KATOOMBA NEIGHBOURHOOD CENTRE

KNC Connecting Our Community

KATOOMBA NEIGHBOURHOOD CENTRE

Blue Mountains Community Support Program; Operation of Client Services Policies & Procedures

July 2015

Client Services Policies, Procedures and Forms Ratified KNC Board August 2015, BMCSP updates November 2015.

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Background

Blue Mountains Community Support Program

Blue Mountains Community Support Program (BMCSP), funded under the Commonwealth Community Home Support Program, began in 2014. It is an initiative of the Blue Mountains Lithgow Integrated Neighbourhood Network Consortium, with Katoomba neighbourhood Centre as the Lead Agency for the program. The program is administered from Katoomba Neighbourhood Centre in partnership with; Blackheath Area Neighbourhood Centre, Mid Mountains Neighbourhood Centre, Springwood Neighbourhood Centre Cooperative and Lower Mountains Neighbourhood Centre. In 2015 the program switched from the former Home and Community Care Funding to the Community Home Support Program funding and the program's name change followed.

Current status of BMCSP 2015

The Blue Mountains Community Support Program operates utilising our purpose developed continuum modeldesigned to incorporate existing funded Community Builders and CHSP services offered by the participating Blue Mountains Neighbourhood Centres, integrate the new CHSP services, and ensure that we can be flexible and responsive to our target clients as their needs change and they move along the continuum as their level of need increases.

The program targets individuals who will benefit from opportunities to access social support groups, social transport and domestic assistance services offered by the participating Blue Mountains Neighborhood Centres. The program provides client access to the domestic assistance component of the program, and works collaboratively with all participating service partners in the delivery and development of existing local social support and social transport services. These services will enable the client group to remain connected to their communities and in their home environments for as long as is possible and safe.

BMCSP services are provided in accordance with the Commonwealth Department of Social Services Commonwealth Home Support Program (CSP) Service Description Schedule for Service Types: Domestic Assistance, Social Support & Transport.

Domestic Assistance is coordinated by BMCSP and delivered by Subcontracted Agencies under service level agreements reviewed annually, Wendy's Home Care and Metro CM Pty Ltd. Agencies are selected based on local coverage, reputation around appropriate quality provision. Assistance is tailored to clients to help maintain independence in the home through help with housework, cleaning and shopping, and a range of identified domestic tasks where the client requires assistance to enable their independence.

As stated KNC enters into service level agreements with subcontracted agencies, to ensure that domestic assistance services provided to clients meet quality standards including vetting and training of staff, risk assessments, provision of high quality care services for clients and monitoring and feedback systems.

Social Support is provided through Social Inclusion groups offered at each of the five partnered Neighbourhood centres. These groups encourage social interaction, community involvement and connection, and are diverse in the types of support they offer and specific interest groups or special needs groups they cater to. Groups are facilitated and supported

by paid staff, sessional workers and or volunteers. Each social inclusion support group at individual sites will have a coordinator appointed to oversee these programs.

Social transport services provided by the BMCSP are targeted to existing clients of social support groups, social inclusion activities or programs in each of the partner neighbourhood centre's geographies. Social transport is provided to identified clients to enable them to access existing social inclusion groups and maintain connection to their community. Transport options for clients include subsidised taxis, transport of clients using vehicles owned by partner organisations, transport of clients by volunteers of partner neighbourhood centers using their vehicles and subsidised bus trips for social group events.

BMCSP funding enabled the establishment and support of social inclusion groups broadening the range of activities and experiences available to members to include structured groups, subsidised group outings, education opportunities, guest speakers, and recreational opportunities.

By working collaboratively with the BLINN consortium, BMCSP is able to deliver outcomes for CHSP eligible vulnerable aged community members enabling them to achieve optimal quality of life, remain connected, supported, safe and healthy within their communities.

Operation of Client Services

Carer Support Plan

CIARR

Client Consent Form

Client Agreement

Client Care Plan

Client Satisfaction Survey Instruction and Analysis Guide

Client Satisfaction Survey

Client Service Procedures and Checklist

Feedback Form

Guidelines for Advocate

Notification of an Advocate

Phone and Home Safety Checklist

Pictorial Client Satisfaction Survey

Priority Rating Scale

Service Acceptance Letter

Service Eligibility Checklist

Social Support Groups Registration form

Service Delivery Model

Client Services Policy #001.1

1.0 POLICY STATEMENT

The purpose of this policy is to establish the over-arching parameters and frameworks to ensure our operational service models are planned, developed and delivered with a primary focus on achieving positive client outcomes individualised against their individual goals and consistent with Katoomba Neighbourhood and other participating Neighbourhood Centre's Quality Objectives.[i] When the culture and focus of the organisation is on clients, then it becomes a strategic priority for opportunities to be created and nurtured for client/carer engagement at all levels.

Management and staff are expected to come from a culture that enables clients and carers to determine their goals, supports and encourages personal choice and self-determination around care decisions, enables independence through embracing the concept of dignity of risk in delivering client focused services, enables access to information required by clients and carers to make informed decisions and choices around their care, and continually reinforces mutual respect and valuing of client contributions, both through more formal roles and through regular informal contact and feedback. Through really listening to clients' expressed needs concerns and fears, we can utilise this information to identify issues and plan improvements to ensure our services are flexible and responsive to individual needs, goals and preferences.

When there is mutual trust and respect in a relationship, there is an increased willingness to participate. When action is taken on their feedback, clients are further motivated to participate, as they understand their opinions and expressed concerns will influence our on-going service planning and development. We therefore view the creation of trusting interpersonal relationships as the cornerstone of our service delivery model.

2.0 SCOPE

This policy has application for the planning and delivery of all programs and services of Blue Mountains Community Support Program. The aim of the Blue Mountains Community Support Program is to enable an individual's ability to continue living independently at home as their care needs intensify. Support is provided through the provision of domestic assistance services, support to maintain social connections within the community through enabling transport services and social inclusion. The program supports CHSP eligible clients who are at risk of premature entry to residential aged care as their support needs change, specifically risk factors such as:

• Low income;

• Living alone, limited social supports;

• Lack of access to transport;

• Poor mobility & or limited ability to carry out basic domestic tasks ; and

• Poor health status including poor cognitive functioning.

The aims of the BMCSP program are achieved by providing domestic assistance support to maintain the clients in their home environment by assisting with basic domestic care; facilitating transport needs to enable the client to continue to access established social networks and participation in meaningful and enjoyable activities which are appropriate to the individual's needs, interests and abilities. BMCSP strives to achieve the following outcomes for clients of the service:

• Clients actively engage in directing their own care needs and developing their own goals of care

• Clients can remain living in their own home as independently as possible connected to their community;

• Their quality of life is maintained or enhanced;

3.0 BMCSP SERVICE ELIGIBILITY

BMCSP is a CHSP program (formallyHACC) and is an eligibility-based program. The CHSP program targets those over 65 years of age with specific care needs to be maintained safely within their community environments.Program eligibility includes the following:

♦ A frail older person living in the community who is aged 65 years and over, or 50 and over for Aboriginal/Torres Strait Islanders; AND

♦ Requires assistance with activities of daily living to remain living independently within their own home and the community; AND

♦ Requires assistance due to a long term issue and not an acute issue; AND

♦ Requires a CHSP service type (e.g nursing, allied health, domestic assistance, personal care, meals or transport); AND

♦ Is not eligible for provision of the service from another funding source, for example Department of Veteran Affairs, Workers Compensation or Life Time Care and Support.

4.0 PHILOSOPHY

The philosophy guiding the operation of all Blue Mountains Community Support Program client services is based on our commitment to a client-focused service delivery model. It acknowledges that the clients of our services are central and consequently all service planning, design and development activities should be focused on how to best meet their individual needs and cited goals to facilitate improved independence, community connections and quality of life.

BMCSP aims to provide a caring, effective and accountable service for all people who meet the CHSP guidelines, as identified above, withinthe Blue Mountains Local Government Area. The philosophy underpinning service provision includes:

- Recognition that the needs of clients and carers may change over time and that a regular review of individual service provision, and client and carer consultation and feedback is essential to ensure ongoing service relevance against the clients' individual goals.

- Where clients and/or carers have concerns in relation to BMCSP, their right to make a complaint and have it dealt with fairly, promptly and confidentially without impact on their service or treatment, is supported by BMCSP.

- The belief that clients and carers have the right to access an advocate to represent them and will support and encourage this, when requested.

- Engagement of quality accredited subcontractors to provide domestic assistance services to clients, who are compliant with adhering to all required criminal record checks and insurance requirements.

  Accountability to funding bodies, service partnersclients and their carers.

5.0 PROCEDURE

Referral for Service and or Information

- Referral for BMCSP or an allied CHSP service provided by Blue Mountains Neighbourhood Centres and available to individuals can come from the individual themselves, community members, carers, families, friends and other service providers. As implementation of the My Aged Care system is rolled out, referrals will come primarily through the My Aged Care system.
- Where a referral for services comes from any source other than the client themselves consent must be gained from the individual being referred for service, or their elected guardian or advocate, before the referral for service is enacted.
- Verbal consent to enact the referral from the individual or via their elected guardian or advocate is acceptable to commence the process, including the initial phone

contact, client assessment and home visit. Receipt of the verbal consent must be recorded on the CIARR or Social Support Group Registration/Referral form.

- Signed consent is preferred on the client agreement and care plan, however where the individual is unable to sign, verbal consent is acceptable. The Coordinator/worker undertaking the assessment must sign indicating verbal consent and why verbal consent has been taken.
- Information can be supplied to any individual making an enquiry; individuals may be referred from the Coordinator or KNC Intake worker to other appropriate services or sources of information appropriate to their expressed need.
- At point of referral the client will be initially assessed, usually over the phone, using the fields contained within the Blue Mountains CHSP program Social Support Group registration form, or the CIARR in the case of BMCSP and Blue Mountains Domestic Assistance and Social Transport clients.
- At this point the client or referrer will be advised of the purpose of the assessment, any relevant, requested or required literature or information will be provided over the phone, posted where applicable or they will be directed to relevant service organisations or websites e.g. My Aged Care.
- This initial assessment will cover:-
    - Relevant personal details,
    - Why assistance is being sought
    - Services or family/ community supports currently being received (i.e. church,
    - Health information,
    - Home & safety and access issues,
    - Client carer needs and referral actions required
    - Other relevant information
    - Priority assessment rating scale
    - Rights and responsibilities if felt appropriate at this point, otherwise this will be discussed at the first face to face visit
- At the conclusion of the initial phone assessment, a time will be made with the client and or carer for a home visit to be conducted where the full assessment will be completed and all relevant service literature provided e.g. Blue Mountains Community Care Guide, the Domestic Assistanceflyer and the BMCSP Client Handbook
- Depending on service availability within the BMCSP program, all referrals will undergo a priority ranking process to determine which referrals are of greatest need to receive service as the priority, and to guide the booking of home assessment

visits by the relevant Coordinator. Priority assessed need will be undertaken the CHSP Intake worker at point of intake, when multiple referrals are received for service (see attached Client Priority Rating Scale designed to provide an indication of the relative needs of each client, based on the completed individual assessment).

- The Priority Rating Scale assessment process is designed to indicate levels of need and involves:-
    - Brief assessment of function
    - Brief behaviour assessment
    - Brief assessment of cognitive function
    - Brief assessment of social needs, levels of social isolation , community connection
    - Indication of required supports in the event of natural disaster or emergency

The priority rating scale is preferably undertaken on the initial phone assessment when demand for service is high therefore availability may be impacted.

- CHSP eligibility applies for the Blue Mountains CHSP program/BMCSP Social Support groups. In line with Home Care Standards, participants are required to complete a Blue Mountains Social Support Group Participants Registration form. Completion allows each Coordinator to have the minimum amount of client data recorded to ensure

Independence, Autonomy and Inclusion

- Clients will be assessed to determine individual needs, and any service provided will occur in consultation with the client and carer, advocate or guardian where appropriate. The needs of each client are recognised as being individual, and options for service delivery will be provided based on these expressed individual needs and cited goals.
- The service respects the client's desire to remain living in their own home as independently as possible, and the service will aim to facilitate or assist the client and carer to maintain links with the broader community.
- The service enables independence through embracing the concept of dignity of risk in delivering client focused services
- BMCSP believes that each individual has the right to privacy and confidentiality, and that service delivery must occur to ensure respect of the individual and maintenance of their dignity.

- All workers (paid and unpaid) are required to sign confidentiality agreements to ensure maintenance of clients privacy and that client information is held in confidence[1]
- Education and training and the Organisational expectations of volunteers and paid workers, related to privacy and confidentiality is covered in the relevant service induction and orientation processes, and relevant Organisation's policies and procedures
- All client records are held according to the relevant standards covering client records and documentation

Client Goal Directed Planning

- BMCSP believes that clients and carers have the right to make choices in their lives, including choosing the appropriate services from a range of options which will assist them to maintain a quality of life and level of independence which is appropriate for them. The service respects the right of each individual to determine how they will live their lives and the service BMCSP can provide is aimed at assisting them to achieve this.
- Through the assessment process, clients and carers choice and self-determination around their care decisions and goal setting forms the basis of the individuals' care plan (client or carer)
- Client independence is enabled through the concept of dignity of risk in goal setting and developing a client centred plan of care. All relevant information is supplied to clients around their cited needs, through the assessment process, to facilitate them to make informed decisions and choices around their care.
- The process of goal directed planning is a facilitated process between the coordinator/worker undertaking the assessment, the client and or the carer. The client care plan reflects the client/carers goals.

Blue Mountains Community Support Services

Social Support Groups

- Social support groups are a service provided by BMCSP and or the Blue Mountains Neighbourhood Centres participating in the CHSP programs. The individual social support group is encouraged to take shared ownership of the group, group members are encouraged to be involved in the development of the group, input around group activities, frequency of meetings, group purpose, and where appropriate group membership. The level of participant involvement in the activities, form and function of social groups will differ depending on the nature and purpose of the group and the capacity of group participants. Wherever possible, participants are encouraged to determine the group's direction.

[1] It is acknowledged that each Blue Mountains Neighbourhood Centre with a relevant service may have differing confidentiality and privacy agreements and procedures, all are however required to comply with the Home Care Common Standards.

Social Transport

- Social transport is provided to enable access by existing, registered clients to current social support groups operating out of partner neighbourhood centres.

- Social Transport is provided in two ways:
    - 1:1 transport by taxi, volunteer or in the KNC vehicle to enable a client to participate in social inclusion activities or a specific social support group
    - group outings for social support groups in a chartered bus, or the KNC vehicle for small groups
- 1:1 Social Transport can be provided to clients sporadically, as required by the client, or on a regular basis, subject to available resources.
    - Access to the Social Transport programme is by way of:
    - referral by a service coordinator
    - identification of client need at intake
    - direct referral from My Aged Care
    - client request,
    - eligibility is then assessed using the CHSP criteria as applies to clients of the Domestic Assistance programme.

- Client contribution for 1:1 Social Transport is $5 per trip. Clients will not be refused service on the basis of inability to pay the client contribution.
    - Kilometre radius:
    - For 1:1 transport provided volunteers and in the KNC vehicle, a maximum 20km one way trip/40 km round trip applies.
    - For 1:1 transport provided by a taxi, a maximum of 5 kms one way or 10 kms round trip applies

- Group outings will be organised by the relevant service coordinator at the participating neighbourhood centre, based on planning done with the members of the social support group.

- Taxis will be organised through the relevant local provider aligned with each participating neighbourhood centre. For Upper Mountains clients (Wentworth

Falls to Mt Victoria) taxis are organised through Katoomba-Leura Radio Cabs, who are a trusted source provider.

- Chartered buses will be organised through an accredited service provider, such as Smartlink Transport to ensure all quality service provision requirements are guaranteed.

- Social Transport clients receiving 1:1 transport must complete a Client Registration form and CIARR. Clients accessing group transport in chartered buses need only have a Client Registration form as per their Social Support group registration.

Domestic Assistance

Client Referral

- Client referred by any one of the Neighbourhood Centres or Trusted Sources
- Client self-refers to program
- MAC referral

Intake

- KNC Intake confirms client/carer eligibility for program as per the Client Services Policy
- If a client/carer is not eligible for program client is referred to a different service and/or provided with appropriate information regarding available services
- If service place is not available for client they will be placed on Wait List and recontacted in two months regarding service availability to check ongoing interest in service if domestic assistance has not commenced in the interim
- Client/carer gives verbal consent for information sharing and this is noted in the client CIARR
- Written consent relevant to the specific care plan and agreement will be sought from the client/carer/advocate following assessment
- CIARR completed with or by either referring party or directly with client/carer/advocate
- Phone Home Safety Check completed with client on the phone and provided to Coordinator or relevant staff member undertaking initial home visit
- If Phone Home Safety Check identifies safety risks/concerns the Risk Assessment Analysis is conducted consultation with the Coordinator
- In negotiation with client times for home visit assessment are identified
- BMCSP Coordinator or relevant staff member is advised of available times for home assessment visit

- BMCSP Coordinator or relevant staff member is responsible for scheduling home assessment visit
- For the purpose of managing the available spaces and hours for service the client's place of residence is matched to the appropriate BMCSP Program site
- Where the service being sought requires a co-contribution the relevant working taking the referral identifies that there a client contribution provision.
- Client is advised by intake that inability to make a contribution to the service will not impact their eligibility to receive the service
- At intake the client is informed that a baseline level of information may be recorded and kept in line with policy and merged into the client file upon commencement or acceptance of the service. In the event the service is not provided the note will be filed for a period of 12 months.
- Every 12 months the inactive client records are reviewed and destroyed if appropriate

Client documentation

- CIARR completed at intake and forms the basis for the client information and data contained within the client file
- Original CIARR form printed and placed into client file located in locked cabinet
- Client information entered into Pynx database
- Client information entered into Pynx forms the basis for the MDS Report to DSS
- Client file created for BMCSP Program clients contains: CIARR, Service Eligibility Checklist, Phone & Home Safety Checklists, Assessed priority ranking scale, Client Care Plan, Carer Support Plan (where appropriate), Client/Carer/Advocate Signed Agreement and Consent, Notification of Advocate (where appropriate) Client Services Procedure and checklist, and any other relevant documentation.

Provision of client services

- BMCSP Coordinator visits client's home and undertakes assessment to identify client needs and goals and have program and costs explained
- Full Home Safety Check completed during home assessment
- Client provided with service information pack
- Client advised of complaints procedure
- Clients provided with of their rights and responsibilities
- Client care plan developed with client and BMCSP Coordinator
- Client risk management plans developed as required
- Client feedback form provided to referring party upon commencement of service

Wendy's/ Metro Referral

- BMCSP Coordinator refers client to Wendy's or Metro via email and phone call
- Client contacted advised regarding commencement of service
- If required referring service updated regarding outcome of assessment and service delivery to client

Monthly client billing

- Finance provided with approved invoices for payment
- Finance provided with accompanying letter for attachment to client invoice for co-contributions owed

Service Review

- Reviews are conducted bi annually by the BMCSP Coordinator for review of individual goals and care plan
- Client satisfaction surveys are conducted annually with clients/carers using the BMCSP client satisfaction survey, results are collated and used to improve servicedelivery

- CHSP eligibility applies for the Blue Mountains CHSP program/BMCSP Social Support groups. In line with Home Care Common Standards, participants are required to complete and or have their details recorded on either a CIARR and or a Blue Mountains Social support Group Participants Registration form, depending on the services required.

Culture, Customs and Beliefs

- BMCSP will provide services that are non-discriminatory, non-judgmental and non-biased, accepting each person's right to individual religious, cultural and political beliefs. The service needs to be provided in a manner which will make people from a range of backgrounds and dispositions feel welcome and comfortable. All subcontractors are required to also adhere to this service criteria.
- Clients will be given information on their rights and responsibilities when being assessed for service or request service information. The rights and responsibilities information is located in the client handbook and reflects the need for service to adhere to best practice around culture, custom and beliefs and how to make a complaint in the event a participant or client feels this is necessary.

Participation

- Clients and carers are the focus of the service. The service exists to meet the needs of the client and carer and each client and carer is an individual with different needs determined by various factors and lifestyles.
- Client and carer feedback is actively encouraged formally and informally. Formal bi-annual service reviews are undertaken by the BMCSP coordinator for current clients

receiving domestic assistance or discreet social transport services. If a biannual review is unable to be attended, an absolute minimum is an annual service review.

- Arrangements for the biannual review are made with the client directly by the Coordinator.
- Client Care Plans (see attached Care plan template) are developed for each client that identify and respond to their particular preferences and needs. These may include the physical, emotional, cultural, religious and or social economic needs and preferences of the client. The care plan is developed with the client and reflects and directs their goals of care. A copy of the care plan is provided to the client and kept on file.
- At the bi annual review the care plan will be fully revised and amended where necessary to reflect the client and carers current needs. The new care plan will again be provided to the client and placed on file.
- Formal feedback is also actively sought from both clients/carers and where appropriate volunteers providing service. Client and carer satisfaction surveys are attended annually (see attached survey templates). Feedback is also obtained from volunteers through an annual review process
- The feedback obtained from these processes informs the BMCSP annual planning review.
- Carers, clients and volunteers have the opportunity to apply as representatives on the relevant BMCSP's and or Neighbourhood Centres service Advisory Group(s).
- Informal feedback mechanisms include support meetings and individual phone calls.

Information Provision

- Clients and their carers assessed for the BMCSP service are provided with information to assist them make decisions about service provision. This relates both to the service BMCSP can provide and information relevant to other services available in the community.
- Clients are assessed using the CIARR Assessment Form; this incorporates information about other service providers and includes referral action as part of its process.
- Other client information actively provided to BMCSP clients include:-
    - the BMCSP service brochure,
    - BMCSP Client handbook,
    - The Blue Mountains Community Care Guide produced by Blue Mountains City Council which includes information on CHSP transport services, food services, dementia support services, the Aged Care Assessment Team and how to access services such as Commonwealth Carelink and Carer Respite Information Line.
    - Provision of links to the My Aged Care website and the contact phone number.

Special Needs

The following general strategies are utilised to ensure special needs are met:

- BMCSP ensures it is up-to-date with the demographics of special needs groups in the Blue Mountains by reviewing the relevant demographic profiles e.g. BM Community Profile, Tri-Community Multicultural Carer Profiles and actively engaging in KNC planning processes and analysis of emerging trends.

- BMCSP ensures that clients and carers who request or require an advocate or guardian are supported in gaining access to one (refer Client Advocacy Policy).

- Clients and their carers are provided with information to assist them make decisions about service provision. This relates both to the service BMCSP can provide and to other services available in the community. The CIARR Assessment Form incorporates information about other service providers and includes referral action as part of its process. Some examples of other client information provided includes the BMCSP service brochure, Client handbook, the Blue Mountains Community Care Guide produced by Blue Mountains City Council which includes information on CHSP transport services, food services, dementia support services and the Aged Care Assessment Team. Clients may also be referred to the My Aged Care website, Commonwealth Carelink and Carer Respite Information Line.

- Client Care Plans are developed for each client that identify and respond to their particular preferences and needs. These may include the physical, emotional, cultural, religious and or social economic needs and preferences of the client.

- A bi- annual client review is conducted by the BMCSP Co-ordinator with the client and this provides an opportunity to review and assess whether the client's needs are being met, and whether there are changing support needs and referral requirements to other services (for details, refer Ongoing Service Provision PolicyOperation of Client Services Manual).

- Details on the special and specific needs of clients are collected as part of the standard information requested on the CIARR Form. This data is analysed using the Minimum Data Set (MDS) and the Data Exchange requirments into the future, which then informs the BMCSP's planning and evaluation process

Addressing Barriers to Access

BMCSP has developed specific strategies to overcome access barriers for special needs groups. These strategies are outlined below.

Culturally and Linguistically Diverse Clients

- BMCSP has access to and ensures CHSP brochures that have been produced in various community languages are available at strategic locations in the local community.

- BMCSP has obtained and utilises the CHSP CALD Resource Manual, as required. A CALD resource manual developed by Tri Community Exchange is also available.

- In cases where the client does not speak English, an interpreter service will be used to ensure that the client understands the assessment and review processes, and the services available or being offered. The need for an interpreter service will be clearly identified on the client's file. The interpreter service's phone number is also provided for easy access on the back of the Client Handbook, which is given to clients at the initial meeting

- Cultural safety issues will be included in relevant staff and volunteer training.

Links are made with the Multicultural Resident's Association and other local CALD groups and communities, as appropriate, to assist when necessary with the needs of clients and or carers from specific cultural and linguistic backgrounds

Aboriginal and Torres Strait Islander Clients

- BMCSP endeavours to provide Aboriginal clients with culturally appropriate service contact and will seek guidance, advice, training and support from releavant Indigenous services e.g. the Aboriginal Culture and Resource Centre, Katoomba to ensure this occurs.

- Clients will be advised of the availability of ATSI specific services and where requested, client referrals will be made to CHSP services at the Aboriginal Cultural and Resource Centre (ACRC) at Katoomba and to the 'Healthy for Life' program, and other relevant local Indigenous services and programs.

Clients with Dementia, Memory Loss and other related conditions

- The BMCSP Coordinatorand workerswill receive training in how to support people with dementia or specific disabilities (where possible and as resources allow) and every effort made to ensure that services are delivered in an appropriate and sensitive way.

- For people with severe dementia, severe intellectual or psychiatric disability or brain injury, BMCSP will ensure that the carers, advocates and/or guardians are fully aware of the contents of the Client's Handbook and that they are aware of the information regarding assessment, review, client care plans and services. However, to whatever extent possible, the client should also be given the same information and their questions answered.

- BMCSP will liaise with local services related to special needs e.g. Dementia Specific Day Care Programs, Dementia Carers Group, when required or requested.

- In cases where a client cannot read or write, the BMCSP Co-ordinator will ensure that the information in the Clients Handbook and information regarding the assessment,

review, client care plan and services are clearly explained and understood by the client. Audio tapes/CD from Vision Australia are also available for use by people who have visual impairment.

- For people who have physical impairments that restrict their movement, most social support is offered in the client's home. The BMCSP offices, however, are located in accessible buildings, providing access for clients with disability or mobility issues requiring mobility aids to the administration offices, meeting rooms, toilets and Neighbourhood Centre reception.

Client Contributions

- Client contributions are requested for the Blue Mountains CHSP program service types Domestic assistance and Social Transport.
- No client will be refused service for inability to meet a requested client contribution.
- Clients will be billed directly for any agreed to client contribution for Domestic Assistance or social transport services
- To ensure financial equity of access for all clients, BMCSP does not charge a fee for client participation in social support groups.
- A client contribution will be requested for attendance at a special social event outside the routine service delivery parameters

Service Access

Client Services Policy #001.2

Katoomba Neighbourhood Centre's Access and Equity Policy applies to Blue Mountains Community Support Program. Please refer to the KNC Manual for full policy details. Below outlines specific policies and procedures that must be met by the service in relation to that policy.

1.0 POLICY STATEMENT

The purpose of this policy is to ensure that each client's access to a service is based on program eligibility, equity and relative need,available resources and the capacity of the Blue Mountains Communty Suport Program to respond.

It is the policy of Blue Mountains Community Support Program that clients and/or their carers or advocates participate in entry and care planning consultation processes and be given all relevant information to assist them in making informed choices from available service options.

2.0 SCOPE

This policy applies to all programs and services of Blue Mountains Community Support Program.

3.0 DEFINITIONS

Eligibility refers to the specified criteria for access for each program type, as determined by the relevant funding agreements.

4.0 PHILOSOPHY

This policy reflects the commitment of Blue Mountains Community Support Program to the social justice principles of equity and access and the application of these principles organisation-wide to eliminate any form of discriminatory practice. It acknowledges our social and ethical obligations to all clients and prospective clients to respect their individual human rights to be treated with equality and dignity.

5.0 PROCEDURES

Eligibility for Entry

BMCSP is a CHSP program and is therefore an eligibility-based program.
Program eligibility includes the following:

♦ A frail older person living in the community who is aged 65 years and over or 50 and over for Aboriginal/Torres Strait Islanders; AND

♦ Requires assistance with activities of daily living to remain living independently within their own home and the community; AND

♦ Requires assistance due to a long term issue and not an acute issue; AND

♦ Requires a CHSP service type (examples include nursing, allied health, domestic assistance, personal care, meals or transport); AND

♦ Is not eligible for provision of the service from another funding source, for example Department of Veteran Affairs, Workers Compensation or Life Time Care and Support.

Therefore, clients must be considered CHSP eligible to receive BMCSP services or services operated by the Blue Mountains CHSP Program. Eligibility for services is based on the level of functional needs and or disability the individual is living with. Program eligibility includes the following:

- The client is living in the community
- They are a frail older person (over 65 years of age, 50 years for ATSI clients), who finds independent living difficult, specifically related to:-
  - performing the tasks of daily living without help or supervision (i.e. dressing, preparing meals, house cleaning & maintenance, using or accessing public transport),
  - engaging in social activities and maintaining community connections
  - accessing information and or referrals to other services or supports, due to their disability and or frailty and resulting isolation
- Their capacity for independent living is at risk or they are at risk of premature or inappropriate admission to long term residential care
- They are assessed as having basic needs requiring maintenance & support services within the scope of the CHSP (formally HACC program) to be maintained safely in their home
- This service is also available to carers. Carers are defined as the family members or friends who assist the older person or the person living with a disability to live independently

If the client is found to be ineligible for a particular BMCSP service, and ineligible for other CHSP services offered through Katoomba Neighbourhood and other participating partner Neighbourhood Centres, the client will be provided with relevant information about other services that may be able to assistthem. Intake staff may assess it as necessary to facilitate referral to other appropriate services on behalf of the client/carer.

The program also recognises that there are several groups within the CHSP target population that find it more difficult than most clients to access services. These special needs groups are:

- People from culturally and linguistically diverse (CALD) backgrounds;
- Aboriginal and Torres Strait Islanders;
- People with dementia;
- Financially disadvantaged people; and
- People living in remote or isolated areas.
- People from the LGBTQ community

Prioritisation

Priority for access to services is based on the clients level of need, relative to other people referred for the same service. Priority for available services will be given to those clients with the highest level of need. The service uses the ”Assessed Priority Rating Scale” at the point of referral to determine each client’s priority. If a client is placed on a waiting list, they will be kept informed regarding their progression on that list, and when they can expect their service to commence.

The following factors will be used to determine relative need:
Client’s situation

- The family support structure which is available to the client, and the realistic level of assistance available from family members;
- The client’s living arrangements, considering if they live alone, or with a carer, also assessing the needs of the carer;
- The client’s ability to carry out normal daily living tasks, and the degree of difficulty they may have;
- The client’s social contacts, the extent to which assistance is provided by other individuals and how reliable or appropriate this assistance is;
- Whether the client is socially or geographically isolated;
- Whether the client is financially disadvantaged;
- Other services in place such as Home Care packages.

Carer’s situation:

The relative need for a break for the carer will be based on the following factors:

- Is the carer caring for a person with a severe disability?
- Is the carer the sole carer?
- Does the carer have limited support networks or have dependent children?
- Is the carer frail, ill, stressed or does he/she have a disability?
- Does the carer have extensive commitments which may include employment?
- Is the carer socially or geographically isolated?
- Is the carer financially disadvantaged?
- What are the general health needs of the carer, including emotional health?

Other factors - When considering the level of need of each request for assistance, the following factors will also be taken into consideration:

- The difference the service will make to the person's circumstances;
- The availability of other appropriate services which could meet the client's needs. It should be noted that clients who are receiving other services, whether from CHSP or not, are not discriminated against, based on their access to these other services.

BMCSP's assessment of clients and carers is currently undertaken using the Client Information and Referral Record Form (CIARR). Client information gathered on the CIARR form includes social and family details, relevant health details, home safety and access issues, individual client / carer needs, referral actions and client consent section. At the point of assessment, carers of a CHSP eligible client will be offered referral to appropriate carers or available support groups locally e.g. Men's Carers and Men's Group, Dementia Support groups.

It must be noted that when a client is requesting re-entry to the service this is handled as a new referral/assessment and decisions are made based on current prioritised needs. If a client has previously been refused a service, this will not prejudice future attempts to access BMCSP services. Again, this is treated as a new referral, and decisions are based on prioritised need.

Initial Home Visit

When eligibility has been determined, the client will be contacted to make an appointment to visit with the potential client and his/her carer, family member, advocate or support person.

Information will be provided to assist the client through the service entry process, including their right to have an advocate or support person present, and how they may access an advocate. The initial consultation visit will be planned as soon as it is feasible and convenient for the client and his/her nominated primary carer/advocate.

Inability to Respond

Where it is determined that Blue Mountains Community Support Program cannot provide a service due to inability to respond effectively, capacity issues or the client's ineligibility for service, a referral to other more appropriate services will be discussed with the client and/or carer/advocate, and written information will be provided on alternative service and support options. In the provision of information, consideration will also be given to addressing the needs of the carer. When requested, referrals will be made on the client and/or carer's behalf (see also *Referral Protocols)*.

Reasons for refusal of entry are to be explained to the client and documented on the assessment record.

Referral Protocols

Once eligibility has been determined, the relevant Service Coordinator or, at the point of intake if appropriate, the Blue Mountains Intake Worker, are to ensure that all incoming and outgoing client referrals are recorded on the CHSP Program Client Referral Record .

The *Referrals Register* will record:

- The date the referral was received
- The source of the referral
- The date of home visit/assessment
- Identified special needs
- The priority needs rating
- The date services actually commenced
- Outgoing referrals made on behalf of the client
- The date the outgoing referral/s was made
- The due date for client follow up/review/reassessment

Entries are to be monitored against the anticipated response times identified in this policy (see also *Response Times)*. Any identified timeline deviations are to be analysed to determine whether patterns are arising that represent a reducing capacity to respond as a result of increasing demand, with results reported to management to inform on-going service planning.

No incoming referrals will be accepted without the express consent of the potential client/representative.

Referrals made by Blue Mountains Community Support Program to other service providers and agencies may only be made with the client's informed consent. Consent to share information in the form of referral to other services at the point of intake, or registration is to be indicated on the CIARR. Once a client has been assessed and is receiving service, signed client consent form (see Client Consent), is required before referral can progress.

Where regional protocols have been established for internal or trusted source use for support & care coordination, those protocols are to be followed.

Response Times

When a client has been referred to Blue Mountains Community Support Program it is anticipated that an initial contact call to the client will be made within 3 working days and that the home visit/assessment will be conducted within two working weeks of initial contact, or as soon as is convenient for the client. In the event the relevant Service Coordinator is on leave and not replaced, the client, their carer or representative will be given the expected return date of the Coordinator and informed that contact will be made

within 3 days of their return to work. The client and their representative will be given the CHSP Intake phone number and asked to call if their needs change during the period of Service Coordinator leave. At this point any appropriate referrals to other services will be made. If the period of leave is in excess of one moth, the KNC Intake worker will contact the client,

The anticipated response time for actual commencement of Blue Mountains Community Support Services will be determined by the Priority Rating allocated as a result of the assessment. It is expected that service delivery for clients with a rating of 2-3 (extremely urgent or urgent) would be initiated within 5 days (1 week) of the home visit/assessment. Clients with a rating of 1-2 (moderate need) should expect services would commence within 2-3 weeks of the home visit/assessment if an appropriate service resources is available.

Clients with a zero priority rating (non-urgent) may be placed on a waiting list. Clients placed on a wait list will have phone contact made with them monthly wherever possible and formal letters confirming their status on the waitlist each 3 months., to keep them informed of their progress on a waiting list. Once a client reaches 12 months on the waiting list they will formally notified that they have been removed from the list and encouraged to recontact MAC.Alternative support service options are to be discussed with each client on a waiting list for whom access to services within 3 months is unlikely. With the client's consent, every effort is to be made to refer the client to alternative support services for the short-term.

The Right to Refuse

Any potential client has the right to refuse an offer of support from the BMCSP Services, such a refusal will not prejudice any future attempt to access any of Blue Mountains Community Support Program or any relevant Neighbourhood Centre general services or CHSP program services.

Should a client refuse care, the relevant BMCSP Service Coordinator or the KNC Intake worker is to contact the referring agency and explain the reason for refusal of service. The CHSP Program Client Referral Record will reflect that the client refused service & the date of refusal. The refusal of service by the client will also be noted in either the initial intake/assessment record or the clients file.

In the event a client's needs progress beyond the ability of BMCSP or the Blue Mountains CHSP program to adequately provide basic service to the client, the relevant Service Coordinator will discuss with the client and or carer/representative referral to more appropriate services for their level of need. The relevant Service Coordinator will also clearly identify through review of the client's care plan with the client, the level of care that can be offered under their existing program. A notation of the client refusal is to be made in the client file.

Where a client's care and support needs escalate beyond the capacity of the respective program to respond, or impact on Blue Mountains Community Support Program' compliance obligations for ensuring worker safety, Blue Mountains Community Support Program reserves the right to refuse or withdraw services to that client.

Service Interruptions or Closure

Where a client is temporarily absent from home in hospital, overnight respite or on holiday, the agreed service support hours will be held and reactivated on the client's return, provided that the client has provided Blue Mountains Community Support Program with appropriate notification.

If the client is absent for a period of more than six weeks, a formal reassessment will be undertaken in consultation with the client and his/her carer/advocate/representative , to decide what continuing services, if any, may be required.

Should the client's care needs change to the extent that the current program can no longer provide the level of care and support needed, a review will be undertaken by the Blue Mountains Community Support Program Service Coordinator in consultation with the client and his/her carer/advocate, to discuss alternative care and to provide the client with information about more appropriate support options.

The Right to Appeal

During each individual assessment and review meeting, clients will be informed of the services Blue Mountains Community Support Program agrees to provide with the care plan reflecting the agreed to services and activities, and the circumstances in which the agreed service/s may need to change. Clients will be informed that should they wish to appeal a service provision decision about service changes or closure, the procedures for raising a complaint are to be followed.

Assessment and Review

Client Services Policy #001.3

1.0 POLICY STATEMENT

The purpose of this policy is to ensure that each Blue Mountains Community Support Program client participates in assessment and review processes that are appropriate and responsive to their individual needs, respectful of their individual rights, and encourage maximum independence and autonomy.

Holistic approaches will be adopted in conducting assessments, which acknowledge the interdependence of socio-economic, psychological, physical, cognitive and environmental indicators in determining individual wellbeing, as well as the role and place of the individual's culture, customs and beliefs.

2.0 SCOPE

This policy applies to all programs and services of Blue Mountains Community Support Program.

3.0 PHILOSOPHY

In supporting our individualised, client-focused service delivery model, the community development principle of empowerment drives our operational practices. In accordance with this philosophy we will act to ensure clients and/or their carers/advocates are provided with relevant and appropriate information to enable them to make informed choices from the service options available to them, and that assessment and review processes are conducted in a manner designed to facilitate participation in decision-making processes.

4.0 PROCEDURES

Individual Needs Assessment

Clients will be assessed to determine individual needs, and any service provided will occur in consultation with the client and carer, advocate or guardian where appropriate. The needs of each client are recognised as being individual, and options for service delivery will be provided based on these expressed individual needs.

Holistic client assessments are undertaken by appropriately trained staff. The assessment tools and processes used will reflect the specific needs and cited goals of the individual client and the requirements of the relevant program guidelines. Specialised assessments will be conducted as required to clearly identify the individual care needs and level and type of support required. Should this involve referral to external clinical specialists, a written consent is required to be obtained (see the attached Client Consent form). Approved assessment tools are considered to be controlled documents, accessed by staff

responsible for conducting assessments. These documents are version controlled and cannot be altered without administrator approval and access

Each individual assessment forms the basis for determining the relative needs and priorities of the client. The Priority Assessment Rating Scale is to be completed, using the assessment information. The "Priority Rating" allocated as a result of this process will determine the frequency and composition of services which may be offered, and is to be recorded in the *CHSP Program Client Referrals Record.*

Client Representatives

All clients are to be encouraged to have a representative/advocate or a support person with them during the home assessment. When conducting the individual assessment in the client's home, the relevant Service Coordinator is to also consider the needs of the primary carer, and in consultation with him/her, plan a range of agreed support strategies which may include referral to other services, these needs will be noted in the Carer Support section of the Client Care Plan. Carers with more complex needs due to their circumstances or the complexity of their care recipient will have or an individual full Carer Support Plan developed collaboratively with them (see attached Carer Support Plan).

The client and their representative/support person will be encouraged to actively participate in the assessment process and to express their preferences for how their support needs, including any special needs, may best be met.

Home Safety Assessment

During the initial phone assessment, the phone home safety checklist will be completed with the referrer, the initial phone safety assessment is designed to indicate issues that the worker needs to be aware of prior to the first home visit when the full Home Safety Assessment will be undertaken (see attached the phone home safety checklist and the home safety & risk assessment form). The full home safety and risk management assessment will be undertaken by the relevant Service Coordinator at the initial home visit and face to face assessment for each client. If hazards or safety issues are identified in the home environment which require some improvement actions to protect both the safety of the client and care staff, the problem and possible solutions will be discussed with the client.

Where a safety hazard is identified, a risk assessment using the Risk Assessment Guide is utilised and a Risk Management plan developed and noted on the home safety assessment form and the clients care plan.

No action may be taken to minimise risk from identified hazards without the client's agreement. Blue Mountains Community Support Program reserves the right to refuse services to a client if the environment is considered unsafe for our staff as this represents a breach in our Duty of Care to the workers.

Development of the Client Care Plan

From all the information gathered during the assessment processes, an individual *Client Care Plan* is to be developed by the relevant Service Coordinator, in consultation with the client and his/her chosen representative or support person, to address the clients identified care & support needs. The *Client Care Plan* will document any special needs, record the agreed risk management plans to address any issues of concern, acknowledge and document any agreed carer support strategies, and articulate the client's personal goals for maintaining his/her independence and quality of life.

To support goal attainment for the client, the agreed *care Plan* will explain the client's desired outcome from the service intervention, exactly what type of support will be provided and how frequently, how progress will be measured, and how frequently the care plan will be reviewed. The *Client Care Plan* is to be signed by the client or his/her representative as confirmation of his/her agreement.

A copy of the individual *Client Care Plan* is to be provided to each client as an attachment to their Blue Mountains Community Support Program Service *Client Agreement.* The *Client Agreement* has been designed as a generic information support tool, with relevance for clients of all Blue Mountains Community Support Program. On acceptance of the agreement, all clients are to sign the Declaration of Acceptance of the conditions.

Should the offer of a copy of the *Client Care Plan* and *Client Agreement* be refused by the client (for example if the client is homeless or at risk of homelessness), the date of offer and refusal is to be recorded on both the care plan document and the agreement, adjacent to the signed confirmation.

Development of the Carer Support Plan

It is acknowledged that for many clients, their capacity to remain living at home is directly related to level of informal support able to be provided by the primary family carer, and the carer's capacity to maintain a safe and supportive environment.

As a standard procedure during each client assessment, the Assessing Officer/Program Manager will discuss the carer's personal support needs with the primary carer, and collaboratively plan an appropriate range of carer support strategies, which will be documented on the *Client Care Plan.*

Where the carer requires a more comprehensive level of support due to high stress, physical or emotional exhaustion or failing personal health (or a combination of these stressors arising from the intensity of the caring role), longer term and/or more intensive interventions for carer support may be appropriate. In these circumstances, the Assessing Officer/Program Manager is to document the agreed plan for supporting the carer, using the *Carer Support Plan* form.

Consideration of the primary carer's psycho-social and physical support needs is integral to the safety and wellbeing of the client. Where identified risk factors combine to constitute a potential risk of harm, the procedures specified in the individual neighbourhood Centres Workplace Safety Policy are to be followed.

Non-response by Clients to a Scheduled Visit

All clients living alone are to be considered vulnerable. The *Client Care Plan* will document the Risk Assessment, and the Plan to Manage Risk. The *Client Care Plan* is to be attached to the *Client Agreement.*

When a client does not respond to a scheduled visit, the volunteer will:

- Note the date and time,
- Contact the Coordinator /Neighbourhood Centre to inform them,

The Coordinator will:

- Attempt to contact the client,
- Contact the noted Next of kin,
- In some instances contact the police to gain entry to the home

Monitoring and Review

Once registered as a Blue Mountains Community Support Program client, the Coordinator is responsible for ensuring a formal reassessment of the client's needs is undertaken twice a year.

Depending on the level and complexity of the client's needs, formal re-assessments may be scheduled more frequently, such as three-monthly. Reassessment can occur at any time as the client and or carers needs change

The specified timeline for each formal care plan review will be documented on the individual Client Care Plan.

Subcontractors providing direct client support are responsible for continually monitoring the client's progress and for reporting any changes in health status or support needs to the relevant Coordinator. Services may be modified or changed in response to this informal monitoring, and may lead to a formal assessment review.

Informal Rrviews of ongoing service provision are conducted by the Coordinator in the form of phone contact with the client, carer and volunteer, and with the volunteers through regular administrative contact.

It is recognised that different options should be offered to clients/carers and their advocates to encourage feedback on whether the service is meeting the clients/carers' needs and enable them to be actively involved in decisions made about changes to their service provision. Some informal options undertaken by BMCSP include the following:

1.1 The BMCSP Coordinator maintains regular contact with clients either over the phone or through home visits. The BMCSP Co-ordinator will check the following:

- If the needs of the client are changing;

- If the client needs to be referred to other services;
- If the service BMCSP is providing is suitable and relevant for the client;
- If the arrangement made between the client and subcontracting agency is satisfactory;
- If the day and time the service is provided is still convenient.

Any requests for changes and follow up actions are to be noted in the client's file.

1.2 The BMCSP Coordinator maintains regular contact with contracted service providers and volunteers where appropriate to obtain feedback on the agreed visiting arrangements,alerting the Co-ordinator to the need for changes to the service, or to any risks or issues in relation to the clients' situation. This information is also recorded in the client's file. Where a concern is identified, the BMCSP Co-ordinator will contact the client directly to follow up the issue or to reassess the client.

1.3 If a service provider, contractor or receive complaints about the service from a client/carer or advocate they should contact the BMCSP Co-ordinator and notify them of the nature of the complaint. Theycan provide the client with information about making a complaint to the service. The process will follow the relevant individual Neighbourhood Centres procedure

1.4 Information is provided to the client/carer and family through service literature, which provides updates on BMCSP and information about other services available. The information also offers an opportunity for client/carer input and this is encouraged and supported by the BMCSP Co-ordinator.

1.5 The BMCSP Coordinator consults with other agencies that are involved in the client's care.

Formal review of ongoing service provision

BMCSP facilitates a bi annual review of the service provided to every client. This review involves the client/carer, advocate (where relevant) and BMCSP Co-ordinator:

- Revisiting the initial assessment process to determine any changes to the client needs or situation. Where appropriate, a referral to other service e.g. ACAT for a re-assessment may be relevant;
- Reviewing the Client Care Plan and the Client Agreement to see if arrangements are still meeting the clients/carers needs;
- Reviewing input received from the volunteer in terms of the client's needs and the Client Agreement;
- Discussing various options to meet the needs of the client and reaching an agreement on any changes required to service provision.

2.2 Organisation of the review includes the following processes:

- At the time of initial assessment and the development of the Client Care Plan, the BMCSP Co-ordinator provides details on the bi annual review process;
- A few weeks prior to the anticipated review date, the BMCSP Co-ordinator contacts the client to organise a review time, date and venue, that is convenient for the client/carer and advocate.
- The review process and agreed outcomes are documented in an updated Care Plan. Copies are given to the client/carer and advocate and a copy is held in the client's file

Client Survey

On an annual basis, a client satisfaction survey is either sent out to clients, carers, or conducted with the client over the phone. The process may differ between Neighbourhood Centres.

Service provision may also be reviewed by each participating Neighbourhood Centre using their internal procedures for periodic reporting to management and the governing board.

Reinforcement of Client Rights and Responsibilities

During each formal assessment review, the client is to be reminded again of his/her rights and responsibilities and of the range of services available. The Client Information Checklist can be completed to ensure that the client understands the process sand outcomes of review, and then retained in the client file.

Particular attention is to be given to ensuring clients understand and are encouraged to exercise their rights in relation to:

- Receiving a quality service
- Autonomy and choice in decision-making
- Protection of their confidentiality and privacy
- Access to information held about them
- Processes for raising a complaint
- Nominating an advocate

Care Coordination and Delivery

Client Services Policy #001.4

1.0 POLICY STATEMENT

This policy establishes operation guidelines to ensure that each client of Blue Mountains Community Support Program receives coordinated and reliable services that respect their individual rights, are responsive to the client's specific needs and preferences, and are delivered in a way that promotes and encourages maximum independence, participation and community integration. Services and programs both within and external to the organisation are coordinated to facilitate a seamless delivery of cross-disciplinary services and community supports.

2.0 SCOPE

This policy is to be applied across the social support services of Blue Mountains Community Support Program.

3.0 DEFINITIONS

Coordination is defined as delivery of services in a harmonious and seamless combination.

4.0 PHILOSOPHY

Our primary focus is on achieving positive client outcomes, consistent with the Blue Mountains Neighbourhood Centre's Quality Objectives. It is therefore a strategic priority for us to ensure services are coordinated across the scope of the community care continuum and across the breadth of available community supports to accrue maximum individual benefit and quality of life outcomes.

5.0 PROCEDURES

Coordination of Care

In situations where there is a requirement for Case Management due to the complex needs of the client, the client will be referred to the appropriate agency able to undertake ongoing case management. In coordinating care, and where case management is required by a "Primary agency" the following procedures will be implemented, if not already done so by another agency:

- The BMCSP Co-ordinator will identify the services to be provided by BMCSP;
- The BMCSP Co-ordinator will identify other agencies already providing services, or which may need to provide services to the client;
- The BMCSP Co-ordinator will identify referrals that need to be made to other services;
- With the permission of the client, the BMCSP Co-ordinator will contact the agencies identified above to discuss a Client Care Plan;
- All services involved will identify which agency is the principal service provider;

- Permission will be sought from the client/carer and advocate from the principal service provider to take on the role of case manager;
- The principal service provider will take responsibility for discussing the Client Care Plan with the client/carer and advocate, negotiating any changes required and gaining the acceptance of the plan by the client;
- Client Care Plans should be reviewed at least every twelve months at a meeting convened by the principal service provider;
- The BMCSP Co-ordinator will discuss any change to the level of service provided to a client with the principal service provider;
- Details of the Key Worker and principal service provider who is undertaking the Case Management role will be noted on the Client's file.

Interagency Cooperation and Collaboration

Coordination of care in collaboration with external service providers may be required in order to develop effective responses for clients with complex care needs, for example, arranging required mobility equipment/aids, supplies of continence aids, home modifications to maintain safety and/or independence, home delivered meals, or personal emergency alarms. Staff are expected to utilise the resources and range of services available across the region to plan, coordinate and implement care plans that achieve positive client outcomes.

Where applicable and with the client's consent, staff are to cooperate with external agencies in joint assessment activities (for example, with bi-lingual workers, occupational therapists conducting home modification assessments), sharing of referral data sheets and assessment records between other agencies involved in the client's care, and participation in case management meetings.

Blue Mountains Community Support Program staff are expected to establish and nurture close collaborative relationships with other providers across our region to contribute to a more effective use of resources and to avoid unnecessary and inefficient duplication of services. We acknowledge these relationships are consolidated through participation in interagency group meetings, special interest groups, and regional planning forums. It is expected staff will give priority to attendance at these networks to share information and develop collaborative working relationships.

Relationship with Blue Mountains Community Support Program Service

As part of the CHSP Funding Agreement, Blue Mountains Community Support Program service (BMCSP) is committed to work in co-ordination with other CHSP social support services in the Blue Mountains local government area. In particular, each individual BMCSP will consult and work together across the group of social support services operating out of and auspiced by 5 Neighbourhood Centre's in the Blue Mountains including:-

- Katoomba Neighbourhood Centre

- Blackheath Area Neighbourhood Centre
- Mid Mountains Neighbourhood Centre
- Springwood Neighbourhood Centre
- Lower Mountains Neighbourhood Centre.

BMCSP services believe that by working collaboratively, the best outcomes for clients and carers can be achieved in the Blue Mountains, including:

- Clearly defined service delivery catchment areas within the Blue Mountains local government area for each service,
- Prompt and timely referrals across services,
- Sharing of knowledge and skills,
- Shared volunteer training and support for volunteers,
- Improved planning and evaluation processes particularly taking into account special needs groups in the Blue Mountains,
- Cost and time effective promotion and publicity for the service,

PROCEDURES

BMCSP will work in the following ways to achieve positive outcomes for clients and their carers in the Blue Mountains.

1. The BMCSP Coordinator plays an active part in the Blue Mountains Community Care Interagency attending all monthly meetings as standing members
2. The BMCSP Coordinator attends quarterly meetings as a standing member of Blue Mountains City Council Squalor and Hoarding Committee

Brokerage and Outsourcing

Where a Blue Mountains Community Support Program' Coordinator believes it to be in the best interests of an individual client to enlist the support of another service provider to address a client's special needs, we assert our right to establish brokerage arrangements with that provider to deliver services on our behalf (for example, for provision of a bi-lingual, bi-cultural care worker). This strategy is designed to strengthen our service delivery capacity in provision of individually responsive and flexible services. Similarly, where a particular qualification, competency and skills set exist within our own staff team, their services may be brokered to other providers to enhance their service options in delivering an optimum client outcome.

Formal agreements are to be entered into for all brokerage situations to provide confidence in the delivery of continuous, sustainable, high quality services. Individual service agreements or contracts will be developed for each brokerage agency covering the

period of brokerage or service provision, as per the policy of the individual neighbourhood Centre or a program's Lead Agency (e.g. Katoomba Neighbourhood Centre for the Blue Mountains CHSP program). A brokerage service agreement will clearly state the expected deliverables in relation to the type and frequency of service and anticipated quality of output, agreed payment arrangements, responsibilities of each party, review mechanisms, and processes for dispute resolution.

Where a service or part of a service is outsourced to a third party, it is the responsibility of the respective Coordinator to ensure that the product or service provided by the third party is monitored and evaluated against specified quality criteria (for example, through use of the *Training Evaluation* form to assess participant satisfaction).

Principles of Service Delivery

Blue Mountains Community Support Program provides only domestic assistance, social support and transport services and does not provide medical or health services. For clients with complex care needs, where support is not already in place referral processes to appropriate services are followed. Gaps and issues relating to special needs groups are discussed at CHSP (also referred to as Community Care) Forum meetings, and at Service Co-ordinators' meetings.

Blue Mountains Community Support Program is committed to the on-going professional development and training of staff and volunteers as well as providing high quality services through professional subcontractors to ensure an appropriate range and level of skills and competencies in delivering planned services (refer to Human Resource Management Policy #002.4 *Strategic Performance Management* for further information). The Coordinator is responsible for ensuring relevant subcontracted care workers are kept informed of care plan changes or modifications in response to progression in goal attainment or changing health status. Subcontractors are responsible for immediately notifying the Coordinator of any client concerns or changes in health status (refer to Information Policy #006.1 *Internal Communications* for further information). Wherever possible and with the consent of the client or their delegate, subcontractor staff and partner agency staff involved in a client's care will be given access to the KNC cloud based client documentation system to update the client's file and calendar with their interactions or observations, and to be able to see changes in care plans, stated client goals and relevant aspects of the clients care.

The social and emotional needs of clients are also taken into account in care planning and delivery. Within the capacity of Blue Mountains Community Support Program to deliver support, clients are to be encouraged and assisted to maintain their preferred community involvements and personal social networks, to enable an optimal level of independence, community participation and integration. We acknowledge each client as an individual, and care planning and delivery processes are to be as flexible and responsive as possible to individual needs and circumstances. The coordination of service delivery activities is directed towards achieving this goal.

Client Assistance in Exercising their Rights

All staff and volunteers of Blue Mountains Community Support Program are expected to acknowledge the rights of each individual client and to support him/her in exercising those rights. Staff and volunteers will be provided with information on client rights and responsibilities during their induction program. This is a mandatory training requirement. The induction program includes familiarisation with all operational policies, and each member's responsibility to understand and comply with documented procedures. All staff are required to sign an *Induction Checklist* to verify completion of the induction program and their acceptance and understanding of the information provided.

Clients of Blue Mountains Community Support Program services will be assisted by staff in exercising their right to:

- Decline an offer of service without penalty
- Be treated with dignity and respect
- Have their individual customs, culture and religious beliefs respected without discrimination or prejudice
- Have a support person or advocate of their choice present during any care-related discussions
- Have their personal information, and/or their personal images or photographs protected in accordance with our legal obligations to them, and only released with their written consent
- Request access to any personal information we hold about them
- Make a complaint without fear of retribution.

We acknowledge that with rights come reciprocal obligations which may impact on the rights of others. Staff and volunteers will ensure clients are informed of their responsibility to:

- Treat staff and other clients of Blue Mountains Community Support Program with respect and courtesy
- Provide a safe work environment for care workers coming into the client's home
- Accept responsibility for the results of any decisions or choices they make in relation to the care and support they receive.

Client Records

The Coordinator is responsible for ensuring that a new client file is established within five working days of the initial home visit. The standard data collection is to include a complete record of referrals, assessed priority rating scale, completed assessment tools, safety checklists and risk management plans, signed care plan and agreement that reflects the clients individual goals of care, signed consent form, client profile and entry data, emergency contacts and next of kin details, and signed information checklist.

Where relevant, a copy of the *Carer Support Plan* and *Notification of an Advocate or Support Person* is also to be included in the client file, as well as other applicable records *Feedback Forms* submitted by the client. Progress reports and/or instructions from external agencies (for example, from ACAT) are to be included in the relevant section in the client's file.

The Coordinator is responsible for ensuring client file updates of progress notes, formal review documentation, and outcome assessments are promptly recorded in the client file.

Please note the client file can be either hard copy or electronic cloud based. All client documentation systems and processes will meet required legislative and funder requirements around privacy and confidentiality.

Progress Notes

The progress notes are to document the individual client's progression in reaching his/her personal goals and/or changing care and support strategies to enable goal attainment, and results of care plan monitoring processes. All entries are to be dated, clearly legible, and include the designated position title and signature (including digital signature) of the staff member making the record entry.

The Coordinator involved in the individual client's care is required to record details of the client's progress and changes on a regular basis in the progress notes. As stated in client records, progress notes can be in hard copy contained within a hard copy client file or electronic and noted within the KNC cloud based PNYX system in the notes section or recorded against a scheduled calendar activity/visit.

Complaints and Feedback

Client Services Policy #001.5

1.0 POLICY STATEMENT

The purpose of this policy is to establish an effective and consistently applied framework for the management of complaints and feedback so that Blue Mountains Community Support Program services, activities, systems and processes can be continuously improved. Underpinning our Complaints and Feedback Policy and our procedures for resolution are principles of natural justice, and we support the right of clients and stakeholders to equal and fair treatment, to protection of confidentiality, to promptness of response, and to access to advocacy support.

2.0 SCOPE

This policy is to be followed by staff for all feedback, complaints or concerns received in relation to the provision of Blue Mountains Community Support Program services.

3.0 PHILOSOPHY

Our organisational values confirm our commitment to quality in client services. Quality is ultimately determined by the client, and it is therefore critical that we encourage feedback from clients, and that the information received is linked into action planning cycles for continuous improvement. Any complaints, concerns or suggestions regarding the planning and operation of our service will therefore be welcomed as opportunities for improvement.

4.0 PROCEDURES

Informing Clients

On entry to the service all clients are presented with an information package that includes a copy of the "Tell Us What You Think" *Feedback Form.* Clients and their representatives are advised that if they should need assistance in completing the form, such assistance will be provided. The processes for raising a complaint, and those for accessing external complaints resolution support mechanisms, are explained in the *Client Agreement and Conditions of Service Handbook.* Clients are informed of their right to access and be supported by an independent advocate of their choice to assist them through the complaints process. Reminders of our complaints process are given at each formal review meeting.

Clients are required to sign and date the the client agreement to confirm their understanding and acceptance of the information provided within the client handbook including information on their rights and responsibilities, including the right to make a complaint without fear of retribution, and to expect a fair and just resolution to their problem.

Encouraging Feedback

All input from clients and stakeholders is valued, and we aim to remain open to positive change and development. Our quality commitment is verbally explained to clients on entry to any Blue Mountains Community Support Program service, and is reinforced in writing in the *Client Agreement.* Clients are to be encouraged to raise any concerns or complaints if they are dissatisfied with any areas of service delivery. They are to be reassured that all complaints or concerns raised will be dealt with in a fair, prompt and confidential manner, and will not result in discriminatory treatment or retributive action toward them. Clients are to be assured that by raising their concerns or complaints they will be making a positive contribution towards assisting us improve services for themselves and others.

Processes for Raising a Complaint or Concern

Client/carer feedback is obtained both formally through bi-annual service reviews and surveys and informally on an ongoing basis to ensure accessibility and relevance of service provision. Feedback is also obtained from volunteers through an annual review process and informally at support meetings and individual phone calls. The feedback obtained from these processes will inform BMCSP Planning. Clients, carers and volunteers are also invited to participate in BMCSP Planning, Neighbourhood Centre Annual General Meetings and representatives are invited to become members of relevant BMCSP's Service Advisory Group(s).

Clients are given a copy of the KNC Complaints resolution flow chart outlining mechanisms for making a complaint on admission to the service. A client can raise a complaint or concern in writing or verbally with a staff member or volunteer by phone or in person. In this instance a verbal complaints form will be completed and forwarded to the relevant staff member for follow up and investigation according the policy and procedure of the relevant Neighbourhood Centre. All complaints are taken seriously and investigated with documentation outlining the process of investigation and resolution strategies completed (see KNC Complaints Handling Policy & Procedure within the Human Resources Manual) Issues can also be raised by clients using the "Tell Us What You Think" form given to clients on admission.

Registering Complaints

All complaints received are to be documented in the relevant Neighbourhood Centre's *Complaints Register.* The staff member receiving the complaint is responsible for ensuring the initial entry has been made.

Anticipated Response Timeliness

Complaints received are expected to be dealt with promptly. A response to the complaint is to be initiated within two working days of its receipt. It is anticipated that the majority of complaints will be able to be resolved to the complainant's satisfaction within 30 days of the complaint being raised.