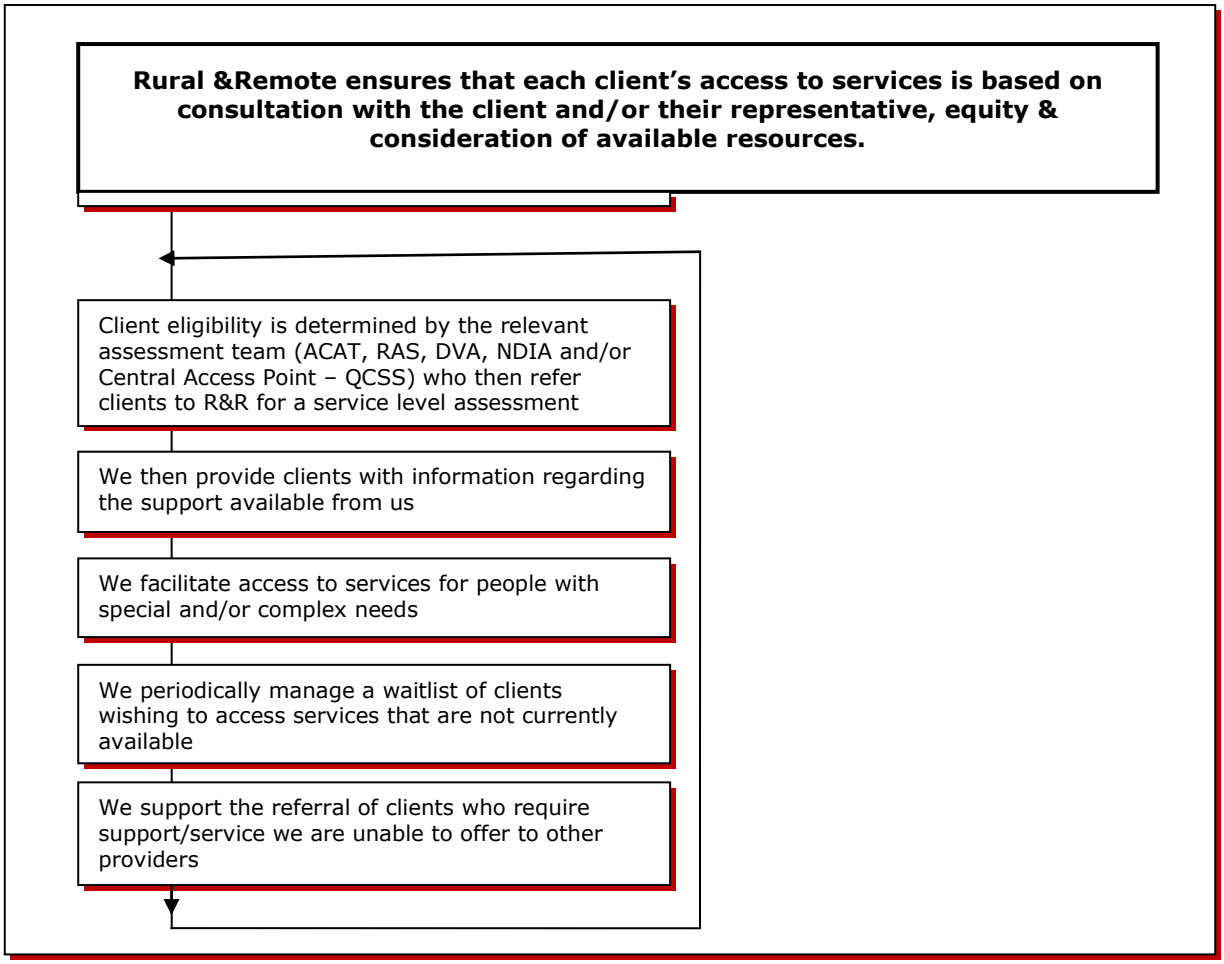
SERVICE ACCESS



FORMS AND RECORDS

Client Assessment/Reassessment	Client files – shared drive
Home Safety Checklist	Client files
Deciding Priorities for Assistance	Client files
Deciding Priorities for Respite Care	Client files
Client Records	Information Management System and client files
Client Spreadsheet/s & Reports	Shared Drive – Information Management System RnR
Funding Body Service Agreements	Shared Drive

9.1 Accessing Services

Client access to support/care delivery is underpinned by and incorporates the following considerations, in particular those outlined in **Standard 1 & 2 and 5.1 of the Aged Care Quality Standards:**

- ***Each client is treated with dignity and respect – with their identity, culture and diversity valued***
- ***Care and services provided, are culturally safe and appropriate***
- ***Each client is supported to exercise choice and independence, including to – make decisions about their own care and the way such care and services are delivered; make decisions about when family, friends, carers or others should be involved in their care, and; communicate their decisions, and; make connections with others and maintain relationships of choice, including intimate relationships***
- ***Each client is supported to take risks to enable them to live the best life they can (Dignity of Risk) See Section 11 – Support Planning and Delivery.***
- ***Information provided to each client is current, accurate and timely, and communicated in a way that is clear, easy to understand and enables them to exercise choice***
- ***Each client's privacy is respected and personal information kept confidential***
- ***Assessment and planning, including consideration of risks to the consumer's health and wellbeing, informs the delivery of safe and effective care and services***
- ***Assessment and planning identifies and addresses the client's current needs, goals and preferences, including advance care planning and end of life planning if the client wishes***
- ***Assessment, planning and review is based on an ongoing partnership with the client and others that the client wishes to involve, and includes other organisations and individuals/providers of other care and services that are involved in the care of the client***
- ***The outcomes of assessment and planning (including any identified risks and mitigation strategies) are effectively communicated to the client and documented in a care/support plan that is readily available to the client, and***
- ***Care and services are reviewed regularly for effectiveness, and when circumstances change or when incidents impact on the needs, goals or preferences of the client.***
- ***The service environment is welcoming and easy to understand, and optimises each client's sense of belonging, independence, interaction and function.***

Clients are referred by the relevant assessment agency. Any referrals from other sources, including the potential client/carer, their doctor, other health professionals, family members or people in the community are sent to the relevant authority who then determines eligibility.

Where possible, priority is given to those people most in need (see 9.2.2: Prioritising Need). Referrals may be generated and/or received via telephone, fax, email, face-to-face or via the DVA, PRODA, Community Access Point or MAC (My Aged Care) portal.

Clients and carers are not excluded from access to the service on the grounds of their gender, marital status, religious or cultural beliefs, political affiliation, particular disability, ethnic background, age, sexual preference or identity, inability to pay, geographical location or circumstances of the carer.

9.1.1 CLIENT INVOLVEMENT

Clients (and/or their representatives) are consulted about the services that they need after we have received the referral, during the service level assessment and support planning process.

9.1.2 REFERRALS TO OTHER AGENCIES

All services for clients are reviewed and monitored on an ongoing basis to ensure they are appropriate and effective. Where necessary, clients are referred to an Assessing Agency (for a formal review) or other providers. This process is described in Section 13: Client Referral.

R&R provides information regarding other local community care services to clients as needed and will provide relevant brochures.

9.1.3 SAFE ENVIRONMENT

The organisation and staff of R&R ensure that all services are provided in a safe environment in line with Workplace Health and Safety requirements and our duty of care to clients, staff and volunteers. This can be challenging to achieve in some instances, depending on the nature and type of home environment. In these cases, staff members are made aware of the need to ensure the safety of the client and themselves and remedial action is taken to reduce risk to all parties.

The Cluster Team Leader completes a Home Safety Checklist at the clients home prior to the service commencing, if the client moves to a new location or if a staff member has noted that conditions have changed. In addition, staff have access to an Incident report to record accidents or incidents. A Hazard Report is used to record workplace health and safety hazards in client homes, which are then actioned by the RnR Team Leader or Program Manager.

Should an unsafe environment be evident, staff contact their Cluster Team Leader for advice and assistance and should endeavour to control the risk until further action can be taken.

See also 5.2 Continuous Improvement Forms for details on processing the forms.

9.2 Eligibility and Access to Services

9.2.1 SUMMARY OF ELIGIBILTY CRITERIA FOR FUNDED PROGRAMS

R&R provides services to a range of clients and carers funded by the Department of Health, Department of Communities, Disability Services and Seniors, National Disability Insurance Scheme &Veterans Home Care Programmes in Croydon, Etheridge and Mareeba shires and the current Rural & Remote areas of the Tableland Regional Council.

The following eligibility criteria apply:

CHSP (Commonwealth Home Support Program)

The Commonwealth Home Support Program provides basic services and maintenance services to frail aged people, younger people with disabilities and their carers to assist them to continue living independently at home. This includes:

- Support to participate in social activity in a group or one-on-one
- Assistance with everyday household tasks
- Assistance to enhance nutrition, function, strength, independence and safety
- Assistance to support independence in personal care activities such as showering and dressing
- Assistance to keep up with essential activities such as shopping, banking and maintaining social contacts.[1]
- Lawn mowing
- Meals from cafes or hotels where no Meals on Wheels exist
- In home respite and Centre based day respite.

To be eligible for CHSP you are:

- Over 65 years of age, or over 50 years of age and of Aboriginal and/or Torres Strait Islander descent
- Living in the community and have an ongoing functional disability that impacts on your capacity to live independently or
- Be a carer of an eligible person.

[1] http://www.livinglongerlivingbetter.gov.au/

NOTE: Eligibility for access to QCSS, NDIS and DVA funded services are determined by their relevant assessment agencies, who have responsibility for prescribing the level of care to be provided. All R&R service level access and assessment documentation and procedures reflect the relevant service agreement requirements pertinent to each funding type.

9.2.2 PRIORITISING NEED

When deciding priorities for clients the following factors are considered

- Does the home appear environmentally unsafe?
- Is family support at risk of breaking down?
- Does the client need ongoing medical or nursing help?
- Does the client live alone, or with a carer who is also frail aged or has a disability?
- Does the service user experience difficulty with a range of daily living tasks?
- Is the client geographically isolated?
- Is the client socially isolated?

When deciding priorities for respite care (or carers needs) the following are considered

- Is the carer caring for a person with a disability?
- Is the carer a sole carer, has poor support networks or has dependent children?
- Is the carer frail, ill, stressed or has a disability?
- Does the carer have extensive commitments, which may stop them providing care?
- Is the carer socially or geographically isolated?

9.2.3 ASSESSING ELIGIBILITY

All our referrals are assessed by the relevant assessment agency, to ascertain their eligibility.

This process is further described in Section 10: Assessment.

9.2.4 RECORDING CLIENT WAITLIST AND REFUSALS

Records are maintained re: waitlisted clients, client refusals of service, refusal to provide services by the organisation (and reason), and other relevant statistics used for planning purposes. The Program Manager is responsible for maintaining and/or overseeing the maintenance of these records.

The waitlist is maintained and reviewed each month, and clients are advised of their position on the waitlist as it is updated via telephone and a formal letter.

9.3 Clients with Special Needs

9.3.1 AAC – AUGMENTATIVE AND ALTERNATIVE COMMUNICATION STRATEGIES

AAC refers to other methods of communication people may use when they have difficulty speaking. AAC can assist clients to express their needs, hopes and ideas and to connect with their family, friends and the broader community.

AAC may be used to assist a client to understand what is being said to them and/or to help a person express what they wish to say. AAC strategies and/or systems may be *aided or unaided, electronic or non-electronic.*

AAC Strategies/Systems may include but are not limited to:

- Body movements, facial expressions and gestures – common signals recognised by people may include waving, pointing, shaking hands
- Signs – this may involve use of *key word sign* which uses a combination of manual signs and speech
- Body sign – modified or individualised signs are performed onto the hands or other agreed body part for clients who are both sight and hearing impaired
- Touch cues – the use of contacts to the body (such as a tap on the elbow or a firm hold on the shoulder) to assist clients to understand and anticipate actions or activities
- Picture and/or communication books – a compilation of personalised symbols, cues, likes, dislikes etc used to communicate on a range of topics or issues.
- Voice amplifiers, speech generating devices, communication software and apps.

Clients who may require inclusion of AAC strategies or systems as a part of their care/support plan, will have this noted in the service level client assessment/reassessment process.

The subsequent client support/care plan will reflect the specific requirements regarding the agreed AAC strategies or systems to be utilised. These will be noted in detail and provided to both the client/carer and the home care support worker to ensure all parties are clear in relation to the strategies or systems for communication.

Depending on the complexity of the required supports, this information may either be included in the generic **Client Support Plan** or the **Complex Care Support Plan.**

Where AAC strategies/systems are in place, the relevant CTL (cluster team leader) will conduct a home visit during a scheduled service time, to monitor and review the effectiveness of the AAC systems implemented. This visit will occur one month after the service has commenced.

At this point, the client support/care plan may be amended or adapted to better meet the individual needs of the client. Home care support workers are also required to complete client progress notes following each scheduled visit and provide these to their CTL to inform the monitoring and review process. Any barriers to implementation and suggestions for improvement are to be included in the review process and subsequent amended documentation.

9.3.2 ABORIGINAL AND TORRES STRAIT ISLANDER CLIENTS

R&R endeavours to provide Aboriginal and Torres Strait Islander clients with culturally appropriate services, and where possible, services are delivered by Aboriginal and/or Torres Strait Islander staff. R&R works closely with relevant local agencies e.g. Yabu Mija, to ensure that services are culturally appropriate and clients are supported whilst accessing and receiving support.
The relevant Cluster Team Leader ensures that the information regarding the service plan and services is clearly explained and understood by the client and their family.

9.3.3 PEOPLE WHO DO NOT SPEAK ENGLISH

If a person does not speak English an interpreter is used. If the person has a family member with them, they are used as the interpreter if this is acceptable to the client. Other options for interpreter services include a staff person (who speaks both languages) or the Telephone Interpreter Service. R&R regularly provides support to Italian clients and we provide them with our client handbook in Italian.

9.3.4 CLIENTS WHO DO NOT READ OR WRITE

In cases where the client does not read or write, the Cluster Team Leader makes sure that the information in the Client Handbook, and information regarding the assessment, reviews, service plans and services is clearly explained and understood by the client and/or their carer.

9.3.5 CLIENTS WITH DEMENTIA AND OTHER SPECIAL NEEDS GROUPS

When necessary, the RnR Team Leader/Cluster Team Leader identifies the need for support for clients with dementia or other special needs groups, such as those with disability or specific care needs. R&R provides training for relevant staff in how to work with people with dementia or

people with disability or specific care needs. R&R makes every effort to ensure that services are delivered in an appropriate and sensitive way to all people, and in particular, to people with dementia and other special needs.
Rural and/or remotely located clients are our priority target group & have priority in accessing services over other areas we service that do have access to other service providers.

Client/carer verbal consent is always noted on the relevant service level documentation.

9.4 Team Communication

9.4.1 TEAM MEETINGS

The Program Manager, RnR Team Leader and Cluster Team Leaders at R&R have ongoing informal discussions regarding client needs and there are regular formal meetings (every 2 months) to discuss organisational operational issues. Feedback from home care support workers about their clients is encouraged, in particular when there is a change in client health, functional capacity or circumstances.

Home care support worker feedback is formally documented via client progress notes and retained in the client file and in the information management system.

Clients may decide to cease their services or may require referral to another provider, if needs change or if R&R is unable to provide services.

If a client chooses to cease service delivery or R&R services are unable to be delivered the RnR Team Leader and/or relevant Cluster Team Leader ensures that:

- Clients and their representative/s are assisted to seek other care options (if appropriate)
- Clients are provided with ongoing support and information during the transition
- Actions taken to assist the client are documented in their client records.

9.4.3 CLIENTS WHO DO NOT RESPOND TO A SCHEDULED VISIT[2]

See 11.2.4: Action in the Event of a Client not responding to a scheduled visit.

9.5 Termination, Withdrawal or Change of Services

Services may be terminated, withdrawn or changed by R&R in the following circumstances:

- Workplace health and safety risk to staff/volunteers that can't be rectified
- Inappropriate client behaviour
- Change in client circumstances that influence eligibility
- The agency ceases to deliver the service.
- To temporarily stop a service if a client is of assessed low need, and if someone of much higher need is waiting for services to begin.

Each of these circumstances is discussed in detail below.

9.5.1 WORKPLACE HEALTH AND SAFETY RISK TO STAFF/VOLUNTEERS

A workplace health and safety risk can arise from a variety of factors including dangerous access to a person's house or dangers inside the house or home environment. These are identified through a Home Safety Checklist conducted when a client is first accepted for services, when reviews are carried out, a client changes location or when staff report a danger to their Cluster Team Leader. Examples of these WH&S risk issues could include:

- Dangerous steps, verandahs, internal flooring

[2] The organisation uses the *Guide for community care service providers on how to respond when a community care client does not respond to a scheduled visit* (Department of Health and Ageing 2009) as a reference.

- Faulty electrical wiring
- Dangerous buildings
- Dangerous dogs
- Smoking in the immediate vicinity of staff.

Where a WH&S risk is identified the RnR Team Leader/Cluster Team Leader works with the client/carer or family to remove or reduce the risk to an acceptable level. If this cannot be achieved through reasonable means the Program Manager can decide to cease the provision of services to the client, where staff are at risk, until appropriate remedial or risk mitigation strategies have been satisfactorily completed.

All consultation, discussions and actions are documented in the client record.

9.5.2 INAPPROPRIATE CLIENT BEHAVIOUR

Inappropriate client behaviour includes any behaviour that causes staff to feel that their safety is compromised. This can include direct physical actions or threats, verbal abuse, sexual suggestions, wilful exposure and foul language. This includes clients under the influence of alcohol or drugs.

If inappropriate client behaviour occurs, staff must immediately leave the clients home and report the behaviour to their Cluster Team Leader verbally, complete an Incident Report and provide it to the Program Manager.

The Cluster Team Leader/RnR Team Leader and Program Manager assess the client behaviour. If it is found inappropriate the RnR Team Leader/Program Manager discusses this with the client/carer and/or family and attempts to find a solution to ensure it does not occur again.

If inappropriate client behaviour continues after reasonable attempts to curb it, the Program Manager can decide to cease the provision of services.

NOTE: Please also refer to Section 14.6 and 14.7

9.5.3 CHANGE IN CLIENT CIRCUMSTANCES THAT INFLUENCE ELIGIBILITY

Where clients circumstances or condition changes to the degree that services are no longer required or appropriate, the Program Manager may decide to change or cease the provision of services to them.

For example, if a person receiving meals and transport due to hip problems has a hip replacement and regains full mobility they may no longer need the service. Where a person's general well-being increases to a point where they can undertake all aspects of daily living independently, their services may be withdrawn.

Any changes required are discussed fully with the client, and their carer if appropriate, and are fully documented in the client record.

9.5.4 THE AGENCY CEASES TO DELIVER SERVICES

If R&R ceases to deliver services, clients are given maximum notice possible (at least 1 months notice) that the services are ceasing, and they are provided with support to access other services, including referral or advocacy processes.

9.5.5 PROCESS FOR TERMINATION, WITHDRAWAL OR CHANGE OF SERVICES

If support to a client is terminated, withdrawn or changed the following process applies:

1. Give the client as much notice as possible with a minimum of 1 (one) month

2. Explain face to face to the client, and their carer/family if appropriate, why the services are being ceased or changed and any arrangements required for the client

3. Provide written notice and retain a copy in the client record

4. Attempt to find another agency to provide the required service and try to ensure services are provided without any break

5. If no other agencies are available identify other options in consultation with the client

6. Advise the client that they can appeal to the Program Manager, the decision to terminate, withdraw or change their services

7. Assist the client to contact an external advocacy agency if necessary e.g. ADA (Aged and Disability Advocacy)

8. Record all relevant information in the client records.

9.6 Monitoring Service Access Processes

Client processes and systems are regularly audited as part of the R&R audit program, and staff, clients and other stakeholders are encouraged to provide ongoing feedback on issues and areas where improvements can be made (see Corporate Calendar and Section 5: Continuous Improvement).