environmental interventions (Gitlin, Corcoran, Winter, Boyce, & Hauck, 2001; Mann, Ottenbacher, Fraas, Tomita, & Granger, 1999; Stark, 2004), occupational therapy intervention based on activities of daily living (Logan et al., 2004; Steultjens et al., 2004; Walker et al., 2004) and the provision of physical therapy, including strength and balance training (Gill et al., 2002)."

Quality of life

ii) Can be broadly conceptualised as a global assessment of well-being. Assessed quality of life can be based on judgments about a wide range of factors including an individual's health, family relations, friendships, occupation and finance as well as sexual activity and leisure time. Most people would agree that many of the chronic illnesses associated with ageing, such as stroke, diabetes, osteoarthritis and dementia, constitute a major challenge to an individual's quality of life across a number of these dimensions.

Programs utilising a wellness approach, with their potential capacity to enhance functional and social independence, are likely to have a positive impact on quality of life for clients. However, to date, the focus of the majority of intervention studies has been on improvement of basic functional status and measurement of ongoing use of services rather than the broader effects of interventions on clients' lives, including their well-being and social status. There are only a few studies, albeit with generally positive findings, that have directly investigated the impact of programs utilising a wellness approach directly on clients' quality of life.

Mortality

iii) If programs utilising a wellness approach have a beneficial effect on functional and health status of older adults, they may also have the potential to prolong life span. To date there have been relatively few attempts to measure the extent to which more active programs may impact on mortality, perhaps due to the fact that the majority of evaluations have involved relatively high functioning participants and small sample sizes, and have occurred within 12 months of program implementation.

Nevertheless, there is some limited evidence based on a larger intervention trial and meta-analysis, that more active or preventative approaches may indeed have a tendency to reduce mortality rates in intervention participants.

Use of Services

iv) Use of community services

One of the key objectives is 'to attempt to provide more timely, flexible and targeted services that are capable of preventing further exacerbation of dependency'. Therefore, an important side effect of programs utilising a wellness approach may be to reduce the use of ongoing services. There is now a strong body of evidence that suggests that time limited multi-component interventions appear to result in a reduction in the ongoing use of HACC services in comparison to what would have

been anticipated with the provision of "usual" HACC services, at least in the short term.

v) Admission to residential care

Another important and cost effective outcome that may result from more active intervention programs is a delay in the need for residential care. To date, however, only a few evaluations of multi-component programs have attempted to investigate the relationship between programs that utilise a wellness approach and admission to residential care.

vi) Hospital admissions

To date very few studies have investigated the extent to which programs utilising a wellness approach may reduce the number of hospital admissions, either in the short or longer term. The exception is the evaluation of the restorative home care agency (one of the three key examples) undertaken by Tinetti et al. (2002) in which restorative care was associated with a significantly reduced likelihood of visiting an emergency department during the duration of the intervention (approximately two months). No studies have investigated the extent to which programs utilising more active service approaches reduce hospitalisations in the longer term.

Social Support and Centre Based Day Care Programs

If we take the wellness and restorative approach key components of promoting a client's capacity to live as independently as possible, by aiming to improve functional independence, quality of life and social participation within a holistic 'person-centred' approach which promotes clients' wellness and active participation in decisions about care and provision of more timely, flexible and targeted support.

Centre Based Day Care Programs?

Some considerations could include 're-framing' the way services initiate contact with older people and their families who are potential service users, the language we use, the service objectives we develop, assessment practices, a greater emphasis on coordinating effectively with primary health care and health education professionals and services, individual and participatory care planning and goal setting, staff and volunteers spending more time as facilitators, educators, and mentors than providers of assistance, focus on preventing people becoming socially isolated and care outcomes could be assessed in terms of the older person's perception of their quality of life improvement.

Exercise and Recreational Needs

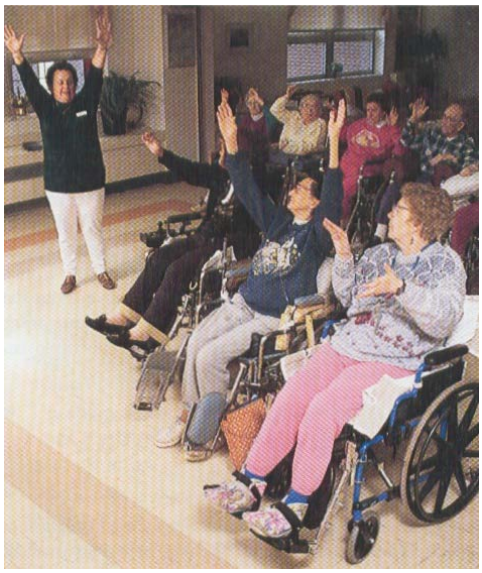
Residents in long-term care facilities need the stimulation of planned recreation and exercise. The type of activity must be carefully tailored to the needs and abilities of the residents. Health workers in these facilities are often responsible for coordinating this aspect of care.

Recreation

It is important for those who do the activity planning to keep in mind:

- The age and possible physical limitations of the participants.
- The fact that older people have less coordination and are more apt to have hearing and vision deficiencies.
- The fact that recreation with a purpose is considered the most stimulating and enjoyable by mature people.
- That activities planned by the participants are generally the most successful. Shows and skits call for many different talents. Exhibits, sales, and making gifts for others are some other examples of activities that combine recreation with purpose. These types of activities are usually enjoyed by everyone. Most facilities have a special room where out-of-bed residents can gather.

With care, activities that meet special rehabilitation objectives can be planned. For that reason, the occupational therapist is a valuable person who can serve in a consultant capacity, both in care facilities and recreational centers. Recreational planning can thus combine physical and rehabilitative activities with enjoyment.



- Exercising, singing, and clapping hands to music can be enjoyed by bed residents, wheelchair residents, and those who are confused
- For residents who are ambulatory, dancing can be stimulating as well as enjoyable.
- Handicrafts, games, television, and conversation all offer a measure of entertainment to the less active.

Learning Activity 6:

Using the 'Aged Care in Australia: a guide for aged care workers', another aged care text or the Internet, research information on carers and answer the following questions.

1. What types of services are available to carers both financially and emotionally?

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2. Research what services are available in your local area to assist carers in their critical roles. How do they assist?

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Once you have answered the questions, please have your assessor or facilitator check your answers to see if you are on the right track.

1.5 Prepare for support activities according to the person's individualised plan, preferences and organisation policies, protocols and procedures

What does access and inclusion mean?

Access and inclusion means different things to different people. Processes and outcomes for access and inclusion cannot be prescriptive, and must take into account the diverse needs of individuals and the nature, strengths, priorities and resources of a community. The common elements of access and inclusion are the removal or reduction of barriers to participation in the activities and functions of a community, by ensuring that information, services and facilities are accessible to people with various disabilities.

A person's ability to access information, services and facilities is affected by a number of factors, including the degree and type of disability, which can vary considerably between individuals.

Example

An example of how access and inclusion matters

To appreciate the diverse facets of access and inclusion, imagine that you are a person who uses a wheelchair and you wish to visit your local community centre. You are able to drive your own car and therefore do not have to try to use public transport.

When visiting your community centre:

- You ring to check the accessibility of the venue and are assured that it is accessible. You arrive and park in an accessible parking bay, however you cannot get to the footpath as there is no ramped kerb from the parking bay to the footpath.
- You make a long detour through the parking area and when you get to the front door find it is too heavy for you to open. You wave and someone opens the door for you.
- You get to the reception counter and, although it is high, you can partially see the receptionist and get your query answered.
- You are directed to the enrolment desk for community courses. Your chair cannot fit under the desk. You go back and wait in line until the receptionist is available to help you fill in your form.
- You prepare to pay your enrolment fee. The cashier's desk, however, is upstairs and, as there is no lift you have to wait while the receptionist arranges for the cashier to come to you with a receipt book.
- You wait in the foyer for the cashier and look at the noticeboard. You see a flyer and pamphlets promoting a community consultation about proposed changes to zoning in your district. As a resident you are interested, however, you cannot reach the pamphlet dispenser. You also notice the venue for the consultation, and know that it is not wheelchair accessible.
- You bump into a friend and decide to have a coffee. However you skip the idea when you see that the entrance to the coffee shop is up three steps.
- You decide to visit the toilet prior to going home and are pleased to find that it is accessible.

To demonstrate the application to a Disability Access and Inclusion Plan (DAIP), the access and inclusion barriers encountered in the above example have been applied to the six desired outcomes.

Barriers to services and events:

The reception desk in the foyer was too high for a person in a wheelchair to be able to communicate comfortably and therefore access services at the centre.

Barriers to physical access:

In this instance the kerbs, footpaths, weight of doors, access to desks, the cashier counter and the steps to the coffee shop all created physical barriers.

Barriers to accessible information:

It was good that there was a notice board in the community centre foyer, however, the information was out of reach for a person in a wheelchair.

Barriers due to lack of staff awareness:

The receptionist remained behind the desk and was unaware that it would have been preferable for her to come from behind the counter and sit at eye level with the person in the wheelchair when answering queries.

Barriers to participate in public consultation:

The person with the disability did not have the same opportunity as others to participate in the community consultation because neither the information nor the consultation venue was accessible.

Barriers to participate in making a grievance:

Staff awareness, counter heights to write a complaint and information not available in an alternative format meant that it would be difficult to make a grievance complaint for this person.

In addition to the above DAIP outcome areas, there were also barriers to opportunities to socialise. The lack of physical access at the coffee shop resulted in the loss of an opportunity to socialise with a friend and inclusion into the community.

If a person with a hearing or vision impairment was visiting the same local community centre as the one used in the above example, they would have faced different barriers.

Identifying solutions to access barriers requires careful thought and informed planning. Solutions to access barriers may not always involve major expenditure and can benefit the whole of the community.

Designing access for people of all ages and abilities

The following section highlights design implications for access.

There are many different types of disabilities, but there are implications for service planners and providers in three major areas of disability:

- physical, including people who use wheelchairs, people who have difficulty walking and people who have difficulty with finger or hand control;
- sensory (vision, hearing); and
- people with disabilities that affect communication and thought processes.

People with physical disabilities

People who use wheelchairs

Although the number of people who use wheelchairs is small compared with other physical disability groups, the implications for designers are, in many ways, the greatest. If the needs of a person who uses a wheelchair are considered by designers of facilities used by the general public, then the vast majority of people (including people with prams, goods or shopping trolleys) will also benefit.

Design considerations for people who use wheelchairs include:

- avoidance of abrupt vertical changes of level (eg kerbs, steps, ruts, gutters) to ensure a continuous accessible path of travel;
- avoidance of excessive slope (camber) across the direction of travel on a footpath, which makes control of the wheelchair difficult;
- provision of adequate forward reach and available clearance under basins, tables and benches to allow access for the person using the wheelchair as well as their wheelchair footrests and front wheels;
- provision of adequate doorway width and space within rooms to allow for wheelchair dimensions and turning circles; and
- avoidance of surface finishes which hamper wheelchair mobility (eg gravel, grass or deep-pile carpet) and surfaces that do not provide sufficient traction (eg polished surfaces).

People who experience difficulty walking

People who experience difficulty walking may have disabilities that arise from medical conditions including stroke, lower limb amputation, cerebral palsy, Parkinson's disease and arthritis.

This description includes those people who:

- use a walking aid (crutches, stick, frame, guide dog);
- wear a leg brace or have an artificial limb;
- have limited physical stamina;
- have stiff or painful back, hips, knees or ankles;
- have uncoordinated movements;
- walk slowly; and
- have balance problems.

Design considerations for people who experience difficulties walking include:

- specific attention to steps and handrail design to ensure adequate support and a feeling of confidence and ease when negotiating steps;
- provision of cover from weather, as slowness of movement can result in greater time spent along walkways and getting into buildings;
- provision of seating in waiting areas, at counters and along lengthy walkways to reduce fatigue;
- awareness that a ramp can prove difficult for some ambulant people, steps and lifts providing useful alternatives;
- identifying access hazards associated with doors, including the need to manipulate a handle while using a walking aid and difficulty moving quickly through swinging doors;
- providing surface finishes that are slip-resistant, evenly laid and free of hazards to minimise risk of injury; and
- Minimising street clutter caused by signs and billboards and placing these away from the main pedestrian flow.

People who have difficulty holding and/or manipulating objects

Problems associated with manipulation and holding may be due to arthritis, neurological conditions (such as Parkinson's disease, multiple sclerosis or cerebral palsy), nerve injuries and upper limb (finger, hand or arm) amputation.

Design considerations include:

- the operation of fittings such as door handles, switches, lift buttons and taps, (generally levers are preferable to knobs); and
- the operation of switches or buttons (large switches or push buttons that can be used by the palm of the hand are preferable to switches or lift buttons that need finger operation) while sensor devices may assist some people.

People with sensory disabilities

People with sensory disabilities may have partial or complete loss of sight or hearing.

Design considerations for people who may have partial or complete loss of sight include:

- providing ways they can identify changes in direction, changes in level, hazards and obstacles such as projecting signs and windows;
- attending to the size, colour, colour contrast, location, illumination and type of signs;
- providing for clear, even illumination levels in and around buildings so they are not dangerous and confusing;
- planning so that a person who is unable to see will know whether a lift has arrived at the floor or whether it is going up or down; and
- being aware that escalators can be difficult to use and that well-designed stairs or ramps are a useful alternative.

Considerations when designing facilities or services for people who are Deaf or who have a hearing impairment include:

- providing information that is both written and spoken in public buildings such as transport terminals and airports (eg visual display boards as well as voice announcements); and
- providing an audio loop system or other appropriate hearing augmentation systems to assist people who use hearing aids in public places such as auditoriums and conference facilities.

People with disabilities affecting communication and thought processes

People with a wide variety of disabilities, including intellectual, cognitive and psychiatric disabilities, may have significant difficulty when it comes to asking for and understanding information. Clear information also assists children and people from culturally and linguistically diverse backgrounds.

Design and service provision considerations when planning for people who have intellectual, cognitive or psychiatric disabilities include:

- need for clear signage;
- need for clear pathways through a building;
- provision of information with clear instructions;
- service provision through personal assistance; and
- well-planned, uncluttered environments.[1]

The organisation promotes the rights and responsibilities of people using its services by:

- promoting opportunities for clients and other stakeholders to provide feedback
- using feedback to improve services
- providing information to clients about internal and external mechanisms for making a complaint
- acting fairly and appropriately when a complaint is received.

A client's individualized plan will be developed and written in conjunction with the family, client and facility.

Individualised care plans should be reviewed once a year or more often if circumstances or condition changes, by the Facilitator / Supervisor and the client / individual support worker / advocate.

Clients should be supported to access an advocate of their choice whenever the need is identified.

Your clients plan and related information will be confidential. The client/ individual support worker/advocate will be in receipt of a copy of the plan and the original should be held securely at your head office accommodation

Clients' rights and responsibilities will be respected and supported.

Individual client care plans will support the needs of the individual support worker and the carer, including physical, emotional, social, environmental, cultural, interests and skills, will be recorded during the client assessment, and incorporated into the plan.

Individual support workers will value and respect the individual support worker's intimate knowledge of the carer, and will respond to issues /concerns expressed by the individual support worker / advocate regarding any changing needs.

You and your supervisor of your organisation should work in partnership with the client / individual support worker / advocate in a positive and respectful manner and will be flexible with meeting times etc., so as to fit in with the family and their specific needs.

As people age, they encounter new challenges in their life more so and harder to cope with in their 60's and above as opposed to their midlife. Retirement, loss of spouse, children leaving home, health problems, decline in energy, and disability are major life stressors that may cause feelings of uselessness and inadequacy in elderly people. Depression featured very high in the list of disabilities that confront the elderly.

Dysfunction is likely to make a person feel sad, anxious, and worthless, which are also signs of major depression. In major depression, individuals find themselves in deep sadness and tend to withdraw from functioning in the social environment (Psyweb, 2007). Also, major depression may impair the ability of individuals to perform activities of daily living.

[1] This information comes from a paper called - Designing for Access and Inclusion has been taken from *Designing for Access - Beyond Minimum Requirements*, a paper presented by Helen McAuley of ACROD National at an Australian Standards seminar on access.

Individualised plans can include the following services...

- Recreational and diversional therapy
- Allied health services such as physiotherapy and occupational therapy
- Clinically necessary equipment
- Participation in day programs and community access
- Support to visit family and friends and assistance to maintain family and social relationships
- Accommodation
- Home modification and
- Transitional case management and advocacy support.

Learning Activity 7: – Inclusion Strategies

As part of your learning journey recap what you have learnt and answer the question below.

A disability may be defined as any physical, sensory, neurological, intellectual, cognitive, or psychiatric condition that can impact on a person's lifestyle and / or everyday function.

According to the Australian Bureau of Statistics, in 2006, more than 405,000 Western Australians were identified as having a disability. There are many types of disabilities, including sensory, physical, intellectual, cognitive, neurological and psychiatric disabilities. As a result some people may have difficulty with mobility, hearing, vision or communication.

Disabilities can occur at any time in a person's life. For some, the disability begins at birth. For others, it can be the result of a sporting or motor vehicle accident. Other people acquire disabilities later in life through various illnesses or ageing.

Some disabilities can affect a person's ability to communicate, interact with others, learn or get about independently. A disability can impact on a person's employment, education, recreation, accommodation and leisure opportunities.

You are to develop a strategy for inclusion for 3 of the following groups of people and detail them below:

- People who are blind or have vision impairments
- People who are Deaf and have hearing impairments
- Cerebral Palsy
- Multiple Sclerosis
- Intellectual disability
- Paraplegia and Quadriplegia
- Arthritis
- Acquired Brain Injury
- Stroke
- Psychiatric And Behavioural disabilities

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Once you have developed the strategies' for the 3 groups discuss your decisions with your assessors or facilitator to see if you are on the right track.

2. Provide support services

2.1	Conduct exchanges with the person in a manner that develops and maintains trust
2.2	Provide support according to the individualised plan, the person's preferences and strengths, and organisation policies, protocols and procedures
2.3	Assemble equipment as and when required according to established procedures and the individualised plan
2.4	Respect and include the family and/or individual support worker as part of the support team
2.5	Provide support according to duty of care and dignity of risk requirements
2.6	Provide assistance to maintain a safe and healthy environment
2.7	Provide assistance to maintain a clean and comfortable environment
2.8	Respect individual differences to ensure maximum dignity and privacy when providing support
2.9	Seek assistance when it is not possible to provide appropriate support

2.1 Conduct exchanges with the person in a manner that develops and maintains trust

As a home individual support worker or personal individual support worker, you will have access to confidential information about clients and their families. What sort of information is confidential varies from person to person, but generally, it refers to personal information relating to financial, health, family, sexual or legal issues.

Some people are sensitive about other issues such as age;

- It is essential that you treat all client information as confidential.
- Respect your client's right to privacy at all times.
- If you do speak about your work to others do so in a way that does not identify specific clients or situations.

When you do have to pass on sensitive or private information, do so in a place that is private and out of earshot of other people, and only to a representative of your organisation who is entitled to know such information.

If a client reveals sensitive information to you and you feel that it would be appropriate to pass it on, ask the client if they mind.

It is important to remember 'duty of care' in this situation;

- Before passing on any information, stop and ask yourself if the person concerned would mind if you passed it on.
- Do not discuss clients with or in front of other clients.

- Be responsible to your organisation at all times.
- Any breach of confidentiality will be treated seriously and may result in dismissal.

Boundaries

As a personal individual support worker/home individual support worker, it is important to have a clear understanding of where your role begins and ends. While you work closely with your client to perform the specific duties outlined in the job description, it is important to remember at all times that you are an employee of your organisation. Many home based individual support workers become very close to clients and their carers and families, It is important to remember that you are not a family member, and it is a substantial conflict of interest and highly detrimental to clients well being to consider yourself as one.

You need to adhere to the following guidelines at all times:

- As part of your employment conditions you are not permitted to disclose your private telephone number to any client or their family members.
- Do not work extra hours at a client's home unless authorised by your Coordinator.
- Do not visit clients out of hours.
- Children, family members and pets must not be taken into a client's home.
- Try not to get emotionally involved. This can result in you losing your objectivity.
- Hugging kissing or other close physical contact not directly related to personal care with clients is not acceptable practice.
- Avoid becoming involved in client's family problems and/or disagreements. It is not your role to solve your client's problems.
- Do not discuss your personal problems with your clients.
- Personal Individual support workers and Home Helpers are not permitted to sign or witness any legal document regarding a client All such requests must be referred to your coordinator or team leader. Individual support workers are not permitted to act as Executor or take up the role of Power of Attorney for their clients.

Indications that Care Workers have breached the Professional Boundaries of the Individual support worker/Client relationship include:

- Favouritism: e.g. friendship, socialising with clients, disclosing personal information not of a therapeutic nature to clients, giving or receiving gifts from clients.
- Minimal care/neglect: e.g. under involvement, failing to meet identified client needs.
- Judgmental attitudes e.g. disapproval of a client's behaviour.
- Burn out.
- Co-dependence: e.g. performing 'extra' jobs for a client outside the assessed care needs, this can promote dependence on the individual support worker and decrease a client's independence.
- Possessive or secretive behaviours.
- Rudeness.
- Roughness or bullying behaviours.

Individual support workers are encouraged to reflect on those behaviours that may lead to the crossing of professional boundaries.

The following are examples of warning signs individual support workers should be aware of:

- Frequent thinking of a client while away from work.
- Spending time with a client outside of work hours.
- Self-disclosure of information of a personal nature to a client.
- Feelings of personal responsibility for a client's progress.
- Awareness of unnecessary physical contact or touching of a client.
- Performing tasks that you have been instructed not to, or know are not safe because of your feelings for the client.

The recognition of any of these warning signs indicates the need to reflect and review one's motivations and the need to make changes in the provision of care, it is important that Individual support workers recognise the limits of their role and the need to maintain a high level of self-awareness of appropriate professional boundaries and seek support from coordinators when required.

Learning Activity 8:

As part of your learning journey have been exploring the issue of gaining trust of your client/resident

Which of the list below do you believe will assist to establish and maintain trust with your client/resident? Circle the answers.

a) Respect of confidentiality
b) Privacy
c) Discussing your client with others out of work
d) Discussing your client with other team members
e) Being honest
f) Once you have answered the question, discuss with your facilitator or assessor to see if you are on the right track.

Why do you think these are the correct responses? Detail your reasons below.

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Once you have developed the strategies' for the 3 groups discuss your decisions with your assessors or facilitator to see if you are on the right track.

2.2 Provide support according to the individualised plan, the person's preferences and strengths, and organisation policies, protocols and procedures

A Policy is a statement of agreed intent that clearly and unequivocally sets out an organisation's views with respect to a particular matter.

It is a set of principles or rules that provide a definite direction for an organisation

Policies assist in defining what must be done.

A Procedure/Practice is a clear step-by-step method of implementing an organisation's policy or responsibility.

Procedures describe a logical sequence of activities or processes that are to be followed to complete a task or function in a correct and consistent manner.

Procedures can be produced in the form of;

- Flowcharts
- Checklists
- Written steps of the process

For each established policy, there will need to be a supporting procedures format.

What is a Policy and Procedures Manual

A policy and procedures manual is a written record of the agreed policies and practices of an organisation. It should be readily available to all persons involved in the management or work of an organisation. The manual should be kept in a loose leaf file so that it can be undated and added to as policies and practices are reviewed and amended.

UNWRITTEN POLICIES AND PROCEDURES OFTEN LEAD TO CONFUSION AND CONFLICT.

On assessment of your client, their individualised plan should be developed in consultation with the client, family and the facility or individual support workers.

When providing support as an individual support worker you need to be open to your client's needs, desires and preferences, but you also have to be mindful of the risk associated with complying with the client's preferences.

And you need to review your plan to ensure that your clients proposed activities comply with your organisations policy and procedures, to ensure that your care and the program does not encroach on the organisation's Occupational Health, Safety and Welfare Policy. There are standards for each part of the Health and Community sector. Below are the services standards for disability.

The Disability Services Standards

In 1993 the Disability Services Commission established a set of Disability Services Standards which apply to all organisations and services that it funds or provides. The Disability Services Standards are based on the federal Disability Services Act (1986) and similar Disability Services Acts that were subsequently passed in each State and Territory of Australia as a pre-condition of the Commonwealth State Disability Agreement.

The draft standards were developed in 1992 by a working party made up of Commonwealth and State Government representatives. The draft standards were then further refined though a series of national consultations with stakeholders.

The primary intent of the standards is to ensure that services that are provided to consumers are consistent with the Principles and Objectives enshrined in Commonwealth and State disability services legislation, which is the basis on which disability services are funded and provided.

Governments, as both funders and providers of disability services, see the role of service standards as:

- empowering consumers by clearly defining what standards of service they should expect when accessing disability services,
- providing a basis for individual support workers and consumers to jointly improve service quality,
- assisting individual support workers to meet the Principles and Objectives of Commonwealth and State Disability Services Acts by clearly defining what is expected of them in terms of minimum service quality,
- assisting prospective individual support workers by defining what is expected of services to be eligible for funding, and
- providing a means of satisfying government accountability requirements.

Services that are funded by the Disability Services Commission are required to negotiate a Service Agreement with the funder. Services that are provided by the Disability Services Commission are covered by a Performance Agreement. The Disability Services Standards are a central plank in those negotiations and provide a means of assessing whether the individual support worker is meeting its service obligations and responsibilities under the Disability Services Act.

There are eight specific service standards that individual support workers are required to meet as a condition of their funding.

STANDARD 1 - SERVICE ACCESS

Each consumer seeking a service has access to a service on the basis of relative need and available resources.

STANDARD 2 - INDIVIDUAL NEEDS

Each person with a disability receives a service which is designed to meet, in the least restrictive way, his or her individual needs and personal goals.

STANDARD 3 - DECISION MAKING AND CHOICE

Each person with a disability has the opportunity to participate as fully as possible in making decisions about the events and activities of his or her daily life in relation to services he or she receives.

STANDARD 4 - PRIVACY, DIGNITY AND CONFIDENTIALITY

Each consumer's right to privacy, dignity and confidentiality in all aspects of his or her life is recognised and respected.

STANDARD 5 - PARTICIPATION AND INTEGRATION

Each person with a disability is supported and encouraged to participate and be involved in the life of the community.

STANDARD 6 - VALUED STATUS

Each person with a disability has the opportunity to develop and maintain skills and to participate in activities that enable him or her to achieve valued roles in the community.

STANDARD 7 - COMPLAINTS AND DISPUTES

Each consumer is free to raise, and have resolved, any complaints or disputes he or she may have regarding the agency or service.

STANDARD 8 - SERVICE MANAGEMENT

Each agency adopts sound management practices which maximise outcomes for consumers.

In order for individual support workers to meet the eight standards they are required to have in place written policies and procedures that address each of the standards.

The Need for Policies and Procedures

As stated earlier in this manual, policies are intended to help, not hinder, organisations.

Some of the benefits that properly developed policies bring to an organisation are:

- written policies are an objective way of establishing that an organisation is attempting to comply with the standards or principles that apply to the delivery of services,
- management and staff are provided with a clear framework within which to carry out their duties,
- the process of developing draft policies puts the management committee in touch with its staff, consumers, members, other stakeholders and the wider community,
- written policies signal that the management committee is acting in a professional, business-like manner and is willing to be publicly accountable for its decisions,
- an organisation that is governed by well written policies will be a more attractive proposition for prospective management committee members,

- the management committee will need to make fewer decisions on the run (with its attendant risks of inconsistency in decisions made across different events and different management committees),
- written policies build efficiency and consistency into the management committee's deliberative processes because decisions can be made quickly and confidently within an endorsed policy framework,
- incoming management committees do not have to continuously 're-invent the wheel' and run the risk of making decisions that are inconsistent with previous decisions,
- written policies provide the mechanism for the management committee to delegate authority to management whilst retaining overall control,
- written policies provide an excellent orientation to incoming management committee members and staff of the organisation.

Policy does not need to be confusing, concerning or complicated. Donovan and Jackson (1991) define policy simply as,

"Any generalised decision that serves as a guide to action for organisation members."

This definition tells us that policies are not restricted to a single event, but apply to all similar events. It tells us that policies influence the way that the organisation, its staff and members, behave and the way that its services are delivered.

An even more pragmatic definition has been developed by Roberts (1996), who defines policy as,

"A statement of principles or standards of conduct which guide any decision making in relation to processes, activities and initiatives which happen, or are expected to happen, frequently."

This definition tells us that organisations only need to develop policies for activities that occur with sufficient frequency as to warrant the time and effort expended in developing a formal written policy.

The point at which policies are 'operationalised' (i.e., converted into specific actions) is often referred to as 'procedures'. Thus, policies and procedures might be viewed as the thoughts and actions of an organisation. Dyson (1994) says of procedures:

"Where policies provide the signposts or guidance, the procedures tell people how things will be done. A procedure specifies what will be done, when and by whom."

Learning Activity 9 – Policy and Procedures

Using Resource documents numbered RDN-020 to RDN-044 you are to compare these standards against a facility you are able to have access to – what similarities and differences are there?

List these similarities and differences below then suggest why they may be different

Similarities	Differences

Once you have developed the strategies' for the 3 groups discuss your decisions with your assessors or facilitator to see if you are on the right track.

2.3 Assemble equipment as and when required according to established procedures and the individualised plan

Self-help equipment is often needed to assist the client/resident to perform activities of daily living (ADL). These activities can include bathing, dressing, oral hygiene, eating, bowel and bladder elimination and moving about.

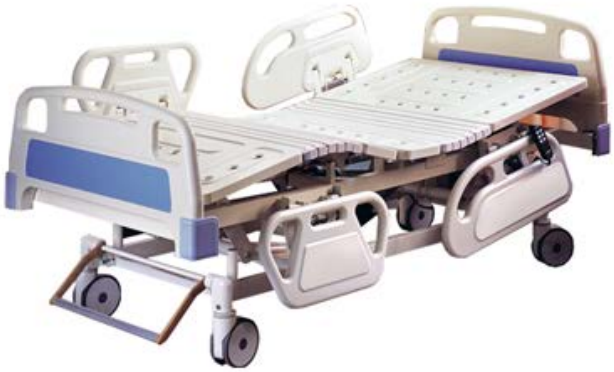
Equipment that can be used to assist with ADL may include:

- Manual or electric adjustable bed
- Manual or electric adjustable chair
- Wheelchair
- Wheelie walker, crutches, cane or brace
- Nutritional devices e.g. modified cutlery, lipped dishes
- Electric toothbrush
- Extra long handles for regular items like hair brushes
- Prosthetics
- Personal & hygiene equipment
- Hoists
- Shower chairs

Any equipment assembly must be done according to the manufacturer's instructions to ensure the equipment is properly assembled and safe for the client/resident as well as any care providers to use.

New equipment must be added to an equipment log and also an equipment maintenance log according to manufacturer's recommendations and organisation policies and procedures.

Manual handling is a necessary task in aged care facilities and in the community. Risk assessments (discussed at length in unit HLTWHS002) are completed before any manual handling is recommended. The type of equipment required for the individual is explained in the client/resident care plan, giving details of when, why and how many people are required to complete the task. If there are any changes in the requirements of your client/resident, document and report to your supervisor for re-assessment.

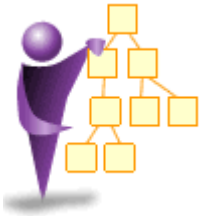


Remember: If the piece of equipment is not working properly, document as per policy or procedure and put an 'out of order' sign on it to alert other staff members not to use it.

All care providers are required to have policies and procedures for each piece of equipment under the Aged Care Act, 1997.

For each new piece of equipment purchased a new policy and procedure will be written. Staff are to undertake training in the safe and correct usage of each new piece of equipment.

Table 2: Correct use of equipment



Preventing Equipment Accidents	
Follow organisation or facility policy and procedure for each piece of equipment.	Do not use unfamiliar equipment. Ask for training where needed.
Follow manufacturer's instructions.	Use equipment only for its intended purpose.
Read all caution and warning labels.	Make sure item works before you begin. E.g. correct sling for that hoist.
Ensure correct sling for the individual. Check care plan.	
Make sure you have all needed equipment including power outlets within reach.	Place a "Do Not Use" sign on broken or damaged items.
Report to your supervisor about broken items.	Do not try to repair broken equipment.
Keep electrical items away from water.	Keep work areas clean and dry, clean spills immediately.
Ensure work space free from clutter with ample room to prevent unnecessary twisting.	Turn off all equipment when you have finished using it.

Learning Activity 10:

As part of your learning journey you have been discussing assembly and use of equipment according to policy and procedures

Give 4 examples of the types of equipment you may use as an individual support worker.

1. _____
2. _____
3. _____
4. _____

Explain what you would do if you wanted to use a piece of equipment and found it was out of order or broken.

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Once you have answered the questions above, please check with your facilitator or assessor to see if you are on the right track.

2.4 Respect and include the family and/or individual support worker as part of the support team

Family and friends can offer support and comfort and can lessen loneliness. In some cases a family member will be the primary individual support worker or help in some way with the persons care. The presence or absence of family members affects the person quality of life.

The person has the right to visit with family and friends in private without unnecessary interruptions. If you need to give care while visitors are present, protect the person's right to privacy by not exposing their body. If appropriate you may need to politely ask visitors to leave the room, show them where to wait and tell them when they can return. A partner, individual support worker or close family member may want to help you. If the client consents, you may allow that person to stay.

Treat visitors, family members and individual support workers with courtesy and respect, they need support and understanding as well. They may have concerns or questions about the person's condition and care which should be directed to your supervisor or nurse.

Making decisions

As individual support workers we always ensure that the client is part of the decision making process in determining care. This extends to the family and/or individual support worker when these people are involved. We consult with our clients directly and their carers and families and they are seen as essential for any decision making.

Family attitudes

Many cultural groups hold strong beliefs in caring for the older person. The idea of admitting a relative into a care facility or employing a non-family member to enter the home to attend and care can be seen as shameful. They could see this as a failure on their own behalf. Always be mindful of this when giving care or communicating with relatives.

Be aware of the possibility of this sensitivity and recognise behaviour such as the client or their family appearing to be shameful or angry or appear not to listen to what you are saying as an indication of this belief/feeling. Always be patient and try to reassure them that they have made an appropriate choice to ensure their family member receives support and care.

In some cultures, the role of healthcare provider is seen as the "expert", and the client is seen as a passive participant. In this case to offer too many choices can result in the client becoming confused and perhaps the client and family viewing you as incompetent. It is imperative to be open and aware of cultural sensitivities such as this when providing care.

Communication

For various reasons, communication with your client may difficult. There may be language barriers, physical impairment or memory issues just to name a few. When communication is difficult, family members can be imperative to helping you understand cultural differences and preferences the client might like.

Considerations such as appropriate dress, diet and taste preferences and physical touch should be discussed with the family of the client to aid in your understanding of your client and help their comfort and individuality.

For example, hospital gown can be embarrassing and degrading for long-term facility residents. You can discuss what type of clothes the resident prefers or even have family members bring clothing in for them. If your client wears clothing that you are unfamiliar with, such as a sari, ask your client or their family the correct way of arranging the clothing.

2.5 Provide support according to duty of care and dignity of risk requirements

The Work Health and Safety Act 2011 states:

An employer must ensure the health, safety and welfare at work of all the individual support workers of the employer.

An employer must ensure that people (other than individual support workers of the employer) are not exposed to risks to their health or safety arising from the conduct of the employer's undertaking while they are at the employer's place of work

Section 9 states:

A self-employed person must ensure that people (other than the individual support workers of the person) are not exposed to risks to their health or safety arising from the conduct of the person's undertaking while they are at the person's place of work.

An individual support worker also has a duty of care (Section 20) to take responsible care for the health and safety of people who are at the place of work and may be affected by the individual support worker's acts or omissions

An individual support worker must also cooperate with his or her employer or other person to enable compliance with the Act and regulation.

This legislation is the basis of the duty of care requirements.

This and other provisions of the Act require employers to ensure that:

- systems of work are safe;
- equipment is safe and properly maintained;
- individual support workers receive health and safety information and training;
- individual support workers are properly supervised.

Implementing the duty of care principle requires all people in the workplace to pay constant attention to, and be aware of, the possible consequences of their actions. These people include employers, individual support workers, manufacturers, suppliers and other persons at a place of work.

With this legislation in place, this then reinforces social and business management in ensuring that all persons take all necessary actions so as to not expose people to risks to their health or safety arising from the conduct of the person.

Individual care workers have a responsibility to their clients/residents to reduce or limit any harm or injury they may experience. This responsibility is known as 'duty of care'.

There are several aspects to duty of care:

- **Legal** - What does the law suggest we do?
- **Professional/ethical** - What do other workers expect us to do?
- **Organisational** - What does our organisation, and its funding body, say we should do?
- **Community** - What do the families of our clients and other community members expect us to do?
- **Personal** - What do our own beliefs and values suggest we do.

Your clients/residents have the right to make an informed choice; to experience life and take advantage of opportunities for 'adventure', developing new skills and independence and, in doing so, take a calculated risk. As an individual support worker you have an obligation to ensure duty of care is carried while supporting the person to fulfil their desired goals.

Duty of Care Vs Dignity of Risk

Balancing Duty of Care and Dignity and Risk

Supporting someone to become independent means that they have to take some risks - both small and large. Keeping them safe may mean limiting their opportunities to learn and enjoy a satisfying life.

When a parent is cautious about supporting someone to take a risk they are sometimes labelled as being 'over-protective'. When service providers are cautious they may say they are acting within their 'duty of care'.

Many workers take on a caring role when supporting someone with a disability. They blend the values they have developed in their own culture and family to their work values. This may mean that they also want to be cautious in supporting someone to take risks.

They are also aware of their duty of care that is a significant legal responsibility. However workers also have a responsibility to take on an education role - working with the person so that they become as independent as they possibly can and so reduce their reliance on others.

How to achieve the balance?

- Get to understand what duty of care means for you - there is a lot of misunderstanding about this. Duty of care does not exist to create restrictions for people with or without a disability.
- Work with the person to develop their skills so that they can make their own decisions and be able to communicate their choices. Education provides a person (with or without a disability) with information that makes them more able to make informed decisions.
- Work as a team so that all issues are debated and joint decisions are made.

Learning Activity 11:

As part of your learning journey you have learnt that 'duty of care' is covered in the WHS Act and regulations 2001.

In your own words explain what 'duty of care' meant to you.

_____

_____

_____

_____

_____

Again, in your own words, write what your obligations are to the client/resident who chooses to take risks.

_____

_____

_____

_____

_____

_____

Once you have discussed what 'duty of care' and 'dignity of risk' mean to you, have your facilitator or assessor check your responses to see if you are on the right track

2.6 Provide assistance to maintain a safe and healthy environment

Maintenance of the facility involves having and keeping the building, grounds, furnishings, and equipment in good repair.

Competent maintenance requires thoughtful planning related to four elements:

- Outside structures and features of the property
- Interior structures and furnishings
- Mechanical components
- People and procedures for maintenance

As part of the accreditation process (Standard 4), Physical Environment and Safe Systems.

Principle: Care recipients live in a safe and comfortable environment that ensures the quality of life and welfare of care recipients, staff and visitors.

Table 3: Accreditation Standard 4

No	Element	Criteria
4.1	Continuous improvement	The organisation actively pursues continuous improvement.
4.2	Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about physical environment and safe systems
4.3	Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively.
4.4	Living environment	Management of the residential care service is actively working to provide a safe and comfortable environment consistent with care recipients' care needs.
4.5	Occupational health and safety	Management is actively working to provide a safe working environment that meets regulatory requirements
4.6	Fire, security and other emergencies	Fire, security and other emergencies Management and staff are actively working to provide an environment and safe systems of work that minimise fire, security and emergency risks.
4.7	Infection control	An effective infection control program

It is with this planning that your organisation's WHS policy comes into play. If you see something which is considered to be a risk to the client or in fact to other staff members or visitors, it is your responsibility under the WHS act to notify these risks to your supervisor or to management and if the situation is in a non institutionalised situation, then notify them to the client direct as well.

For anyone who enters your organisation, your goal should be for them to see that clients and families are valued in our program. You will want them to go away with a feeling that if they have a loved one at home who needs care, then living in an environment like this is where they would like them to be, and that they feel honored referring your facility to others.

The built environment has a major impact on the health and development of all persons but more so the young and the elderly.

The built environment includes the buildings, parks, businesses, schools, road systems, and other infrastructures that the young and the elderly encounter in their daily lives. The young and the elderly need protection and a safe physical environment. Protection from physical injuries is a key aspect of a healthy physical environment. Having well designed homes, streets, transportation systems, and roads, malls and halls will promote the safety and health of children and youth.

Populations of Special Vulnerability

The safety of all patients is of paramount concern for all care providers. However, some patients—for example, the very young and the very old—are particularly vulnerable to the effects of medical errors, often due to their inability to participate actively as a member of the healthcare team, most commonly related to communication issues. Individual support workers and other care providers need to recognize the special needs of these patients and act accordingly.

Older Patients

The normal ageing process commonly includes some degree of impairment in vision and hearing. Older people may also suffer varying degrees of cognitive impairment. Alone or in combination, these problems contribute to difficulties in communication between patients and care providers. Serious illness, accidents, or trauma such as surgery that require hospitalisation add another layer of anxiety and possible confusion that can further interfere with communication between patients and care providers, potentially leading to errors.

Older patients are at special risk from medication errors, which can have life-threatening or even fatal effects due to the declining ability of the ageing body to metabolize drugs. According to researchers from AHRQ and the National Center for Health Statistics, women 65 to 74 years of age had the highest incidence of ADEs (Zhan et al., 2005). Visual, hearing, or cognitive problems may lead to misunderstanding of instructions or failure to question an incorrect or unfamiliar drug. When caring for older patients, communication with a responsible family member or other patient advocate is essential.

Older patients are also at high risk of falling. Reasons include medication effects, existing health problems such as arthritis, confusion or other cognitive deficit, or postural hypotension. Many older people need to use the bathroom during the night and need assistance to avoid falls.

Fall Risk

Falls are a commonly reported sentinel event, and can be fatal. Older patients are not the only population at risk. Any patient who has had excessive blood loss may experience postural hypotension, increasing the risk of falling. Maternity patients or other patients who have epidural anesthesia are at risk for falls due to decreased lower-body sensation. Factors that increase the risk of falls are summarised below.

Special risk factors for falls include:

- Age 65 or over
- History of falling
- Impaired mobility or difficulty walking
- Need for assistance in getting out of bed or transferring to/from chair
- History of dizziness or seizures
- Impaired vision, hearing, or speech
- Need for mobility-assistive devices (cane, walker, wheelchair, crutches or braces)
- Weakness or fatigue
- Confusion, disorientation, impaired cognitive function
- Use of medications such as diuretics, laxatives, or consciousness-altering drugs including sedatives, analgesics, hypnotics, antidepressants, tranquilizers.

Infants and Children

The younger the patient, the greater the risk of serious medication errors with devastating effects. Weight-based dosing is required for almost all pediatric drugs, and errors often occur when physicians or pharmacists convert dosage from pounds (for adults) to kilograms (for children). The USP advises that parents should know their child's weight in kilograms and reconfirm with the doctor that the dosage is correct for that weight.

Infants and young children do not have the communication abilities needed to alert clinicians about adverse effects that they experience. Infants, particularly newborns, are physiologically ill-equipped to deal with drug errors. Parents of infants and children need to be fully informed and involved in their child's care during hospitalisation and must be educated to question caregivers about medications and procedures.

Learning Activity 12:

The safety of all patients is of paramount concern for all care providers. Who are the most vulnerable to the risk of falls.

_____

_____

Which of the 4 Accreditation Standards addresses the physical environment and safety issues in an aged care facility.

2.7 Provide assistance to maintain a clean and comfortable environment

Home Care Packages

A Home Care Package provides a coordinated package of services tailored to meet the specific care needs to:

- help clients stay in their own home as their needs change
- give clients choice and flexibility in the way their care and services are provided to them at home.

These services can include (but are not limited to);

- Help washing and ironing
- House cleaning
- Gardening
- Basic home maintenance
- Home modifications related to care needs
- Transport for shopping, appointments, social activities.

A home care package may be a part of the client's individual plan and can provide these support services to clients who are needing help to maintain a clean and comfortable environment.

Cleanliness

Cleaning removes debris and organic matter from objects and areas, it also reduces the number of microbes (germs) that are present.

Disinfection is the process of destroying pathogens, however spores are not destroyed. Spores are bacteria protected by a hard shell which are killed by extremely high temperatures.

Sterilisation destroys all pathogens, including spores.

Different items and areas will need to be treated to different levels of cleanliness according to facility policies and procedures and/or the individualised plan.

Follow these general guidelines when cleaning;

- Always follow the policies and procedures of the facility and/or the personalised plan.
- Use only designated cleaning and disinfecting products according to the personalised plan.
- Wear personal protective equipment such as gloves, gowns and masks) when handling any item contaminated with blood, body fluids, secretions or excretions.

Consider the safety of others and use warning and/or wet floor sign wherever appropriate to avoid slip, falls and chemical exposure.

The Resident's Unit

The residents unit is the personal space, furniture and equipment provided for the individual by the nursing home or other facility.

Keeping the client's unit or leaving area clean and tidy makes the space safer and more comfortable.

Some areas to pay particular attention to with cleanliness are;

- Bathroom
- Bed & Linen
- Bins
- Odours
- Fridge & Food

Some facilities may allow residents to bring in their own furniture or other belongings to make them feel more "at home", and comfortable.

Arrange personal items as the resident prefers and where they can be reached.

Always treat a resident's personal items with care and respect.

Other considerations for client/resident comfort

Temperature & Ventilation

Care facilities have heating, air conditioning and ventilation systems to maintain a comfortable temperature and provide fresh air for residents.

What is comfortable for one person may be too hot or cold for another and older or chronically ill people may feel the cold or draughts more than healthy people. Good communication with residents is essential to ensure they are comfortable. If temperature cannot be controlled in individual rooms, extra blankets may be needed or windows can be opened or closed to help control temperature and comfort of residents.

In home care situations, temperature needs to be monitored. Air conditioning units may need to maintained, serviced or operated as per individualised plan or client. Clients may need assistance opening or closing windows. Make sure that they are secure windows and/or able to maintain a comfortable temperature after you have left.

Odours

Good ventilation will help to decrease any unpleasant odours that often occur in care facilities and in homes of clients who need assistance with daily living activities. These odours can not only be unpleasant but can embarrass clients/residents and visitors. Some people are particularly sensitive to odours and become nauseated.

Good nursing care is most important to keep unpleasant odours at a minimum.

To control odours and provide good nursing care you should;

- Check incontinent resident often
- Change and wash residents who are wet or soiled promptly
- Dispose of incontinence products immediately
- Change and Dispose of soiled linen or clothing as soon as you have finished the change
- Keep soiled linen containers and rubbish bins closed
- Empty and wash bedpans, urinals, bedside commodes and emesis basins promptly
- Use air freshening products according to the clients individualised plan and the facilities policies and procedures. Do not use spray deoderisers round clients with breathing problems, refer to individualised plan or nurse if unsure.
- Provide good personal hygiene for your clients to prevent body and breath odours.

Noise

Common health care noise can easily disturb residents and or clients who are chronically ill or sensitive to noises. They can become irritated, annoyed, confused or even scared.

Things like the clatter of metal or dishes, loud talking, laughing, televisions, radios, ringing telephones or signal buzzers and noises from equipment needing repair such as squeaky wheels on trolleys bed or stretchers can becomes very irritating especially if they are continuous or if the client is unable to decipher what the noise is or where it comes from.

Some of these noises can be reduced by handling equipment carefully, controlling the volume of your voice, answering phone calls and call buzzers promptly and making sure that equipment is in good working order, i.e. wheels oiled.

Light

Good lighting in resident's rooms in facilities as well as clients at home is very important for safety as well as comfort of the client.

For safety, lightening needs to be bright enough for individual support worker's to perform procedures and for mobile clients, visitors and individual support workers to be able to see well enough to move around the room without tripping or bumping into anything.

For comfort, the right level of lighting will be different at different times for each client.

Dim light is usually better for resting and relaxing whereas brighter lighting can be more cheerful and stimulating.

Lighting in most rooms can be adjusted to meet the changing needs of your client. Shades, drapes or curtains should also be used to control natural light in the resident's room or clients home.

If possible keep controls for lighting within reach of client's reach to allow for the right of personal choice.

Learning Activity 13:

As part of your learning journey you have discovered that it is not just health care and personal care that can be delivered in a client's home, there is a variety of services available.

List 4 other services that can be provided.

1. _____
2. _____
3. _____
4. _____

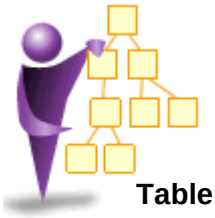
What other considerations are there to be made for client/resident comfort.

Name 3:

1. _____
2. _____
3. _____

Once you have answered these questions, have your facilitator or assessor check the answers to see if you are on the right track.

2.8 Respect individual differences to ensure maximum dignity and privacy when providing support



Many individual support workers are unaware of their own ethnocentrism, and movement along the continuum of cultural competence may not be possible until the students encounter individuals whose cultural beliefs, values, and needs differ significantly from their own

Table 4: Stages of Cultural Competency

Stage	Name	Definition
1	**Cultural Destructiveness**	• Purposefully destructs culture
		• Dehumanizes or sub-humanizes minority clients
2	**Cultural Incapacity**	• Holds paternal posture toward "lesser" races
		• Believes in the supremacy of the dominant culture
3	**Cultural Blindness**	• Holds philosophy of being unbiased
		• Believes that helping approaches traditionally used by the dominant culture are universally applicable
		• Behaviors reflect a well-intended liberal philosophy
		• Ignores cultural strengths, encourages assimilation, and blames the victim for their problems
		• Views differences from the cultural deprivation model which asserts that problems are the result of inadequate cultural resources
4	**Cultural**	• Pre competence
		• Realizes own weakness in serving minorities and attempts to improve some aspect of service
		• Desires to deliver quality services by asking "What can we do?"
		• Has begun the process of becoming culturally competent but lacks information on what is possible and how to proceed
		• Has a false sense of accomplishment or of failure that prevents the person from moving forward along the continuum
5	**Cultural Competence**	• Engages in continuous self-assessment
		• Focuses attention on the dynamics of difference, continuously increases cultural knowledge, and implements a variety of adaptations to service models
6	**Cultural Proficiency**	• Holds culture in high esteem
		• Conducts research, develops new therapeutic approaches, publishes, and disseminates

While a few individuals seem to be born with cultural competence, the rest of us have had to put considerable effort into developing it. This means examining our biases and prejudices, developing cross-cultural skills, searching for role models, and spending as much time as possible with other people who share a passion for cultural competence.

The term multicultural competence surfaced in a mental health publication by psychologist Paul Pedersen (1988) at least a decade before the term cultural competence became popular. Most of the definitions of cultural competence shared among diversity professionals come from the healthcare industry. Their perspective is useful in the broader context of diversity work.

Consider the following definitions:

A set of congruent behaviors, attitudes and policies that come together as a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations.

Cultural competence

Cultural competence requires that organizations have a defined set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them to work effectively cross-culturally.

Cultural competence is defined simply as the level of knowledge-based skills required to provide effective clinical care to patients from a particular ethnic or racial group.

Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum.

It is not surprising that the healthcare profession was the first to promote cultural competence. A poor diagnosis due to lack of cultural understanding, for example, can have fatal consequences, especially in medical service delivery.

Cultural incompetence

Cultural incompetence in the business community can damage an individual's self-esteem and career, but the unobservable psychological impact on the victims can go largely unnoticed until the threat of a class action suit brings them to light.

Notice that some definitions emphasize the knowledge and skills needed to interact with people of different cultures, while others focus on attitudes. A few definitions attribute cultural competence or a lack thereof to policies and organizations. It's easy to see how working with terms that vary in definition can be tricky.

Can you even measure something like cultural competence? In an attempt to offer solutions for developing cultural competence, Diversity Training University International (DTUI) isolated four cognitive components: (a) Awareness, (b) Attitude, (c) Knowledge, and (d) Skills.

Awareness

Awareness is consciousness of one's personal reactions to people who are different. A police officer who recognises that he profiles people who look like they are from the Philippines as “illegal aliens” has cultural awareness of his reactions to this group of people.

Attitude

Paul Pedersen’s multicultural competence model emphasised three components: awareness, knowledge and skills. DTUI added the attitude component in order to emphasise the difference between training that increases awareness of cultural bias and beliefs in general and training that has participants carefully examine their own beliefs and values about cultural differences.

Knowledge

Social science research indicates that our values and beliefs about equality may be inconsistent with our behaviors, and we ironically may be unaware of it. Social psychologist Patricia Devine and her colleagues, for example, showed in their research that many people who score low on a prejudice test tend to do things in cross cultural encounters that exemplify prejudice (e.g., using outdated labels such as “illegal aliens”, “coloured”, and “homosexual”.). This makes the Knowledge component an important part of cultural competence development.

Regardless of whether our attitude towards cultural differences matches our behaviors, we can all benefit by improving our cross-cultural effectiveness. One common goal of diversity professionals is to create inclusive systems that allow members to work at maximum productivity levels.

Skills

The Skills component focuses on practicing cultural competence to perfection. Communication is the fundamental tool by which people interact in organisations. This includes gestures and other non-verbal communication that tend to vary from culture to culture.

Notice that the set of four components of our cultural competence definition—awareness, attitude, knowledge, and skills— represents the key features of each of the popular definitions. The utility of the definition goes beyond the simple integration of previous definitions, however. It is the diagnostic and intervention development benefits that make the approach most appealing.

Cultural competence is becoming increasingly necessary for work, home, community social lives.

Culture (including spirituality and religious) provides a framework for a person understands of the world around him and of what happens to him in his daily life

Cultural sensitivity is indispensable for anyone who would attempt to understand someone else's public or private world. It is especially important, though, for those who would presume to develop long-term care policy or for those who would serve as professional help providers to ethnically diverse clienteles.

Cultural competency is a process that requires knowledge, diligence, and availability of resources. For the individual support worker / practitioner, it may be unfeasible to expect expert-level knowledge of any more than a few cultural groups

Culture (including spirituality and religious) is always emerging in therapy and care. In therapy, sometimes it comes in the foreground or background.

Culture should be seen as integral to all aspects of life: social, cognitive, political and emotional and therapy. Culture constructs us and we construct culture.

We simply have no other way of seeing or talking about the world than through the cognitive schemes and linguistic apparatus that are part of the culture into which we are born and which has become part of our taken-for granted reality. Luckily, though,

none of us is inevitably trapped in our culture of origin, or in only one way of viewing the world.

Perhaps we can never come to know another culture as intimately as someone who is born into it, but just as with great effort we can learn their languages, so can we gain useful insight into others' cultural and social worlds.

The rapid ageing of the world's population, especially in the developed world, has brought the great cultural diversity within that older population into sharper focus.

Organisations and Individual support workers need to spend a certain amount of time emphasising the importance of understanding the client's language and culturally based communication style, as well as his or her family situation and family members' role in treatment.

Every cultural group possesses its own definitions of and expectations for rapport and trust. Because becoming informed about someone else's culture is a difficult task, it is suggested to use bicultural pairs, in which a monolingual English speaker teams up with a culturally competent collaborator to better provide culturally appropriate services.

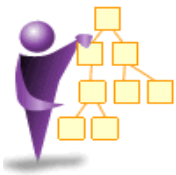
Learning Activity 14:

As part of your learning journey you and your classmates have discussed the importance of respecting individual differences to ensure dignity and privacy are maintained.

Using the definitions and the chart below/over make points on how you would deal with the stigmatisation of dealing with a person who has a chronic illness or disability. Make sure you go from Level 1 through to Level 6 with your examples.

Use the following scenario to formulate your answers:

Mrs. Vinh is in her mid-60s and of Asian ethnicity. She is dependent on her pension for her income. Somewhat hard of hearing, she has a slight tremor in her voice and arthritis in her hands. The three-bedroom house in which she lives is in poor condition. The house is unkempt. For meals she relies on her neighbours and junk food.



Mrs. Vinh is admitted to the rehabilitation unit after experiencing a mild stroke that leaves her impaired on the right side. Her treatment sessions consist of transfer training, learning one-handed cooking, and dressing with adaptive equipment. A variety of equipment and devices are recommended and ordered for her. At the discharged planning session, the occupational therapist states, "Mrs. Vinh has refused all the equipment even though she is able to use them safely and properly.

Table 5: Dealing with a person with cultural challenges

Stage	Name	Definition
1	Cultural Destructiveness	
2	Cultural Incapacity	
3	Cultural Blindness	
4	Cultural	
5	Cultural Competence	
6	Cultural Proficiency	

Once you have competed this form please have your assessor or facilitator check to see if you are on the right track.

2.9 Seek assistance when it is not possible to provide appropriate support

As a health care worker you will have the ability to improve your client's quality of life. You can provide care for the client's health and safety, assist with personal hygiene, improve self-esteem and even support the client in being more independent.

There will be situations however, when you are unable to provide appropriate support to an individual in general or in certain circumstances.

Some situations where you may not be able to provide appropriate support are;

- An emergency
- Medical care
- Challenging behaviour
- Cultural difference

An emergency

If you are presented with an emergency in the home of a health care client or in a public place with your client. Always check for immediate danger to yourself, your client and anyone else and then call emergency services (000). Make sure you are aware of your exact location so that you can communicate where you are. If appropriate it may be better to ask another person to call, while you, for example attend to your client, apply first aid, reassure your client or other people or protect your client from further harm or loss of dignity.

Medical care

Your client's needs are continuously changing and it is important that the individual care plan is reviewed regularly according to your organisation policy and procedures. If the client requires medical care beyond your scope make sure that your supervisor is aware ahead of time to ensure that a qualified person is ready at the appropriate time to meet their needs.

If you believe for some reason that the medical needs of the client has changed since the individualised care plan has been reviewed, you must notify your supervisor immediately and follow their instructions. If you are unable to contact your supervisor, it may be appropriate to call your client's family or a designated contact person for advice. Make sure that any decisions or actions you are make are within your scope and in the best interests of the client.

Challenging behaviour

When a client presents with challenging behaviour it can be very confronting. There are many reasons why a client may have challenging behaviour including physical or psychological illness, delirium, depression or dementia. Pain and/or anger can effect behaviour due to feelings of isolation, loss of control or independence, boredom and lack of opportunity for pleasure and enjoyment.

Caring for people with challenging behaviour requires a holistic and individualised approach. Many challenging behaviours can be prevented by providing effective person-centred care which accommodates individual differences and requires a thorough understanding of the resident including their cultural, linguistic and religious background, their sense of identity and life experiences.

This understanding is imperative to inform the effective assessment, treatment and delivery of appropriate interventions that are tailored to a person's specific needs. Such care is respectful of individuality and aims to promote dignity and quality of life through maximising independence and providing opportunities for pleasure and enjoyment.

Being familiar with and correct reporting in the individualised plan can assist health care workers to know and understand triggers for challenging behaviour and avoid these triggers whenever possible.

Dealing with challenging behaviour may be outside of your training, experience or scope. If you are presented with behaviour that is outside of your scope you should contact your supervisor immediately for advice and to get assistance to deal with the situation, either short or long term.

Cultural differences

The care plan should reflect the person's culture and religion. Some cultures do not like physical touch from the opposite sex or at all. Be aware of the patient's preferences and learn and understand about their culture as much as you can. A person of the same sex may be required to perform certain procedures, for example, bathing, dressing, grooming.

In some cultures it is important for the family to perform certain procedures or care activities with the client. Once again, be familiar and understand the care plan and follow it precisely.

3. Monitor support activities

3.1 Monitor own work to ensure the required standard of support is maintained

3.2 Involve the person in discussions about how support services are meeting their needs and any requirement for change

3.3 Identify aspects of the individualised plan that might need review and discuss with supervisor

3.4 Participate in discussion with the person and supervisor in a manner that supports the person's self determination

3.1 Monitor own work to ensure the required standard of support is maintained

It is important to observe not only your clients actions but also those of yourself. This involves monitoring and evaluating the quality of your work activities and outcomes and taking appropriate actions to support continuous improvement. Monitoring and an audit may be required for national, regional or local purposes.

You need to show that you can apply relevant quality standards and procedures to your working practice and identify any deviations from these. You need to use a range of sources of information to support your monitoring activity including feedback from service users and work colleagues. You will report cases of non-compliance with quality standards and identify and use opportunities for quality improvement.

Recording your own and your work colleagues' activities and what percentage of contribution to the activities is being provided by each party to the plan.

If you find that your client is performing less and less of the activities, you need to question;

- Is this occurring because your client is slow and you have a tendency to take over the task so as to speed up the task and finish it or
- Is it a sign of your clients deterioration in health and as such they can no longer perform these activities.

Within each care plan there should be an evaluation column whereby you are able to do your review and mark your comments.

3.2 Involve the person in discussions about how support services are meeting their needs and any requirement for change

Evaluation and review of an Individualised Plan is a continuous cycle. Provision should be made on all plans for a review date to be recorded. At the end of an agreed upon timeframe, a meeting should be held and the Individual Plan goals reviewed. As we are all individuals and our dreams and goals can change and take new direction from time to time, it is important that reviews are completed and evaluation of the goals and method of achieving those goals are organised.

The participation of people with support needs in the process of focusing on what is important to them now and in the future, and acting upon this in alliance with their family and friends, is examined in the review. This involves considering the ability of service providers to continually listen to, learn about, and facilitate opportunities with, the people they are supporting.

It is important to note that client participation is considered beyond the individual planning meeting (which may be an important part of the decision making process).

Rather, active participation throughout the entire individual planning process is discussed.

Learning Activity 15:

Involvement of the client in decision making is crucial to meeting the needs of the individual. Who else could you involve in the process?

_____

_____

Once you have answered this question, check with your facilitator or assessor to see if you are on the right track.

3.3 Identify aspects of the individualised plan that might need review and supervisor

It is crucial to implement strategies that continually monitor the person's progress towards meeting their goals. Monitoring processes need to check that strategies are working, and that the person is satisfied with the service they are receiving. Monitoring also enables the worker to evaluate their role in the process. The strategies described in the individual plan are also regularly reviewed to explore ways of getting over barriers, which have arisen. Individual plans are regularly changed to reflect achievements, new priorities, changing goals or abilities.

Reviews also consider whether resources are being used effectively. This includes staff, equipment, and funding.

Monitoring is often informal and part of the day-today contact between the person and support staff. This is when minor changes or adjustments can occur, in collaboration with the person. Any changes to the individual plan, however small, must be made only within your scope of responsibility or otherwise authorised by your supervisor or employer. In addition to this a formal review process is important for checking the progress being made on the support plan.

Good practice in monitoring and review. The principles of good practice in monitoring and review are:

- Each person is provided with opportunities for ongoing assessment and reassessment of their needs. The assessment may involve family, friends and advocates as well as service providers.
- Each person is provided with the opportunity for the monitoring and review of the strategies outlined in their support plan on a regular and timely basis.

- The person is directly involved in the monitoring and review process and is conducted in a way that respects the person's culture.
- If any action needs to take place as a result of a review, responsibilities need to be allocated to workers and time frames determined to ensure that change occurs.

Developing a monitoring and review process

The key tasks in developing a monitoring and review process may include:

- Deciding on the frequency of monitoring/reviewing. When the worker and client meet to develop a support plan, an arrangement should be made to monitor progress. The frequency of monitoring and review will depend upon the client's needs and progress towards meeting goals and will be recorded in the plan.
- Developing a tool for monitoring/reviewing. Some services may use a review form to review the support plan. An alternative is to make notes on the support plan itself, or make notes in the case notes.

Questions to be included on a review checklist may be:

- Have the goals been achieved?
- Have the goals changed?
- Are additional resources required to achieve goals?
- Are different strategies required to achieve goals?
- Should new goals be developed?
- Should the plan be signed off as completed?

All planning processes including review and monitoring need to be included in the organisation's policies and procedures.

These will cover such issues as:

- Frequency of monitoring/review sessions.
- Client involvement.
- Tools to be used.
- Privacy and confidentiality of client information.
- State Disability Service Standards.

If there is no progress in working through a support plan arrange a review to look at what is happening and make changes to the support plan if necessary. If you are unsure about what needs to happen, talk to the Coordinator.

Learning Activity 16:

As part of your learning journey you have learnt how to identify that the individual care plan requires reviewing

Giving examples and reasons how would you as an individual support worker for either an aged and/or disabled person provide support according to the individualised plan, the client's preferences and organisation policies, protocols and procedures?

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Giving examples and reasons how would you as an individual support worker for either an aged and/or disabled person provide support in a manner that contributes to the client's skill development and/or maintenance?

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Giving examples and reasons how would you as an individual support worker for either an aged and/or disabled person provide support according to duty of care requirements?

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Giving examples and reasons how would you as an individual support worker for either an aged and/or disabled person monitor support activities to determine capacity for the client's participation?

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Giving examples and reasons how would you as an individual support worker for either an aged and/or disabled person monitor support activities to determine contribution to the client's independence?

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Giving examples and reasons how would you as an individual support worker for either an aged and/or disabled person monitor support activities to determine contribution to the client's emotional wellbeing?

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Giving examples and reasons how would you as an individual support worker for either an aged and/or disabled person monitor support activities to determine relevance to the client's individualised plan?

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Giving examples and reasons how would you as an individual support worker for either an aged and/or disabled person monitor aspects of the individualised plan that might need review and report to supervisor?

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3.4 Participate in discussion with the person and supervisor in a manner that supports the person's self determination

Once the goals and the outcome criteria have been developed, the individual support worker and their supervisor consider what interventions would help move the client towards their goals. You should consider the broad interventions that can be tailored towards the individual plan based on the related component of the plan.

As with any care plan, you will have the opportunity to work with your supervisor or manager and client in helping them develop a care plan which enhances your client's self-determination as well as helping them develop a healthy lifestyle and a healthy self-concept.

It is the client's care plan which is being formulating; this is done with listening and aptitude. Information will be tailored from the assessment tools completed to develop the individual care plan. The client puts forward their needs and desires and you have to be objective without being subjective in providing information which will see the care plan work. It is not appropriate to force your views on your client just because you don't consider the care plan appropriate.

It is often in a long-term support worker-client relationship in a home health or restorative care environment that an individual support worker has the opportunity to work with a client to reach the goal of attaining a more productive self- concept.

Evaluating success in meeting each client goal and the established expected outcomes requires critical thinking. Frequent review of client plan and progress is recommended, to evaluate and so changes can be made if needed.

Learning Activity 17:

As part of your learning journey you have determined that a care plan is formulated to assist you as a support worker meets the needs of your clients/residents.

In what way would you as an individual support worker for an aged and/or disabled person participate in discussion with the client and supervisor to identify areas of the individualised plan that require review?

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In what way would you as an individual support worker for an aged and/or disabled person participate in discussion with the client and supervisor in a manner that acknowledges the client as their own experts?

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In what way would you as an individual support worker for an aged and/or disabled person participate in discussion with the client and supervisor in a manner that supports client self-determination?

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Once you have completed the above learning assessment, check with your trainer/ facilitator to obtain feedback.

4. Complete reporting and documentation

4.1 Maintain confidentiality and privacy of the person in all dealings within organisation policy and protocols

4.2 Comply with the organisation's informal and formal reporting requirements, including reporting observations to supervisor

4.3 Identify and respond to situations of potential or actual risk within scope of own role and report to supervisor as required

4.4 Identify and report signs of additional or unmet needs of the person and refer in accordance with organisation and confidentiality requirements

4.5 Complete and maintain documentation according to organisation policy and protocols

4.6 Store information according to organisation policy and protocols

4.1 Maintain confidentiality and privacy of the person in all dealings within organisation policy and protocols

Residents and clients have the right to personal privacy. This includes using the bathroom in private. Privacy is maintained for all personal care measures. The person's body is not exposed unnecessarily. Only staff directly involved in the person's care are present. The person must give consent for others to be present. Clients and residents have the right to visit with others in private – in areas where others cannot see or hear them. If requested, the centre must provide private space. Offices, chapels, dining rooms, and meeting rooms are used as needed.

The right to privacy also involves mail and phone calls. The person has the right to send and receive mail without others interfering. No one can open mail the person sends or receives without his or her consent. Mail is given to the person within 24 hours of delivery to the facility. (Sorento-Gorek, Basic skills for nursing assistants in Long-term Care, 2006).

Policies and procedures should be available at all services proving care.. As part of the orientation process you should get access to all Policies and Procedures.

In any organisation, there is an implied obligation of good faith and fidelity owed by a carer to his or her employer. Every carer has a duty in common law to provide faithful service as well as a duty not to act in a manner, which is hostile to the interests of the organisation.

A Code of Conduct is aimed at encouraging positive and efficient workplace behaviour for the mutual benefit of the organisation and its carers. The standards reflect values that are regarded highly by the service provider and all members of the organisation.

They are consistent with the core values of the organisation and are generally about issues such as honesty, courtesy, safety, fairness and diligence.

Every carer also has an obligation of confidentiality in relation to information about clients. A carer holds a position of trust and confidence with a client and consequently must be aware of the sensitivity and obligations, which arise to both the client and the employer.

- **Compliance with the Law:**

  Carers are expected to comply with all Federal and State laws, Local Laws, regulations and delegations exercised by relevant carers.

- **Conflict of Interest:**

  Carers should ensure that there is no conflict or incompatibility between their personal interests and the impartial fulfilment of their duties.

- **Desired Behavioural Characteristics:**

  Organisations require all carers to develop behavioural logics, which are consistent with the principles and imperatives underpinning their quality management philosophy.

  These include:

  - **Recognition of the importance of the client.**

    Within your organisation, we have two main roles to be fulfilled - serving clients and serving those who serve clients. Your aim would be to build long-term partnerships and relationships both internally and externally within your organisation. You need to recognise both internal and external clients as part of your commitment to being client driven in everything you do.

  - **Working together**

    No carer is an island unto himself or herself. Your organisation will benefit from you working collaboratively in a team-based environment, which recognises the worth of the individual and the importance of processes in achieving outcomes

  - **Communication**

    All management, supervisors and carers are encouraged to actively communicate about their work environment as part of a process of sharing information and enhancing knowledge management within the organisation.

- **Conflict resolution**

  All staff should be encouraged to observe their organisations established policies and procedures relating to conflict resolution and grievance procedures

  Personal Benefit

  - **Company Information;**

    Carers must not use confidential or any other company information (this includes documents and computer data) to gain an improper advantage for themselves or any other person. Company information is not to be used in ways that may cause harm or detriment to any person, body or the company.

  - **Undue Influence:**

    Carers must not use their position to influence other carers to perform their duties in a way that gives personal advantage to themselves or to any other body or persons.

- **Employee Conduct**

  - **EEO Principles;**

    Carers are expected to actively encourage a workplace atmosphere that is free from discrimination, harassment and unfair treatment.

  - **Work Performance:**

During work hours carers shall apply responsibilities. Carers are expected to perform their duties and responsibilities in an efficient and effective manner.

- **Compliance with Lawful Orders/Directions;**

  Carers are expected to comply with any lawful order or work direction given by any person authorised to make such an order or work direction.

- **Honesty, Integrity and Fairness;**

  Carers are expected to maintain the highest standards of honesty, integrity and fairness, and shall perform their duties on this basis at all times.

- **Attendance;**

  Carers are expected to be punctual and regular in their attendance during normal working hours and shall not absent themselves during hours of duty without prior approval, except in **emergencies.**

- **Drugs and Alcohol;**

  Carers must not attend for duty affected by intoxicating substances (i.e. drugs, alcohol etc.). If a carer is on medication that affects their ability to perform their duties, a medical certificate should be produced from a duly qualified medical practitioner. The medical certificate should explain the carer's incapacity to perform their duties and responsibilities. Carers must not consume intoxicating liquor or drugs on duty.

- **Courtesy and Presentation;**

  Carers are expected to behave courteously to fellow carers, clients, relatives and the public. Carers are also expected to present themselves in a neat and tidy manner, relative to the duties they perform.

- **Occupational Health and Safety;**

  Carers have a responsibility to ensure their own health and safety as well as that of any other person who may be affected by the carer's acts or omissions at the workplace. Carers are required to adhere to their organisation's occupational health and safety policies and procedures. Where you are concerned about the safety of a work situation, contact your supervisor immediately.

- **Smoke Free Workplace;**

  The organisation you work for would now most probably work under a Smoke free workplace policy. This means that carers are only permitted to smoke during an authorised recess at work. Clients are requested not to smoke in the presence of carers.

- **Obligations to Employer;**

  As a home carer or personal carer working in the home and the community you are expected to adhere to the Australian Home Care Code of Conduct.

  Specific responsibilities relating to your role as a home helper or personal carer with your organisation include:

  - To be reliable and arrive on time.
  - To notify your supervisor if you are unable to work or are running late.
  - To respect the privacy and confidentiality of clients and work colleagues.
  - To respect the rights of clients and other workers in the organisation.
  - To support the independence of clients.
  - To have a non-judgmental approach.

- To understand and respect your boundaries.
- To represent the interests of your organisation (eg. by not soliciting clients from your organisation to other agencies).
- To carry out the specified job required.
- To complete assigned tasks as well as possible within the allocated time.
- To give feedback, communicating relevant and important information.
- To be accountable, and to work within your capabilities and skills.
- To be committed to clients individual programs.
- To recognise personal and external limitations on commitment.
- To acknowledge decisions made by staff.
- To undertake training as required.
- To have a good understanding of services provided by your organisation.
- To address areas of conflict with your supervisor.
- To ask for support when it is needed.
- To act professionally at all times.
- To be appropriately dressed at all times.
- To participate in all actions taken by your organisation to ensure the health and safety of staff.
- To not willfully place at risk the health and safety of any person in the workplace.

In Australia there are Acts and legislations, below are a few examples that are available in Queensland. Each state and territory has their own.

Legislation: Privacy and Confidentiality

Queensland legislation which provides privacy and confidentiality protections for personal information include:

Information Privacy Act 2009

Information Privacy Regulation 2009

Hospital and Health Boards Act 2011

Hospital and Health Boards Regulation 2012

Applications for access and/or amendment of personal information may be sought under:

Information Privacy Act 2009

Information Privacy Regulation 2009

Right to Information Act 2009

Right to Information Regulation 2009

Learning Activity 18:

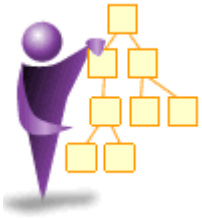
As part of your learning journey Privacy and confidentiality of your client/resident has been discussed.

Give 3 examples of when your resident or client deserves privacy.

1. _____
2. _____
3. _____

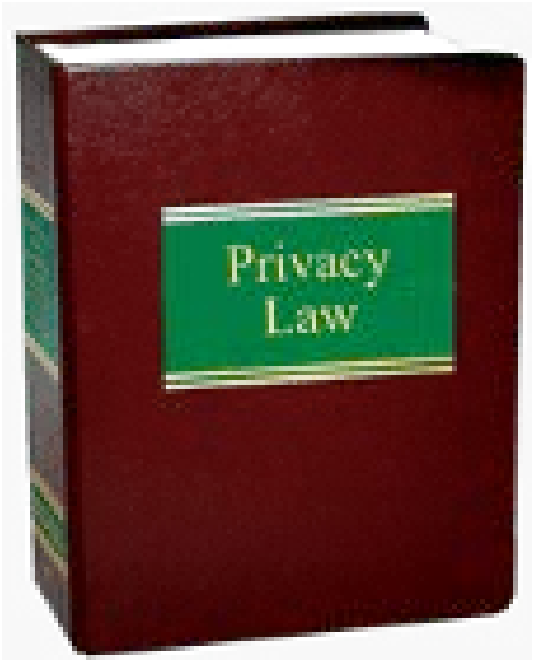
Check all other States and Territories to see if they have similar legislations to Queensland. Give one example for each State and Territory.

Table 6: State Legislations or Acts



New South Wales	
Western Australia	
Victoria	
Tasmania	
South Australia	
Northern Territory	

Once you have answered these questions, check your answers with your facilitator or supervisor to see if you are on the right track.



4.2 Comply with the organisation's informal and formal reporting requirements, including reporting observations to supervisor

All organisations will require progress notes to be written and maintained in a secure and confidential manner. The golden rule of nursing and care and documentation is

"If it's not written, it didn't happen."

You probably didn't become an individual support worker in order to master the art of charting. You probably didn't get into the field to prevent a malpractice suit from occurring. You most likely do not spend your waking hours fantasising about documentation. How could you possibly want to chart, let alone enjoy it, when it keeps you from giving direct patient care…but in reality, documenting is patient care!

Any change in a client's situation or condition should be noted in their progress note. All organisations will stipulate in their policy and procedure manual their requirements for reporting, and any apart from recording basic observations as per requirements any acute change to condition should be immediately reported to your supervisor.

Your documentation needs to be legible to anyone who may read it. If you know you have poor penmanship, begin to print. Your printing will make life much easier for a person who is reading or may need to be transcribing from your notes.

Over time nursing assistant (support worker) documentation has changed. Where once nursing assistants may have done some narrative charting, today charting is most often made on flow sheets or charts where only a check mark is required to indicate the care that has been provided. A Daily Nursing Care Record is one kind of flow sheet used by support workers to document their daily care.

Aspects of care such as the client's daily bath, oral, denture, and hair care (ADL's) appear on a preprinted form. All the nursing assistant has to do is check off the box next to the aspect of care, after that care has been completed. Only rarely would the nursing assistant have to add a word or two of detail. An example might be in the recording of a bowel movement (BM), the nursing assistant may add whether or not the BM was small, moderate or large in amount.

It can be a tedious and time-consuming task for the nursing assistant to make sure that each and every box is either checked off or is recorded with a zero which indicates to anyone reviewing it that the care was not done for whatever reason. For example: the client may have refused the care; therefore, it could not be done.

Nursing assistants are required to immediately report care that was not done or was refused to their charge individual support worker or team leader. The individual support worker is then responsible for charting a narrative note as to why the care was not done as ordered.

Although it is very time consuming for nursing assistants to check off or enter with a zero all the many boxes on the flow sheets provided for them to record care, it is important for the individual support worker to encourage and monitor their charting efforts. Remember, if absences appear on flow sheets, then legally care was not offered or provided. Since nursing assistants report to individual support workers, it is a individual support worker's responsibility to periodically monitor nursing assistant documentation for accuracy and completion.

Learning Activity 19:

Documentation is very important for many reasons, explain in your own words why this is.

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Once you have answered this question, check with your facilitator or assessor to see if you are on the right track.

4.3 Identify and respond to situations of potential or actual risk within scope of own role and report to supervisor as required

Factors That Increase the Risk of Errors

"To err is human." However, research has shown that certain factors can increase the error rate (Reason, 1990):

- **Fatigue.** Working a double shift, for example, can increase the likelihood of errors. Medical residents on call for 24 hours or more are also at high risk for errors. Research shows how such system-based changes as reducing the work hours of medical personnel can reduce the error rate in hospitals (Landrigan et al., 2004).
- **Alcohol and/or other drugs.** Use of alcohol and/or drugs is incompatible with competent, professional, safe patient care. Unfortunately, the combination of high stress and easy access to medications has led to substance abuse by physicians, individual support workers, and other healthcare professionals.
- **Illness.** Coming to work when you aren't well jeopardises your health and the health and safety of patients.
- **Inattention/distraction.** A noisy, busy emergency department can make it difficult to concentrate on one patient's care, especially if you know that other patients are waiting to see you.

- **Emotional states.** Anger, anxiety, fear, and boredom can all impair job performance and lead to errors. A heavy workload, conflict with other staff or with patients, and other sources of stress increase the likelihood of errors.
- **Unfamiliar situations or problems.** Individual support workers who "float" from one hospital department to another may not have the expertise needed for all situations.
- **Equipment design flaws.** Here again, training and experience with equipment are key to avoiding errors.
- **Inadequate labeling or instructions on medication or equipment.** Look-alike or sound-alike drugs can lead to errors. Incomplete or confusing instructions on equipment can result in inappropriate use.
- **Communication problems.** Lack of clear communication among staff or between providers and patients is one of the most common reasons for error.

Hard-to-read handwriting. Physicians' handwriting has long been criticised for its illegibility, particularly on prescriptions. Fortunately, computerised medication ordering has eliminated this problem in many healthcare organisations.

- **Unsafe working conditions.** Poor lighting and/or slippery floors can lead to errors, especially falls—a costly hazard in every hospital.

Focusing on the multi-causal nature of errors does not alter the role of individual accountability for safe practice. In fact, the National Council of State Boards of Nursing has testified as follows:

Both systems liability for mistakes and individual accountability are important to protect the public. Absent individual accountability standards, practitioners who leave organisations after serious errors occur and are employed elsewhere will never receive necessary remediation or education to address human factors, thus compromising the safety of the patient (Ridenour, 2000).

Risk Management is the identification, assessment, and prioritisation of risks followed by coordinated and economical application of resources to minimise, monitor, and control the probability and/or impact of unfortunate events.

Risks can come from uncertainty in financial markets, project failures, legal liabilities, credit risk, accidents, natural causes and disasters as well as deliberate attacks from an adversary. Several risk management standards have been developed

In ideal risk management, a prioritisation process is followed whereby the risks with the greatest loss and the greatest probability of occurring are handled first, and risks with lower probability of occurrence and lower loss are handled in descending order. In practice the process can be very difficult, and balancing between risks with a high probability of occurrence but lower loss versus a risk with high loss but lower probability of occurrence can often be mishandled.

Intangible risk management identifies a new type of a risk that has a 100% probability of occurring but is ignored by the organisation due to a lack of identification ability. For example, when deficient knowledge is applied to a situation, a knowledge risk 108aterializes. Relationship risk appears when ineffective collaboration occurs. Process-engagement risk may be an issue when ineffective operational procedures are applied.

These risks directly reduce the productivity of knowledge workers, decrease cost effectiveness, profitability, service, quality, reputation, brand value, and earnings quality. Intangible risk management allows risk management to create immediate value from the identification and reduction of risks that reduce productivity.

In communicating and assessing your client, you can build a rapport with your client and as such can assess if there are risks to your client, remembering that risks can come from all sources, not just the immediately visual ones of wet floor or unsteady gait.

Risk can include the following:

Insufficient food or non-nutritional food

Your client may not have enough food to eat or may not be eating what is provided to them. Or they may be eating enough but there is limited or no nutrition in the food. This is often applicable to those who live on bread and butter with little or no fresh fruit and vegetables or meat. This could be declared as evidence of self – neglect.

Unhealthy lifestyles – smoking, alcohol, exercise

This is applicable to those who are habitual smokers or drinkers and who run the risk of contributing to a fire or a fall due to their lifestyle.

Impaired judgment and problem solving abilities

Inappropriate or unsatisfactory housing or heating. There may be clients of yours who do not have adequate or appropriate housing or heating, who do not have adequate and warm clothing or bedding to cope with the changes in weather.

Financial risks - either gambling or family matters

Some clients may have a gambling problem which could need addressing, or they may have family members or friends who will prey on them for financial assistance and leave the elderly destitute because they don't have the strength or fortitude to stand up and say *"no more".*

Medication risks

Some persons are non-compliant with medication, confusion may well result in medications either not being taken or in fact being taken too often and leading to an unintended overdose.

The risks of falls due to uneven ground or floor fixtures

Carpet and rugs, for example, or even wet floors. Long grass and poor garden maintenance are also a contributing factor to falls.

Risks of falls due to poor or inadequate lighting

Stairwells that are poorly lit are a significant concern. Because depth perception can be skewed with age, the descent down poorly lit stairwells can be a risk.

Problematic roommates or neighbours

It is well known that it is impossible to get on with everyone thru every stage of your life. Neighbors move house and new people arrive in the area. If you notice that your client's neighbors are disruptive or are considered a risk, it is essential that you report the situation to your supervisor.

Violence

Either from neighbors / family / other residents / staff / unknown is always a risk that cannot necessarily be pre known but which can be prevented.

Responding to situations of risk

Risk Management is ideally undertaken by a team of three to five people.

A team will be more effective in coming up with a robust risk management plan;

- It is important to ascertain the baseline function of your client or patient.
- It is important that individual support workers gain competency in the care of the elderly patient, particularly the frail elder.

The most vulnerable elderly patient is commonly referred to as frail. A frail elder may be defined as a person with an unstable disability in which even the smallest event may affect his or her ability to function daily.

Immobilisation causes many complications in the elderly, and represents many risks. The most common complications due to immobilisation in the elderly include constipation, decrease in appetite, and decline in function (physical and cognitive), depression, pneumonia, pain, incontinence, and pressure ulcers. Again, many of these can be prevented with minimal intervention, by simply encouraging self-care and maintaining functional level.

Functional decline or a change in activity level may represent an underlying medical cause.

A change in ADL may include a change in: basic self-care activities or ability, mobility, eating, feeding, hygiene, or continence.

Mental status changes can be seen in an acute change of condition include confusion, lethargy (arouses but falls back asleep easily), agitation, change in sleep pattern, a family member or nursing assistant saying “the patient just isn’t right today,” apathy (sluggish or indifferent), or restlessness can be seen as a potential risk and should be reported to your supervisor.

Learning Activity 18:

As part of your learning journey you and your classmates have discovered how to identify **and** respond to situations of potential or actual risk within scope of own role and report to supervisor as required.

Name 4 examples of certain factors that can contribute to error in judgement causing risk.

1. _____
2. _____
3. _____
4. _____

In your own words discuss what risk management means to you.

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Once you have answered these questions please have your assessor or facilitator check your answer to see if you hare on the right track**.**

Other areas of potential risk for the elderly is abuse.

As part of your 'duty of care', abuse in any form, proven, witnessed or suspected is to be reported to your supervisor immediately so she/he is able to submit a 'compulsory report' to the Dept of Ageing and Health.

Physical abuse

Physical abuse is a non-accidental use of force against an elderly person that results in physical pain, injury, or impairment. Such abuse includes not only physical assaults such as hitting or shoving but the inappropriate use of drugs, restraints, or confinement.

Emotional abuse

In emotional or psychological senior abuse, people speak to or treat elderly persons in ways that cause emotional pain or distress.

Verbal forms of emotional client abuse include:

- intimidation through yelling or threats
- humiliation and ridicule
- habitual blaming or scapegoating

Nonverbal psychological client abuse can take the form of:

- ignoring the elderly person
- isolating an client from friends or activities
- terrorizing or menacing the elderly person

Sexual abuse

Sexual client abuse is contact with an elderly person without the client's consent. Such contact can involve physical sex acts, but activities such as showing an elderly person pornographic material, forcing the person to watch sex acts, or forcing the client to undress are also considered sexual client abuse.

Neglect or abandonment by caregivers

Client neglect, failure to fulfill a caretaking obligation, constitutes more than half of all reported cases of client abuse. It can be active (intentional) or passive (unintentional, based on factors such as ignorance or denial that an elderly charge needs as much care as he or she does).

Financial exploitation

This involves unauthorised use of an elderly person's funds or property, either by a caregiver or an outside scam artist.

An unscrupulous caregiver might:

- misuse a client's personal cheques, credit cards, or accounts
- steal cash, income cheques, or household goods
- forge the client's signature
- engage in identity theft

Typical rackets that target clients/residents include:

- Announcements of a "price" that the elderly person has won but must pay money to claim
- Phony charities
- Investment fraud

Healthcare fraud and abuse

Carried out by unethical doctors, Carers, hospital personnel, and other professional care providers, examples of healthcare fraud and abuse regarding clients/residents include:

- Not providing healthcare, but charging for it
- Overcharging or double-billing for medical care or services
- Getting kickbacks for referrals to other providers or for prescribing certain drugs
- Overmedicating or under-medicating
- Recommending fraudulent remedies for illnesses or other medical conditions
- Medicare fraud

Signs and symptoms of client abuse

At first, you might not recognise or take seriously signs of client abuse. They may appear to be symptoms of dementia or signs of the elderly person's frailty — or caregivers may explain them to you that way. In fact, many of the signs and symptoms of client abuse do overlap with symptoms of mental deterioration, but that doesn't mean you should dismiss them on the caregiver's say-so.

General signs of abuse

The following are warning signs of some kind of client abuse:

- Frequent arguments or tension between the caregiver and the elderly person
- Changes in personality or behaviour in the client

If you suspect elderly abuse, but aren't sure, look for clusters of the following physical and behavioural signs.

Table 7: Signs and symptoms of specific types of abuse

Physical abuse	• Unexplained signs of injury such as bruises, welts, or scars, especially if they appear symmetrically on two sides of the body • Broken bones, sprains, or dislocations • Report of drug overdose or apparent failure to take medication regularly (a prescription has more remaining than it should) • Broken eyeglasses or frames • Signs of being restrained, such as rope marks on wrists • Caregiver's refusal to allow you to see the client alone
Emotional abuse	In addition to the general signs above, indications of emotional client abuse include • Threatening, belittling, or controlling caregiver behaviour that you witness • Behaviour from the client that mimics dementia, such as rocking, sucking, or mumbling to oneself
Sexual abuse	• Bruises around breasts or genitals • Unexplained venereal disease or genital infections • Unexplained vaginal or anal bleeding • Torn, stained, or bloody underclothing
Neglect by caregivers or self-neglect	• Unusual weight loss, malnutrition, dehydration • Untreated physical problems, such as bed sores • Unsanitary living conditions: dirt, bugs, soiled bedding and clothes • Being left dirty or unbathed • Unsuitable clothing or covering for the weather • Unsafe living conditions (no heat or running water; faulty electrical wiring, other fire hazards) • Desertion of the client at a public place
Financial exploitation	• Significant withdrawals from the client's accounts • Sudden changes in the client's financial condition • Items or cash missing from the senior's household • Suspicious changes in wills, power of attorney, titles, and policies • Addition of names to the senior's signature card • Unpaid bills or lack of medical care, although the client has enough money to pay for them • Financial activity the senior couldn't have done, such as an ATM withdrawal when the account holder is bedridden • Unnecessary services, goods, or subscriptions
Healthcare fraud and abuse	• Duplicate billings for the same medical service or device • Evidence of overmedication or under-medication • Evidence of inadequate care when bills are paid in full • Problems with the care facility: • Poorly trained, poorly paid, or insufficient staff • Crowding • Inadequate responses to questions about care

Risk factors for client abuse

It's difficult to take care of a senior when he or she has many different needs, and it's difficult to be elderly when age brings with it infirmities and dependence. Both the demands of care giving and the needs of the client can create situations in which abuse is more likely to occur.

Risk factors among caregivers

Many nonprofessional caregivers — spouses, adult children, other relatives and friends — find taking care of a client to be satisfying and enriching. But the responsibilities and demands of client caregiving, which escalate as the client's condition deteriorates, can also be extremely stressful.

The stress of client care can lead to mental and physical health problems that make caregivers burned out, impatient, and unable to keep from lashing out against clients/residents in their care.

Among caregivers, significant risk factors for client abuse are:

- inability to cope with stress (lack of resilience)
- depression, which is common among caregivers
- lack of support from other potential caregivers
- the caregiver's perception that taking care of the client is burdensome and without psychological reward
- substance abuse

Even caregivers in institutional settings can experience stress at levels that lead to client abuse. Nursing home staff may be prone to client abuse if they lack training, have too many responsibilities, are unsuited to caregiving, or work under poor conditions.

The client's condition and history

Several factors concerning clients/residents themselves, while they don't excuse abuse, influence whether they are at greater risk for abuse:

- The intensity of an elderly person's illness or dementia
- Social isolation; i.e., the client and caregiver are alone together almost all the time
- The client's role, at an earlier time, as an abusive parent or spouse
- A history of domestic violence in the home
- The client's own tendency toward verbal or physical aggression

In many cases, client abuse, though real, is unintentional. Caregivers pushed beyond their capabilities or psychological resources may not mean to yell at, strike, or ignore the needs of the clients/residents in their care.

In every state, physical, sexual, and financial abuses targeting clients/residents violate laws against assault, rape, theft, and other offenses and are punishable as crimes. With some variation among states, certain types of emotional client abuse and client neglect are subject to criminal prosecution, depending on the perpetrators' conduct and intent and the consequences for the victim.

Many seniors don't report the abuse they face even if they're able. Many fear retaliation from the abuser, while others believe that if they turn in their abusers, no one else will take care of them. When the caregivers are their children, they may be ashamed that their children are behaving abusively or blame themselves: "If I'd been a better parent when they were younger, this wouldn't be happening." Or they just may not want children they love to get into trouble with the law.

Our States differ on who is required to report suspected client abuse (there's no federal standard), though the categories of mandatory reporters are expanding. Typically, medical personnel, nursing home workers, peace officers, emergency personnel, public officials, social workers, counselors, and clergy are listed as mandatory reporters, and that responsibility is spreading to financial institutions and other entities that work with seniors.

P**reventing client abuse and neglect**

You can help reduce the incidence of client abuse, but it'll take more effort than is being made now.

Preventing client abuse means doing three things:

- Listening to seniors and their caregivers
- Intervening when you suspect client abuse and reporting it to your supervisor or other authority bodies.
- Educating others about how to recognise and report client abuse

What you can do as a health care worker a concerned friend or family member:

- Watch for warning signs that might indicate client abuse. If you suspect abuse, report it.
- Take a look at the client's medications. Does the amount in the vial jive with the date of the prescription?
- Watch for possible financial abuse. Ask the client if you may scan bank accounts and credit card statements for unauthorised transactions.
- Call and visit as often as you can. Help the client consider you a trusted confidante.
- Offer to stay with the client so the caregiver can have a break — on a regular basis, if you can.
- Find an adult day care program.
- Find a support group for caregivers of the elderly.

Working with senior citizens presents a number of specialised challenges not the least of which is diminished capacity and the potential for abuse. It is your duty, as their carer, to assist in protecting your elderly clients/residents' from abuse by reporting any identified variations to your supervisor.

Learning Activity 20:

As a support worker, what would make you suspect that your client is a victim of elder abuse. In your own words describe what may alert you.

_____

_____

_____

_____

_____

_____

List 4 forms of abuse:

1. _____
2. _____
3. _____
4. _____

Once you have completed this activity, check with your facilitator to see if you are on the right track.

4.4 Identify and report signs of additional or unmet needs of the person and refer in accordance with organisation and confidentiality requirements

Observing clients is a vital part of the aged care and health support worker's role. To be able to report changes in a client's condition or needs, the individual support worker must be a good observer. To observe people in your care, you must use ALL your senses. Observing is much more than just looking at the person.

Anything unusual or out of the ordinary should be noted and reported to the supervisor. For example, you may smell a strange odour, hear a moan or groan or feel an unusual swelling or lump on the skin.

It is important to know your client to be effective in the care you give. 'Care' includes being attentive to change and reporting any changes to the relevant person. The worker must first know what is 'normal' before they can recognise what is not normal. The age, gender and known medical condition and diagnosis of the client must be kept in mind

Accurate, objective reporting is a skill, which needs practice. The reports made by a worker often affect the type and level of support the person in care will receive. Reports which are inaccurate, and coloured with personal interpretation and perceptions, may result in inappropriate support and assistance to the client.

Aged care and health support workers should consult the client about their observations wherever possible, to make sure that what they have seen is accurate and true.

Aged care and health support workers should also ask the following questions:

- What information is relevant to report?
- What information is not relevant to report?
- To whom should I report the information?
- When is it appropriate to report?
- Have I reported objectively and without value judgement?
- Have I consulted the client and obtained their consent to pass on the information I think needs to be given?
- Do I have enough information about the issue?
- Is it necessary for me to consult or seek advice from anybody and am I clear who that person should be?

Learning Activity 21:

As part of your learning journey you should now be able to identify any changes or unmet needs of your resident or client. ,

Upon visiting Mrs. James, you have noticed she is not able to get out of bed unaided, as she usually is. When asking her is she in pain, she states 'no dear, just a bit still this morning'. You assist her to the bathroom and shower, dry and dress her (normally she only requires supervision). You observe when putting Mrs. James's soiled clothing in the laundry that there is dirty washing all over the floor. At that time, Mrs. James has visitors arrive for a cup of tea. They ask you how she is?

Do you:

a) Tell them what Mrs James told you about how she was feeling?
b) Tell them about the dirty clothes in the bathroom
c) That you had to shower and dress her today
d) Suggest they speak to Mrs James about how she is feeling when she comes out of her room.

Circle the correct answer.

What have you observed out of the ordinary?

_____

_____

_____

_____

_____

Who would you report the changes to?

_____

_____

_____

_____

Once you have answered these questions please check with your supervisor or facilitator to see if you are on the right track.

4.5 Complete and maintain documentation according to organisation policy and protocols

Protocols are an agreement to a particular sequence of activities, which assist individual support workers to respond consistently in a complex area of clinical practice. Procedures may be written where the task is highly technical and dependent or an exact order of events, or to support unqualified nursing staff in order that they develop competencies.

Where necessary, each policy statement will be supported by protocols (guidelines) and/or procedures (for more exacting specific tasks).

The old saying "if it's not documented in the medical record it was not done" has never been more timely as state and federal governments continue to enact legislation to protect various healthcare consumers.

To avoid litigation, health care providers must comply with established standards of care. Standards of care arise from:

1. Regulations based on state and federal legislation or statutes. Regardless of the term used, they are the law.
2. Practice guidelines

Failure to document or faulty documentation on your part is risky behaviour that should be avoided. Knowing that, it is highly suggested that you obtain a copy of the documentation standard (policy) where you are employed and become very familiar with it.

It may seem obvious but be sure to include the **date and the time** you wrote your entry. The date should include the year; the time should indicate am or pm. don't chart in blocks of time such as 0700 to 1500. This makes it hard to determine when specific events occurred.

Other essential information to record is: the client's history (including unhealthy conditions or risky health habits such as scalp lice, smoking, failure to take prescribed medication, etc.)

A client's history is usually reflective of trends and may offer valuable hints about what to expect in the future. It is important that you chart any subjective (what you hear) and objective (what you see) observations (especially changes in health status such as the emergence of a productive cough, difficulty in breathing or feelings of anxiety or depression).

Document any actions that you did in response to any of your observations and the client's response to your actions. These responses to your interventions are commonly called client outcomes.

Other information that needs to be recorded in the medical record includes any education or instructions you give to the client, his family or significant other.

Anytime a client, family member or significant other is given a referral to a community resource, it should be recorded. It is obvious that any authorisation or consent for treatment is a documentation priority so that legally, permission to provide care has been given.

We don't often think about phone calls as documentation but they can contain certain information for which we have obligations such as advice that we may give to a client or a phone order that we may take from a doctor.

It is a very good initiative to record or make a record of phone calls, a log of such phone calls could be included in the patients file and / or in a separate LOG file... an example of such could be

For a Client Call:

- Date and time of call
- Caller's name and address
- Caller's request or chief complaint
- Advice you gave
- Protocol you followed (if any)
- Other caregivers you notified
- Your name

For a Physician Call:

- Date and time of call
- Physician's name and "T/O" to indicate order
- Verbal order, written word-for-word
- Documentation that you've read back the order, to be sure you heard it correctly
- Documentation that you've transcribed it according to your facility's policy
- Your name

Be sure to **record your full name, credentials and job title** in the required section on documentation forms. Some forms will ask you to **record your initials** as well. Your signature must be in cursive writing so a word of final caution: do take the time to sign your name legibly

Maintaining documentation

Upon reading your organisations policy and procedure manuals you will be required to document your work and observations accurately and concise on a daily or shorter basis.

The correct way to chart a client's/residents progress notes include the following golden rules of documentation;

- Check that you have the correct chart before you begin writing.
- Make sure your documentation reflects the nursing process and your professional capabilities.
- Write legibly.
- Use a permanent black ink pen other colours do not copy well.
- Chart completely, concisely and accurately ("Tell it like it is.")
- Write clear sentences that get right to the point.
- Use simple, precise words.
- Don't be afraid to use the word "I."
- Chart the time you gave a medication, the route you gave it and the client's response.
- Chart precautions or preventive measures used, such as bed rails.

Include the following information when documenting nursing procedures:

- What procedure was performed
- When it was performed
- Who performed it
- How it was performed
- How well the client tolerated it

Adverse reactions to the procedure;

1. Record each phone call to or from a physician, including the exact time, message, and response
2. Chart what you feel is important data from visits by physicians or other members of the health care team such as the dietitian, social worker, etc.
3. Chart as soon as possible after giving care; don't wait to chart until the end of your work day.
4. Chart a client's refusal to allow a treatment or take a medication. Be sure to report this to your immediate supervisor and the client's physician
5. Chart client's subjective data (what the client perceives and the way they express it) by directly quoting it. This is the one time you can use quotation marks.
6. If you don't give a medication, circle the time and document the reason for the omission.
7. If you remember an important point after you've completed your documentation, chart the information with a notation that it's a "late entry." Include the date and time of the late entry.
8. If information on a form such as a flow sheet doesn't apply to your client, write NA (not applicable) in the space provided.
9. Chart often enough to tell the whole story.
10. Use only commonly used or approved abbreviations and symbols.
11. Document discharge instructions including any referrals to home health agencies and other community providers as well as any patient teaching that was done.

12. Post a list of commonly misspelled words or confusing words, especially terms and medications, regularly used in your work setting. Remember many medications have similar names but very different actions.

13. When documentation continues from one page to the next, sign the bottom of the first page. At the top of the next page, write the date, time and “continued from previous page.” Make sure each page is stamped with the client's identifying information.

These are the DON’T”S OF CHARTING

Don't chart a symptom, such as "c/o pain," without also charting what you did about it.

Don't alter a client's record...this is a criminal offense.

Here are the four (4) don'ts or "red flags" of chart altering that are to be avoided:

1. Don't add information at a later date without indicating that you did so.
2. Don't date the entry so that it appears to have been written at an earlier time.
3. Don't add inaccurate information.
4. Don't destroy records.

- Don't use shorthand or abbreviations that aren't widely accepted or at least not accepted in your facility. If you can't remember the acceptable abbreviation, then write out the term.
- Don't write vague descriptions, such as "drainage on bed" or "a large amount."
- Don't give excuses, such as "Medicines not given because not available."
- Don't chart what someone else said, heard, felt, or smelled unless the information is critical. In that case, use quotations and give credit to the individual who said or experienced it.
- Don't chart your opinions.
- Don't use language that suggests a negative attitude towards your client such as the words stubborn, drunk, weird, looney or nasty.
- Don't be wishy-washy. Avoid using vague terms like "appears to be" or "apparently" which make it seem as though you are not sure what you are describing or doing.
- Don't chart ahead of time...something may happen and you may be unable to actually give the care that you've charted. And that goes for charting care given by others...don't do it.
- Notes filled with misspelled words and incorrect grammars are as bad as those done in illegible handwriting. Information may be misunderstood if such notes end up in a court room.\
- Don't record staffing problems.
- Don't record staff conflicts.
- Don't document casual conversations with your colleagues.
- Don’t chart care that you haven’t performed as this is considered fraud.

- Don't use white out or an eraser...if you make a mistake, draw a single line through the entry and write “mistaken entry” rather than “error.” The word error could seem to indicate that a mistake in care, not documentation, was made. Write in the correct entry as close to the mistaken entry as possible and sign with your first initial, last name and title (Eliopoulos, 1998, p, 71). Also writing "oops,” "oh no" or "sorry" or drawing a happy or sad face anywhere on a record is unprofessional and inappropriate.

- No empty lines or spaces... fill in the empty line or space with a single line to prevent charting by someone else
- No writing in the margins.
- No mention of any incident or accident report in the medical record ... document only the facts of an incident and never write the words "incident report" or indicate that you have filed one.
- Don't use words associated with errors or ones that suggest that the patient's safety was in danger such as: "by mistake," "accidentally," “unintentionally," "miscalculated," "confusing."
- Don't name a second patient … doing so violates that patient's confidentiality. If you have to refer to a second client, do so by using the word "roommate" or the room number.

All organisations have policies and procedures related to the confidentiality of client or resident information.

Learning Activity 22:

As part of your learning journey you have learnt how to complete and maintain documentation according to organisation policy and protocols

List 5 of the basic rules for documenting in progress notes:

1. _____
2. _____
3. _____
4. _____
5. _____

List 5 of the Don’ts when documenting:

1. _____
2. _____
3. _____
4. _____
5. _____

Once you have answered this question please have your assessor facilitator check your answer to see if you are on the right track.

4.6 Store information according to organisation policy and protocols

When storing and maintaining confidential information, it is essential to keep legal requirements in mind. Ignorance of the law is never an excuse. Because legal requirements change and are often very issue specific, all workers should make it a priority to find out what the requirements are for the area in which they work.

Also, different government departments produce circulars or documents that outline the legal requirements for their staff in relation to storing and maintaining information. Your agency or department should be able to provide you with the relevant documents..

Generally, progress notes should be kept for seven years after the last entry. In some medical settings however, they have to be kept for 15 years after the last entry. Notes on people under the age of 18 years also have to be kept for 15 years after that person reaches 18.

The types of information and the ways that information can be stored are endless. It is up to workers to find out the different ways information is stored in their agency and to follow proper procedures. Systems are usually in place for a reason.

Because there are exceptions to confidentiality, it is always good practice to tell clients at the beginning of your contact with them that whatever they tell you is confidential except in the above circumstances. This means that if you do have to act to keep them safe, it is not a shock to them.

Confidentiality is not just about health records, it also applies to names and addresses of clients or residents, phone numbers and addresses of staff and volunteers, names and personal details of people who donate money or time, details of funding agreements and information about strategic planning.

Upholding confidentiality and security involves keeping information and documents in a place that can't be easily accessed by non-authorised people. Filing cabinets that are locked, rooms that are locked, passwords on computers and drawers that are locked are examples of secure spaces. Talking about clients in a private and soundproof place or not using their names are other ways of respecting security and confidentiality.

Clients must give permission, (preferably in writing), for information to be released to another person. In the case of a deceased person, consent may be gained from their executor. Where a client is unable to give consent due to an irreversible medical condition or a cognitive disability e.g. dementia, then the person's guardian may give consent.

Clients/residents have a right to view their records. Complex health records and sensitive health information such as information about treatment should only be released to the client/resident or an authorised person, by a health professional only, for example, a Nurse Unit Manager or Medical Officer should issue health information such as test results, a social worker should issue information about the results of an aged care assessment.

Judgements may need to be made about information that is damaging to the physical or mental health of the person.

When access is denied, the client/resident should be given the reason(s) for refusal and advised that the decision may be reviewed if desired.

When a client/resident disagrees with the information in the record, the client's comments should be attached as an addendum. Alterations should not be made.

For a full account of appropriate organisational policies and procedures regarding the collection, storage and retrieval of health/service records, check in the policy and procedure manual, either hard copy or on the data base.

All agencies should have guidelines in place for dealing with workers who breach confidentiality. If they don't have a specific policy for breaches of confidentiality they

should have grievance and dispute procedures in place. Most policies require a worker to either approach the person involved first or else take concerns to a supervisor or to management who will then deal with the situation.

Consequently, all staff must know about the legal aspects of confidentiality, the organisation's policies, and what constitutes confidential information. They must know what policies and procedures apply and in what situations. Training is imperative.

Remember: No information regarding the resident may be disclosed to those who are not directly involved in their care.

Learning Activity 23:

As part of your learning journey discuss as part of your role as an individual support worker, how would you comply with the organisation's reporting requirements? Give examples of your reasoning

_____

_____

_____

_____

_____

_____

_____

_____

In the service provider you work for or have worked for, how do you complete documentation according to their policy and protocols? Give examples.

_____

_____

_____

_____

_____

_____

_____

_____

How do you maintain documentation in a manner consistent with reporting requirements? Give examples of your reasoning

_____

_____

_____

_____

_____

_____

_____

_____

Once you have answered the above question, check or discuss your results or findings with your facilitator or assessor in the class.

Resource Evaluation Form

Please return to this page when you have finished working on this resource and complete this form. Your feedback can assist us to continually improve this resource.

Course Unit: CHCCCS015 – Provide individualised support	
RTO: The Learning Collaborative	**Date at finish of unit:**

	Please Circle			
Was your learning totally external, with occasional phone contact with a designated trainer/teacher?	**Yes**		**No**	
Was your learning externally supported by a study group of other students studying the same unit?	**Yes**		**No**	
How many workshops were given to support your learning? (Please circle a number 0,1,2,3)	**0**	**1**	**2**	**3**
Did your learning involve class support material at your college?	**Yes**		**No**	
Did you find this resource easy to use?	**Yes**		**No**	
Any Comments?				
Was the content useful/clear/relevant?	**Yes**		**No**	
Any Comments?				
Please comment on any ways this resource could be improved for future students				
What other resources did you find that helped you with your studies?				

Thank you for your time to give us your valuable feedback. Please give this to your trainer/facilitator/teacher who can send it to us at the address below – or if you prefer you can do it yourself.

The Learning Collaborative

PO Box 5867 Q Supercentre QLD 4218

Unit summary sheet	
CHCCCS015	**Provide individualised support**

What is the unit about?

This unit describes the skills and knowledge required to organise, provide and monitor support services within the limits established by an individualised plan. The individualised plan refers to the support or service provision plan developed for the individual accessing the service and may have many different names in different organisations.

This unit applies to workers who provide support under direct or indirect supervision in any community services or health context.

The skills in this unit must be applied in accordance with Commonwealth and State/Territory legislation, Australian/New Zealand standards and industry codes of practice.

The main outcomes of this unit are:

1. Determine support needs

2. Provide support services

3. Monitor support activities

4. Complete reporting and documentation

Evidence Requirements:

The student must show evidence of the ability to complete tasks outlined in elements and performance criteria of this unit, manage tasks and manage contingencies in the context of the job role. There must be evidence that the student has:

- used individualised plans as the basis for the support of 3 individuals

CHCCCS015	Provide individualised support

Types of Evidence (Use these codes to identify the types of evidence within the unit)		
E1 – Observation	**E2** – Third Party Evidence	**E3** – Assignments/Written/ Oral Questions
E4 – Mandatory written Papers	**E5** – Product Based Methods	**E6** - Simulation
E7- Recognition of Prior Learning (RPL)	**E8** – Professional Discussion	**E9** - Resume

Feedback Comments:		
We confirm that the evidence is authentic, all performance criteria, range and essential knowledge requirements have been met for this unit and the assessments were conducted under specified conditions		
Student:	Signature:	Date:
Assessor:	Signature:	Date:
Summative Internal Verification (Complete Unit)		
Assessor:	Signature:	Date:

Unit tracking and verification	
CHCCCS015	**Provide individualised support**

	Your Reference:							
	Observation No:	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Outcome:	Date:							
1. Determine support needs								
2. Provide support services								
3. Monitor support activities								
4. Complete reporting and documentation								
Number of Outcomes Assessed:								
Assessor's Signature:								
Interim Internal Verification (Observation of Assessor) Internal Assessor's Signature:								
Date:								

CHCCCS015	Provide individualised support
Element 1	DETERMINE SUPPORT NEEDS

Performance Criteria:	Your Reference:								Type of Evidence	Portfolio Folio
	Observation No:	1	2	3	4	5	6	7		
	Date:									
1. Interpret and clarify own role in implementing individualised plan and seek appropriate support for aspects outside scope of own knowledge, skills or job role										
2. Confirm individualised plan details with the person and with family and individual support workers when appropriate										
3. Ensure the person is aware of their rights and complaints procedures										
4. Work with the person to identify actions and activities that support the individualised plan and promote the person's independence and rights to make informed decision-making										
5. Prepare for support activities according to the person's individualised plan, preferences and organisation policies, protocols and procedures										
Number of Performance Criteria Assessed:										
The assessor and student signatures confirm the evidence is authentic **Student's Signature:**										
Assessor's Signature:										

CHCCCS015	Provide individualised support
Element 2	PROVIDE SUPPORT SERVICES

Performance Criteria:	Your Reference:									Type of Evidence	Portfolio Folio
	Observation No:	1	2	3	4	5	6	7			
	Date:										
1. Conduct exchanges with the person in a manner that develops and maintains trust											
2. Provide support according to the individualised plan, the person's preferences and strengths, and organisation policies, protocols and procedures											
3. Assemble equipment as and when required according to established procedures and the individualised plan											
4. Respect and include the family and/or individual support worker as part of the support team											
5. Provide support according to duty of care and dignity of risk requirements											
6. Provide assistance to maintain a safe and healthy environment											
7. Provide assistance to maintain a clean and comfortable environment											
8. Respect individual differences to ensure maximum dignity and privacy when providing support											
9. Seek assistance when it is not possible to provide appropriate support											
Number of Performance Criteria Assessed:											
The assessor and student signatures confirm the evidence is authentic											
Student's Signature:											
Assessor's Signature:											

CHCCCS015	Provide individualised support
Element 3	MONITOR SUPPORT ACTIVITIES

Performance Criteria:	Your Reference:								Type of Evidence	Portfolio Folio
	Observation No:	1	2	3	4	5	6	7		
	Date:									
1. Monitor own work to ensure the required standard of support is maintained										
2. Involve the person in discussions about how support services are meeting their needs and any requirement for change										
3. Identify aspects of the individualised plan that might need review and discuss with supervisor										
4. Participate in discussion with the person and supervisor in a manner that supports the person's self determination										
Number of Performance Criteria Assessed:										

The assessor and student signatures confirm the evidence is authentic

Student's Signature:

Assessor's Signature:

CHCCCS015	Provide individualised support
Element 4	COMPLETE REPORTING AND DOCUMENTATION

Performance Criteria:	Your Reference:									Type of Evidence	Portfolio Folio
	Observation No:	1	2	3	4	5	6	7			
	Date:										
1. Maintain confidentiality and privacy of the person in all dealings within organisation policy and protocols											
2. Comply with the organisation's informal and formal reporting requirements, including reporting observations to supervisor											
3. Identify and respond to situations of potential or actual risk within scope of own role and report to supervisor as required											
4. Identify and report signs of additional or unmet needs of the person and refer in accordance with organisation and confidentiality requirements											
5. Complete and maintain documentation according to organisation policy and protocols											
6. Store information according to organisation policy and protocols											
Number of Performance Criteria Assessed:											

The assessor and student signatures confirm the evidence is authentic **Student's Signature:**							
Assessor's Signature:							

CHCCCS015	Provide individualised support
Range of Conditions	

If applicable

Performance Criteria:	Your Reference:									Type of Evidence	Portfolio Folio
	Observation No:	1	2	3	4	5	6	7			
	Date:										
1.											
2.											
3.											
Enter Number of Range Items Assessed:											

The assessor and student signatures confirm the evidence is authentic

Student's Signature:

Assessor's Signature:

CHCCCS015	Provide individualised support
Knowledge Evidence	

To perform this unit successfully, you will need to know and understand;	Type of Evidence	Date	Portfolio location
The assessor and student signatures confirm the evidence is authentic Student's Signature:			
Assessor's Signature:			